OCCUPATIONAL THERAPY GRADUATES' CONCEPTUALISATIONS OF OCCUPATIONAL JUSTICE IN COMMUNITY SERVICE PRACTICE IN SOUTH AFRICA: A UWC CASE STUDY.

LUCIA HESS-APRIL

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor Philosophiae in the Faculty of Education, University of the Western Cape

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Supervisor: Prof. Juliana Smith
Co-supervisor: Dr. Jo-Celene De Jongh

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Occupational therapy graduates' conceptualisations of occupational justice in community service practice in South Africa: a UWC case study.

Lucia Hess-April

KEYWORDS

Occupational therapy

Compulsory community service

Occupational justice

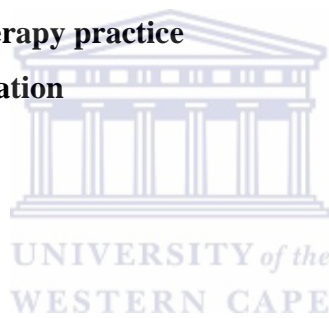**Occupational enablement**

Critical occupational therapy practice

Socially responsive education

Critical pedagogy

Political reasoning

Qualitative research

Case study

ABSTRACT

Occupational therapy graduates' conceptualisations of occupational justice in community service practice in South Africa: a UWC case study.

Lucia Hess-April

PhD thesis
Faculty of Education
University of the Western Cape

The purpose of this qualitative study was to identify ways in which the University of the Western Cape (UWC) occupational therapy (OT) curriculum could be developed to prepare its graduates to advance occupational justice in community service practice. The background to the study is the development of occupational therapy practice and education within a policy context of health reform that gave momentum to the shift in emphasis from a bio-medical to a more socio-political approach to health in South Africa.

Underpinning this study was the assumption that OT education informs professional practice and that uncovering new graduates' practice experiences can inform the development of the UWC OT curriculum. The aim of the study was to examine how UWC OT graduates conceptualised occupational justice and how it manifested in their daily practice of community service in three provinces in South Africa.

The study is framed within the theories of occupational justice and critical curriculum theory, in particular, critical pedagogy. A literature review pertaining to the application of occupational justice in OT practice and education is presented. This includes the background values that inform the practice of occupational justice, the application of occupational justice as it relates to OT practice and the relationship between OT education and occupational justice.

The research design that was adopted is that of a single, interpretive case study. Through purposive sampling seven occupational therapy graduates from UWC who graduated in 2009, and who practiced in under-resourced, rural community service settings in 2010, were selected to participate in the study. The methods of data collection that were utilised were participant observation, a reflective journal, semi-structured paired or dyadic interviews and document review.

The findings revealed that occupational justice held considerable value for the participants. They conceptualised occupational justice as enhanced health and well-being, and broader social change as an outcome of the facilitation of occupational enablement. The nature of their community service practice settings, however, posed several challenges for the participants. From the perspective of the participants, the dominance of the medical model, lack of resources and system of bureaucracy appeared to be the biggest challenges they encountered. While the participants' education was geared towards equipping them to provide appropriate services as indicated by local needs, the health system was not ready to accommodate their practice. Consequently, the participants appeared to encounter hegemony in practice. In encountering hegemony, however, they displayed an attitude of defeatism, leaving them with feelings of guilt, despondency and powerlessness. They lacked the skills to respond to power dynamics and to interact with people in positions of power.

The main conclusion drawn from the study findings is that for OT graduates to impact the contexts in which they practice in South Africa, OT education must ensure that students develop competence to deal with the complexities of community service practice. This implies that transformational learning as pedagogical practice is of the essence, as it frames student preparation not just as learning but as a process of critical reflexivity that equips them to respond to power dynamics and intervene in matters related to occupational justice as active agents of change.

The role and practice of occupational justice are subjects of debate in the context of OT education as they are for the profession broadly. This study contributed to this conversation through its examination of UWC OT graduates'

actual practice and the transmission of occupational justice-promoting practice through UWC OT education. The study highlighted that it is imperative that OT curricula in South Africa provide opportunities for students to engage in critical reflection on ways in which indigenous knowledge and a local understanding of occupational justice, as it relates to collective agency and critical consciousness, can be made more explicit in everyday practices. To this end, recommendations for the development of the UWC OT curriculum are made in respect of curriculum structure, content and approach; interdisciplinary education and practice, support for community service graduates and occupational therapy continued professional development.

November 2013

DECLARATION

I declare that *Occupational therapy graduates' conceptualisations of occupational justice in community service practice in South African: a UWC case study* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Lucia Hess-April   **November 2013**

Signed:..................................

ABBREVIATIONS AND ACRONYMS

ADL	Activities of Daily Living
APD	Association for the Physically Disabled
CAIPE	Centre for the Advancement of Interprofessional Education
CBOs	Community-based Organisations
CBR	Community-based Rehabilitation
CHC	Community Health Center
CP	Cerebral Palsy
CPD	Continuing Professional Development
CRFs	Community Rehabilitation Facilitators
CVA	Cerebrovascular Accident
DG	Disability Grant
DHS	District Health System
DPOs	Disabled People's Organisations
ECHD	Early Childhood Development
FAS	Fetal Alcohol Syndrome
HPCSA	Health Professions Council of South Arica
ILO	International Labour Organisation
INDS	Integrated National Disability Strategy
IOP	Institutional Operational Plan
I/V	Interview
LEO	Leadership in Enabling Occupation
MDT	Multi-disciplinary Team
NDP	National Development Plan
NHI	National Health Insurance
NGO	Non-governmental Organisations
OT	Occupational Therapy
OTs	Occupational Therapists
OTASA	Occupational Therapy Association of South Africa
P4C	Partnering for Change
pADL	Political Activities of Daily Living
PHC	Primary Health Care

POJF 2010	Participatory Occupational Justice Framework 2010
PWDs	Persons with Disabilities
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNESCO	United Nations Educational Scientific and Cultural Organisation
UWC	University of the Western Cape
W/C	Wheelchair
WFOT	World Federation of Occupational Therapy
WHO	World Health Organisation

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DEFINITIONS

Occupational Therapy is a client-centred health profession that is concerned with the promotion of health and well-being through occupation. Occupational therapists work with people and communities to enhance their ability to engage in the occupations they want to, need to or are expected to do, or by modifying their occupations or the environment to better support their occupational engagement (WFOT, 2012).

Occupation refers to the ordinary activities that people do on a daily basis and the way they use their time, energy, interests and skills in meeting their needs (Christiansen & Townsend, 2004). Occupation enables people to meet and obtain the requirements for living, health and well-being (Wilcock, 1998).

Occupational potential is the capacity that people hold to do what they are required to do, and to become who they have the potential to be (Wicks, 2005).

Occupational engagement refers to involvement in occupation and comprises interrelated variables including performance, motivation, interest, and well-being (Kielhofner , 2002).

Occupational needs refer to individuals' needs for expression of self-identity, culture, social connectedness, and fulfillment through occupational engagement (Townsend & Wilcock, 2004); including the need for accomplishment, affirmation, agency, coherence, companionship, pleasure, and renewal (Doble & Santha, 2008).

Well-being is a state of contentment or harmony with one's physical, mental, emotional and spiritual health; personal and economic security; self-worth, sense of belonging, opportunities for self-determination, and opportunities to engage in meaningful and purposeful occupations (Hammel & Iwama, 2012).

Occupational well-being is an experience of personal and social well-being that is derived from satisfaction in engagement in meaningful life occupations (Townsend & Polatajko, 2007).

Social injustice refers to conditions in society that limit meaningful participation, inhibit development, and deny equal opportunities for all people (Van Soest, 1992).

Social justice refers to economic, social and political equality between individuals and groups in a society where the basic needs of all individuals are met (Van Soest, 1992). Emphasis is placed on a fair distribution of resources and compensation for exclusion, discrimination or lack of opportunities that exist in society (Watson, 2004).

Occupational injustice occurs when social, economic, environmental, geographic, historic, cultural or political factors external to the individual prevent engagement in occupations (Townsend & Wilcock, 2004a).

Occupational justice is defined as actions directed at having the occupational needs of individuals, groups and communities met as part of a fair and empowering society (Wilcock & Townsend, 2000).

Human rights are a set of universally endorsed principles that centres on freedom and well-being with freedom referring to the right to make decisions that affect one's own life; and well-being referring to the abilities and conditions needed to achieve one's goals through action (Kallen, 2004).

Occupational rights refers to "the right of all people to engage in meaningful occupations that contribute positively to their own well-being and the well-being of their communities" (Hammel, 2008: 62).

Professional reasoning is a multifaceted process used by occupational therapists to plan, direct, perform and reflect on occupational therapy intervention (Boyt Schell, 2009).

Political reasoning refers to critical thinking around the underlying structural, cultural and contextual factors that impact people's occupational rights (Pollard, Kronenberg & Sakellariou, 2008).

Occupational enablement entails working with people and communities to enhance their ability to engage in the occupations they need to do or by modifying their occupations or the environment to better support their occupational engagement (WFOT, 2012).

Critical occupational therapy is a form of practice that recognises the impact of social differences and inequities on peoples' occupation; and facilitates change at both an individual and environmental level (Hammel & Iwama, 2012).

Community development is "the process of organizing and/or supporting community groups in their identification of important concerns and issues, and in their ability to plan and implement strategies to mitigate their concerns and resolve their issues" (Labonte, 2007:90).

Community-based practice refers to the involvement of community members in solving community problems that are defined by professionals, agencies or funders who also decide on strategies to be implemented to address the problems (Leclair, 2010).

Occupation-based practice is the facilitation of quality of life "through advocacy and mediation and through occupation-focused programs aimed at enabling people to do, be, and become according to their natural health needs" Wilcock (2006:282).

Occupation-based community development is a form of occupational therapy practice with communities where doing is both the means and ends of actions that are aimed at bringing about changes in human connection and occupational engagement. It is a long-term process where hegemonic practices, structural

inequalities and entrenched mindsets in and of everyday life are confronted through promoting participation (Galvaan, Peters, Cornelius & Richards, 2012).

Rehabilitation is a process aimed at enabling people with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels. It provides them with the tools they need to attain independence and self-determination (WHO & Worldbank, 2011).

Compulsory community service refers to the period of one year obligatory service that is required by all persons registered as health professionals under the jurisdiction of the Health Professions Council of South Africa after they graduate (HPCSA, 2002).

Socially responsive education advances the development and transformation of students, the profession of which students are members and the society that they serve. Therefore, socially responsive education underpins values such as human rights and community development that affirm social responsiveness and social justice (Duncan & McMillan, 2006).

Critical pedagogy is concerned with the development of critical consciousness (Freire, 1972), thus it is a teaching and learning approach that attempts to help students question and challenge the beliefs and practices that dominate in society (Blaug, 1995).

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CHAPTER 1

INTRODUCTION

1.1   BACKGROUND TO THE STUDY

The focus of this qualitative interpretive study is occupational justice as conceptualised by occupational therapy (OT) graduates from the University of the Western Cape (UWC) undergoing compulsory community service in three provinces in South Africa. OT is defined by the World Federation of Occupational therapists (WFOT, 2012) as a client-centred health profession that is concerned with promoting health and well-being through occupation. Occupation enables people to meet their needs for living, health and well-being (Wilcock, 1998) and refers to the ordinary activities that people do on a daily basis and the way they use their time, energy, interests and skills in meeting their needs (Christiansen & Townsend, 2004). The primary goal of OT is occupational enablement which entails working with people and communities to enhance their ability to engage in the occupations they need to do or by modifying their occupations or the environment to better support their occupational engagement (WFOT, 2012).

Over the course of the last decade the concept of occupation in the OT profession evolved from therapeutic activity to occupational enablement as a principle of occupational justice (Polatajko, 2001). Occupational justice was derived from a social justice perspective and is defined as actions directed at having the occupational needs of individuals, groups and communities met as part of a fair and empowering society (Wilcock & Townsend, 2000).

1.2   RATIONALE FOR THE STUDY

The introduction of the notion of occupational justice in the OT profession necessitated a critique of dominant discourses that retained OT practice within traditional medical settings (Kronenberg, Algado & Pollard, 2005; Kronenberg

& Pollard, 2006). These dominant discourses that are characterised by structuralist perspectives such as the bio-psychosocial categorisation of human function tend to re-enforce reductionist approaches to OT practice. Therefore the profession also recognised the relevance of critical perspectives on humans as occupational beings that acknowledge the importance of human agency and the fostering of people's empowerment in OT practice (Galheigo, 2011a). This recognition led to the adoption of a critical practice of OT that addresses the conditions of people's lives in addition to enhancing individual abilities (Hammell & Iwama, 2012), and thus signified a reorientation of the profession.

These developments in the OT profession occurred in a context of fundamental changes in South Africa that involved radical reform of the health system aimed at redressing health inequities through the adoption of a social and rights-based approach to health as well as the introduction of the policy of compulsory community service. The compulsory community service initiative was an attempt by the Department of Health to respond to unmet health needs in under-resourced communities, particularly in rural areas in South Africa (HPCSA, 2002). Under this policy, all persons registered as health professionals under the jurisdiction of the Health Professions Council of South Arica (HPCSA) are obligated to perform one year of compulsory community service after they graduate (HPCSA, 2002).

Health reform in South Africa, alongside the global reorientation of the OT profession, gave momentum to the UWC OT education programme to engage in a process of curriculum transformation. This process of curriculum transformation was characterised by an increased understanding of South Africa's social and political context and an interrogation of how teaching and learning could support students to become agents of change in practice (De Jongh, 2009). The process resulted in the inclusion of occupational justice as a key tenet of the UWC OT curriculum and a revised mission statement that embraces socially responsive education. Socially responsive education advances the development and transformation of students, the profession of which students are members, and the society that they serve (Duncan & McMillan, 2006). Inferred here is the responsibility of the educator to engage in

pedagogical practices that promote occupational justice and to utilise relevant teaching and learning strategies for the empowerment of OT graduates as agents of social change.

As an educator interested in teaching and learning with a focus on social justice, I have been closely involved with the process of transforming the UWC OT curriculum to one that focuses on occupational justice. The concept of occupational justice is, however, still evolving and available literature largely offers a theoretical understanding of occupational justice. To date few authors have explored how OT education should prepare students to become agents of occupational justice (Duncan, Buchanan & Lorenzo 2005; Wood, Hooper & Womack 2005; Kronenberg & Pollard 2006; Boggis 2008, De Jongh et al., 2011); or how the theoretical understanding of occupational justice translates into practice (Duncan & Watson 2004; Townsend & Whiteford 2005; Frank & Zemke 2008; Pollard, Kronenberg & Sakellariou, 2008). There is also a dearth of literature that explores the influence of OT curricula on graduates' preparedness for occupational justice-informed practice.

The paucity of literature related to occupational justice and OT education and practice. led me to embark on an evaluation of the fourth year community fieldwork module to explore how students perceived the value of the UWC OT curriculum in preparing them for practice grounded in occupational justice (Hess-April, 2009). The evaluation revealed that the students perceived that community fieldwork enhanced their understanding of occupational justice and how it related to OT practice. Whiteford (2007), however, asserts that, while mission statements may reflect broader professional values and goals, theory covered in the curriculum and actual practice may remain disconnected. Also, Flinders and Thornton (2009) state that examining a curriculum should not only involve the examination of lesson content per se, but also the enactment of content and its consequent meanings for those directly involved. In addition to the generation of an understanding of how students perceived fieldwork, it was thus necessary to generate an understanding of the meaning UWC OT graduates bring to the concept of occupational justice in practice.

1.3   STATEMENT OF THE RESEARCH PROBLEM

The UWC OT curriculum has been transformed to prepare students to become agents of occupational justice and social change in practice. Accordingly, the UWC OT mission statement embraces the position that OT education for occupational justice has the deliberate intention of preparing graduates to be critical OT practitioners. Therefore, the research problem of this study is that the UWC OT Department does not have any information related to how graduates understand occupational justice, how prepared they feel to address it in community service and whether they are able to practise as critical OT practitioners. This research problem informed the research questions of the study.

1.4   RESEARCH QUESTIONS

1.4.1   Main research question

The main research question addressed in this study is: How do UWC OT graduates conceptualise occupational justice in their practice of community service?

1.4.2   Subsidiary research questions

The subsidiary questions are:
(i)   How do UWC community service OT graduates enact occupational justice in their practice?
(ii)   How do the educational processes and content of the UWC OT curriculum support UWC community service OT graduates to enact occupational justice in their practice?
(iii)   What strategies can be employed to address constraints faced by UWC community service OT graduates in incorporating occupational justice into their practice?

1.5   PURPOSE OF THE STUDY

The purpose of the study was to generate an understanding of how community service graduates who participated in the UWC OT curriculum conceptualise occupational justice and how these conceptualisations played out in practice in terms of the graduates' knowledge, values and skills. Underpinning this research is the assumption that OT education informs professional practice and that uncovering new graduates' practice experiences can inform the development of OT curricula (Hodgetts et.al, 2007). It was envisaged that information gained from this study would inform the development of the UWC OT curriculum to support its graduates to embody occupational justice in practice. This was important as the UWC mission aspires to produce graduates who are able to contribute to social change in South Africa. The role and practice of occupational justice are subjects of debate in the context of OT education as they are for the profession broadly. This study contributes to this conversation by examining graduates' actual practice and the transmission of occupational justice-promoting practice through OT education.

1.6   AIM

The aim of the study was to explore how UWC OT graduates' conceptualisations of occupational justice, as instilled by the UWC OT curriculum, manifest in their practice of community service.

1.6.1   Objectives

The objectives of the study were:

(i)   To explore how UWC community service OT graduates enact occupational justice in their practice.

(ii)   To explore how the educational processes and content of the UWC OT curriculum support UWC community service OT graduates to enact occupational justice in their practice.

(iii)   To reflect on strategies that can be employed to address constraints faced by UWC community service OT graduates in incorporating occupational justice into their practice.

1.7   THEORETICAL FRAMEWORK

This study is framed within the theories of occupational justice and critical curriculum theory, in particular, critical pedagogy. The theory of occupational justice offers a lens for interpreting how the concept is understood by the participants and helps to explain how the graduates understand what it means to engage in OT practice that is aimed at effecting social change. Critical curriculum theory helps to understand how the UWC OT curriculum influenced this understanding through the level of preparedness and commitment the graduates feel towards enacting the value of occupational justice in community service practice.

1.7.1   The theory of occupational justice

To understand the theory of occupational justice it is necessary to turn to perspectives of social justice as a background to the conception of occupational justice as articulated by the OT profession. A social justice perspective regards disadvantage as a result of multiple inequalities that exist in society (Blakeney & Marshall, 2009). Considering that some people are socially included and privileged to choose what they do, while others are socially excluded and unable to engage in their choice of occupations (Whiteford, 2010), the central point in this theory is that occupational injustice results when social structures restrict occupational participation through the power it exerts. Therefore, an occupationally just society is one in which people are empowered by doing what is relevant and meaningful to themselves and their communities (Blakeney & Marshall, 2009). Conversely, occupational injustice occurs when "participation in occupations is barred, confined, restricted, segregated, prohibited, undeveloped, disrupted, alienated, marginalised, exploited, excluded, or otherwise restricted" (Townsend & Wilcock, 2004b:77).

Whereas social justice entails economic, social and political equality between individuals and groups in a society where the basic needs of all individuals are met, social injustice entails conditions that limit meaningful participation, inhibit development, and deny equal opportunities for all (Van Soest, 1992). Emphasis is placed on a fair distribution of resources and compensation for exclusion, discrimination or lack of opportunities that exist in society (Watson, 2004).

In contrast to conceptions emphasising a more distributive approach, Young (1990) recognises social structures, culture and relationships among individuals and groups as fundamental to achieving justice. Young (1990:15) challenges the distributive paradigm of justice based on sameness and individual rights by proposing that "issues of decision-making power and procedures, division of labour, and culture" require a paradigm based on enablement of opportunities that respond to differences across social groups. From this perspective, power is understood as a relational issue and social justice as the elimination of institutionalised domination and oppression.

Achieving social justice thus involves respecting differences and challenging the ways in which social relations of oppression and privilege are enacted in particular settings. This perspective on social justice links with a human rights perspective which also offers useful insight on the theory of occupational justice as it highlights the right to participate in occupation despite differences (Hammell, 2008). Hence, the recognition of the above perspective on social justice in the theorisation of occupational justice can be seen in the way that occupational justice is regarded as a justice that recognises human and occupational rights regardless of age, ability, gender, social class or other differences (Townsend & Wilcock, 2004a). Nilsson and Townsend (2010) refer to this as a justice that recognises the right to inclusive occupational participation in everyday occupations regardless of the differences that people may have.

1.7.1.1 Principles of occupational justice

Townsend and Wilcock (2004a) outline enablement of occupational potential; empowerment through occupations, inclusive classification of occupations; and diversity, social inclusion and shared advantage of occupational participation as principles of occupational justice. These principles point to the applicability of the theory as a lens through which to view the graduates' ability to act as change agents in the practice context.

Enablement of occupational potential refers to approaches that support people in developing this potential. In exploring such approaches, Townsend and Palatajko (2007) assert that occupational therapists can enable occupational potential by examining issues from an occupational perspective and by adopting occupation-based practice to facilitate change. Similarly, Townsend et al. (2007) maintain that best practice in occupational therapy seeks to offer effective occupation-based enablement for health, well-being and justice.

The principle of empowerment through occupation is derived from the view that society determines people's opportunities for everyday occupations and supports equality in power sharing. The belief that humans have a choice regarding occupations they consider to be most useful and meaningful to them is therefore fundamental to this principle. Townsend and Wilcock (2004a:261) contend that occupational justice fosters a "culture of choice" by focusing on the empowerment of those who are occupationally deprived, while Townsend et al. (2007) state that people can exert their power by expressing their needs and expectations to participate in the occupations of their choice.

The principle of inclusive classification of occupations addresses the manner in which occupations are classified. For instance, Townsend and Wilcock (2004a) question the classification of the occupation of work as they are of the opinion that people who succeed at work generally generate greater influence in society, while those who are un- or underemployed may often become disempowered.

The principle of diversity, inclusion and shared advantage of occupational participation links key concepts within the overall concept of occupational justice. As an occupationally just society is understood as one that is socially inclusive (Townsend & Wilcock, 2004b), the principle of diversity, inclusion and shared advantage of occupational participation draws attention to the occupational differences between those with and those without resources for occupational participation. In view of this principle, the WFOT position papers on human rights (2006) and cultural diversity (2010) recognise the rights of people to participate in diverse occupations and call on occupational therapists to work with groups, communities and societies to enhance participation in occupations for all persons. The WFOT stance is underlined by the value of diversity, the value of each person's uniqueness and the acknowledgement of rights-abuses such as the exclusion of people due to societal barriers that prevent them from participating in occupation.

1.7.1.2 The link between occupational justice and critical social theory

Critical social theory aims to break down social inequalities that are produced by oppressive social structures that exist in society (Henning, Van Rensburg & Smit, 2004). The theory questions all forms of domination and exploitation and understands itself as contributing to the project of creating autonomous societies (Leonardo, 2004). Linking this understanding of critical social theory with the principles of occupational justice, i.e. empowerment and social inclusion, these principles necessitates that a practice of occupational justice be informed by a critical approach.

Practice that aspires to be critical strives to achieve social justice by confronting inequalities and altering the various social systems upon which society rests (Briskman, Pease & Allan, 2009). It can thus be argued that a critical practice of OT would recognise the impact that social inequalities such as class, gender, age and ability have on occupational engagement and, in view of that, address the conditions of people's lives (Hammell & Iwama, 2012). Congruent with occupational justice's concern with occupational engagement as a human right, this requires occupational therapists to view enabling access to meaningful

occupations as a political endeavour when enacting occupational justice (Pollard, Kronenberg & Sakellariou, 2009).

Praxis is a key concept within critical social theory. Freire (1972) defines praxis as the process that enables us firstly to understand and secondly to transform the world in which we practice. Inferred here is the importance of critical reflection to stimulate critical thinking, awareness of self, and awareness about a situation which in turn allows people to act upon that situation (Freire, 1972). Accordingly, praxis is the practical action undertaken to make a difference that results from knowing in this radical way (Lovat & Gray, 2008). It is informed, committed action that involves careful judgements about how to act in a particular situation (Carr & Kemmis, 1986).

Exploring how UWC OT graduates enact occupational justice in their practice is a key focus of this study. While I draw on the theory and principles of occupational justice as a lens to explore how it is understood by the graduates, the theoretical lens of critical social theory offers a lens to explore the graduates' actual practice. Therefore, by exploring questions like: What is their vision for practice? What informs their practice? What do they actually accomplish? the study aims to understand the knowledge, values and skills that the participants' portray in enacting practise for occupational justice.

1.7.2 Critical curriculum theory and critical pedagogy

The term 'curriculum' has been defined in a number of ways as different meanings have been attached to it. As a result, it is difficult to provide a single, concise definition of the concept. According to Kelly (2004) traditional definitions of curriculum associate it with the subjects to be taught and do not account for unplanned or overt activities that also add up to students' experiences. Kelly (2004) further states that definitions of curriculum that equate the concept with contents or syllabus fail to describe the totality of the educational processes, practices, experiences and outcomes. He therefore argues that a definition of curriculum must embrace all the learning that occurs in an institution, whether it is expressly intended or a spin-off of curriculum planning

and/or practice. This includes learning that is not overtly planned (Kelly, 1999). Kelly thus makes reference to the unspoken or hidden curriculum which refers to those learning experiences that may not be formally documented and arise as a result of the school ethos, i.e. values, attitudes and norms that underlie interactions in the school (Miller & Seller, 1990). In another definition of curriculum provided by Grundy (1987) he refers to curriculum as a dynamic process of planning, acting and reflecting. He further asserts that constructing a curriculum at the hand of underlying theories cannot be divorced from its implementation. In this study, Kelly's definition, which encompasses the entirety of learning inclusive of curriculum contents and ethos, as well as Grundy's definition, which encompasses a process of planning, acting and reflecting, is adopted.

In order to understand how a curriculum would enable graduates to engage in critical OT practice for occupational justice, it is necessary to explore different approaches to curriculum to distinguish how a curriculum for social/occupational justice might be constructed. There are four different curriculum orientations or conceptual frameworks that could shape the actual construction of a curriculum. These are (1) curriculum as content and education as transmission, (2) curriculum as product and education as instrumental, (3) curriculum as process and education as developmental, as described by Kelly (2004); and (4) curriculum as emancipatory and education as critical, as described by Freire (1972).

Curriculum as content and education as transmission

The curriculum as content orientation involves detailed attention to what people need to know in order to work and live their lives. The curriculum is thus a body of knowledge, and education, the process by which this body of knowledge is transmitted to students (Kelly, 2004). Students are seen as passive recipients of information while the educator as expert ensures that all that is crucial to be learned is taught. This curriculum orientation can be attributed to the philosophies of perennialism and essentialism which rest on the foundation that education should concern itself with the intellect and not learner

needs (Tanner &Tanner, 1995). The mind is conceived of as a container and 'education is simply a matter of filling and stretching each mind with that which is essential to learn to the utmost of each mind's capacity' (Tanner &Tanner, 1995:314). One distinction between the two philosophies is that essentialists accept the idea that the core curriculum may change, while perennialists regard core knowledge disciplines as permanent (Tanner & Tanner, 1995.)

Curriculum as product and education as instrumental

According to Kelly (2004) curriculum as product reduces education to a narrow practice of training. The curriculum is conceptualised as a product or a set of documents for implementation that has a discipline-focused orientation (Fraser & Bosanquet, 2006). This implies that the education experience restricts both student and educator as it becomes a type of performance that is governed by outside standards. A systematic plan is followed with the provision of adequate expertise, resources and technology in order for students to achieve common goals (Kelly, 2004). The setting of objectives is thus an important part of this approach. From a perennialist and essentialist perspective, the objectives set would relate to a core body of knowledge in terms of what students should be able to do after completion of a course.

In OT education, the product orientation of curriculum is often associated with professional body requirements and has traditionally been the most widely used approach to designing a curriculum in OT. The starting point for such an OT curriculum is usually a list of content areas that must be taught, often starting from the foundational biomedical sciences and social sciences, followed by occupational science. Lectures, interspersed with discussions, dominate the teaching-learning process where students are expected to assimilate what is taught and to recall it when required to do so in examinations.

Curriculum as process and education as developmental

According to Grundy (1987:115) curriculum as process 'is not simply a set of plans to be implemented, but is rather constituted through an active process in

which planning, acting and evaluating are all reciprocally related and integrated into the process'. In the same way, Kelly (2004) states that the process model of curriculum is framed by the processes of education rather than the content that needs to be delivered. He further states that this approach to curriculum is rooted in a concern for the development of the student as a human being (Kelly, 2004).

Curriculum as process is underpinned by the constructivist educational philosophy. Constructivism is associated with dissatisfaction with traditional education practices that place emphasis on content and disregard the place of students' needs and interest in education (Tanner & Tanner, 1995). From a constructivist perspective, education should not be isolated from its social context because education and experience are intertwined (Dewey, 1961). One central idea is that knowledge is constructed through experience and reflection on experience, thus constructivist education emphasises the active role that students play in acquiring knowledge (Vygotsky 1978).

Another central idea is that knowledge disciplines are important only in so far as they are useful in assisting students to interpret experiences rather than as lessons that have to be passively assimilated (Dewey,1998). Rooted in Dewey's experiential and pragmatist approach, the development of life skills and critical thinking is emphasised (Dewey, 1998). Constructivist education is therefore conceived as the development of students' capacities to assume the role of constructive participant in problem solving (Hickman, 1998). It is hoped that in the process of trying to understand and/or solve real life problem scenarios, students will acquire skills to deal with both current and future life and professional situations. In OT education, dominant approaches within the curriculum as process orientation are the facilitation of lifelong learning, problem-based learning and experiential or service learning.

Curriculum as emancipatory and education as critical

Curriculum as emancipatory is, in many aspects, a development of the process model. While the process model places an emphasis on meaning-making through experiential learning, the emancipatory model of curriculum makes an explicit commitment to emancipation. This curriculum orientation owes more to the Brazilian educationalist Paulo Freire than to any other figure. For Freire (1972), education has a crucial role to play in helping people become agents of social change. Freire (1972) stresses the importance of education as transformative, liberatory and informed by the development of a critical consciousness. He points to the idea that critical education is about creating vision, asking questions about society, and empowerment for those made powerless by society. This understanding of critical education is further explicated by Giroux (2006:75) who describes it as:

…action and engagement, energising people not only to think critically about the world around them but also to use their capacities as social agents to intervene in the larger social order and confront the myriad forms of symbolic, institutional and material relations of power that shape their lives.

In relation to OT education, an emancipatory curriculum would have undergone a shift from the content, product and process driven curriculum orientations toward an understanding and an appreciation of the socio-political nature of occupation, as well as an awareness of the influence of social conditions on health and wellness. Such a curriculum would develop students' capacity for questioning and challenging the status quo with regards to the occupational rights of individuals, groups and communities, and prepare graduates to be politically conscious and participate in transformative action. Kemmis, Cole and Suggett (1983) emphasise that the goal of curriculum as emancipatory is the facilitation of constructive dialogue and critical thinking in students which are necessary tools that students require to challenge assumptions which may interfere with their acquisition of knowledge.

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Dialogue and critical thinking have principally been applied to education by Freire (1972) in his work related to critical pedagogy. The intent of critical pedagogy is not just personal transformation but also societal transformation so that individuals can be creative producers of self and society in terms of its political and economic relations (Allman & Wallis, 1990). He contrasts critical pedagogy with banking education which he asserts has been predominantly used in traditional forms of education as it involves the teacher providing knowledge to students while critical pedagogy involves students and educators learning from each other (Freire, 1972). Critical pedagogy is thus a teaching and learning approach which attempts to help students question and challenge the beliefs and practices that dominate in society.

Critical thinking in education, Freire (1972) aserts, allows students to recognise connections between their individual problems and the broader social contexts in which their experiences are embedded. This is called the development of critical consciousness or 'conscientisation' which refers to learning to perceive social, political and economic contradictions, and to take action against the oppressive elements of reality (Freire, 1972:15). An emancipatory curriculum is thus one that builds critical consciousness in participants and it involves educator and learner in changing the structures in which learning occurs (Grundy 1987).

Duchscher (2000) refers to the emancipatory curriculum as a socially-critical curriculum as it engages social issues and gives students experience in critical reflection. Likewise, Kemmis, Cole and Suggett (1983) emphasise that the goal of a socially-critical curriculum is the facilitation of constructive critical thinking in students. Education becomes the catalyst for empowering students to become critical, active citizens (Giroux & McLaren, 1996). The role of the student therefore is to understand and act against those forces that operate to create and maintain social, economic and political injustices (Tanner & Tanner, 1995).

Accordingly, curriculum as emancipatory is situated in the social constructionist philosophy as it places autonomy, responsibility and empowerment at its

forefront (Grundy, 1987). Social reconstructionism is a philosophy that emphasises a mission to create a better society and focuses on a curriculum that highlights social reform as the aim of education. Schiro (2008:134) elucidates this by stating that schools have "the power to educate people to analyse and understand social problems, envision a world in which those problems do not exist, and act so as to bring that vision into existence".

In OT education, this would involve helping students confront prejudices and stereotypes; debate rights, morals and ethics, and practise political reasoning alongside other forms of professional reasoning in OT practice. OT education would further attempt to shift from merely developing students' professional reasoning and critical thinking skills to developing their critical consciousness. In this sense it would be a catalyst for student empowerment, foster a commitment to occupational rights and occupational justice and empower students to become critical practitioners.

This study's concern lies with how UWC OT graduates understand occupational justice and feel prepared by the UWC OT curriculum to address it in community service. The emancipatory curriculum orientation is thus significant for this study as it implies a curriculum that is aimed at promoting greater equity and social justice in society (Grundy, 1987). Freire and Shor (1987) assert that the influence of a truly emancipatory curriculum will be internalised by its graduates and exhibited in their own empowerment in their areas of practice. Therefore, the influence of an emancipatory curriculum extends beyond the confines of the university. It is precisely this influence that this study seeks to explore.

By examining questions such as: How do teaching and learning processes in the curriculum support the development of politically conscious graduates? and Whose interests are served by the curriculum? the study seeks to generate an understanding of how the UWC OT curriculum facilitates the development of knowledge, values, and skills necessary for graduates to engage in praxis for occupational justice.

1.8   METHODOLOGY

1.8.1   Methodological paradigm

This study falls within the qualitative methodological paradigm as the main purpose of the study is the generation of an in-depth understanding of a specific situation, namely the community service practice of UWC OT graduate participants and how it is influenced by UWC OT education. By studying the participants in their community service practice settings, their subjective practice experience could be better understood through the adoption of the qualitative paradigm. Studying the subjective realities of the participants' practice was important in the generation of an understanding of how they conceptualised and embodied occupational justice. Qualitative research was therefore suited to this study as the study-focus was on the lived practice of the participants which provided the means through which the UWC OT curriculum in relation to occupational justice could be critiqued.
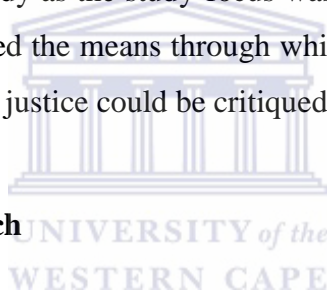
1.8.2   Research approach

This study utilised an interpretive research approach. Researchers that work within an interpretive approach view knowledge as constructed not only by observable phenomena, but also by the way in which people assign meaning to their lives (Henning, Van Rensburg & Smit, 2004). The aim of interpretive research is to understand behaviours, actions and processes within the context of the research participants (Babbie & Mouton, 2001). Therefore the interpretive researcher observes the context in which participants' experiences occur, and allows them to reflect on their world in their own way (Henning, Van Rensburg & Smit 2004:37).   In view of this, the study afforded the participants an opportunity to reflect on their day to day experience of practice and their interpretation the underlying philosophies, values and beliefs that guided their practise.

1.8.3   Research design

The research design for this study was an interpretive and descriptive case study that was generated and analysed through qualitative methods. Case studies facilitate the gathering of information about a single incident or situation (Stake, 2005) and referred to research that involved detailed study of an individual or a group through observation, self-reports and other means. The case under investigation in this study was the practice of a group of UWC OT graduates undergoing community service in three different provinces in South Africa. It was a single case study (Yin, 2003), as it considered the practice of graduates from one OT education programme (UWC) who all completed community service in their first year of practice. The case study of the practice of a group of graduate participants was the vehicle through which I offer a broader analysis of their conceptualisations of occupational justice during community service, and the influence of the UWC OT curriculum on their practice.

1.8.4   Data collection methods

This study employed three methods of data collection namely:

(i)   Participant observation that was utilised to gain an understanding of the participants' practice context, their practice and possible constraints to the practice of occupational justice in community service;

(ii)   Semi-structured dyadic interviews that allowed the participants to reflect on their practice and understanding of occupational justice in pairs; and

(iii)   Document review of practice documents that provided a description of the ways in which the participants enacted occupational justice in practice.

1.8.5   Selection of participants

The method of participant selection that was employed in this study is that of purposive sampling as it allowed for participant selection based on "the researcher's own knowledge of the population, its elements and the nature of the research aims" (Babbie & Mouton, 2001:166). Graduates from the UWC OT department who graduated in 2009, and who had at least six months of community service experience in 2010, were selected to participate in the study. Graduates from the Western, Eastern and Northern Cape Provinces were selected based on the HPCSA's community service policy criteria of under-resourced, rural practice contexts as well as the accessibility of the practice settings.

1.8.6   Data analysis

In this study inductive thematic data analysis, using procedures suggested by Terre Blanche and Kelly (1999) was utilised. The process entailed the breaking down and re-building of the data to finally arrive at new perspectives through a process of familiarisation and immersion in the data, induction of codes, categories and themes and interpretation of the themes.

1.9   ETHICAL STATEMENT

Permission to conduct this study was sought from the UWC Research Ethics Committee, the respective Provincial Health Research Ethics Committees and the management of each community service practice setting where the graduate participants were placed. Informed written consent was obtained from all participants after they were informed about the nature of the study. During each period of participant observation verbal informed consent was obtained from all persons with whom the participants interacted at the time of observation. Participants were informed that they may withdraw their participation at any time during the study without being penalised for doing so. All participants were assured that the principles of confidentiality and anonymity would be

adhered to in the study and that they would have access to the findings of the study once completed.

1.10   OUTLINE OF THE THESIS

This thesis is divided into the following seven chapters:

Chapter One provides the study background, rationale, research question and research aim. The theoretical framework is presented and an introduction to the research methods that were utilised in the study is provided. This is followed by an overview of the thesis structure.

Chapter Two highlights key contextual factors that influenced the development of the UWC OT curriculum and the inclusion of occupational justice as one of its tenets.   The chapter further provides an overview of the UWC OT curriculum in its current form with emphasis being placed on its development in response to the re-orientation of the OT profession around occupational justice.

Chapter Three presents a detailed literature review pertaining to the study. The chapter aims to situate occupational justice within broader discussions related to OT practice and education in order to develop a deeper understanding of the relationship between OT education and occupational justice.

Chapter Four describes the methodology adopted in the study. It includes a description of the methodological paradigm, research design and research methods used in collecting and analysing the data, and makes reference to strategies employed to enhance the trustworthiness and ethical standard of this study.

Chapter Five presents the key findings of the study in two parts. In the first part a case description that comprises the participants' practice contexts and practice settings as well as their primary roles and responsibilities in these settings, is provided. In the second part the themes and related categories that emerged from the analysis of the data are presented.

Chapter Six presents a discussion of the findings and draws together threads from the study-context and the literature review. It addresses how occupational justice was conceptualised by the participants, how they drew on their professional education to make sense of their practice roles, and how they responded to the challenges that they encountered in practice.

Chapter Seven provides the main conclusions and recommendations drawn from the study. The study's limitations and considerations for future research are discussed.

CHAPTER 2

THE DEVELOPMENT OF UWC OT EDUCATION AROUND OCCUPATIONAL JUSTICE

2.1   INTRODUCTION

This chapter highlights key contextual factors that influenced the development of the UWC OT curriculum and the inclusion of occupational justice as one of its tenets. These factors contributed to the evolution of this study and include health reform in South Africa around the shift in emphasis from a bio-medical to a more socio-political approach to health; the introduction of compulsory community service for health professionals as a feature of this reform; and the redefinition of the OT profession's role in health care. The chapter further provides an overview of the UWC OT curriculum in its current form with emphasis being placed on its development in line with the re-orientation of the OT profession around occupational justice.

2.2   HEALTH REFORM IN SOUTH AFRICA

Since the birth of democracy in South Africa in 1994, health reform in the country revolved around policy formulation and changes aimed at redressing inequities in health services (Dayal, 2010). To this end, South Africa adopted the primary health care (PHC) system which seeks to provide equitable, efficient and effective health services (WHO, 1978). PHC is informed by social justice and is structured around five basic principles: (1) universal accessibility and coverage based on needs; (2) comprehensive health care with an emphasis on prevention and health promotion (but including curative and rehabilitative services); (3) community participation and self-reliance; (4) inter-sectoral collaboration to address the social determinants of health; and (5) appropriate and cost-effective technology (WHO, 1978).

PHC recognises the necessity of reducing health inequities and the importance of addressing the underlying social, economic and political causes of poor health. A PHC approach therefore builds on changes not only in the health sector but also in the linked areas of social and economic development (WHO, 1978). An important factor that determines the success of PHC lies in power-sharing, which involves a shift in the control of the health care context by the health care professional to a position where the community is an equal partner with all other participating health workers (Dayal, 2010). In other words, within a PHC philosophy, a shift in emphasis occurs from health professionals supplying curative health services, to the people of the community becoming active participants of a team that advocates an integrated approach to health.

Through the adoption of PHC, health reform in South Africa thus moved the health system to embrace a social justice and rights-based approach to health (Dayal, 2010). A social justice approach to health views both the conditions of people's daily lives and the underlying structures that shape these conditions as social determinants of health (WHO, 2008). A rights-based approach means integrating human rights in the design, implementation, monitoring and evaluation of health-related policies and programmes (London, 2008). To ensure the delivery of comprehensive PHC services, the District Health System (DHS) was adopted as a vehicle for the delivery of health services in South Africa (South African Government, 2004). This is one example of health reform related to the needs of vulnerable groups and the accessibility of health services that occurred in South Africa.

2.2.1 The District Health System

Within the DHS, health services in South Africa were classified into packages according to three different levels of care, i.e. practice settings (South African Government, 2004). These are (i) Level 1 or PHC/Community-based and District Hospital Services; (ii) Level 2 or Regional Hospital Services and (iii) Level 3 or Tertiary Hospital Services. The defining requirement for the provision of Level 1 services are the availability of medical officers; for Level 2 services, general specialists and for Level 3 services, various tertiary specialists.

While it is intended that community outreach and support should occur at all levels of care, it is more central to community-based services, also referred to as PHC services and district hospital services. PHC services include clinics, mobile clinics and Community Health Centres (CHCs). The type of services provided at the community level include antenatal care, mother and child care, reproductive health services, nutritional health services and health management services, i.e. provision of medication for the management of chronic conditions such as hypertension and diabetes (Department of Health, 2000a).

District hospitals play a pivotal role in supporting community based services and provide services to in- and outpatients on referral from a Community Health Centre (CHC) or clinic. With regards to rehabilitation, the role of the district hospital is to provide assistance and training in activities of daily living (ADL); to give support to rehabilitation services in the clinics and community; supply appropriate assistive devices; assess patients for disability grants (DGs); conduct disability awareness programmes, and support the reintegration of persons with disabilities (PWDs) into the community (Department of Health, 2002). Rehabilitation services are implemented by rehabilitation therapists such as OTs or other staff under the guidance of the therapist.

2.2.2 The re-engineering of PHC and National Health Insurance

Although much has been achieved in gearing up the DHS to implement PHC, insufficient attention has been given to the implementation of the PHC approach that includes taking comprehensive services to communities, emphasising disease prevention, health promotion and community participation. Consequently, in recent developments the Ministry of Health (2010) has committed itself to a substantial overhaul of the public health system in order to address South Africa's complex burden of disease; improve health outcomes, access and affordability, and ensure responsiveness to the needs of the population.

These developments are integrally linked to South Africa's National Development Plan (NDP) which aims to eliminate poverty and reduce

inequality by 2030 (South African Government, 2011). A central element to the overhaul of the health system is its strengthening and revitalisation at the hand of two key strategies: namely the implementation of the re-engineering of PHC (Department of Health, 2010) and a National Health Insurance (NHI) system (Department of Health, 2011).

PHC re-engineering initiative aims to place greater emphasis on the delivery of community-based services by reaching out to households with an emphasis on disease prevention, health promotion and community participation. This represents a shift away from the predominantly curative focus that characterises the delivery of health services at present. The main focus of the re-engineering of PHC is to strengthen the DHS and to address population-based health outcomes. Four priority areas of focus within PHC are proposed: (1) increase life expectancy at birth; (2) reduce maternal and child mortality rates; (3) combat HIV/AIDS and TB; and (4) strengthen health system effectiveness (Department of Health, 2011b).

There is greater emphasis on outreach into communities and households with early identification of individuals within families at high risk and interaction with communities to increase their participation in maintaining and improving their own health (Pillay & Barron, 2011). It is envisaged that the community outreach activities will be facilitated by a PHC outreach team consisting of both nurses and community health workers, who in turn will be supported by facility-based and specialist support teams of health professionals. PHC re-engineering further aims to pay greater attention to the social determinants of health through the alignment of intersectoral programmes at district level with integrated development planning processes.

A key development in relation to the re-engineering of PHC was the launch of a new national Integrated School Health Policy in South Africa (Departments of Health and Basic Education, 2012). The policy aims to ensure that a strong school health service operates according to clear standards across the country. It focuses on addressing both the immediate health problems of learners (including those that constitute barriers to learning) as well as implementing

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interventions that can promote their health and well-being during both childhood and adulthood.

Key strategies for achieving these objectives include health promotion and education; provision of an essential package of health services in schools; coordination and partnership; capacity building and community participation. A selected range of basic health services will be provided by a school health nurse to a group of schools, targeting the poorest schools first. These services will include screening of pupils in grade R and grade 1, ensuring that all those children that attend Early Childhood Development (ECD) and primary schools are fully immunised, and strengthen life skills programmes in secondary schools, with specific focus on sexual and reproductive health and prevention of substance and alcohol abuse.

The introduction of NHI aims to ensure universal health coverage to ensure access for vulnerable groups to quality health care in South Africa (Department of Health, 2011). The NHI, as a funding mechanism, will pool mandatory contributions and public sector finance to purchase services from accredited public and private sector providers with the aim of achieving universal health care coverage and access to quality health services. In particular, NHI will reduce inequities in health care financing and strengthen the public health care system by increasing its available income.

In response to these developments, the Western Cape Department of Health (2013) developed a strategic vision and comprehensive service plan that is described in the Healthcare 2030 draft policy document. The strategic vision revolves around access to patient-centred care and a population approach to health services. One area which is poorly defined in the document is that of rehabilitation services. In fact, while South Africa is said to suffer from a quadruple burden of disease: maternal and child mortality, HIV and TB, non-communicable diseases and violence and injury (Pillay & Barron, 2011), a service package for rehabilitation has not been addressed by any of the above-mentioned policies. This shortcoming has however been acknowledged by the South African Government in that it has constituted a national task team

on rehabilitation to formulate a rehabilitation service delivery strategy for South Africa within the PHC framework. This is an important step towards ensuring that that all mainstream health services are inclusive of people with disabilities which is an obligation that South Africa is expected to meet following its ratification of the United Nations Convention on the Rights of Persons with Disabilities (United Nations [UN], 2006).

2.2.3 The Batho Pele policy for service delivery

Because all national departments have to adhere to the principles and rights enshrined in the South African Constitution, the Department of Health is committed to upholding and protecting the rights of patients. This commitment is guided by the White Paper on the transformation of the public services (Department of Public Service & Administration, 1997). This document is also known as the Batho Pele principles which is a Sesotho expression meaning "people first", referring to acceptable service delivery in the public service.

Batho Pele is based on the following eight principles:

(i)   Consultation: Public servants should make sure that they stay in touch with the people they serve by assessing what services are needed, how services should be delivered and what cause dissatisfaction.

(ii)   Service standards: Every department has to set service standards that guide service delivery, quality or standard. Service standards should clearly state what people can expect.

(iii) Redress: When standards are not met the public servant should offer an apology and inform service users what solutions are implemented to address the problem.

(iv)   Access: All citizens have the right to equal access to the services to which they are entitled. This especially applies to disabled people and rural people who may have difficulty accessing services.

(v)   Courtesy: Public servants are employed to provide services to which people have the right.This means that in their contact with the public, public servants should always be courteous and helpful.

(vi)   Information: All citizens are entitled to full, accurate information. Public servants are encouraged to spend some extra time with people who need a better explanation or special assistance because they cannot understand or access information themselves.

(vii)   Transparency: People have the right to know how decisions are made, how a department works, who is in charge and what its plans and budgets are.

(viii) Value for money: Public servants should not waste scarce resources and should deliver a service that is as cost-effective and efficient as possible without compromising the quality of the service delivered.

The eight guiding principles for Batho Pele that were identified called for new ways of effecting service delivery which were more responsive to the needs of the public than the conventional bureaucratic systems, processes and attitudes. These principles illustrate that managers in the public service have a key role to play in creating an environment for their staff to be effective in the way in which they interact with service users and to provide them with support. This is particularly important for community service graduates as novice staff members.

2.2.4   Compulsory Community Service

Another example of health reform related to the needs of vulnerable groups and accessibility of health services that occurred in South Africa is the policy of compulsory community service for all health professionals (HPCSA, 2002). As poverty and poor socio-economic conditions are highly prevalent in South Africa many people do not have access to health services (Duncan & Alsop, 2006). To address this situation, the Department of Health introduced the policy of compulsory community service for all health professionals to increase the provision of health services in South Africa (HPCSA, 2002).

The community service policy obligates all persons that are registered as health professionals under the jurisdiction of the Health Professions Council of South Africa (HPCSA), to perform one year of compulsory community service after

they graduate (HPCSA, 2002). This policy by the Department of Health had, as its first aim, to respond to unmet health needs in under-served communities, particularly in rural areas (HPCSA, 2002). Community service therefore provides health profession graduates with opportunities to gain first-hand experience of practice in conditions of poverty and underdevelopment (Perold, Patel, Carapinha & Mohamed, 2006). The community service policy's second aim is to equip novice health professionals with professional and critical thinking skills appropriate to the South African context (HPCSA, 2002).

While the policy did not identify specific competencies required for community service, its stated aims implied that graduates doing compulsory community service had to function effectively, adapt to sometimes harsh realities (Reid, 2002); be culturally competent (Van der Merwe, 2010), and be proactive towards the needs of the community in which they practice (Duncan & Alsop, 2006). This elucidated the crucial role that health professions education had to play in preparing graduates to be effective and relevant in their community service practice areas. Alsop, Duncan, Lorenzo and Buchanan (2006) assert that traditional approaches to health professions education that occurred exclusively within the medical model with its exclusive focus on bio-medical knowledge were not sufficient to develop graduate competencies required for community service. They were of the opinion that a good match was required between local health needs, emerging paradigms of practice, curriculum contents, and the utilisation of teaching and learning strategies.

2.3   THE RE-ORIENTATION OF THE OT PROFESSION

Like all health professionals in South Africa, the training of occupational therapists within the apartheid context, did not focus on building a health care system based on human dignity, respect for human rights or assisting people to be empowered to take control of their health. It separated social, political, economic and health care issues. As health reform gained momentum in South Africa, the OT profession underwent a growing awareness of the political mechanisms that influence people's participation in meaningful occupations (Townsend & Whiteford 2005; Kronenberg, Algado & Pollard 2005). This

growing awareness manifested in the profession's acknowledgment of occupation as a human right, the adoption of a social and rights-based approach to OT practice, and responsiveness to wider community and social needs (WFOT, 2006). The adoption of a social and rights-based approach to OT practice drew attention to the fact that some people are deprived and alienated from occupational engagement and thus suffer occupational injustices (Townsend & Wilcock, 2004a; 2004b). Accordingly, the theory of occupational justice emerged as the OT profession's response to occupational issues as they related to social justice (Townsend & Whiteford, 2005).

It was increasingly acknowledged within the profession that the main aim of OT was to work towards a state of occupational justice in society, where all people have access to and are enabled to participate in meaningful occupations. Hence, occupational justice provided a framework for OTs to address inequities in occupational engagement (CAOT, 2005 in Wilcock & Townsend, 2009) and to facilitate "equitable opportunity and resources to enable people's engagement in meaningful occupations" (Wilcock & Townsend, 2000:85). Occupational justice was therefore understood as action directed at having the occupational needs of individuals, groups and communities met as part of a fair and empowering society (Wilcock & Townsend, 2000). While historically the profession was seen as an allied health profession with practice predominantly based in hospitals and other institutions, this reorientation gave momentum to the development of community-based services in OT.

Despite many challenges that OTs faced as a result of the profession's shift in focus towards occupational justice, many innovative practices emerged that signalled the profession's commitment to facilitating political change (Townsend & Wilcock, 2004a, Watson & Swartz, 2004; Kronenberg, Algado & Pollard, 2005; Pollard, Alsop & Kronenberg, 2005; Townsend & Polatajko, 2007). There were, however several challenges that OTs encountered in their attempts to incorporate occupational justice in their everyday practice. For example, Pollard, Sakellariou and Lawson-Porter (2010) observed that engaging with their employers regarding more relevant practices was a challenge for OTs, while Kronenberg, Pollard and Ramugondo (2011) maintained that workplace

restrictions such as budget limitations inhibited the full potential of OT. These authors stressed the importance of critical reflection in OT as they believed that it could shed light on opportunities for the negotiation of alternative OT practices with employers and therefore urged OTs to sharpen their reflexivity in developing a social justice approach to OT.

2.4   THE RE-ORIENTATION OF OT EDUCATION

The adoption of the premise of occupational justice and a social and rights-based approach to OT by the profession led to the revision of OT education globally. This was evident in the World Federation of Occupational Therapy (WFOT) revised minimum standards for the education of occupational therapists. These standards provided criteria related to OT curriculum content and emphasised that education programmes design curricula that are responsive to contextual issues and local perspectives of health, rather than taking an exclusive bio-medical approach (Hocking & Ness, 2002). While these standards suggest that OT education programmes focus on one or more of three orientations, namely the biomedical, occupational and social orientations, Duncan and McMillan (2006) assert that the complex context of a developing country such as South Africa requires OTs to adopt an eclectic approach and work flexibly within all three orientations.

The revision of the minimum standards by WFOT gave momentum to discussions in the profession about OT educational approaches that would be responsive to issues related to occupational justice. Galheigo (2011a) called for the re-design of OT curricula and for the development of alternative educational methodologies to foster new practice frameworks other than the biomedical, hospital-centred model that was followed historically.

As the OT profession became more inclusive of social and occupational justice, OT professional education began to facilitate students' understanding that occupation is a human right and that they needed to work as agents of change to address occupational injustices in communities (Lorenzo, Duncan, Buchanan & Alsop, 2006). Several other authors also called on OT education to address

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graduate competencies such as political consciousness, i.e. understanding power issues, in order for graduates to respond effectively to community-based occupational issues (Duncan, Buchanan & Lorenzo, 2005; Wood, Hooper & Womack, 2005; Duncan & McMillan, 2006; Pollard & Sakellariou, 2007; Watson, 2008).

The education and training of South African occupational therapists is governed by the Professional Board for Occupational Therapy, Medical Orthotics and Prosthetics and Arts Therapy. Minimum training standards are prescribed in the Minimum Standards for the training of Occupational Therapists (HPCSA, 2009). Subsequent to the publication of the revised WFOT minimum standards, the Professional Board for Occupational Therapy also undertook the task of reviewing the minimum standards for the training of occupational therapists in South Africa. Although it stressed that aspects of the medical model were still applicable to certain areas of practice, the revised South African standards suggest that the curriculum includes a more social approach to education and practice.

The standards indicate that educational programmes should provide opportunities for students to engage with issues of diversity, to become culturally sensitive and to address occupational injustices. Knowledge that supports the understanding of PHC, Health Promotion and community development is delineated as core content areas of OT education programmes. The document further states that placements in areas where services are established or are being developed for people who are underemployed, disempowered, dispossessed or socially challenged, should be included in the range of student fieldwork experiences offered by the programme. In line with the WFOT minimum standards the revised South African standards further indicate that OT curricula in South Africa should be designed to equip graduates to deliver contextually appropriate services.

There were also developments related to higher education in South Africa of which OT education programmes were required to take cognisance. These developments included the National Plan for Higher Education (Ministry of

Education, 2001), which stressed that higher education has an important role to play in the realisation of social justice in South Africa. Amongst other key issues, the National plan for Higher Education emphasised that South African higher education institutions should produce graduates with attributes that included critical, analytical, problem-solving and communication skills, as well as the ability to deal with change and diversity (Ministry of Education, 2001).

In response to the National plan for Higher Education, UWC developed an Institutional Operational Plan (IOP) that outlined key goals and related strategies for the institution (UWC, 2009). One of the goals of the IOP is to provide teaching and learning opportunities at UWC that are contextually responsive and which enhance students' capacities as agents of change. It is expected of departments to align their education programmes with the IOP.

2.5   THE UWC OT CURRICULUM

The developments around health reform and the reorientation of the profession in line with higher education in South Africa facilitated the review of the UWC OT curriculum. This resulted in a curriculum transformation process through which socially responsive education emerged as an umbrella term that encompassed various teaching and learning strategies that demonstrate UWC OT education's response to society's needs. Informed by the educational philosophies of constructivism and social constructionism, it was envisaged that the curriculum would assist OT students to broaden their understanding of their political role as practitioners and that this would place them in a better position to advocate for social and occupational justice (De Jongh, Hess-April & Wegner, 2012).

The UWC OT education programme's mission statement (see Appendix 1) reflects a commitment to producing socially responsive graduates who are competent in facilitating people's engagement in occupations that are relevant to their environment, background and health needs (De Jongh, Hess-April & Wegner, 2012). The UWC OT education programme's mission statement further reflects a commitment to producing politically conscious graduates who

would be able to act as agents of social change (De Jongh, Hess-April & Wegner, 2012).

Linking with the mission statement, specific outcomes for the UWC OT curriculum in terms of graduate attributes were identified. It was acknowledged that a UWC OT graduate will be:

- A lifelong learner and critically reflexive practitioner who endorses the theoretical foundation of occupational therapy through appropriate interventions and meaningful engagements aimed at meeting South African health and social needs
- A practitioner who is culturally competent and able to apply the occupational therapy process in diverse settings and at all levels of care according to the PHC and District Health System in South Africa
- A professional who complies with the ethics of the profession and who considers personal assumptions, social, legal, cultural and policy issues in ethical decision making; and
- A professional who is committed to occupational justice.
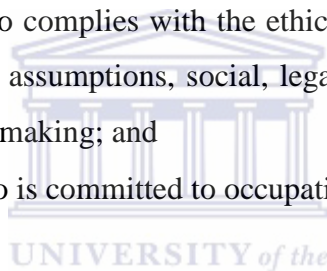
The curriculum is underpinned by four themes that form its core pillars: (1) theories and practice of occupational therapy, (2) human occupation, (3) fieldwork and (4) research. The four themes are horizontally integrated, which allow students to start with the basic material and then progress to more complex ideas over the course of the curriculum. The themes are also vertically integrated, thereby allowing students to integrate their academic and fieldwork experience.

The curriculum is delivered under the umbrella of relevant policy frameworks, as mentioned above. These policy frameworks, related to Primary Health Care and socially responsive education, motivate curriculum content. In addition, policy frameworks related to the minimum standards for OT education and UWC graduate attributes form the basis of the curriculum design. Through their engagement in the process of curriculum transformation, UWC educators identified that teaching and learning around critical or political consciousness is

a developmental process and needs to be reflected as such within the entire curriculum content, outcomes and assessments. For this reason, political consciousness, together with ethics and professionalism, form the foundation of the curriculum.

Figure 1 provides a diagrammatic presentation of the UWC OT curriculum.

Figure 1: UWC OT curriculum
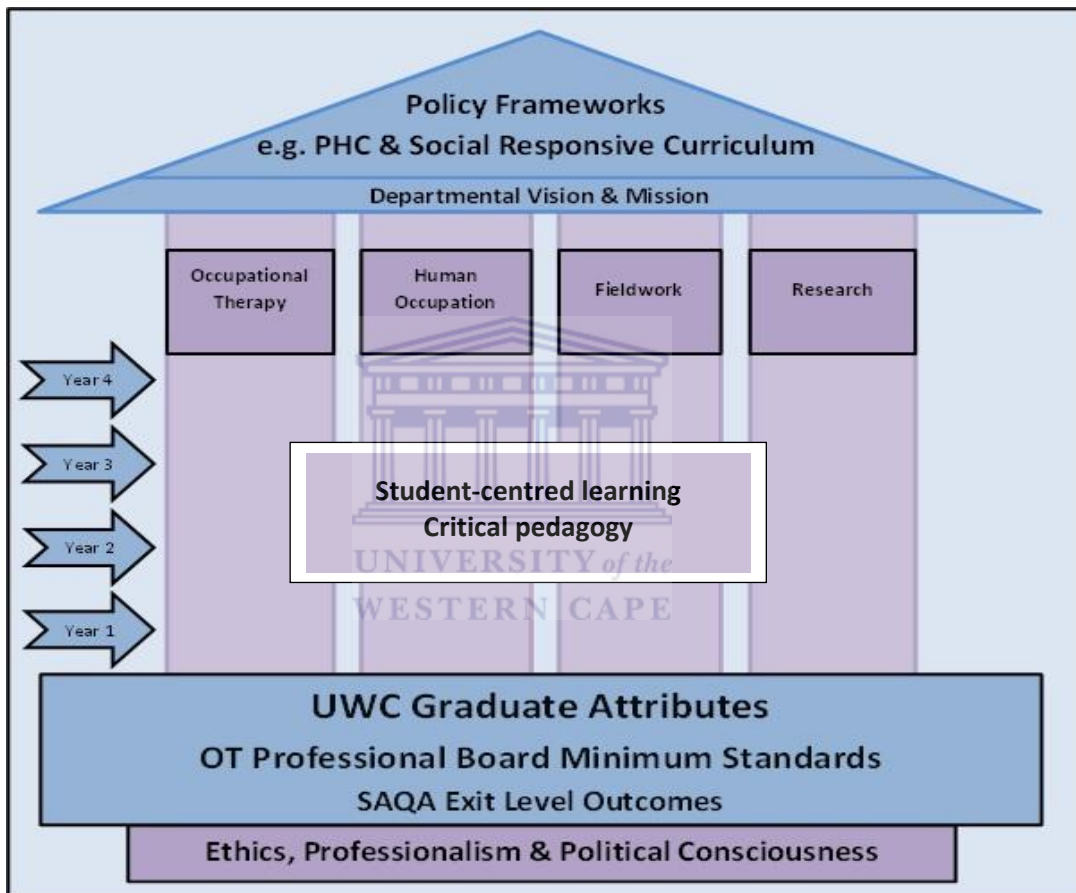
2.5.1   Teaching and learning within the UWC OT curriculum

Although the curriculum incorporates the medical approach, it strongly focuses on the social approach to health and well-being in order to foster a political identity and to be contextually relevant and socially responsive (De Jongh, Hess-April & Wegner, 2012). The diversity of cultures and contexts in South Africa calls for students who are able to practice at all levels of the District Health System, using both medical and social approaches. The curriculum can

therefore be described as utilising an eclectic approach to address the core knowledge, values and skills that new graduates require to practice within the bio-medical and social orientations of occupational therapy. This approach is also reflected in a combination of the process and emancipatory orientations to the curriculum that are underpinned by the educational philosophies of constructivism and social reconstructionism.

The key foci of the curriculum as process and emancipatory is the facilitation of lifelong learning, e.g. helping students to locate, analyse and interpret information in order to solve problems. In an attempt to move away from a technical approach, a more reflective and facilitative approach is adopted. It is hoped that in the process of reflecting on and trying to understand and/or solve real life problem scenarios, students will acquire skills to deal with both current and future life and professional situations. In addition, the curriculum is geared towards enabling students to participate in critical action.

The UWC OT curriculum places a high emphasis on the process of learning and the autonomy, responsibility and empowerment of its students. The two primary approaches to teaching and learning in the curriculum are 1) student-centred learning and 2) critical pedagogy. In particular, learning is facilitated through reflection and the promotion of interaction and active dialogues between educators and students. Weimer's (2002) five guidelines on student-centred learning are guiding principles for how this is applied in the curriculum: (1) Changing the balance of power between learners and teacher; (2) Using content to promote learning rather than to define what will be learned; (3) Shaping the role of the teacher to be a facilitator of learning; (4) Recognising that students have the responsibility for learning and (5) Using the processes of evaluation to promote learning.

In general, the repertoire of teaching and learning strategies utilised in the curriculum includes: active class dialogue and discussions, collaborative learning in small groups, peer tutorials, role plays and presentations and the completion of journals and various assignments that range from formal written

essays to community projects. These include e-learning and technological methods such as blog entries and videography.

Critical pedagogy involves the facilitation of dialogue and reflexivity to help students confront prejudices and stereotypes; debate rights, morals and ethics; and practice political reasoning alongside other forms of professional reasoning in occupational therapy. This is done in such a manner as to facilitate the development of political consciousness; develop students who promote the values of occupational justice and demonstrate social and ethical responsibility, and professionalism. The purpose of these different teaching and learning methods is to enable students to actively participate in the learning process and act as change agents, rather than being passive recipients of knowledge transmitted by the educator.

2.5.2   Occupational justice in the curriculum

In exploring the concept of socially responsive education, Duncan & McMillan (2006) maintain that OT curricula provide the space for students to explore and think critically about social justice issues in South Africa. They further assert that the goal of socially responsive education is to advance the development and transformation of students themselves and ultimately the society that they serve. Accordingly, values such as human rights, community development and reflective practice are stressed in the UWC OT education programme (UWC OT Dept, 2008) as it is understood that socially responsive education should underpin values that affirm social justice (De Jongh, Hess-April & Wegner, 2012). In addition, policies such as the United Nations Convention on the Rights of Persons with Disabilities (UN, 2006) and the National Rehabilitation Policy (Department of Health, 2000b) are covered in the curriculum.

While PHC, human occupation, cultural diversity and community-based rehabilitation (CBR) which adopts equalisation of opportunities, social inclusion, and partnerships with people with disabilities as strategies of CBR (ILO, UNESCO & WHO, 2004) were contained in the curriculum content

previously, political consciousness which encompasses occupational justice was added in the reviewed curriculum content.

The tenet of occupational justice in the curriculum encompasses an understanding of the influence of politics on human occupation and is developmentally integrated throughout its contents from first to fourth year. Occupation is emphasised as the means, (process) and outcome (end) through which people achieve health and wellbeing (UWC, OT Dept, 2008). The UWC OT departmental mission of producing politically-conscious and socially responsive graduates is firstly achieved through curriculum content related to occupational justice and a political practice of OT (UWC OT Dept, 2008). As teaching and learning about occupational justice and political consciousness are regarded as developmental processes, they are reflected as such in the curriculum content from first to fourth year (UWC, OT Department, 2009).

The UWC OT departmental mission is secondly achieved through fieldwork, where students, through service learning and practice education, learn to work collaboratively with communities to address local occupational injustices (UWC, OT Dept, 2008). Students from first to fourth year engage in fieldwork in communities that are characterised by social problems and address occupational risk factors through a social and community development approach. In fieldwork, reflection is generally facilitated through the use of Kolb's (1984) learning cycle, which guides students' reflection on their practice through four stages: (1) concrete experience, (2) reflective observation, (3) abstract conceptualisation and (4) active experimentation. Students describe an experience from practice, reflect on that experience, draw conclusions about their learning from the experience and plan how they will put what they have learned into future practice. Through a repeat of the learning cycle, the student makes the link between theory and action by planning, acting out, reflecting and relating it back to the theory.

The mission is thirdly achieved through research where emphasis is placed on the effects of occupational risk factors on people's engagement in occupation.

Table 1 provides an overview of the integration of occupational justice and a political practice of OT in the curriculum.

Table 1: Content related to occupational justice in the UWC OT curriculum.

	HUMAN OCCUPATION	OCCUPATIONAL THERAPY	FIELDWORK	RESEARCH
Year 4	Distributive justice vs. justice as difference. The critical potential of occupational science.	Policies that inform service delivery. Values of a critical practice of OT. Occupation-based community development. Models of disability. CBR. Occupational justice practice frameworks. Practice possibilities for OT in South Africa.	Integration and application of knowledge, values and skills in community practice settings to address occupational justice in community development projects.	Qualitative research related to occupational determinants of health, well-being and/or outcomes of occupationally just practice.
Year 3	Human occupation and occupational deprivation, alienation and imbalance as it relates to adolescents and older adults.	A Social Approach to OT. Occupation-based practice approaches. Concepts of enablement (participation, choice, social justice).	OT intervention to address occupational enablement with individuals.	Quantitative research related to occupational determinants of health and well-being in individuals, groups and communities.
Year 2	Socio-political perspectives of OT. Human occupation and occupational deprivation, alienation and imbalance as it relates to adolescents and older adults.	Occupation-focused health promotion. Community-focused OT.	Community entry. Community needs assessment. Occupation-focused health promotion project.	Literature search and critique related to human occupation and occupational therapy practice with adolescents and older adults.
Year 1	Core constructs of human occupation Link between human occupation, health and well-being. The impact of social inequality, poverty and development on occupational wellbeing. Occupational deprivation, alienation and imbalance.	The role, scope and philosophy of OT. OT and PHC. Theory and principles of occupational justice.	The role of the OT in diverse practice settings. Assessment of the influence of context on occupation.	Literature search and critique related to human occupation and occupational therapy practice.
Awareness, understanding and demonstration of: respect for human rights, diversity, ethics, professionalism; client-centred practice, critical consciousness and willingness to act as agents of change.				

In relation to interdisciplinary education, first and second year students enrol for two faculty-based interdisciplinary courses namely PHC and Health Promotion respectively. In the health promotion course, students develop and implement interdisciplinary health promotion projects that address the health and wellness of community-based groups such as high school learners. Health promotion for people with disabilities as it relates to the health component of CBR, is addressed in various OT modules in the third and fourth year.

2.6   CONCLUSION

In this chapter key contextual factors that influenced the development of the UWC OT curriculum were highlighted. Health reform that occurred in South Africa since 1994 was described in relation to the adoption of the PHC approach and the organisation of the DHS. Current developments to strengthen and revitalise the health system in relation to NHI and the re-engineering of PHC, were also described. The introduction of compulsory community service for health professionals as one feature of health reform and its implications for health professionals' education in South Africa were further explored. The chapter elaborated on developments in OT practice and education around the theory of occupational justice. Finally the influence of these developments on UWC OT education was described. This was followed by an overview of the curriculum in its current form as it relates to the two approaches adopted namely curriculum as process and curriculum as emancipatory. In the following chapter a comprehensive literature review is presented in order to situate occupational justice within broader discussions related to OT education and practice.

CHAPTER 3

LITERATURE REVIEW

3.1 INTRODUCTION

The previous chapter highlighted key contextual factors which influenced the development of the UWC OT curriculum around occupational justice and contributed to the evolution of this study. This chapter aims to situate occupational justice within broader discussions related to OT practice and education at the hand of related literature. In the first part of the chapter the background values that inform the practice of occupational justice are explained. These values constitute beliefs about human occupation, understandings related to occupational injustice and the values that inform the practice of occupational justice. Following this, the application of occupational justice as it relates to OT practice, is explored. Lastly, literature pertaining to OT education and education for social justice is reviewed in order to develop a deeper understanding of the relationship between OT education and occupational justice.

3.2 THE CONCEPT OF OCCUPATION

Occupation refers to the ordinary activities that people do on a daily basis and the way they use their time, energy, interests and skills in meeting their needs (Christiansen & Townsend, 2004). Occupational engagement refers to involvement in occupation and comprises interrelated variables including performance, motivation, interest and well-being (Kielhofner, 2002). Well-being is a state of contentment or harmony with one's physical, mental, emotional and spiritual health; personal and economic security; self-worth, sense of belonging, opportunities for self-determination, and opportunities to engage in meaningful and purposeful occupations (Hammel & Iwama, 2012). Occupational well-being can thus be described as an experience of personal and

social well-being that is derived from satisfaction in engagement in meaningful and purposeful life occupations (Townsend & Polatajko, 2007).

As occupational beings, humans use their skills, agency, capacities and resources to adapt to and gain mastery over their world (Watson, 2006). In relation to this, occupational needs refer to individuals' needs for expression of self-identity, culture, social connectedness and fulfillment through occupational engagement (Townsend & Wilcock, 2004a); including the need for accomplishment, affirmation, agency, coherence, companionship, pleasure and renewal (Doble & Santha, 2008). What people do as occupational beings is affected by their life experiences, capabilities and the opportunities and choices available to them (Watson & Fourie, 2004). In other words, what people do as occupational beings is as much a function of their personal capabilities as it is of the social and structural systems operating in their context. Context comprises physical, psychological, social, cultural, historical and temporal elements. These elements significantly impact what people do every day.

Over the course of the last two decades the concept of occupation in OT evolved as means in therapy to improve a person's functioning after experiencing impairment or illness, to occupational enablement as a principle of occupational justice (Polatajko, 2001). Occupational enablement entails working with people and communities to enhance their ability to engage in the occupations they need to do or by modifying their occupations or the environment to better support their occupational engagement (WFOT, 2012).

3.3   OT BELIEFS ABOUT HUMAN OCCUPATION

The proclamation of four key beliefs about human occupation as the foundation of the profession was the impetus for the evolvement of the concept of occupation as means in therapy to occupational enablement as end and a principle of occupational justice. These beliefs are (1) occupational engagement is a basic human need; (2) there is a relationship between health and occupational engagement; (3) occupation is a source of meaning and purpose; and (4) occupational participation is contextual.

3.3.1   Occupational engagement is a basic human need

The first belief about human occupation is that occupational engagement is a basic human need. According to the Ottawa Charter people must be able to realise their aspirations, satisfy their needs, and cope with their environment to reach a state of health and well-being (WHO, 1986). In view of this, Wilcock (2006) argues that health and well-being cannot be separated from occupational functioning as people's health and well-being are compromised when their occupational needs are not met. She describes a three-way link between survival, health and occupation where occupation provides, protects, maintains and nurtures so that people's survival and biological needs may be met and health achieved. She therefore asserts that occupation is a requirement for health and well-being. This view of occupation is reiterated by Kronenberg and Pollard (2005:58) who emphasise that "engagement in dignified and meaningful occupations is as fundamental to the experience of health and well-being as eating, drinking and being loved".

Accordingly, the OT profession views engagement in occupation as a human right. This is declared by WFOT (2006) in a position paper on human rights which states that people's capacity to construct their own destiny through occupation constitutes a basic human need and thus is a human right of all people. The WFOT position statement on human rights further states that people have the right to be supported to do things that enable them to flourish, and not to be pressured or coerced into dehumanising, degrading or illegal occupations.

3.3.2   There is a relationship between health and occupational engagement

The second belief about human occupation is that there is a relationship between health and occupational engagement (Wilcock, 2006). This belief stems from the perspective that health can only be achieved when people engage in occupations (Polatajko, Davis, Stewart & Cantin et al., 2007) as it is through engaging in occupations that people are able to exercise their physical, mental, social and spiritual capacities (Wilcock, 2006). In relation to this belief,

there are several authors who assert that health and well-being are enhanced when people experience occupational well-being (Wright-St. Claire, 2003; Doble & Santha, 2008; Hammel & Iwama, 2012). These authors define occupational well-being as an experience in which people derive feelings of satisfaction and meaning from the ways in which they manage their occupational lives. They therefore argue that blocking access to meaningful occupation can lead to negative consequences at an individual as well as a societal level.

The association of well-being with occupation is supported in a survey conducted by Wilcock (1998) in which she asked participants to define their personal concept of well-being. The survey indicated that the participants associated feelings of well-being with occupational engagement. This resonates with an extensive review that was conducted by Law, Steinwender, and LeClair (1998) that aimed to establish a link between health, well-being and occupation. The review revealed that people perceived their quality of life to be positively impacted when they are able to maintain everyday activities, interact socially and have community mobility. Higher stress levels and lack of control within a situation were perceived to influence health negatively. The review further revealed that when people experienced a lack of opportunity to engage in occupation they also experienced a decreased sense of satisfaction as well as a decreased sense of health.

3.3.3   Occupation is a source of meaning and purpose

The profession's proclamation that occupation is a source of meaning and purpose (Wilcock, 1998; Hasselkus, 2002; Hammell, 2004) is the third belief about human occupation that is fundamental to occupational therapy. Wilcock (1999:6) contends that occupation is a combination of "doing, being and becoming". She asserts that a dynamic balance between doing (performing activities), being (discovering and re-discovering oneself) and becoming (envisioning one's future self) is central to the occupational therapy philosophy as jointly these concepts embody occupation.

The link between these three dimensions is expanded upon in a review by Hammell (2004) that investigates the contribution that occupation makes to the experience of meaning in a person's life. Her review identifies 'doing', 'being' and 'becoming' as consistent dimensions of meaning in occupation among diverse client groups. In addition, it also highlights belonging (a sense of inclusion in social interaction) as a dimension of meaning in occupation. Hammell (2004) concludes that 'doing', 'being', 'becoming' and 'belonging' are fundamental sources of meaning that people experience through engagement in occupation. Similarly, Polatajko, Backman, Baptiste and Davis et al. (2007) view the link between meaning and occupation as interwoven with how people portray themselves through occupation. It is for this reason that Polatajko, Davis, Stewart and Cantin et al. (2007) assert that the OT profession's concern with occupation is not only with the performance of an occupation, but also with the degree of satisfaction that people derive from it.

3.3.4 Occupational participation is contextual

The fourth belief about human occupation on which OT is founded is the belief that occupational participation is contextual (Townsend & Wilcock, 2004a): that is, the nature of an individual's occupation is influenced by the social and physical environment where people live, work and play (Watson & Fourie, 2004). This relationship between occupation and context is illustrated in the person-environment-occupation model in which Law et al. (1996) propose that a transactional relationship exists between these three elements. They theorise that people's ability to engage in occupation depends on an optimal fit between their personal skills, the demands of the occupation and the environment in which the occupation is performed. Congruence between the person, environment and occupation is therefore necessary for optimal occupational performance to be achieved. Alternatively, incongruence will impede occupational performance.

An example of an incongruent fit between occupation, person and environment is offered by Watson and Fourie (2004) who state that the ability to perform health-giving occupations can be threatened as the result of personal limitation,

deprivation or debilitating environmental conditions. They list examples of contextual factors that may inhibit occupation as physical, social, economic, cultural and environmental. Consequently, the context in which occupations occur can limit people's occupational choices and engagement, resulting in occupational injustice (Polatajko, Backman, Baptiste & Davis et.al, 2007). As Townsend and Wilcock (2004b) regard occupational justice as the receipt of equal privileges for diverse participation in occupations, they assert that it is important that occupational therapists identify how people are affected by occupational injustices in order to reflect on how they are to proceed towards enabling occupational justice. Likewise, Wolf, Ripat, Davis, Becker and MacSwiggan (2010) maintain that working for occupational justice in practice should commence with the identification of occupational injustice outcomes.

3.4   OUTCOMES OF OCCUPATIONAL INJUSTICE

In discussing occupational injustice and its outcomes, Wilcock and Townsend (2000:12) propose that occupational therapists consider inequities that arise in society when people's participation in occupation is "underdeveloped, disrupted, alienated, marginalised, exploited or otherwise restricted". They outline the outcomes of occupational injustice as occupational deprivation, occupational alienation and occupational imbalance (Townsend & Wilcock, 2004a).

3.4.1   Occupational deprivation

Occupational deprivation refers to a lack of occupational choice that people experience when they find themselves in circumstances beyond their control (Wilcock, 2006). Whiteford (2000) describes occupational deprivation as a state in which opportunities to perform occupations that have social, cultural and personal relevance are rendered difficult or impossible due to external restrictions. Occupational deprivation is therefore a result of people being denied the resources and opportunities to engage in occupations when they experience cultural, institutional, physical, political or social restrictions (Townsend & Wilcock 2004b).

In elaborating on circumstances where people may be restricted from engaging in occupation, Wilcock (2006) includes various minority groups, for example women, people with illness or disability and people living in poverty, in her list of people who are most vulnerable to occupational deprivation. Whiteford (2000) further suggests that occupational deprivation can result when a person experiences geographic isolation, poor working conditions or incarceration. Thibeault (2007) distinguishes between occupational deprivation at an individual, social and societal level. She explains that at an individual level occupational deprivation can translate into bio-medical impairments; at a social level it can draw people into a social void while at a societal level it may lead to the marginalisation of groups that are deprived of meaningful occupation.

3.4.2 Occupational alienation

Wilcock (2006: 343) describes occupational alienation as a "sense of isolation, powerlessness, frustration, loss of control, and estrangement from society or self as a result of engagement in occupation that does not satisfy inner needs". Accordingly, occupational alienation is an outcome of occupational injustice that results when people are required to participate in occupations they find meaningless as they lack the power to exercise occupational choice (Townsend & Wilcock, 2004a). In elaborating on this view, Thibeault (2007) asserts that occupational alienation occurs when external forces impact people's occupational choices to the extent that it results in a misfit between their occupational choices and their potential or aspirations. Examples of such instances are when people have little hope of change occurring in their lives and are forced to perform tasks that lack meaning or affect their dignity. It is Thibeault's view that these situations are often perpetuated by power elites in society.

In acknowledgement of the inequalities that are perpetuated by power elites in society, Kronenberg and Pollard (2005) coined the term of occupational apartheid to expose deliberate political forces behind occupational injustice. From their perspective, occupational apartheid is based on the notion that society perceives some people as being different to others. This perceived

difference leads to the "other" being pushed to the periphery of society thus affecting their social and occupational participation. For this reason, Kronenberg and Pollard (2005:65) define occupational apartheid as "chronic established environmental conditions that deny marginalised people rightful access to participate in occupations that they value as useful and meaningful". Thibeault (2007), however, stresses that the term should be used appropriately in contexts where active political intent to deny people from having access to meaningful occupation is evident.

3.4.3   Occupational imbalance

Wilcock (2006:343) defines occupational imbalance as a "disproportion of occupation resulting in decreased well-being". Disproportion of occupation refers to some people having either too little or too much to do so that their occupational engagement fails to meet their unique social, mental or rest needs as a result. Occupational imbalance will therefore differ from person to person in relation to their capacities, interests and responsibilities and could result in either burnout or boredom, thereby compromising their health and well-being.

3.5   OCCUPATIONAL JUSTICE IN PRACTICE

The reorientation of the OT profession around the concept of occupational justice is perceived by several authors to have necessitated a more critical practice of OT, particularly in the social field (Thomas, Penman & Williamson, 2005; Galheigo, 2005, 2011a; Kronenberg, Algado, & Pollard, 2005; Townsend & Polatajko, 2007; Pollard, Kronenberg & Sakellariou, 2008; Kronenberg, Pollard & Sakellariou, 2011; Hammell & Iwama, 2012). According to these authors the rights-based and enablement approaches, i.e. enablement of occupational potential and empowerment through occupations, to occupational justice is informed by a critical social perspective given its concern to bring about social change. They therefore stress that occupational therapists embrace a critical stance in practice if the values of the profession are to translate into meaningful contributions to social justice.

3.5.1   A critical practice of OT

According to Galheigo (2005:93), embracing a critical stance in OT implies that emancipation and empowerment are constantly fostered and that "the importance of helping people to help themselves to take their history into their own hands" is acknowledged. In a deeper exploration of the adoption of a critical standpoint in OT, authors such as Galheigo (2011b) and Whiteford & Townsend (2011) engage with the notion of epistemic reflexivity. Bourdieu and Johnson (1998) assert that transformation must forego the act of epistemic reflexivity which draws attention to the social conditions under which disciplinary knowledge comes into being. With regards to its practice in a specific situation, Bourdieu and Johnson (1998) explain that epistemic reflexivity firstly entails a critical analysis of underlying assumptions that underline the construction of knowledge in a particular situation and, secondly, an interrogation of what could be possible in that situation. In view of this, Galheigo (2011b) as well as Whiteford and Townsend (2011) call on occupational therapists to engage in epistemic reflexivity to identify how their underlying assumptions impact practice and then to engage critically with broader possibilities in practice from that position.

For Pollard, Kronenberg and Sakellariou (2008:10), embracing a critical stance in OT implies that the profession adopts "a political practice of occupational therapy". They maintain that a political practice of OT demonstrates an understanding that practice with marginalised people should be geared towards enabling them to construct their own destinies. They therefore stress the need for occupational therapists to consider underlying structural, cultural and contextual factors that impact people's occupational rights through a process of political reasoning. A practice of critical OT thus acknowledges that well-being cannot only be achieved by enhancing people's abilities, but also endeavours to address the conditions of people's lives (Hammell & Iwama, 2012). Most of the above views around adopting a critical stance on OT have been incorporated into three occupational justice practice frameworks as evident in contemporary OT literature.

3.5.2 Occupational justice practice frameworks

The first occupational justice practice framework is that of Stadnyk (2007:80) who proposes a practice framework wherein outcomes of occupational justice are conceptualised as having people's occupational rights met. She explains that occupational rights encompass four aspects: (1) the right to experience occupation as meaningful, (2) the right to achieve health and social inclusion through participation in occupation, (3) the right to exert autonomy through choice in occupations and (4) the right to benefit from fair privileges for diverse participation in occupation. Stadnyk (2007) therefore proposes that occupational therapists undertake to have people's occupational rights met by transforming occupational injustices through occupational empowerment.

The second framework that was compiled to guide the practice of occupational justice is the Participatory Occupational Justice Framework or POJF 2010 proposed by Whiteford and Townsend (2011). They name six features of critical OT: (1) critical reflexivity, (2) participation and collaboration, (3) social inclusion, (4) individual and/or shared occupational engagement, (5) social change through occupational enablement, and (6) visions of possibility. In the POJF 2010 occupation, enabling and justice are portrayed as the foundation of practice while the adoption of an occupational perspective, empowerment-oriented methods of working in partnership with people, and social inclusion are profiled as practice processes. Each practice process is supplied with questions that prompt critical reflexivity so that occupational therapists may select enablement skills "that are congruent with the activism, social reform and justice foundations of OT" (Whiteford & Townsend, 2011:72). Social inclusion moves beyond enabling individual well-being to enabling equitable opportunity, resources and occupational rights, while strategies namely CBR, population approaches and consideration of power and inequity in everyday life, are highlighted.

The third occupational justice practice framework, the Leadership in Enabling Occupation (LEO) Model by Townsend, Polatajko, Craik, and Zweck (2011) is presented as a tool to extend the OT profession's strategic use of scholarship,

accountability, funding, and practice to take ownership of occupational justice. In the LEO Model the social foundations of OT are described as collaboration, the facilitation of social change to build structures and processes for equitable citizenship and the enablement of social inclusion regardless of age, capabilities, race, religion or sexual orientation. The LEO Model makes a clear distinction between effective and ineffective enablement in practice. Townsend, Polatajko, Craik, and Zweck (2011) describe effective enablement as real-life engagement where occupational therapists are flexible and responsive to client needs and collaborate with the client in an environment that fosters equity and citizenship. On the other hand, ineffective enablement is described as being passive, disengaged, lacking in action, authoritative and focused on professional expert-centred interventions geared to fix the body.

In each one of the above occupational justice practice frameworks social change through occupational enablement is emphasised as a key approach to occupational justice. The implication of this understanding of occupational justice is that in practice it entails power sharing and collaboration (Townsend & Polatajko, 2007). A shortcoming of all three frameworks is that it does not how occupational therapists could analyse power dynamics in specific contexts and from that point work towards people's empowerment. Rowland's (1997:13) classification of power offers a framework for the analysis of power dynamics that could be useful for occupational therapists. She categorises four types of power relations: (1) 'power over' is the traditional way of defining power where power is connected to coercion and domination with one or more people having control or influence over others; (2) 'power with' stresses the way in which gaining power strengthens the power of others; (3) 'power to' emphasises access to decision making and an ability to resist and challenge domination; and (4) 'power within' that refers to personal agency. She asserts that the process of empowerment must start with the individual and requires a change in their own perceptions about their rights, capacities and potential. Therefore, empowerment, must not just concern gaining access to decision-making, but "it must also include the processes that lead people to perceive themselves as able and entitled to occupy that decision-making space" (Rowland, 1997:14). This is what Rowland means with 'power within'.

According to Rowland (1997:15) empowerment operates within three dimensions: (1) 'personal' that involves developing individual confidence and capacity; (2) 'relational' that involves developing the ability to negotiate and influence the nature of a relationship and decisions made within it; and (3) 'collective' where individuals work together to achieve a more extensive impact that each could have alone. This includes collective action based on co-operation rather than competition.

3.5.3   An African perspective on the practice of occupational justice

While OT has been criticised for largely ignoring social and political contexts that enable engagement in occupation, the literature pays insufficient attention to human relations as part of the context that shapes collective engagements in occupation. In relation to this, Iwama (2006:36) comments that ''the construct of 'occupation' subsumes many of the common assumptions that many Westerners hold to be true of their world''. Likewise, Townsend and Wilcock (2004a:80) acknowledge that occupational justice concepts are based on a ''Western view of individual autonomy''. According to Watson (2006) this view reinforces Western individualism and ignores the interdependent and social nature of occupation in the African context. She argues that whereas the Afrocentric worldview is collectivist and observes all life events as tied together and interacting with one another, the western worldview is more individualistic and generally understood as having the right to autonomy and independence. Galvaan (2012) asserts that this has led to understandings of occupation and related constructs such as occupational identity, choice and motivation being de-contextualised, meaning that it is understood to be existing within the individual but separately from his/her context.

The Western view of autonomy is reflected in Stadnyk, Townsend and Wilcock's (2010: 330) description of an occupationally just world as one that ''enables individuals to flourish by doing what they decide is most meaningful and useful to themselves and to their families, communities and nations''. This description does not pay attention to how cultural contexts may affect individual autonomy or how human relations as part of the context shape collective

engagements. African scholars have been particularly vociferous in highlighting a focus of human occupation that views individuals in transactional relationships with their context (Watson, 2006; Sherry, 2010; Galvaan, 2012; Ramugondo & Kronenberg, 2013).

Sherry (2010:69) observes that "African culture does not promote the concept of individuals being in complete control of their own fate, and this is certainly not the lived experience of the majority, who live their lives vulnerable to disease, poverty, conflict, the elements and other factors way beyond their control". What Sherry firstly refers to here is the African ethic of Ubuntu that governs human engagements on the African continent and depicts the philosophy that a person is a person through other persons, highlighting interconnectedness between individuals.

Drawing on the ethic of Ubuntu, Ramugondo and Kronenberg (2013) assert that occupational therapists have the obligation to identify instances of occupational injustices which ultimately impact negatively on collective occupational well-being. According to Ramugondo and Kronenberg Ubuntu implies an interactive ethic in which relationships and who people are as human beings is always being shaped by their interaction with other people and by what they are able or unable to do within the context of their community. They suggest that this necessitates the analysis of occupations not only in terms of those who are excluded on the basis of personal attributes or group affiliation, but also in terms of the position that communities adopt for themselves. Ubuntu therefore presents a philosophy on the basis of which a social orientation of occupational therapy may be expanded, with an emphasis on collective occupational well-being as a principal focus of practice (Ramugondo & Kronenberg, 2013).

In alerting to the conditions of poverty and deprivation experienced by the majority of people on the African continent, Sherry secondly refers to the idea that structural and chronic poverty compromise people's occupational potential which, in turn, narrows their possibilities for experiencing health and well-being (Fourie, Galvaan & Beeton, 2004). According to the Ottawa Charter for Health Promotion (WHO, 1986) an individual or group must be able to identify and

realise aspirations, satisfy needs and change or cope with the environment in order to reach a state of complete physical, mental and social well-being. In other words, for people to experience health and well-being they must be able to practice agency in their lives. Being able to practice collective agency could thus be regarded as a prerequisite to health and well-being from an African perspective.

While taking an occupational justice approach to health and well-being requires a broader conceptualisation of human agency that introduces a collective element, Ramugondo (2012:337) raises the issue of occupational consciousness, which she defines as "an appreciation of the role of personal and collective occupations of daily life in perpetuating hegemonic practices, and an appraisal of resultant consequences for individual and collective well-being" In explaining how this applies to practice, Ramugondo cautions that an external approach, where occupational therapists make observations about the impact of hegemonic practices on people's occupation and resultant consequences for their health and well-being, cannot result in radical change. She therefore asserts that this analysis needs to be done by the collectives themselves. Hence, she proposes the creation and facilitation of opportunities for people to reflect on the nature of their everyday occupations themselves. Through this process, Ramugondo argues, people may become conscientised about how their own choice of everyday occupations could possibly perpetuate hegemonic practices. It is this process that Ramugondo refers to as the facilitation of occupational consciousness.

Taking cognisance of the above-mentioned issues, literature from South Africa offers strategies for practice that can be understood as constituting an 'African' approach to occupational justice. Watson and Fourie (2004) argue that understanding how occupation is constructed within a particular society requires an exploration of culturally appropriate occupational forms in order to build an understanding of what a particular community may consider as important for their health and well-being. Galvaan (2012) maintains that given the connection between the individual and the collective in the African context, interdependence rather than independence, maintaining relatedness and

promoting the needs of others in one's group, become an important focus in the occupational enablement of individuals, groups and communities. Similarly, Watson (2013) asserts that if occupational justice is to be claimed for people in Africa, occupational therapists need to adopt a population approach to social change which implies the inclusion and participation of the whole community and the promotion of people-centred development. In other words, an African approach to occupational justice should mirror the African orientation to collective values which acknowledge that the health and well-being of communities are developed through interdependence and interconnectedness.

Examples from South Africa of occupational therapists working together with groups of people with disabilities and youth illustrate how occupation-based strategies that consider diverse opportunities for participation build collective agency through participation in disability research (Lorenzo, 2004) and community development (Galvaan 2012). One example related to disability research conducted in several provinces of South Africa, illustrates how strategies such as the generation of collaborative partnerships involving community-based organisations (CBOs), disabled people's organisations (DPOs) and researchers led to reciprocal capacity building (Lorenzo & Joubert, 2011). Strategies such as the creation of spaces for reflection and action were build into the research process and fostered the collective agency of all involved: firstly in the identification of barriers to inclusion, and, secondly, in developing strategies for social change to achieve equal opportunities for youth with disabilities.

The above literature illustrates that if occupational justice is to be claimed for people in the African context, strategies that recognise people as a resource; incorporating African values such as Ubuntu; and indigenous traditions such as narratives, need to be dimensions of OT practice. Most importantly, the literature illustrates that the inclusion and participation of groups and even whole communities in joint reflection and action, would have to occur so as to understand the nature of daily life within people's particular contexts and to work with them in building their collective agency in order to address occupational injustices.

3.6   OCCUPATIONAL ENABLEMENT APPROACHES, STRATEGIES AND SKILLS

3.6.1   Occupation-based practice

Occupation-based practice is an occupational enablement approach that is defined by Wilcock (2006:282) as the facilitation of quality of life "through advocacy and mediation and through occupation-focused programs aimed at enabling people to do, be and become according to their natural health needs." Similarly, Townsend, Beagan, Kumas-Tan, Versnel, and Iwama et al. (2007) regard best practice in OT as the offering of effective occupation-based enablement so that health, well-being and justice may be achieved.

In communities, the occupation-based therapist interprets local needs from an occupational and social perspective rather than from an individual (medical) perspective (Townsend, Cockburn, Letts, Thibeault & Trentham, 2007). This is illustrated in a study on the leisure needs of people with mental health problems in which the findings revealed that occupational therapists could address occupational justice by enabling clients with mental illness to overcome contextual factors that hinder their participation in leisure occupations (Pieris & Craik, 2004). These factors include transport difficulties and lack of opportunities for socialising and networking (Pieris & Craik, 2004). This example also supports the viewpoint of Townsend, Polatajko, Craik and Davis (2007) who state that it is difficult for occupation-based practice to be separated from the client-centred approach.

3.6.2   The client-centred approach

Traditionally, client-centred practice focused on practice with individuals but efforts to extend it beyond the individual are emerging in OT literature (Scaletti, 1999; Banks & Head, 2004; Pollard, Alsop & Kronenberg, 2005; Sakellariou & Pollard, 2006; Lauckner, Pentland & Paterson, 2007; Leclair, 2010). The importance of human agency and self-reliance is acknowledged as it is recognised that humans participate in occupations as individual, autonomous

agents (Townsend & Wilcock, 2004a); that communities need to be active participants in shaping their own destinies (Thibeault, 2002); and that people's capacity for self-healing can be enhanced when they take responsibility for their own health (Finlay, 2001).

According to Law, Baptiste and Mills (1995) client-centred practice embraces a philosophy of respect for people in that it recognises the autonomy of people, the strengths that they bring to the occupational encounter and the benefits of a client-therapist partnership in ensuring that services fit the clients' context. In the same way, Townsend, Polatajko, Craik and Davis (2007) assert that client-centred occupational enablement necessitates that practice is focused on clients' needs, goals, values and interests in collaboration with them. This implies that the inherent power imbalance between therapist and client is recognised and that a power shift from the therapist to the client is facilitated in addressing his or her needs.

In addressing the power imbalance between client and therapist, Sumsion and Law (2006) identify four core elements that relate to the power differential between OT and client: (1) listening and communication that, if used effectively, can address this power differential; (2) partnership that involves respecting clients' experiences; (3) choice, through which clients' values are respected and they are given an opportunity to set their own goals; and (4) hope that relates to respecting the clients' personal sense of wellness and spirituality. Polatajko, Molke, Baptiste, Doble and Santha et al. (2007) further suggest that occupational choice and control are imperatives for OT practice as they pave the way for human agency as a key feature in addressing occupational injustice. McCormack and Collins (2010) furthermore assert that if the power differential between therapist and client is not addressed by shifting the balance of power towards the client, OT practice may actually be oppressive and disempowering.

3.6.3   Health promotion

The Ottawa Charter for health promotion (WHO, 1986) defines health promotion as the process of enabling people to increase control over and improve their health. Health promotion thus moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions. It is argued that as enablement from a health promotion perspective implies creating possibilities and building people's capacity for occupational engagement, it highlights the role of occupational therapy in health promotion (Townsend & Palatajko, 2007).

According to Scaffa, Van Slyke and Brownson (2008) health promotion efforts cannot focus only on intervention at the individual level if it is to be effective. This understanding of health promotion is informed by Wilcock (2006) who asserts that because of the reciprocal links between people and their environments, organisations, communities, populations and policymakers must also be involved in intervention. It has further been suggested that through health promotion occupational therapists can develop partnerships with community members that can create opportunities for occupational engagement that meet local needs (Restall, Leclair & Banks, 2005). Through partnerships, networks among community members can be strengthened to promote their ability to determine community goals and to develop courses of action to pursue those goals (Trentham, Cockburn & Shin, 2007).

Enabling together with advocacy and mediation are named as key strategies of health promotion in the Ottawa Charter (WHO, 1986). In OT practice, enabling refers to the facilitation of people's agency over those things which impact their health (Townsend, Beagan, Kumas-Tan & Versnel et al., 2007), advocacy refers to actions undertaken to include different occupations as a major resource for people's development (Watson, 2004), while mediation highlights coordinative actions between different stakeholders in pursuit of health (Townsend, Beagan, Kumas-Tan & Versnel et al., 2007).

Dhillon, Wilkins, Law, Stewart and Tremblay (2010) explored occupational therapists' reasons for advocacy in practice and found that they advocate for equality in opportunities for occupational engagement to facilitate occupational performance. In addition, the POJF 2010 (Whiteford & Townsend, 2011) specifically profiles advocacy, collaborative engagement and mediation as specific enablement skills related to occupational justice. Similarly, Townsend and Palatajko (2007) describe enablement as a process in which skills such as collaboration and attentiveness to issues of power and diversity are employed to bring about social change.

An enablement checklist devised by Townsend, Beagan, Kumas-Tan and Versnel et al. (2007) provides a useful tool for occupational therapists to determine whether practice is in fact enabling. The checklist contains client-centered practice, visions of possibilities and collaborative power-sharing as enablement foundations, while advocacy, collaboration, consultation, educating, designing and building are listed as enablement skills. In addition, Watson (2004) names policy development as an enablement skill.

An example of collaboration is described by Campbell, Missiuna, Rivard and Pollock (2012) in their application of the Partnering for Change (P4C) model which is a school-based service delivery model. In the P4C model of service delivery, partnership focuses on capacity building through collaboration with teachers in the classroom. Occupational therapists assist teachers to identify children with learning difficulties and then develop their skills in supporting children's everyday functioning in school. OT intervention does not focus on remediation. Instead, teachers' capacity to manage children's learning difficulties in the classroom is developed. The focus is on knowledge transfer to ensure that teachers acquire the information and strategies they need to identify and manage children who present with difficulties in the classroom.

3.6.4   Community development

Community development has been identified as an approach which occupational therapists can use to make a unique contribution to the health of communities (Lauckner, Pentland & Paterson, 2007). The literature differentiates community development approaches based on meaningful participation, empowerment and community capacity building from those labeled as community-based practice. In community-based practice, professionals identify problems and develop strategies to address them, while community development supports community groups to address self-identified health priorities and strategies (Labonte 1993).

Wilcock (1998:238) defines community development as "community consultation, deliberation and action to promote individual, family and community-wide responsibility for self-sustaining development, health and well-being". She asserts that community development is an holistic, participatory approach that is aimed at facilitating a community's social and economic development based on community analysis, use of local resources and self-sustaining programmes. Community development is therefore understood as an approach that occupational therapists employ to respond to community-identified occupational needs by strengthening local resources and capacities (Leclair, 2010).

A widely known typology of community development is that of Rothman and Tropman (1987) in which they outline three approaches for working with communities: (1) social planning, (2) locality development and (3) social action. The social planning approach emphasises high reliance on outside experts who take on the role of advisor and consultant. Through the provision of formal services these experts attempt to solve community problems logistically. Due to its expert orientation, this approach is often criticised for not incorporating key principles of community development such as participation.

The locality development and social action approaches emphasise consensus and collaboration. In locality development, the community developer is the

facilitator or catalyst who brings people together to share experiences which are essential for understanding the community's issues. The prospect of enablement thus becomes greater when community members are all involved. The social action approach builds on the belief that marginalised groups experience social injustice, thus real change occurs through the re-distribution of power.

3.6.5   Occupation-based community development

In light of recent developments in the profession, occupational therapists began to explore how community development can be integrated into OT practice (Banks & Head, 2004; Watson & Swartz, 2004; Lauckner, Pentland & Paterson, 2007; Leclair, 2010). In one study designed to explore OT perspectives regarding their role in community development, the participants described community development as a multi-layered community-driven process in which the community's capacity is strengthened to effect social change that results in increased access to occupational participation (Lauckner, Pentland & Paterson, 2007). In another study, conducted by Lauckner, Krupa and Paterson (2011), three cases of Canadian occupational therapists that worked in community development were examined to develop a conceptual framework for community development from an OT perspective. The resultant framework outlined nurturing community partnerships, building community capacity, influencing health services and linking sectors as strategies within community development. The use of self which allows for the sharing of power to create opportunities for meaningful occupational engagement is identified as a key practice process that grounds each strategy.

Watson (2004) is of the opinion that the four main areas that should be addressed in practice are the creation of an enabling environment, opportunities for employment, poverty alleviation and the eradication of social exclusion. She asserts that OT could significantly address these four areas if the profession adopts a population rather than individual perspective. Watson (2004) further contends that a population approach to community development can only be successful when appropriate community entry is conducted and partnerships

with the community established to bring about transformation for the improvement of the community.

A newly developed framework, which is particularly relevant to the African context as discussed earlier, is that of occupation-based community development introduced by Galvaan and Peters (2013) who stress that this form of practice is a long-term process where hegemonic practices in and of everyday life are confronted through promoting participation. Not only are structural inequalities challenged in the process but so are entrenched mindsets. The rationale behind this approach is that possibilities for reducing poverty and inequality are not only restricted by limited structural opportunities, but also by the notion of internalised oppression (Galvaan, 2012). This links with Ramugondo's (2012) conceptualisation of occupational consciousness which highlights the power of self-directed occupational analysis in relation to health and well-being, and purports that individuals and collectives have the ability to influence their own unfolding occupational narratives.

In occupation-based community development opportunities for people to reflect on the nature of their everyday occupations are facilitated to assist them to identify and reflect on the manner in which hegemonic practices influence their occupational engagement, and the way in which their own occupations may serve to perpetuate these hegemonies (Galvaan & Peters, 2013). Hence, occupation-based community development encompasses building people's capabilities while challenging disadvantage; increasing people's power over their choices, chances, resources and institutions; and utilising policy, political action and education to achieve this (Galvaan & Peters, 2013).

According to Watson (2013) a practice of community development that is occupation-based could be implemented according to the principles of community based rehabilitation (CBR). She proposes that by adopting the CBR implementation model (WHO, 2010), occupational therapists could approach empowerment of communities within a person-environment-occupation diagnostic, planning and implementation perspective.

3.6.6 Community based rehabilitation (CBR)

CBR is a strategy within general community development for the rehabilitation, poverty reduction, equalisation of opportunities and social inclusion of all people with disabilities (WHO, 2010). It is implemented through the combined efforts of people with disabilities themselves, their families, organisations and communities, and the relevant governmental and non-governmental health, education, vocational, social and other services (WHO, 2010). This approach places CBR within an inclusive development framework as the strategy to achieve the goal of community-equal opportunities for persons with disabilities. Inclusive development in the CBR context means that partnerships and alliances are necessary between different stakeholders, especially between CBR, disabled people's organisations (DPOs), families of persons with disabilities and governments (Thomas, Kuno, Nazmdeh, Davies, Kumazawa & Ilagan, 2010).

The World Health Organization (WHO) CBR guidelines (WHO, 2010) were developed to implement the definition of CBR. The guidelines target the key sectors of development that need to become inclusive. It lists the main objectives of CBR as the reduction of poverty by ensuring that health, education and livelihood opportunities are accessible to people with disabilities, ensuring their equal rights and participation in society as well as the empowerment and capacity building of people with disabilities (WHO,2010). These objectives are supported by the World Disability Report which states that more than a billion people or about 15% of the world's population live with a disability (WHO & Worldbank, 2011). The report further indicates higher disability prevalence among people who live in conditions of poverty. A key issue highlighted by the report is the lack of service provision experienced by people with disabilities who are particularly vulnerable to deficiencies in services such as health care, rehabilitation, support and assistance.

The majority of the population in South Africa lives in conditions of poverty and universal and equitable access to health care is still out of reach. A study conducted by Grut, Mji, Braathen and Ingstad (2012) in the rural Eastern Cape, revealed that people with disabilities who live in resource-poor areas experience

a number of barriers associated with individual and societal poverty. Key challenges for people with disabilities in these areas were highlighted as unavailability and inaccessibility of the health services combined with financial constraints and inadequate and inaccessible transport. This concurs with findings of another study conducted in the rural Eastern Cape by Duncan and Watson (2009) which revealed that people with disabilities are subject to institutional and environmental exclusion which are relative to their community's pervasive poverty. The impact of structural poverty i.e. the situation of people whose advancement is blocked by patterns of power and discrimination in society (Graaf, 2001), can be seen in these findings in terms of how structural inequalities render people with disabilities powerless. The removal of social, economic and institutional barriers would thus need to be addressed if the empowerment of people with disabilities is to be facilitated.

This is indeed achievable through CBR as shown by a study conducted by Chappell and Johannsmeier (2009). They employed qualitative methods to evaluate the impact of CBR as implemented by community rehabilitation facilitators (CRFs) in both urban and rural settings within six provinces of South Africa. The study showed that the impact of CRFs was not just the result of individual medical rehabilitation but included aspects of community development, poverty reduction, social inclusion and equalisation of opportunities. The study did, however, also point out gaps in service-delivery perceived by persons with disabilities including, poor identification of needs, not having basic needs met and inadequate community interventions.

International and national policies furthermore provide a strong directive for adopting rights-based inclusive development and empowerment approaches to service delivery for people with disabilities. At an international level, the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) elaborates on the rights of persons with disabilities in detail and states that comprehensive rehabilitation services are needed to ensure the equal rights and participation of persons with disabilities in societies (UN, 2006). The principles of the UNCRPD include: respect for dignity, autonomy, freedom and independence, non-discrimination, full and effective participation and inclusion

in society, respect for difference and acceptance of persons with disabilities as part of human diversity, equality of opportunity and accessibility. The UNCRPD was formally ratified by South Africa and thus it was accepted by the Government as legally binding. At a national level, the Integrated National Disability Strategy (INDS) serves as a framework for the integration of disability issues in all governmental programmes in South Africa (Office of the Deputy President of South Africa, 1997), while the National rehabilitation policy (Department of Health, 2000b) adopts CBR as an integral part of PHC.

The CBR guidelines (WHO, 2010) are based on the principles of the UNCRPD and can be seen as a tool for its implementation. The CBR matrix (figure 2) was used as a framework for developing the CBR guidelines and consists of five components of well-being: health, education, work, empowerment and social participation, of which each has five key elements that inform the implementation of CBR (WHO, 2005). The guidelines provide practice principles to guide the implementation of the various components in the matrix.

Figure 2: CBR Matrix (WHO, 2005)
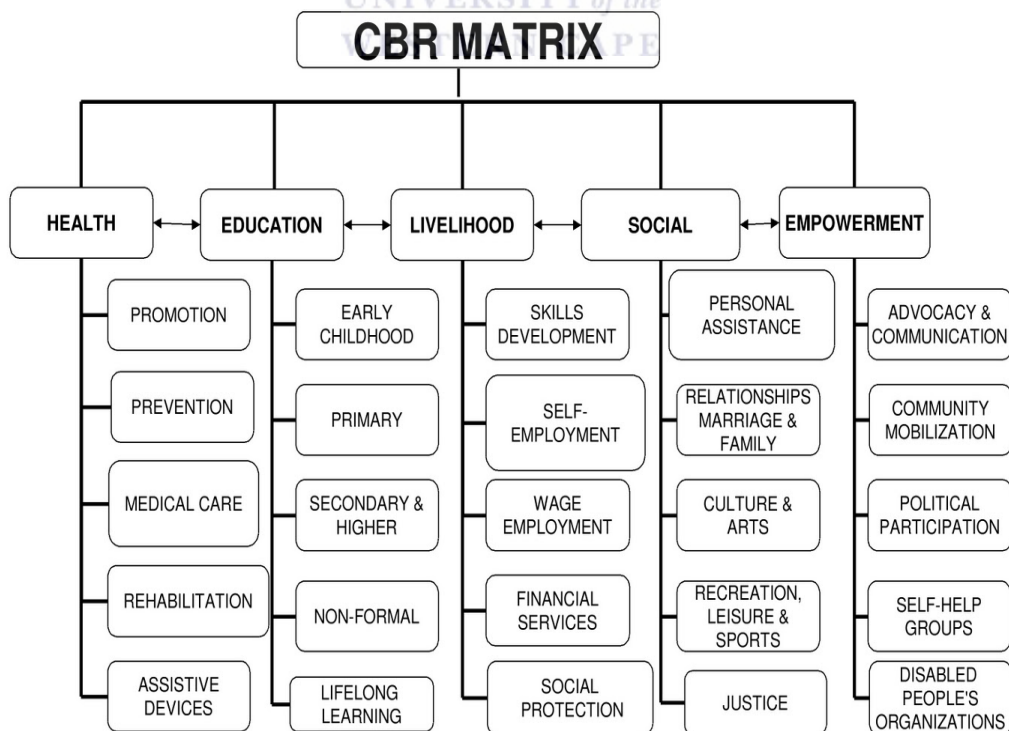
The health component is geared towards assisting people with disabilities to achieve their highest attainable standard of health. The role of CBR is to work closely with the health sector to ensure that the needs of people with disabilities and their family members are addressed in the areas of health promotion, prevention, medical care, rehabilitation and assistive devices. Rehabilitation services can be offered in a wide range of settings, including hospitals, clinics, specialist centres, community facilities and homes. Professionals are encouraged to become trainers and mentors so that they can reach as many people with disabilities as possible. The guidelines addresses access to specialised rehabilitation services which are often based in large urban centres, and state that consideration must be given to the cost implications for people with disabilities. In this regard it is suggested that professionals build the capacity of local resources and contribute to ensuring strong linkages with specialist services not available at the local level.

The education component addresses access education and lifelong learning in order for people with disabilities to fulfill their potential and effectively participate in society with a sense of dignity and self-worth. A livelihood comprises the capabilities, assets (including both material and social resources) and activities required for a means of living and is sustainable when it can cope with stress, maintain or enhance its capabilities and assets, and provide sustainable livelihood opportunities for the next generation (Chambers & Conway, 1991). The goal of this component of CBR is for people with disabilities to gain access to social protection measures, generate enough income to lead dignified lives and contribute economically to their families and communities. The role of CBR is to facilitate access to skills development and livelihood opportunities and to enhance participation in community life for those people with disabilities.

The social participation component is geared towards the equalisation of opportunities and social inclusion of people with disabilities through collaboration with all stakeholders to bring about social change. Although it is presented as a separate component to signify its importance, empowerment is a common thread in the guidelines. It is described as a process that begins when

people recognise that they can change their situation and then do so. This implies the facilitation of human agency and capacity building of people with disabilities, their families and communities and highlighting the promotion of self-reliance as well as community action to remove barriers for active participation (WHO, 2010).

The CBR matrix allows programmes to select options which best meet their local needs, priorities and available resources. In order to ensure the relevance of CBR for people with disabilities, their families and the communities in which they live a comprehensive multi-sectoral approach to address the five CBR components of well-being is adopted. The five components and their elements are underpinned by the principles of participation, inclusion, sustainability and self-advocacy (WHO, 2010). The CBR guidelines emphasise that community involvement is an essential element of inclusive development and therefore of CBR programmes. These principles should inform the activities within each of the five components.

3.7 THE CHALLENGE OF APPLYING OCCUPATIONAL JUSTICE IN PRACTICE

In the course of this literature review it became apparent that OTs experience several constraints in their attempts to embody occupational justice in practice. The literature highlights a number of factors that inhibit OTs' ability to promote occupational justice in everyday practice. Méthot (2004) is of the opinion that the OT profession's emphasis on the promotion of healthy occupation may be at odds with the curative approach of the medical model that in some instances, is still dominant in health care. She states that as OTs are often pressured by managers to be cost-effective and to offer short-term interventions, it creates a disjuncture between the profession's philosophical roots and the realities of practice. As a result, OTs may feel that they are not able to practice according to the way in which they were educated. Méthot (2004) therefore asserts that OTs require support in order to combat professional isolation that may result from the philosophical, geographical and institutional barriers that they may encounter in practice.

Similarly, Whiteford (2007) maintains that there are threats to the continuing development of diversity in occupational therapy. She states that current OT practice occurs in a time of managerialism in which economic considerations dominate OT practice, thereby forcing it to become homogenised and rigid despite complex needs. Likewise, Creek (2011) maintains that the likelihood of OT becoming so conformist that its capacity to adapt to the rapidly changing social, political and economic conditions in society may be lost, poses a great risk to the OT profession.

Townsend, Polatajko, Craik and Zweck (2011) identify several challenges that OTs may encounter around the implementation of occupational justice-informed practice. They, however, suggest that in encountering these challenges opportunities may arise where OTs could demonstrate leadership around occupational justice in practice. The first challenge described by Townsend, Polatajko, Craik and Zweck (2011) relates to the lack of appropriate evidence that supports OT practice. They therefore assert that an opportunity for leadership lies in the generation of evidence that addresses human rights and restrictions in occupational participation from the perspectives of those who are at risk or marginalised. The second challenge is that accountability documentation (e.g. statistics forms) does not link OT with injustice. They therefore contend that an opportunity for leadership lies in the design and negotiation of accountability documents that take occupational injustice issues into consideration.

A third challenge in relation to occupational justice identified by Townsend, Polatajko, Craik and Zweck (2011), is that funders for programmes on enabling justice, participation and human rights are scarce with virtually no awareness of the role that OTs could play in such programmes. They therefore argue that this challenge creates an opportunity for collaboration with like-minded partners so that OT may be presented as a translational profession that can bridge health, social and educational sectors. A fourth challenge is that occupational therapists practice in settings where systems narrow OT practice and overlook the work of enabling occupational justice. According to Townsend, Polatajko, Craik and Zweck (2011) this presents an opportunity for occupational therapists to partner

with clients and communities to motivate practice that has the social trademark of enabling occupational justice.

A key challenge related to the application of occupational justice in practice that is highlighted in the literature, is that of a lack of OT awareness and professional recognition found among policymakers, other health care professionals and consumers (Newton & Fuller, 2005; Lysaght & Wright, 2005; Wilding, 2011; Tariah, Abulfeilat, & Khawaldeh, 2011). For instance, Newton and Fuller (2005) identify a number of challenges that OTs, who work in rural and remote areas, may encounter. These challenges include professional isolation, resource constraints and limited opportunities for professional development. Newton and Fuller (2005) emphasise that when OTs find themselves in situations where other professionals do not appreciate their role, due to a lack of OT awareness, practice becomes even more challenging as interprofessional networks for communication may be non-existent, thus raising the possibility of occupational therapists encountering hegemony in practice.

Hegemony refers to the power that a dominant group exerts over another, regardless of whether the other group has consented to this (Gramsci 1978). In order to counter hegemony OTs would have to resist the hegemonic pressure exerted on them by developing alternative strategies (Cascao, 2008). Kronenberg, Pollard and Ramugondo (2011) suggest that occupational therapists engage in a political possibilities-based practice when they perceive themselves to be in conflict with hegemony. This implies that OT practice influences to the extent that others are attracted to adopting their perspectives. Accordingly, Kronenberg, Pollard and Ramugondo (2011) name skills such as creative networking, writing proposals, political lobbying, debating and negotiating as requisites for occupational therapists to shape and influence the face of health care in South Africa.

In a participatory action research study conducted by Wilding (2011) to better understand issues related to occupational therapy awareness in a hospital setting, she discovered that the OT profession is not well understood by other professionals. What surfaced as rather significant is that Wilding's (2011)

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discovery that this lack of regard for the profession may have been perpetuated by occupational therapists' conformist behaviour, thereby increasing hegemony and contributing to professional identity problems. The occupational therapists that participated in Wilding's study passively complied with others expectations of them even if it meant that they had to practice in ways they did not fully agree with. Wilding concluded that the dominant discourses of financial rationalisation and medical epistemology in the hospital acted as hegemonies that manifested in the occupational therapists' unconscious compliance with the processes and protocols of the hospital.

Rather than questioning whether they ought to do what others wanted them to do, they experienced guilt at not being able to meet the demands that were placed upon them. However, as the occupational therapists began to reflect upon their practice within the research group, it started to change. Consequently, Wilding (2011) proposes that the challenge of hegemony can be overcome when occupational therapists engage in ongoing reflection on the impact that discourses have on their practice as well as on their own attitudes and behaviours. This, she argues, may enable them to improve the professional recognition, representation and autonomy of OT.

Hegemony as a challenge to occupational justice also surfaced in a study conducted by Galvin, Wilding and Whiteford (2011) that explored how human rights relate to the daily practice of OT. These researchers identified that a dissonance exists between the ideal and the reality of human rights' practice in OT. The findings of their study concur with that of the study conducted by Wilding (2011) in that they related this dissonance to the medical dominance in the health service. Galvin, Wilding and Whiteford (2011) concluded that medical dominance obscures clients' needs (other than medical needs), thus having a homogenising effect that makes it difficult for occupational therapists to see injustices experienced by individual persons.

They also identified that occupational therapists may neglect occupational injustices due to an overemphasis on civil and political rights in the societal context and an under-emphasis on occupational needs and rights within the

practice context. As proposed by Wilding (2011), they also recommend that occupational therapists engage in reflection and dialogue around occupational justice and how the ideals of human rights can be incorporated in practice with each other. Galvin, Wilding, and Whiteford (2011) further assert that opportunities to participate in a dialogic space that centers on human rights and occupational justice may expose participants to new and different ways of thinking about practice which otherwise would have remained in the academic domain.

3.8   OCCUPATIONAL JUSTICE AND OCCUPATIONAL THERAPY EDUCATION

There is a dearth of OT research studies that actually ascertain how new graduates understand and experience occupational justice. This is significant as it highlights the gap in understanding of how the concept is applied in practice or how it relates to OT education. In response to this gap in the literature, Mace, Wright-St Clair, Thomas and Burnett (2011) recently initiated an examination of the WFOT human rights agenda in relation to Australian curricula with students, academics, practice educations and researchers. This was done by conducting a workshop in which participants were invited to engage in facilitated small group discussions to generate a vision for educational curricula that is grounded in occupational justice. At the time of this review, the outcomes of this workshop were not yet published but it is believed to have laid the groundwork for the continued development of OT educational curricula in Australia.

Literature suggests that there needs to be extensive research on all aspects of OT education, in particular the value of the experiences from both a student and graduate perspective. There is little research that truly explores these notions, although the importance of fieldwork in preparing students for practice has received considerable attention in OT literature (Lorenzo, Duncan, Buchanan & Alsop, 2006; Kirke, Layton & Sim, 2007; Doherty, Stagnitti & Schoo, 2009;

Overton, Clark & Thomas, 2009; Rodger, Fitzgerald, Davila, Millar, & Allison, 2011).

In one study conducted by Tryssenaar and Perkins (2001) the researchers explored the lived experience of rehabilitation graduates during their first year of practice. A finding of significance that surfaced from this study was that the idealism of the new graduates appeared to be tempered by the reality of the workplace. Politics, organisational battles, paperwork and the hierarchy of the system shocked the participants. Tryssenaar and Perkins (2001) concluded that educators need to recognise the realities of these issues and provide students with resources that may help them to respond effectively to these realities. They propose that access to mentors and support, opportunities for continuing education and each participant's motivation and efforts to make changes, can assist their positive response. They also suggest that teaching skills for coping with stress will prepare students for the political challenges of practice and can be integrated in teaching and learning through case study examples and small group work.

In a study conducted by Doherty, Stagnitti and Schoo (2009) the researchers utilised a questionnaire to examine new OT graduates' perceptions on how their course prepared them for practice. The participants expressed the need for more practical learning and fieldwork placements in acute hospital settings. This feedback led to the inclusion of practical sessions in the curriculum. Another study investigated the transition experience of graduates from a master's program to practice (Seah, Mackenzie & Gamble, 2011). The eight novice graduate participants, who had started work as occupational therapists in Australia, reported that their education adequately prepared them for practice. The outcomes of OT education on the participants' knowledge, skills and attributes are, however, not well described.

Some OT education programmes have, however, begun to address the development of essential graduate attributes such as cultural awareness and political consciousness that are required for OT graduates to be agents of occupational justice (Wood, Hooper & Womack, 2005; Duncan, Buchanan &

Lorenzo, 2005; Boggis, 2008; De Jongh, Hess-April & Wegner, 2012). Several authors also acknowledge OT education programmes' responsibility to adequately prepare students for professional practice in a changing health care environment (Prigg & Mackenzie, 2002; Lorenzo, Duncan, Buchanan & Alsop, 2006).

3.8.1 Graduate attributes for the practice of occupational justice

According to Alsop (2006) graduate attributes can be understood as the qualities, values, attitudes, skills and understandings that a particular university sets out as being important for students to develop by the end of their studies. These attributes are intended both to equip OT graduates for employment and to contribute to the social and economic well-being of society. Alsop (2006) thus asserts that while the facilitation of students' knowledge is important, their reasoning skills must also be facilitated in order to develop their capacity to practise in contexts that are constantly evolving and changing.

The necessity for OT education to become responsive to its social context and how this is reflected in the graduate attributes it develops, is extensively addressed in the literature (Duncan & McMillan, 2006:31; Buchanan & Cloete, 2006; Kronenberg & Pollard, 2006; Thomas & Clark, 2007). Duncan & McMillan (2006:31) identify six sets of attributes that constitute the graduate profile of a curriculum that is responsive to its social context: (1) a lifelong learner, reflective practitioner and health service provider who endorses the theoretical and philosophical base of OT through appropriate actions responsive to local needs; (2) a skilled practitioner who is able to practice in a variety of settings and in different sectors; (3) an effective team worker who has the ability to create and optimise opportunities for the occupational enablement of persons who are occupationally at risk; (4) a self-motivated individual who is committed to working with others in a spirit of collegiality, social justice and collaboration; (5) a professional who is compliant with the ethics, norms, values and standards of the OT profession; and (6) a conscientised citizen who is committed to the affirmation of diversity and transformation of society through addressing occupational justice.

These graduate attributes are essential in view of the transformation of the South African health system. For instance, it is Buchanan and Cloete's (2006) view that due to the transformation of the health system, graduates must be flexible, work timeously and cope with constantly changing practice environments. They emphasise that occupational therapists no longer have the luxury of working with clients for undefined periods of time as opportunities for long-term rehabilitation, particularly in rural areas, are limited and outpatient follow-up may be inaccessible to clients due to transport constraints.

Thomas and Clark (2007) aimed to identify the attributes required in allied health professionals working in remote rural locations in Australia. These professionals, that included occupational therapists, dieticians, physiotherapists, social workers and speech pathologists, participated in the study that employed a narrative approach. A range of attributes were identified that included cultural awareness, resourcefulness, resilience, adaptability and reflexivity. Thomas and Clark (2007) concluded that being flexible, cooperative and culturally aware assisted in dealing with the unpredictable nature of remote practice, while sensitivity in communication and collaboration with others facilitated positive outcomes for clients.

3.8.2   Socially responsive and critical OT education

According to Duncan & McMillan (2006) socially responsive education advances the development and transformation of students, the profession of which students are members, and the society that they serve. Therefore socially responsive education underpins values that affirm social responsiveness and social justice. Examples of such values are commitment to "whole person care", reflective practice, human rights and community development (Duncan & McMillan 2006:27). Accordingly, socially responsive OT education aims to produce graduates who are conscientised citizens that are committed to addressing occupational justice (Duncan & McMillan 2006).

Bettez (2008) outlines various skills, practices and dispositions of social justice education. These include the promotion of critical thinking; engaging in explicit

discussions of power and oppression; maintaining compassion for students and believing that change toward social justice is possible. Similarly, Leyshon (2002:471) holds the position that professional education should assist students to develop the competence needed to engage with a constantly changing world and to question assumptions held within this world through critical thinking and reflexivity. He proposes a participative rather than a directive model to empowerment in health profession's education where the educator utilises listening, observing, challenging, providing support and offering suggestions in a collaborative process with the students. The goal is to enable students to bring about social change rather than merely providing them with discipline-specific knowledge and skills. This links with Hackman's (2005: 103) definition of social justice education as education that "encourages students to take an active role in their own education and supports teachers in creating empowering, democratic, and critical educational environments".

According to Griffin (2001) as well as Mortenson and Dyck (2006), OT education programs should address and develop specific knowledge and skills related to power. Griffin (2001) suggests the development of skills such as the ability to function effectively in the political climate in which OTs work; assertiveness skills; negotiation and conflict resolution skills; and skills to influence decision making within the health care system. In addition, Mortenson and Dyck (2006) suggest that education programmes engage students in strategies beyond the typical focus of direct client care. They propose the development of skills around the examination of institutional systems that facilitate and hinder client-centred practice and advocating for institutional changes that would facilitate it.

These authors' arguments resonate with the results of a survey conducted by Ramklass (2009) in which she explored physiotherapy graduates' experiences of community service and how they felt their undergraduate curriculum prepared them for practice. The results of the study revealed that the graduates lacked competencies necessary to practise effectively in community service. For example, the graduates indicated that they felt uncertain in their role as advocates for social justice within their practice settings and that they lacked

knowledge underpinning socio-cultural relations and community-based practice. Hence, Ramklass (2009) concludes that academic knowledge alone is inadequate to support novice physiotherapists to be socially responsive in community service and that education should also develop their competence to facilitate community development.

Kronenberg and Pollard (2006) elaborate on the concept of socially responsive OT education by describing it as politically relevant education that enables students to understand critically the influence of politics on human occupation and on the practice decisions that they make. They propose a curriculum that includes an exploration of how persons who experience occupational injustices understand their realities and how to address these realities in practice. In commenting from a South African perspective, where policies specify that higher education address "the diverse problems and demands of the local, national, southern African and African contexts", Joubert (2003:2) asserts that OT education should reflect the needs of the service in which new graduate OTs will practice. She argues that as the challenge for the OT profession is to devise and implement culturally relevant practices that reflect local needs and working methods, OT education should take cognisance of this and prepare graduates accordingly.

Similarly, Iwama (2003) stresses that OT education needs to identify and adopt culturally relevant practices and calls attention to the need for differences in viewpoints around cultural practices to be acknowledged in OT. He argues that OT generally tends to adopt Western models of practice that value empowerment and control, whereas Asian cultures, for example, centre on harmony and embrace values around adaptation and accommodation. It has also been suggested that by including indigenous ways of knowing in the construction of OT curricula, universities will advance knowledge that may be more appropriate for the solution of local challenges (Alsop, Duncan, Lorenzo & Buchanan, 2006).

For education to be culturally and politically relevant, Kronenberg and Pollard (2006) assert that the education offered has to enable students to understand the

influence of politics on human occupation and on the practice decisions that they make. They propose the use of a set of questions that they refer to as 'political Activities of Daily Living' (pADL) questions, as a political reasoning tool that may increase students' understanding of the political nature of people's participation in daily life (Kronenberg & Pollard, 2006:620). By focusing on the actors in the situations, the questions explore who actors are, what their means are and how they conduct themselves while considering the broader political context. Kronenberg and Pollard (2006:624) further propose that students be invited to engage in '3P archaeology' through which process students could be assisted to explore interrelated personal, professional and political perspectives of who they are and what they do. The purpose of this engagement is for students to investigate the underlying assumptions they may hold in relation to that which drives them personally and as professionals.

In exploring the nature of engagement and the incorporation of political reasoning into OT education, De Jongh et al. (2011) acknowledge the importance of an explicit acknowledgment of issues of difference and a truthful interaction between people when power issues are addressed. These authors describe their own experience of engagement and how feelings of discomfort surfaced as they dealt with power issues that surfaced in their effort to collaborate with one another as OT educators. Consequently, they assert that students will be better able to understand the nature of political reasoning through real experiences and reflection on those experiences. They further maintain that OT educators set an example to students of what it means to be authentic by sharing reflections on their own experiences of differences with students.

3.8.3   Interdisciplinary and interprofessional education

In the context of social responsive and politically relevant professional education, the need for education to engage more seriously with interdisciplinary or interprofessional education is foremost in the literature. Jones (2005) suggests that health professionals must be able to understand and respect each other's philosophical views so that they can complement each

other's contribution to team efforts. Likewise, Alsop, Duncan, Lorenzo and Buchanan (2006) argue that OT curricula need to consider opportunities for shared learning across disciplines. They, however, stress that interprofessional learning should not be present only within the academic environment as students' understanding of teamwork will be limited until it is experienced in the reality of practice. They therefore propose that interprofessional teams of students are provided with learning experiences together in practice.

According to a recent report on interdisciplinary education that was compiled by a global, independent Lancet commission (Julio, Chen, Bhutta, Cohen & Crisp et al., 2010) professional education has not kept up with contemporary health challenges. They attribute this occurrence to five factors: (1) fragmented, outdated curricula and static pedagogy that produce ill-equipped graduates; (2) a mismatch of competencies to population needs; (3) insufficient adaptation of education to local contexts; (4) professions operating in silos; and (5) a lack of team spirit and tribalism among professionals. The commission asserts that as a result of these factors professionals have become mere managers of technology and are reluctant to serve marginalised communities. At the same time, they are not able to exercise effective leadership to transform health systems. They therefore call for the education of health professions to be re-designed as interdisciplinary education to allow for mutual learning. It is their position that interdisciplinary education will break down professional silos while enhancing collaborative and non-hierarchical relationships in effective teams that will foster the development of joint solutions to health issues.

With reference to OT education, literature shows evidence of positive changes reported by students after working interprofessionally. These changes include an improved understanding of the roles of other health professionals and what it means to work collaboratively within a team environment (Mackenzie, Craik, Tempest, Cordingley & Buckingham et al., 2007; Mueller, Klinger, Paterson & Chapman, 2008; Rose, Smith, Veloski, & Lyons et al., 2009). Generally, interprofessional education is understood as instances where two or more professions learn with, from and about each other to improve collaboration and quality of practice (CAIPE, 2002). The underlying assumption to

interprofessional education is that enhanced collaboration between professionals will lead to better use of scarce resources and a more effective response to complex health needs (Reeves, 2000).

According to the Lancet commission (Julio, Chen, Bhutta, Cohen & Crisp et. al., 2010) the realisation of enhanced collaboration between professionals requires instructional and institutional reforms that should be guided by two proposed outcomes: transformative learning and interdependence in education. They describe the essence of transformative learning as developing leadership attributes and producing enlightened change agents. Interdependence in education involves a shift from isolated to harmonised education and health systems as well as a shift from stand-alone institutions to networks and alliances that harness educational content, teaching resources and innovations. Accordingly, these proposed shifts imply not just a change in educational practices, but also a change in the culture of health services.

3.8.4   OT education and pedagogical strategies for social and occupational justice

Despite the recent talk about social and occupational justice in the OT profession, there is a dearth of literature on how it influences educational practice. For this reason I turned to literature in education and other health fields, particularly nursing and social work, as these professions have contributed significantly to the literature on professional education and social justice.

Galheigo (2011a) holds the view that addressing human rights issues brings forth ethical and political responsibilities for OTs and requires new educational approaches. She stresses the importance of developing political literacy to prepare the new generation of OTs to engage in social transformation. With reference to the development of political literacy in OT education, Creek (2011) maintains that educators should not only facilitate students' knowledge but also transmit their beliefs, values, principles and ways of doing things to students. Creek (2011) proposes that OT educators adopt teaching and learning strategies

that are encompassed in critical pedagogy. She cautions OT educators that employing a banking model of education, i.e. teaching students to follow models and processes rather than thinking through the complexity of clients' situations, will produce therapists who conform and clients who comply.

According to Creek (2011) banking education imposes a passive role, discourages critical thinking, minimises creativity and encourages students to adapt to the world as it is, rather than seeking to transform it. An OT education programme that employs the banking model of education thus presents theories, models and approaches to practice as though they are both true and universally applicable. Creek (2011) asserts that in this instance, educators pay lip service to teaching critical reflection as they discourage any real challenge to their professional authority. Accordingly, she asserts that OT education adopts Freire's (1972) mode of dialogical and problem-posing education. Dialogue in this sense means more than just having a discussion. It is the role of the teacher to learn and discover alongside the students. Through this process, students not only learn as a result of information that is imposed on them but also question their own knowledge and assumptions that might be distorted (Freire, 1972).

3.8.5   Critical pedagogy in the classroom

In relation to the implementation of critical pedagogy in education, Giroux (1985) stresses the importance of developing a language of possibility as part of what makes a person critical. This view is further elaborated on by Simon (1987: 375) who refers to   critical pedagogy as pedagogy of possibility which is transformative and:

> …require forms of teaching and learning linked to the goal of educating
> students to take risks, to struggle with ongoing relations of power, to
> critically appropriate forms of knowledge that exist outside their
> immediate experience, and to envisage versions of a world that is 'not yet'
> in order to be able to alter the grounds upon which life is lived.

Thus, an examination of power needs to probe the inclusionary and exclusionary practices within the classroom and explore the issues of difference

that students bring to the classroom. As an example, Kincheloe (2004) argues that when critical pedagogy embraces multiculturalism, it focuses on the subtle workings of racism, sexism, class bias, cultural oppression and homophobia. To this end, critical pedagogy must not only attend to issues of difference through inclusivity, but also through understanding power relations that cause social inequities. These relations of power need to be deconstructed as part of educating for social justice.

As this involves the development of critical consciousness, Keesing-Styles (2003) argues that educators do not only focus on the facilitation of critical thinking as, although this may advance understandings about the social and human condition, it is limited in empowering students because it does not specifically demand social action. She asserts that educators adopt a pedagogy that examines practices but also has the potential to transform oppressive institutions.

This links with critical curriculum theory that has as its key premise 'that quality education is as much about teaching students the ability to read the world more critically as it is imagining a better world that is less oppressive' (Leonardo, 2004: 16). Advocates of critical curriculum theory envision a curriculum that seeks to develop in their students what Shor (1992:56) refers to as "critical thought". In line with this, Blaug (1995) defines critical education as the utilisation of teaching and learning strategies that raise students' critical consciousness about injustices that exist in the world so that they may be able to work for transformation, greater equity and justice.

With regards to the promotion of students' critical consciousness in education Kumagai and Lypson (2009) propose that educators stimulate critical reflection and critical analysis of personal assumptions, biases, values and perspectives. They furthermore stress that educators model the same type of reflective approaches in their teaching that is expected in their students. They argue that case studies or stories of injustice per se are not sufficient to enhance the development of critical consciousness but that it is the pedagogic approach that is used that is crucial to their effectiveness. In this regard Mace, Wright-St

Clair, Thomas and Burnett (2011) suggest the use of small groups where students discuss issues around occupational rights, investigate possible solutions and uncover good practice. They assert that in promoting critical action, educators should encourage students to recommend real solutions to occupational injustice for people who are experiencing this. Examples of this might be teaching students how to write submissions for change or participating in action research projects that deal with occupational justice issues (Mace, Wright-St Clair, Thomas & Burnett, 2011).

In Mezirow's (1991) view, the gateway to the development of critical consciousness is transformative learning. According to Mezirow (1991) transformative learning involves a process through which the distorted assumptions individuals use to interpret experience and enact their lives are brought to light, challenged and reformed. Distorted assumptions are described by Mezirow (1991: 118) as assumptions 'that limit insight and openness to other ways of seeing themselves and other people'. In other words, when assumptions are distorted, they can limit an individual's capacity to be open to other perspectives, adopt new ways of being with others, and to do things differently. Thus, transformative learning happens when assumptions are questioned and clarified in order to render individuals more open to do things in ways that are more true or justified (Mezirow, 1991).

3.9   CONCLUSION

This chapter presented a literature review pertaining to the application of occupational justice in OT practice and education. In the first part of the chapter the background values that inform the practice of occupational justice were explained. Following this the application of occupational justice as it relates to OT practice was explored. Lastly, literature pertaining to OT education was reviewed and the relationship between OT education and occupational justice explicated. The importance of OT educators and practitioners embracing a critical stance if the values of the profession are to translate into meaningful contributions to occupational and social justice was emphasised in the literature.

In relation to this, socially responsive education, interdisciplinary and interprofessional education and the application of critical pedagogy and transformational learning in the classroom as addressed in relevant literature was highlighted. In the next chapter the methodology that was utilised in this study is presented.

CHAPTER 4

METHODOLOGY
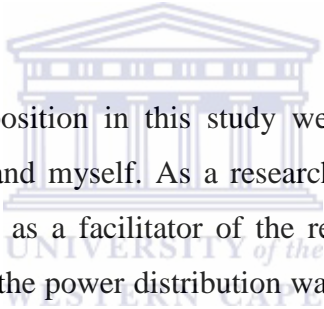
4.1   INTRODUCTION

This chapter describes the methodology adopted in the study. Following a description of the methodological paradigm, research approach and research design, I describe the process of selecting participants and the data collection methods that were utilised in the study. Lastly, I present the approach to data analysis, as well as strategies employed, to enhance the trustworthiness and ethical standard of this study.

4.2   RESEARCHER POSITIONALITY

In any qualitative research study that seeks to give meaning to participants' voices, it is important to remember that the research process can be influenced by the researcher's identity. In conducting qualitative research, researchers recognise the importance of reflecting on their own values, assumptions, beliefs and biases, and monitoring these throughout the research process to determine their impact on the study (Mertens, 2005). This was an important aspect of the reflexive and interactive processes in which I engaged in this study. My approach to this study has been informed by my life experiences as a coloured South African female who was born and raised in a rural town in the Western Cape. Born to parents who actively participated in the anti-apartheid struggle in South Africa, I have been aware of oppression and the need for social justice in South Africa for as long as I can remember. My family inspired me to pursue social justice and gave me an appreciation for our capacity as people to create change. The context of my childhood allowed me to explore and express my ideas about social justice and, since my primary school years and later as a university student, I have actively participated in anti-apartheid protests in South Africa.

My desire to make a difference to society has been the driving force behind my journey as an occupational therapist and as an OT educator. In this regard I have always envisioned myself as a fighter against oppression whether it manifests as prejudice and discrimination; the inability to have people's basic needs met; or the failure of institutions to recognise and support basic rights. As an OT educator interested in teaching and learning with a focus on social justice, I have been closely involved with the process of transforming the UWC OT curriculum to one that adopts a social and rights-based approach to health. I am motivated as an educator as I feel that it is in education where future occupational therapists can best be prepared to develop the knowledge, values and skills they require to address the complex health and social needs of South Africa. Accordingly, I became increasingly interested in examining the extent to which the practice of UWC OT graduates is influenced by the UWC OT curriculum.

Further influencing my position in this study were issues of power arising between the participants and myself. As a researcher, I occupied the outsider position and my role was as a facilitator of the research process. Due to the nature of this relationship the power distribution was not equal between me and the participants. The fact that it was also their former OT educator who observed and interviewed them could possibly be a further cause for anxiety in the participants. I accepted that the participants might not share my view of us being co-learners in this study and that they may express the views they thought I wished to hear. However, as an OT myself, I was an insider amongst the participants and they could comfortably speak their familiar language with me and feel that they were understood. I could see how my role as an insider and my previously established relationship with the participants could be beneficial. I could, however, also see how this familiarity posed challenges such as trying to remain objective when interpreting the data.

With all these issues in mind, I endeavoured to remain as reflexive as possible throughout the research process. Considering my various roles, I remained acutely aware of how I needed to step back and allow the participants' voices to

emerge and yet at the same time let go of any preconceived assumptions so that I could see clearly what the data was revealing.

4.3   METHODOLIGICAL PARADIGM

In this study the following main research question is explored: How do UWC OT graduates' conceptualisations of occupational justice as taught by the UWC OT curriculum manifest in their practice of community service? The study falls within the qualitative methodological paradigm. The qualitative paradigm is distinguished from the quantative paradigm in that research is conducted in the natural setting of participants; their perspective is emphasised and the primary aim of research is in-depth description and understanding (Babbie & Mouton, 2001). According to Guba and Lincoln (1994) quantitative approaches that focus on variables through controls or randomisation do not take other variables that exist in the context into account, thereby minimising its relevance to other situations. They assert that qualitative approaches can redress that imbalance as it is geared towards providing contextual information.

Likewise, Denzin and Lincoln (2005) assert that in contrast with the quantitative paradigm which is not geared towards capturing the perspectives of participants due to its reliance on empirical methods, the qualitative paradigm locates the researcher in context. They state that the qualitative researcher seeks answers to questions that address how social experiences are perceived and given meaning. They further describe the qualitative researcher as a "bricoleur" who works within competing and overlapping perspectives to produce a "bricolage", which is a reflexive creation that is fitted to the specifics of a complex situation and represents the researcher's analysis and interpretations of the world (Denzin & Lincoln, 2005:6).

Babbie and Mouton (2001:272) refer to this form of qualitative description as a "thick description" and stress that qualitative research places events in contexts that are understandable to the participants themselves. This, according to Creswell (2003), allows the qualitative researcher to be so highly involved in the actual experiences of research participants that the researcher is able to

generate in-depth detail about them. Qualitative methodology is therefore characterised by the selection of a small number of research participants, the utilisation of multiple sources of data and the adaptation of the study where applicable (Babbie & Mouton, 2001).

This study falls within the qualitative paradigm as the main purpose of the study was the generation of an understanding of how students understood occupational justice (theory) and how they enacted it (practice). I endeavoured to gain an in-depth understanding of UWC OT graduates' conceptualisations of occupational justice and their interpretation of their role as agents of occupational justice in their practice contexts. By studying the participants in their community service practice settings, their subjective practice experiences could be better understood through the adoption of the qualitative paradigm. In addition these subjective realities of the participants were important in developing an in-depth understanding of the participants' perceived preparedness for practice in relation to their education and the value of the UWC OT curriculum in facilitating graduate competencies aimed at enhancing occupational justice.
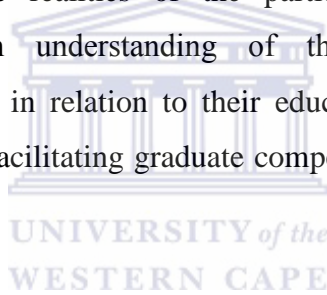
4.4   RESEARCH APPROACH

The interpretivist research approach was adopted in this study. Unlike researchers that work within a positivist approach, seeking to test and prove theories through empirical means, researchers that work within the interpretive approach view knowledge as constructed by the way in which people assign meaning to their lives (Henning, Van Rensburg & Smit, 2004). According to Terre Blanche and Kelly (1999:123) interpretive methods of research are methods that "try to describe and interpret people's feelings and experiences in human terms rather than through quantification and measurement". Consequently, interpretivist researchers recognise that there is no single objective reality but that multiple realities exist, thus research cannot be regarded as value free (Creswell, 2003). The aim of interpretive research is to understand behaviours, actions and processes within the context of the research participants (Babbie and Mouton, 2001). To this end, the interpretive researcher

observes the context in which participants' experiences occur and allows them to reflect their world in their own words (Henning, Van Rensburg & Smit 2004:37).

The intention of interpretivist research therefore is to understand the subjective and socially constructed realities of people. Thus, interpretivist researchers utilise meaning-oriented methodologies, such as interviewing or participant observation, that rely on a subjective relationship between researcher and participants. The key words pertaining to this methodology are participation, collaboration and engagement (Henning, van Rensburg & Smit, 2004). Descriptive and interpretive questions are asked about what people say and why they might think that way. In recognising the subjectivity, social construction and situatedness of knowledge, whereby meaning is negotiated and renegotiated through interaction (Creswell, 2007), the interpretivist approach was adopted in this study. In view of this, the participants were asked to reflect on their practice and the UWC OT curriculum, the emerging findings of the study, and on actions that could be employed to develop the curriculum.

4.5   RESEARCH DESIGN

The research design for this study is an interpretive case study. Babbie and Mouton (2001:281) state that the interaction of the unit of study with its context is a significant part of case study investigation. Merriam (1998: 27) describes the qualitative case study method as "an intensive, holistic description and analysis of a single instance, phenomenon or social unit". The most important reason for employing case studies, however, is that a case study's emphasis is on an individual unit, group or organisation. Creswell (2002: 496) recommends case study as a methodology if the problem to be studied "relates to developing an in-depth understanding of a case or bounded system" and if the purpose is to understand "an event, activity, process, or one or more individuals".

In defining a case study Stake (2005:448) states that a case study is "the study of the particularity and complexity of a single issue", while Merten (2005) states that a case study refers to research that involves the detailed study of an

individual or a group through observation, self-reports and other means. A case study design was therefore appropriate for this study as it allowed me to generate an in-depth and true picture of the participants' understanding and practice of occupational justice within their community service practice contexts because it was in these contexts that this understanding and practice were demonstrated. The case study of the group of graduate participants' conceptualisations of occupational justice is the vehicle through which I offer a broader critical analysis of the influence of the UWC OT curriculum on their practice.

Stake (2005) characterises three types of case study: (1) intrinsic, (2) instrumental and (3) collective. An intrinsic case study is typically undertaken to learn about a unique phenomenon with a clear argument describing the uniqueness of the phenomenon. However, if the intent is to gain insight and understanding of a broader phenomenon, for example OT education with a focus on occupational justice as in this study, then Stake suggests that an instrumental case study be used to gain an understanding of that phenomenon. Baxter and Jack (2008) explain that in the instrumental case study its context is scrutinised in depth and its ordinary activities (i.e. the practice of community service graduates) are detailed, because it facilitates understanding of something else (i.e. OT education). Therefore, as this is a study of a group of community service OT graduates from a single institution, UWC, it is defined as a single instrumental case study.

4.6   CONCEPTUAL ISSUES GUIDING THE STUDY

In addition to identifying the type of case study, both Yin (2003) and Stake (1995) emphasise the importance of establishing a conceptual framework that guides the research process followed within the study. Whereas Yin (2003) refers to 'propositions' to guide the research process, Stake (1995) refers to 'issues'. They both suggest that these elements of a case study are necessary in that they assist with the development of a conceptual framework that guides the research. While Yin notes that propositions may not be present due to the exploratory nature of a case study, Stake (1995:17) states that "issues are not

simple and clean, but intricately wired to political, social, historical and personal contexts" which are all important in studying cases. Stake further explains that initial issues may be influenced by the participants in a study and may therefore develop as the researcher gains a greater understanding of the case. The exploratory nature of this case study prompted me to follow Stake's suggestion in outlining main issues that highlight the phenomenon under investigation. These conceptual issues are summarised in Table 2.

Table 2: Conceptual issues guiding the study

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1   OCCUPATIONAL JUSTICE VALUES:

- What values, knowledge, skills and attitudes are necessary for graduates to be able to engage in occupational justice-informed practice?

11   OCCUPATIONAL JUSTICE AND OT PRACTICE:

- How do graduates embody occupational justice in practice?
- What are the constraints that graduates encounter in their practice?
- How can these constraints be addressed?

111   OCCUPATIONAL JUSTICE AND OT EDUCATION

- How does OT education facilitate values, knowledge and attitudes necessary for graduates to engage in occupational justice-informed practice?
- How can OT education be developed around occupational justice?

Baxter and Jack (2008) caution that one of the drawbacks of a conceptual framework is that it may limit the inductive approach when exploring a phenomenon. To safeguard against this, they encourage researchers to journal their thoughts and decisions and discuss them with other researchers to determine if their thinking has become too driven by the framework; these approaches were therefore employed in this study and are described in Section 4.10.3.

4.7   SELECTION OF PARTICIPANTS

It is proposed by Babbie and Mouton (2001:166) that purposive sampling allows for participant selection based on "the researcher's own knowledge of the population, its elements and the nature of the research aims". It is further proposed by Creswell (2007) that purposive sampling allows the researcher to seek out those participants with the most direct experience with the phenomenon under study in order to elicit the most pertinent and information-rich data. Accordingly, purposive sampling was used to select participants for this study.

The participants were selected from the population of all UWC OT graduates who graduated in 2009 and completed compulsory community service in South Africa in 2010. Although a single case can be studied in great depth, case study researchers recommend a minimum sample size of four (Creswell, 2007). A total of seven graduates were, however, selected to participate in this study. All the participants were females which is generally a reflection of the gender disparity within the profession. In terms of ethnicity, the majority of the participants were Coloured (six) while the rest were African (two) which is a general reflection of the racial disparity of the population of all UWC OT graduates who graduated in 2009.

Graduates in under-resourced, rural practice contexts were selected as this was in line with the community service policy objective of prioritising these contexts for community service to ensure availability and equity in services. Also, considering that occupational justice is concerned with addressing occupational risk factors such as occupational deprivation, selection was based on those contexts that were particularly relevant to the research questions. Furthermore, rurality in South Africa is often associated with poverty and it is here that occupational injustices have its greatest impact. In view of this, two graduates in the Eastern Cape and three in the Northern Cape were selected, as the majority of people in those provinces reside in rural areas. A further two graduates in the rural Western Cape were selected.

According to Hodgetts, Hollis, Triska, Dennis, Madill & Taylor (2007) it takes between six months and two years for novice occupational therapists to feel competent in practice; therefore UWC OT graduates who had at least six months of community service experience were selected to participate in the study. Graduates were further selected on the basis of the particular level of care where they were placed for community service, i.e. level 1 (PHC and district hospitals) and level 2 (regional hospitals), to further ensure variation in the sample.

4.8   DATA COLLECTION METHODS

In order to develop a thorough understanding of a case, the case study approach usually involves the collection of multiple data collection methods (Crowe, Cresswell, Robertson & Huby et. al. 2011) as multiple sources of data are important in ensuring triangulation and the reliability of the study (Stake, 1995; Yin, 2003). The methods of data collection that were utilised in this study include participant observation, a reflective journal, semi-structured interviews and document review. The observations and interviews were primary sources of data while documents as a secondary source were reviewed to gather background information in relation to observations made.

Data collection was conducted between July and November 2010. Yin (2003) proposes that a data collection protocol regarding the type of information to be collected be devised to guide the collection of data in case studies. For this reason, I developed a data collection guide (see Appendix 2) to direct the collection of data. As the process of data collection progressed the guide was applied in a flexible manner in each setting. All data was captured in textual form in order for it to be analysed.

4.8.1   Participant observation

One of the objectives of this study was to develop an understanding of the participants' practice and the constraints they faced in doing this. It was

therefore important to gain an understanding of the participants' practice contexts and settings as it was within these contexts that they engaged with issues related to occupational justice. Participant observation was thus utilised as a data collection method in this study as it allowed me to experience firsthand the participants' practice in their respective settings.

In the case of rehabilitation research, Clarke (2009a) contends that the value of participant observation is that the researcher develops some understanding of what the social and occupational world feels and looks like to those who work in rehabilitation. He explains that being a participant does not mean "doing what those being observed do", but that it means that the researcher finds ways of "interacting with them while they do it" (Clarke 2009a: 413). Similarly, Leedy and Ormrod (2005) state that an advantage of participant observation is that it can be done in an intentionally unstructured and free-flowing manner. This allows flexibility in that the researcher can take advantage of unforeseen data sources as they surface. One of the disadvantages of participant observation is that by his/her very presence a researcher may affect people to the extent that they may be influenced to alter what they say and do (Leedy & Ormrod, 2005). Clarke (2009b), however, argues that this does not negate the value of participant observation and stresses that the researcher acknowledges the impact of his/her presence on the processes observed.

I spent a minimum period of one week in each practice setting for the purpose of participant observation. This period of participant observation was conducted in 2010 when the participants were between six to eight months into their community service year. Participant observation entailed the recording of details about the participants' practice settings, i.e. information about the physical environment and social factors that influenced the setting (Leedy & Ormrod, 2005). Fieldwork further entailed observations of general routine activities that occurred in relation to the participants' practice. A summary of observations conducted in this study can be found in Appendix 3.

Throughout participant observation I took field notes to provide a description of each practice setting and to describe a typical day of practice in the life of each

participant, i.e. activities, meetings, consultations and interventions. An observation guide to direct the writing of field notes was developed prior to data collection and can be found in Appendix 4. This guide was, however, utilised in a flexible manner according to the way that events and activities unfolded during the period of observation. I also recorded field notes on the informal conversations I had with the participants and other staff members.

4.8.2 Reflective journal

During the period of participant observation I recorded my personal reflections in a reflective journal so that these could be explicit (Mertens, 2005). I reflected on my experiences, as well as any personal thoughts or feelings that occurred throughout the research process.This was done as close to the actual time of observation as possible and mainly occurred at the end of the day on which the observations were conducted. I initially used the guide to field notes to shape my reflections but gradually stopped referring to it as my reflections became more spontaneous and in-depth over the course of the study. The reflective journal also assisted me to interpret the data from the interviews and document review and to develop an argument.

4.8.3 Semi-structured dyadic interviews

Kvale (1996) defines qualitative research interviews as attempts to understand the world from participants' points of view and to uncover their lived world. Semi-structured interviews are in-depth interviews usually conducted between the researcher and a single research participant and allow for a more natural way of interacting with participants (Terre Blanche & Kelly, 1999). Semi-structured interviews were conducted with the participants to gain a deeper understanding of how they perceived their practice and the values that informed it. However, to provide participants with an opportunity to interact with another participant and to reflect together on their practice, semi-structured paired or dyadic interviews (Highet, 2003; Parrish, Yeatman, Iverson & Russell, 2012; Morgan, Ataie, Carder & Hoffman, 2013) were conducted with the exception of

one interview with a single participant in the Northern Cape who was not in close proximity to another participant.

Dyadic interviewing involves the posing of open-ended research questions to two people together (Morgan et. al. 2013). Dyadic interviews allow participants to co-construct their understanding of the research topic and to stimulate ideas that might not have been recognised by the researcher (Morgan, 2012). The interview process underlines the principle of the "active interviewing method" and sees the interview as a "site of, and occasion for, producing reportable knowledge itself" (Holstein & Gubrium 1997: 114). In view of this, I conducted the interviews as discussions, rather than one-way question and answer sessions. I, however, took care to allow opportunities within the interviews for individual depth of response.

While a disadvantage of dyadic interviewing is the possibility that one participant may dominate the other, an advantage is the generation of more comprehensive data through the elicitation of shared and/or dissimilar understandings (Arksey, 1996). The purpose of the interviews was to offer the participants an opportunity to reflect on their understanding of occupational justice, their enactment of occupational justice in practice, and the constraints they experienced with regards to this. In addition, the participants were asked to reflect on the influence that their education had on their practice.

As I had already formed a personal relationship with the participants over a period of four years while they were undergraduate students, trust between me and them was firmly established. Therefore an informal, reflective style of interviewing (Foley & Valenzuela, 2005) was possible from the start. The research themes were well suited to dyadic interviews as the participants had an established relationship as friends and colleagues who worked closely together. A feature of the participants' established relationship was their familiarity with each other's experiences and ideas. This gave them more confidence to speak and enabled them to supplement each other' views in a relaxed manner.

I occupied a dual role within the interviews of being both participant and facilitator. As an OT, I was an insider amongst the participants and they could comfortably speak their familiar language with me and feel that they were understood. However, as the researcher I occupied the outsider stance position at times, i.e. when I encouraged the participants to reflect deeper on underlying issues around the challenge of bringing an occupational justice perspective to their practice.

I also had to constantly reflect on my own underlying expectations and assumptions while conducting the interviews. The issue of power dynamics surfaced when the participants initially expressed their anxiety about the fact that it was me (as their OT lecturer) who interviewed them. This immediately brought the power dynamic between educator and student to the fore and signalled that the power distribution was not equal between me and the participants due to the nature of this relationship. I, however, endeavored to minimise this uneven distribution of power by explicitly valuing the contribution the participants made in exploring the issues in this study. I shared my general observations with the participants at various times as the interviews progressed. This was done to acknowledge my interest in their points of view. I also occasionally shared my own reflections with the graduates in order to elicit theirs in return. I took care not to be judgmental in my interactions with them and not to impose my views on them. The goal was to prompt reflection, not to impose ideas about the 'right' way to practice. In the end the interviews offered me, together with the participants, the opportunity to explore a deeper analysis of their practice experience.

Trede, Higgs and Rothwell (2008) suggest that reflexive questions such as Why are you thinking this? How do you know what you know? and Why are you concluding this? elicit reflective practice, therefore a set of predetermined questions was developed as a guide for the interviews (see Appendix 5). The questions were, however, used in a flexible manner (Terre Blanche, Kelly & Durheim, 2006). In addition, in following Lather's (1986) suggestion that interviews be conducted in a sequential manner to facilitate a deeper probing of research issues, initial interviews, ranging between forty five minutes and one

hour in duration, were conducted with the participants during the period of participant observation, while follow-up interviews that lasted for about one hour were conducted after the completion of data analysis.

Initial interviews
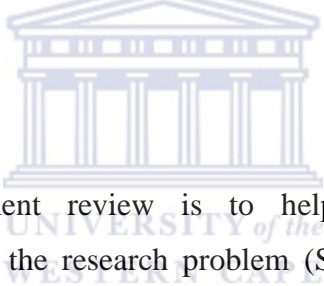
Conducting initial interviews with the participants allowed me to capture their reflections as they occurred over the duration of the period I spent with them in their respective practice settings. Two initial interviews were conducted with the Northern Cape participants, while only one was conducted with those in the Eastern and Western Cape as these participants were unable to fit a second interview into their schedule due to work commitments and time constraints. The first interview with the Northern Cape participants occurred in the first few days and the second towards the end of my visit. These first interviews lasted for about forty five minutes to one hour and focused on the participants' practice contexts and their roles in their respective practice settings. This involved a discussion of their daily routines and activities as well as specific topics like the type of services, client-profiles and their general community service experiences. The second interviews were longer in duration and ranged from between one hour and one hour and twenty minutes. They aimed to gain a deeper understanding of the values that informed the participants' practice and the rationale behind the activities and interactions in which they engaged. I also explored the participants' views on the role that UWC OT education played in preparing them for practice.

Due to the participants in the Eastern and the Western Cape only being able to fit in one initial interview, I conducted this interview towards the end of my visit. As I had by then observed and informally discussed their practice contexts, daily routines, activities, type of services, client-profiles and general community service experiences with them, the interviews focused on gaining a deeper understanding of the values that informed their practice and the rationale behind the activities and interactions that they engaged in. I further explored the participants' views on the role that UWC OT education played in preparing them for practice.

Follow-up interviews

Each participant was invited to a follow-up interview to check the accuracy of the research findings and to further reflect on how the curriculum could support graduates' conceptualisations of occupational justice in practice. My initial plan was to conduct one focus group with all the participants but this was not possible as it was difficult for them to attend the group at the same time due to their personal schedules. Participant 1 could not attend any of the follow-up interviews for personal reasons. Hence, three separate follow-up dyadic interviews that lasted for about one hour each were conducted with the remaining participants. This meant that the second pair (Western Cape participants) and third pair (Eastern Cape participants) could build on the reflections of the first pair (Northern Cape participants) leading to a deeper critique of the UWC OT curriculum in relation to occupational justice.

4.8.4   Document review

The purpose of document review is to help the researcher develop understanding relevant to the research problem (Scott, 1990). McMillan and Schumacher (2006: 356) refer to documents as "artefact collections which are tangible manifestations that describe peoples' experience, knowledge, actions and values". Documents range from public through private to personal documents (Payne & Payne, 2004). Scott's (1990) four criteria associated with using documentary data were followed in the selection of documents for review. These are: (1) authenticity that refers to whether a document is an original or technically sound copy; (2) credibility that refers to accuracy; (3) representation that refers to the completeness of the record and whether it is typical of its kind; and (4) meaning that refers to the clarity and comprehensibility of the document.

In an attempt to meet the study objective to ascertain in what ways graduates enact occupational justice in community service, participants were asked for documentation that demonstrates their practice for the purpose of document review.

Approximately 20 documents (see Appendix 6) were reviewed and coded for analysis. These included private documents, for example minutes of rehabilitation (staff) meetings, practice protocols for OT and routine monthly reports that included statistics for OT, as well as public documents such as OT departmental annual reports.

While the participants were asked to select documents that they regarded as demonstrative of their practice, some documents became more relevant on the basis of knowledge I gained from the interviews and participant observation. These included pamphlets, training materials and newspaper articles that were specific to the individual participants' practice in their particular settings. This meant that the same set of documents was not utilised across all practice settings. Document review nonetheless proved to be beneficial in establishing corroboration between different data sources, i.e. participant observation and interviews.

4.9   DATA ANALYSIS

According to Terre Blanche, Kelly and Durrheim (2006) qualitative analysis is done from a position of emphatic understanding which is gained from the researcher staying close to the data. They explain that the purpose of analysis is to provide a thorough description of the data, placing real-life events into some kind of perspective. The process entails breaking the data down and then building it up to finally come up with a new perspective on the data through a process of reflection and interpretation of the issues being studied. Creswell (2007) states that, given this perspective, the analytical process can be best described as fitting a spiral contour. By examining information collected through different methods, the researcher can triangulate or corroborate findings across data sets.

In this study, data analysis for each data set, namely interview transcripts, field notes from participant observation and synthesis of documents, was done by following the process of analysis as suggested by Terre Blanche and Kelly

(1999). The following steps were generally followed although in reality the process did not progress in an orderly step-wise manner (Terre Blanche & Kelly, 1999):

 1. *Familiarisation and immersion.* The data was read and re-read to gain a sense of the whole database. The process involved the development of ideas about the participants' understanding and practice of occupational justice.

2. *Introducing themes.* This process is inductive in that I tried to move beyond summarising by thinking in terms of processes and the meaning behind the practice demonstrated by the participants.

3. *Coding.* This phase happened concurrently with introducing themes. Different sections of the data were marked as relating to one or more of the initial themes.

4. *Evaluation.* After all data sets were coded, the material for the same codes was put into categories that were emerging through this process. During this stage, the material was examined and re-examined in light of the themes that emerged.

5. *Interpreting themes.* To begin the final data analysis all the material from all the data sets that referred to one theme or concept was put into one category. The categories were compared and examined for various meanings and connections between them. When the process was completed, the analysis was checked with the participants in the follow-up interviews and additional comments made by them were re-worked into the final analysis.

4.10   TRUSTWORTHINESS

In conducting qualitative research it is necessary to ensure trustworthiness and rigour during the research process (Babbie & Mouton, 2001). Qualitative researchers employ different techniques such as credibility, transferability, dependability and confirmability to ensure the trustworthiness of their findings (Lincoln & Guba, 1985).

4.10.1 Credibility

Credibility refers to the confidence that the researcher has in the truth of the findings of the research, informants and context (Krefting, 1991). To ensure credibility in this study, data source triangulation (Babbie & Mouton, 2001) and theoretical triangulation (Johnson, 1997) were used. Field notes, in depth interviews, document analysis and reflective journals are examples of different data sources utilised, while the literature offered multiple perspectives to help explain the data through theoretical triangulation. Once the data was transcribed and analysed, member checking was done to offer the research participants an opportunity to check the accuracy of the findings (Babbie & Mouton, 2001) and to engage with the analysis.

4.10.2 Transferability

According to Mertens (2005) the burden of transferability in qualitative research is on the reader to determine the degree to which the study results can be applied to other contexts. Detailed description of research methods, contexts, study population and the lived experience of participants can achieve this (Krefting, 1991). Therefore, a detailed description of the participants' practice contexts, practice settings and practice experiences were presented in this study.

4.10.3 Dependability and confirmability

Dependability considers whether the findings would be consistent if the study was to be replicated with the same subjects or in similar contexts (Krefting, 1991). This was achieved by presenting a detailed explanation of the research design and process as well as providing the main instruments used to gather data such as the list of interview questions (Lincoln & Guba, 1985). Confirmability refers to the extent to which others can confirm the findings in order to ensure that the results reflect the understandings and experiences from the perspectives of the participants. For this reason I kept a rigorous record of the research process and trail of data analysis throughout this study and

transcripts, analysed documents, formulated themes and process notes were open for scrutiny by my research supervisors.

According to Krefting (1991), dependability and confirmability can further be assured through peer examination and reflexivity. Therefore, staff in the UWC education programme was offered an opportunity to engage with the findings and to offer their reflections on them. Reflexivity can be understood as the ongoing self-awareness of researchers that makes the construction of knowledge within research visible during the research process (Pillow, 2003). In this study, reflexivity occurred throughout its various stages and was documented in a reflective journal. Emerging issues were addressed as critical incidents in the reflective journal and also discussed with my supervisors to deepen my understanding of the case.

4.11   RESEARCH ETHICS

In this study, the ethical considerations that were applied were informed consent, confidentiality and anonymity, as well as the appropriate dissemination of the research findings.

4.11.1 Informed Consent

Permission to conduct the study and ethical clearance was obtained from the UWC Research Ethics Committee (see Appendix 7). Ethics requirements for the respective Provincial Health Research Ethics Committees located in the Eastern Cape (see Appendix 8); Northern Cape (see Appendix 9); and Western Cape (see Appendix 10) were completed and approved after a letter of information (see Appendix 11) and consent form (see Appendix 12) were sent to each prospective participant. This was done to obtain informed written consent from all participants after they were informed about the nature, benefits and risks of the study. The participants were provided with an opportunity to ask questions and discuss any queries they had about the study, the research process or their participation. Participation in the study was voluntary and participants could

withdraw their participation at any time without being penalised if they opted to do so.

After permission for me to visit the participants in their respective practice settings was obtained from their managers, each participant liaised with them regarding a convenient time for me to visit. In conducting observation sessions which involved people other than the participants, my general role as a researcher was explained and verbal informed consent obtained from all persons that the participants interacted with at that time.

4.11.2 Confidentiality and anonymity

Issues of confidentiality and anonymity were explained to participants and adhered to in the study. Confidentiality was maintained by ensuring that persons who had access to the data, i.e. those who assisted with the transcribing of the data, were contractually obliged to maintain confidentiality. The anonymity of participants was maintained in that participant numbers were used to label the data. In addition, the participants were asked to remove any identifying information from the documents that they submitted for utilisation in this study. I also undertook to ensure that this thesis and publications that may result from the study do not contain information that may identify participants, their practice settings or individuals with whom they interacted in practice.

4.11.3 Dissemination of the research findings

Current and future OT students and graduates of UWC and ultimately broader society, have a right to benefit from the findings of this study. Therefore, the study information will be disseminated through various channels such as professional development events and academic publications. Most importantly, the study will also be disseminated to the HPCSA and OT professional board as well as the Occupational Therapy Association of South Africa (OTASA), WFOT and the Department of Health. All participants will have access to the findings of the study as copies of the research report will be made available to them.

4.12 CONCLUSION

In this chapter the methodological paradigm and approach adopted in this study, as well as the methods used in collecting and analysing the data, were described. These included a description of the qualitative research paradigm, the interpretivist research approach and a case study research design. The conceptual issues guiding the research process, the process of participant selection and data collection methods utilised in the study, namely participant observation, semi-structured dyadic interviews and document review, were also described. Lastly, the approach to data analysis, as well as strategies employed to enhance the trustworthiness and ethical standard of this study were described. In the following chapter the study findings are presented.

CHAPTER 5

PRESENTATION OF FINDINGS

5.1   INTRODUCTION

The aim of this study was to explore how UWC OT graduates'
conceptualisations of occupational justice, as instilled by the UWC OT
curriculum, manifest in their practice of community service. This chapter
presents the key findings of the study and is divided into two sections. In the
first section a case description that comprises the participants' practice contexts
and practice settings, as well as their primary roles and responsibilities in these
settings, is provided. In the second section the themes and related categories
that emerged from the analysis of the data are presented.

5.2   CASE DESCRIPTION

5.2.1   Practice context

The general practice contexts of the participants were rural in nature. This
means that the participants practised in settings in which poor socio-economic
conditions, i.e. poverty, unemployment and poor infrastructure; poor health
status indicators, i.e. high prevalence of TB, HIV/AIDS, chronic diseases of
lifestyle; and lack of access to health services were prevalent.

Table 3 shows the community service placement allocation for the seven
graduates who participated in this study.

Table 3: Participants' community service placement allocations

Participant	Province	Practice Setting
1	Northern Cape	Dept of Health District Office
2	Western Cape	Community Health Center (CHC)
3	Eastern Cape	Level 1 District Hospital
4	Eastern Cape	Level 1 District Hospital
5	Northern Cape	Level 1 District Hospital
6	Northern Cape	Level 1 District Hospital
7	Western Cape	Level 2 Regional Hospital

In the Eastern Cape the communities in which the graduates practised were characterised by scattered villages and poor infrastructure. Public transport was either too expensive or non-existent and the sub-standard conditions of the roads made travelling difficult and slow. As I drove through the scattered villages, I noticed a lack of development in the area. There were no schools, sports grounds or any other form of recreational facilities. The wandering livestock and dogs along the roads appeared malnourished. I observed women working in small vegetable gardens here and there but crops were scattered and the ground seemed rather dry. The houses ranged from rondawels to clay houses to face brick houses and were often indicative of people's socio-economic status. The majority of households did not have access to piped water or electricity.

There was a high population density in the towns and health problems were described as typical of a developing context with entrenched poverty and a high prevalence of major health issues, i.e. TB, HIV/AIDS and chronic diseases of lifestyle, i.e. hypertension and diabetes. Clinics were situated in remote, mountainous areas and many disabled adults and children were confined to their homes with no access to rehabilitation services. The majority of referrals for

rehabilitation at the hospitals were for patients with neurological conditions such as strokes in adults and cerebral palsy in children. The high unemployment rate in the area was evident by the many people I observed just sitting around in the towns. Everywhere people were trying to sell products which seemed to be one way in which they endeavoured to sustain their livelihoods.

In the Northern Cape the distances between towns were vast. This meant that residents had to pay exorbitant transport costs to access health services. The majority of the population resided in rural villages and numerous small residential areas. There was also evidence of a lack of economic development in the region and a shortage of basic infrastructure such as proper housing, roads, sanitation, and access to water and electricity.

The main economic activities in the Northern Cape were manganese mines and livestock farming. However, due to the closure of some mines and the downscaling of others, many jobs were temporary in nature. The majority of people were unemployed or economically inactive and dependent on social grants. As a result, the region was characterised by poverty and a high prevalence of HIV/AIDS and TB. In addition, teenage pregnancies and alcohol abuse were reported as key health concerns. Alcohol abuse was a contributing factor to the high number of children in the province that displayed signs of stunted growth and foetal alcohol syndrome (FAS). Other priority health problems were reported as chronic diseases and neurological problems such as cerebrovascular accidents *(*CVAs*)* and cerebral palsy (CP) in children, while there was a high prevalance of spinal cord and orthopaedic injuries due to the number of motor vehicle accidents caused by livestock roaming in the roads.

In the Western Cape the unemployment rate was reported to be as high as 95% in one of the communities where the participants practised. The only form of employment in the area was seasonal work which was only available for three to six months of the year. I noted that the majority of people who attended the clinics either received some form of social grant or wanted to apply for a disability grant. For many people this grant would be their only form of income.

The region was further characterised by a high prevalence of alcohol abuse, particularly in the villages that surrounded the farms in the area. It was reported that alcohol abuse was not just prevalent over weekends but also throughout the week. Consequently this area was characterised by a high incidence of FAS. In addition, there was a high prevalence of TB and HIV/AIDS as well as complications from diabetes, i.e. CVAs and amputations as a result of poor treatment adherence for hypertension.

With regards to the availability of resources for OT practice in the three provinces, there was a vast discrepancy between the Western, Northern and Eastern Cape provinces. The Western Cape appeared to be better resourced in comparison to the other two provinces. For instance the OTs at the CHC and hospital were able to issue assistive devices i.e. wheelchairs, crutches and splints, which were readily available, while there were long waiting lists for equipment and assistive devices in the other two provinces.

5.2.2   Practice settings

The community service practice settings of the graduate participants covered three of the four levels of care as outlined in the District Health System (South African Government, 2004), namely Level 1 Community-based Services/PHC Services and District Hospital Services, and Level 2 Regional Hospital Services. Participant 1 was placed at a district health office, while participant 2 was placed at a CHC. Participants 3, 4, 5 and 6 were placed at a district hospital while participant 7 was placed at a regional hospital.

The community service placement for participant 1 was at the district office. She shared an office with two senior OTs in a building which housed several other health professionals and administrative staff. The OT office was spacious and equipped with a desk for each therapist and one computer that was shared by them. There was no therapy space, materials or equipment as the office only served as a base for the OTs who provided services at the 30 PHC clinics in the district.

Participant 2 was placed at the CHC that hosted a rehabilitation department that consisted of a joint office space for the OT, PT and speech therapist, a gymnasium, a speech therapy room and a store room. The therapists had one computer available for their use. The store room appeared to be well stocked with assistive devices and materials such as educational toys. There was adequate space in the gym area for therapists to see clients and to run groups.

Participant 3 was placed at a newly built district hospital that commenced operations in 2009. It was situated about 60km from the nearest Level 2 referral hospital. The hospital appeared to be well resourced with an equipped gym, splinting room, activities of daily living (ADL) room, and adapted bathroom and kitchen. It served 11 clinics and two CHCs that referred clients to the hospital; however, rehabilitation services were available only at the hospital. Besides participant 3, there was one other senior OT and two physiotherapists that comprised the rehabilitation staff.

The district hospital where participant 4 was placed had a capacity of 267 beds. The majority of patients that were seen at the hospital for the purpose of rehabilitation had neurological conditions such as strokes in adults and cerebral palsy in children. Besides participant 4, there were two permanent OTs employed at the hospital. In addition, two physiotherapists and a community service physiotherapist comprised the rehabilitation team.

The practice setting of participant 5 was also a district hospital. It acted as a point of referral for 28 PHC clinics for a population of +- 158 000. There were five in-patient wards as well as an out-patient and casualty department. Services included OT, physiotherapy, dietetics, social work and radiology. Due to financial constraints the maintenance of the old and dilapidated hospital building, as well as the procurement of hospital equipment, appeared to be a challenge. Some of the buildings were built as early as 1926 and, due to their dilapidated state, did not always meet building standards in terms of the availability of emergency exits and adequate ventilation.

At the district hospital where I visited participant 6, my first impression was that it was indeed rural. The hospital was situated on the outskirts of town on a vast open space. The building looked bare and uninviting with dry weeds surrounding the hospital. The OT office was a very small room in which two senior OTs and three community service OTs competed for space. Besides a small desk and cupboard with a few toys and files, the office contained one mat, physiotherapy ball, wheelchair and about three seating pillows that were stacked in one corner. During meetings some of the OT's sat on the floor. I learned that this small space was where most of the OT intervention sessions with their clients took place as there was no separate area for consultation.

Participant 7 was placed at a newly renovated 215-bed regional hospital. Besides participant 7, there were two permanent OTs who worked in the hospital. The OT department was spacious and appeared to be well resourced. It consisted of an open therapy/gym area, store room, consultation area and OT office. The rehabilitation department comprised occupational-, speech- and physiotherapy, while other services offered included dietetics, radiology and social work services.
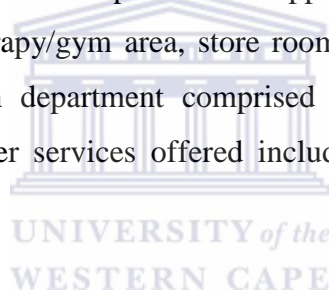
5.2.3   Participants' roles and responsibilities

For all participants individual interventions were the focal mode of practice in their respective settings. The primary responsibility of the participants was to provide clinical services i.e. consultations and interventions to in-patient and out-patients. These involved assessments, intervention planning and therapy sessions.

Table 4 below provides a summary of the participants' roles in their respective practice settings.

Table 4: Summary of participants' roles in their practice settings

PARTIC.	SETTING	PRIMARY ROLE	OTHER
1	Dept of Health District Office (N Cape).	Clinics/hospital individual consultations. Health promotion groups. Home visits.	Community outreach.
2	Community Health Center (W Cape).	Individual Consultations. Weekly clinics. Health promotion groups. Home visits. Outreach and support to: home-based carers, NGO's, Dept. of Education, Social Development., DPOs.	Community meetings. Health forum meetings. Awareness campaigns.
3	Level 1 District Hospital (E Cape).	Individual in- and out-patients. DG assessments. Rehabilitation and OT forum meetings. CP groups.	Community project. Clinics. Community Outreach.
4	Level 1 District Hospital (E Cape).	Individual in- and out-patients. DG assessments. Rehabilitation and OT forum meetings.	Community project. Clinics. Community Outreach.
5	Level 1 District Hospital (N Cape).	Individual in- and out-patients. Individual consultations at clinics.	Occasional community educational talk.
6	Level 1 District Hospital (N Cape).	Individual in- and outpatients. Individual consultations at clinics.	Occasional community educational talk.
7	Level 2 Regional Hospital (W Cape).	Individual in- and outpatients. In-patient groups. Rehabilitation meetings.	None.

The primary role of participant 1 was to provide individual interventions to clients at 12 of the 30 clinics in her district. Her days were mostly spent driving the vast distances to the clinics. On these visits she often found only one or two

or, at times, no clients that were booked for OT by the nursing staff. As there were no materials or equipment at the clinics she had to take whatever materials she thought she might need with her to the clinics. This applied to all the participants with the exception of participant 7 and participant 3 who did not do clinic visits. Participant 1 also saw patients at the district hospital on referral. Here she was also involved in the maternity ward where she provided educational input on baby stimulation, early childhood development and kangaroo mother care to the mothers.

The responsibilities of participant 7 included the provision of assessment and intervention services at three hospital wards, i.e. surgery, paediatrics and psychiatry. She was also responsible for the facilitation of paediatric stimulation groups, kangaroo care groups and daily psychiatric groups with acute patients. She further attended specialist outpatient clinics where patients could only attend if they had an appointment and referral letter from the CHC, clinic or district hospital.

Community outreach activities were inconsistent for all the participants. Participant 2, who was based at a CHC, and participant 1, based at a district office, were the only two participants whose primary responsibilities included community-based activities in addition to individual consultations. The only two participants that were involved in the facilitation of a community project were participants 3 and 4. The other participants engaged in community activities on their own initiative as it was not expected of them in terms of their role requirements in their settings. With regards to outreach activities, participant 2 performed these on a regular basis, while participant 1 performed them occasionally. Participant 5 and 6 performed an occasional educational talk in the community while participant 7 was not involved in any outreach activities at all.

5.3   THEMES AND CATEGORIES

The themes and categories presented in this chapter were derived from participant observation that was done in the practice settings, individual and dyadic interviews with the participants about their practice experiences, and the review of practice documents. In exploring the research objectives, the participants' personal vision for OT was explored and they were asked how they understood and incorporated occupational justice into their practice. This was followed by an exploration of their broader practice experiences as well as an exploration of how they perceived their education to be in relation to their practice.

Six themes, underpinned by related categories, emerged from the findings: (1) The meaning of occupational justice; (2) Practice approaches to promote occupational justice; (3) Practice strategies to promote occupational justice; (4) Skills applied as tools of occupational justice; (5) Contextual constraints to occupational justice; and (6) Contextual facilitators of occupational justice.

Table 5 outlines the themes and related categories that emerged from the analysis of the data.

Table 5: Themes and categories

THEMES	CATEGORIES
1. The meaning of social justice.	Health and wellbeing through social change Social change through occupational enablement.
2. Practice approaches to Promote occupational justice	Occupation-based practice. Community –based practice.
3. Practice strategies to address occupational justice	Health promotion. CBR.
4. Skills applied as tools of occupational justice	Attending to power issues. Attending to diversity issues. Collaboration. Advocacy. Building capacity.
5. Contextual constraints to occupational justice.	Lack of OT awareness. Resource constraints. Complex process of bureaucracy. OT Vision does not fit the system. Practice-education gaps.
6. Contextual facilitators of occupational justice.	Context supports practice. Living OT vision. OT recognised as valuable resource. Education guides practice. Graduate attributes.

5.3.1 Theme 1: The meaning of occupational justice

This theme illustrates the participants' perceptions of the meaning of occupational justice. Because it can be difficult to define explicitly the concept of occupational justice due to its overarching significance to occupational therapy, and because I did not want the participants to provide me with a text book definition of occupational justice, I did not directly ask participants to define the concept. Instead, I explored the participants' personal vision for OT

to elicit their perceptions of the meaning of occupational justice. The findings that follow illustrate this and how the participants understood the concept of occupational justice as embedded in their vision for OT. Two categories, namely Health and wellbeing through social change and Social change through occupational enablement, support this theme.

5.3.1.1 Health and well-being through social change

Two questions: How would you describe yourself as an OT? and What is your vision for OT in your practice setting? were posed to the participants to elicit their vision for practice. The participants' reflections on their vision for OT highlighted their beliefs around health and well-being and its enhancement. All participants expressed a vision of OT as being part of a health service that embraces an understanding of health and well-being determined not only by biological factors but also by social factors. Consequently much of the discussion revolved around the importance of taking cognisance of how people themselves view the impact that social context has on their health and well-being, as illustrated by the following quote:

> *...if I must look at health and the theoretical meaning of health and overall well-being psycho-social-emotional...what really stands out for me in this context is who am I, to tell someone else what is health...when you within your context perceive something else as being healthy...everyone is different...everyone is absolutely different in terms of what they perceive as...healthy...* (participant 1, initial I/V 1).

The discussion further revolved around social conditions that underlie health and well-being. The participants' responses revealed insight into social injustice and those populations considered to be disempowered or vulnerable by nature of economic status or belonging to certain social groups, for example people with disabilities, as illustrated by the following quote:

...the disability grant is like the big social issue and it has a lot...a lot to do with the socio-economic status over here...so that is like one thing that is really...an issue for us...we try to look at the person within his social context also...there are a lot of things that...that impact on the person... (participant 1, initial I/V 1).

The uniting factor amongst all populations discussed by the participants was some type of disadvantage by virtue of the conditions of their lives, such as living in a rural community and not having access to information as illustrated by the following quote:

In this rural community the people...they are at the bottom and they have difficulty to access information... (participant 2, initial I/V)

Examples of disadvantaged populations to which they drew attention were children with disabilities and the aged, as illustrated by the following quotes:

... and they (children with disabilities) *can't go to the special school because it's very full, there's a long waiting list for people waiting to get in (participant 4,* initial I/V*).*

...like all these old gogos they didn't engage in any occupational activities...and they felt so frustrated because they stayed alone at home, there are no recreational activities in the community... (participant 3, initial I/V)

Some participants thought of disadvantage in terms of the inequity that people experience within or as a result of the health system. Chief among these was access to health services, as illustrated by the following quote:

Most of the out patients I may only see once a month...they come once a month because they live so far away and sometimes they don't have money to come even that one time in the month... (participant 5, initial I/V 1).

Building on perceptions of who is affected by occupational injustice, participants also shared their perceptions about disadvantage or disempowerment in the context of the client-service provider relationship, as illustrated by the following two quotes:

The problem is there are some resources available in the community, but the people don't know about it...nobody makes them aware... (participant 2 initial I/V).

...and especially coming from...a doctor that just looks at you and...don't discuss anything with you, just sends you away...nobody understands what the person is going through... (participant 5, initial I/V 2).

As participants discussed injustice and its impact, they also provided insight into the meaning of occupational justice. How an individual experienced injustice in relation to their health and well-being informed participants' conceptualisations of occupational justice. Participants 3 and 4 illustrated their understanding of the relationship between well-being and occupational justice when they described the children's home where they were jointly engaged in a community outreach programme. The following two quotations are evidence of this:

...when we went there the kids didn't...they didn't have a healthy diet to start with, they did have a shelter, but they didn't have enough blankets...and they were all put into one bed and others had contractures...they were all screaming on the bed...the context wasn't right at all for them to be growing in there... (participant 3, initial I/V).

...the first word that came to us when we went to the centre was that there was no occupational justice for the kids that were staying there... (participant 4, initial I/V).

A focal point in the participants' articulations of their vision for OT was a perception of the meaning of occupational justice as the enhancement of health and well-being through social change. They expressed the belief that occupational therapists have a valuable contribution to make in enhancing people's wellness. In view of this, they stressed that occupational therapists address social issues that impact people's occupational performance in addition to biological problems, as illustrated by the following quotations:

...the medical is obviously important because that is what is wrong with the person and you will work on that...but you can't do anything...you can't send the patient back to her community without considering if she will be able to perform her occupations at home...so that is also important...I can't start with her unless I also focus on the social... (participant 5, initial I/V 1).

*...sometimes you just do stuff and then you know what you are doing and why you are doing it, but you don't label it as being social...it's your work...you look at everything and focus on the context of the patient...it's not just the physical things it's the social environment also and how that impacts on the patient...and how the patient will function or do his or her occupation... (*participant 1, initial I/V 1).

The interviews further provided an opportunity for the participants to express their thoughts around possibilities for enhancing people's health and wellbeing through social change in their practice contexts. One such possibility articulated by the participants was to work beyond the borders of the hospital. This was evident in their acknowledgement of the conflict they experienced around having to do mainly individual interventions, as illustrated by the following quotation:

...the expectations that we were expected to do at the hospital...that was even more frustrating for me...because I knew from the bottom of my heart that OT is not just being stuck in a hospital...apart from knowing that I'm more than a physical therapist (laughs)... (participant 4, initial I/V).

5.3.1.2 Social change through occupational enablement

As the participants reflected on their vision for OT, they began to engage more enthusiastically with how occupational justice and injustice related to their everyday practice. Another focal point in the participants' reflection on their vision for OT was a perception of the meaning of occupational justice as the enhancement of social change through occupational enablement. They regarded occupational enablement as a key principle of occupational justice. They stressed that as people's social context had an impact on their occupation;

occupational enablement also had to address social change, as illustrated by the following two quotations:

...my first focus is primarily or firstly the context and then from there you go on and you look at everything else, how the person fits into the context, how is the context supporting the person and how is the person able to perform the occupation within the context...(participant 1, initial I/V 1).

...when I have...a new referral...I ask about their family, I ask where they come from...what they do...and then I always in my mind try to reason or just go through how...erm their occupation is impacted by...their social context, their condition or their pathology...I know they...they gonna (sic) *go back to the same environmen*t... (participant 7, initial I/V).

They also stressed the importance of addressing environmental barriers that prevented people from engaging in occupations and achieving quality of life, as illustrated by the following quotation:

...in the wheelchair application...where we ask about the home environment...when I have a session with the client I ask if the wheelchair will fit through the door...is it possible to make a path or a ramp...I give the wheelchair but the question is: can it really be used...can it be used in the context? (participant 6, initial I/V 1).

The participants further regarded occupational enablement as an outflow of the nature of the OT profession and their professional responsibility. This was evident in their explanation of what meaning occupational enablement held for them personally, as explained in the words of participant 6 who stated: "*...that is how we can also show other professionals what is unique about what we do compared to what they do*". This was reiterated by participant 2 as illustrated by the following quotation:

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...the question that sticks in my head is what is the difference between occupational therapy and social work?...you need to be able to show the difference...sometimes it worries me...I must be able to say, OK...this is who I am as a professional...for me that is important (participant 2, initial I/V).

Participant 1 articulated how, despite the fact that directing her attention to issues of social or occupational justice was not seen as "*part of the job*", she still maintained a focus on occupation. Her words were in response to the question 'How do you actualise occupational justice in your practice?', and highlight the value she placed on occupational enablement as illustrated by the following quotation:

It's not so big like in policy, but it is something you can start with like to implement programs and change the whole way of doing things from an OT point of view...children play as their primary occupation so it's equipping the teachers with skills you know...developing personal skills so that they can at the end of the day deliver a better service to the children... (participant 1, initial I/V 2).

While the participants predominantly felt that "*there was only so much you could do as a therapist in the hospital'* (participant 7), they envisioned ways of extending occupational enablement into the broader community. For instance, in expressing her OT vision, participant 5 demonstrated the understanding that by training a home-based carer to do home visits and developing clients' skills, she, together with the home-based carer, could work towards achieving broader OT goals. The following quotation provides an illustration of this:

...the hospital have home-based carers and we could...we could give them...especially people who are very far out and don't have the resources to come to the hospital...we could give them...exercises and things to do at home...sessions or...positioning...things like that...that they could take to their villages... (participant 5, initial I/V 2).

They appreciated that by focusing occupational enablement more on the micro level (aimed at individual clients) and the meso level (aimed at caregivers and

families) in an attempt to influence the clients' immediate environment, they could work towards their vision of impacting their clients' lives at the macro level (aimed at social change), even if it provided just a glimpse of what they thought was possible. The following two quotations are evidence of this:

...your care-giver is part of your environment so if we focus on the care-giver...we are focusing on the environment of the patient also...I know how the patient will function or do his or her occupation with the balance between the...the input of the care-giver, the physical environment and the motivation of the person...   (participant 1, initial I/V 1).

I'm so glad that you actually came here...having this discussion here...I'm realising ...even if it is only on a small scale and working with what we have available here and working with what we can do...we can make a difference... (participant 5, initial I/V 1).

The issue of empowerment was central to participants' perceptions of the meaning of occupational justice as social change through occupational enablement. For instance, participant 1 envisioned practice in a community-based service centre where she would start a community project and use occupation as a form of economic empowerment. For her, occupational justice did not only revolve around creating individual opportunities for occupational enablement but around the creation of sustainable occupational opportunities in the community, as illustrated by the following quotation:

...I would start like a sheltered workshop...yes...or an arts and crafts group to make things...because they have lots of functions like the 'fees' (festival)*...there's a lot of community development...so they have lots of projects here...they can make things and sell it for income...and the people who have mental retardation, I would go to Pep* (Pep Stores)*, Ackerman's and Foschini erm...and then find out if I can't have a contract there for cleaning hangers, sorting hangers...so it will be cost effective for the company and then we can also generate income…that is the basic project that I have in mind...* (participant 1, initial I/V 1).

In Theme 1 the participants' perceptions of the meaning of occupational justice was presented as embedded in their reflections on their vision for OT. The participants understood occupational justice as an important element in the achievement of health and well-being and emphasised the importance of social change for this achievement. The participants further highlighted occupational enablement as a key factor in achieving occupational justice.

The following three themes capture the ways in which the participants practice actions and behaviours promoted occupational justice. These practices, characterised as occupational justice-promoting, ranged from broader practice approaches adapted to work for occupational justice, to more specific practice strategies and skills applied in their practice of occupational justice.

5.3.2   Theme 2: Practice approaches to occupational justice

This theme captures the practice approaches to occupational justice that the participants employed. The categories that underpin this theme are: Occupation-based practice and Community-based practice.
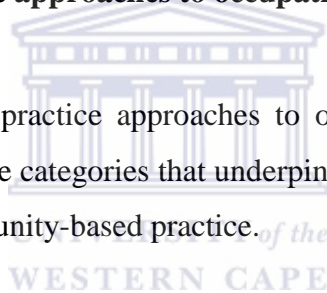
5.3.2.1 Occupation-based practice

When I observed the graduates in their practice settings, occupation-based practice emerged as the first key approach to occupational justice that they implemented in practice. Within the occupation-based approach, occupational enablement as a principle of occupational justice, was a key feature of the participants' practice. This entailed working towards improving people's ability to engage in occupation and the implementation of adaptations to support their occupational engagement. With regards to individual clients, evidence of the implementation of occupation-based practice was illustrated in the facilitation of a gradual return to occupations as their clients' strength and endurance recovered, as illustrated by the following quotation:

...it's like seeing or being able to help him get up onto the bed...and eating by himself or erm...washing himself...even though it's just a little...maybe it's just his upper body...it's little things where I can see I am making a difference in somebody else's life... (participant 5, initial I/V 2).

The participants focused on improving their clients' functioning by practising adapted ADL techniques in individual sessions. They issued wheelchairs and made splints so that the clients could be more functional in performing their daily occupations at home, and they discussed specific adaptations in performing those occupations with the clients and their families (field notes, 29/07/10).

They geared occupational enablement to meet their clients' goals. This was evident in the way they conducted practice in collaboration with their clients and in the way they respected their needs and interests. By adopting the client-centred approach the graduates ensured that their intervention remained meaningful to those people to whom they were providing a service. The following field note extract is relevant to this:

Participant 1's right hemiplegic client wanted to be able to make a simple meal. At a previous session participant 1 enquired about the client's goals and about the type of activities he would like to learn. Based on his suggestion, she planned the session on sandwich making with an adapted sandwich board. During the session she enquired about the kitchen set-up at the client's home and addressed work simplification principles while they made the sandwich. The client was very engaged in the activity during the session and appeared to be pleased with the assistive device stating that now he will be able to assist his wife at home (field notes, 2/08/10).

In reflecting on the session in the interview, participant 1 explained her motivation behind her practice as follows:

I always ask people and that...comes back to client...client centred practice..."what is it that you want?", because what I have in mind or my goals for you may be totally different... (participant 1, initial I/V 2).

Table 6 provides examples of activities that the graduates utilised within the occupation-based practice approach**.**

Table 6:   Examples of activities within the occupation-based practice approach

ADL	SCHOOL/ WORK	PLAY/LEISURE
Self-care activities. Household activities. Dressing. Transfers.	Educational activities. Classroom adaptations. Work assessments. Vocational counselling.	Play stimulation. Arts and crafts.

Other participants also stressed that occupation-based practice held meaning for their clients, as illustrated by the following quotation:

I especially see it in my psych groups...I can immediately see the difference...I dont always have the resources to do creative activities with them every day, but the day that I do...the next day they will come to me and ask me..."what are we going to do today"...so I think that...we can definetly use more...erm occupation-based practice...I know I can...and I don't always do it, but the times that I do...I've noticed that my outcomes are more successful (participant 7, initial I/V).

During participant observation I, however, observed that the participants predominantly focused on occupation as an end in their interventions. There was little evidence of occupation being used as a means, i.e using activities during intervention sessions. When I shared this observation with the participants, they acknowledged that the lack of occupation in their practice was something they often reflected on. The following two quotations are evidence of this:

I'm laughing because sometimes in a session then you forget about...where the occupation is in everything you do and then you end with only doing exercises...the question I ask myself is...now where is the occupation then now? (participant 2, initial I/V).

...I personally feel that there is not enough occupation in my intervention...it's not that I don't think about it...in this setting there is so much focus on the medical...You can really just do exercises and functional activities that they can do at home...and most of the clients you may only see once a month (participant 5, initial I/V 2).

The participants further reflected on various factors that impacted their implementation of occupation-based practice. They explained that they do not always have sufficient time to use occupation in their intervention. The following two quotations are evidence of this:

...I'm just using time as an example and your patient load...it's easier...to just do exercise or just take them through full range of motion and then once they have that...to do ADL, but you don't...like I don't really work on ADL to gain range of motion...by the time you want to do ADL or function then the patient is discharged...and then you just accept...but...okay...I know...he can fully flex and extend his fingers... (participant 7, initial I/V 2).

...we don't always have time to look at every aspect of the person...to analyse their occupation...it's...too much time...so then I focus with the physio on the body and after that I will focus on the occupation...but it's not a wide focus...basically everyday roles that the person fullfils...I focus on the functional to get the person to be independent...for instance, I have not given much consideration to the use of leisure activities... (participant 5, initial I/V 2).

Another factor that impacted on the implementation of occupation-based practice was the availability of resources, as illustrated by the following quotation:

I think that that erm...sometimes...it is difficult to use occupation as a means and as an end...you aim to restore occupation in the end but to use it as a means is very difficult...it's about resources, because sometimes you just don't have any resources to work with... (participant 6, initial I/V 2).

5.3.2.2 Community-based practice

Community-based practice emerged as the second key approach to occupational justice employed by the participants. For the participants, community-based practice meant building upon existing community resources rather than creating new services and involved the following activities: weekly visits to clinic areas, community outreach activities and visits to schools, children's homes and clients' homes (field notes, 11/10/10).

Table 7 outlines examples of activities that were implemented within the community-based practice approach.

Table 7: Examples of activities within the community-based practice approach

COMMUNITY-BASED ACTIVITIES	INTERVENTION
Community entry	Meeting with village chief and community leaders.
Community outreach	Home visits and educational talks. Presentation to grade 12s about support measures and study skills. Presentation on ECD to teachers and school nurses.
Community projects	Occupational development of disabled children's home. Health worker training. Mental health support group.

The participants regarded activities such as community outreach and community projects as important in facilitating occupational enablement as a principle of occupational justice. They thought that this was particularly relevant as community members experienced difficulty with transport or mobility and therefore did not have easy access to OT. Their practice actions were typical of a community-based practice approach where they identified problems and developed strategies to address them, as opposed to community development that is geared towards supporting community groups to address self-identified health priorities. For example, participant 3 reflected on the outreach to a children's home for disabled children in the community in which she and participant 4 identified the need for the occupational development of the children, as illustrated by the following quotation:

> *When we went there* (home for disabled children in the community) *we saw that kids did not engage in any occupational activities, they did not attend school, uh...they would just lie there for the rest of the day, so we thought our role was needed there...we explained to them* (the caregivers) *the importance of occupation...that the occupation of those children is playing and education and we reflected on how we could use our skills to make a difference* (participant 3, initial IV).

The identification of their clients' needs was prioritised by the participants, and community outreach afforded them the opportunity to do this, as explained by participant 2 (initial I/V) when she stated: "*I basically run a mini assessment of the community like...who the community members are, what the community think is lacking and what I know is lacking*".

Community entry, i.e. building relationships in getting to know the community, was the first step towards identifying priority needs. This entailed a gradual process the success of which depended greatly on how the community was approached, as illustrated by the following quotation:

...we needed to have very good community entry skills for them to gain our trust...so when we went there we dressed down, we didn't wear high heels or make-up and...fancy clothes that would really intimidate them...and we talked with the kids, we showed them what we could do, we didn't go there to intimidate them...we wanted them to feel comfortable around us (participant 3, initial I/V).

Through observation, listening, questioning and discussion with various role-players in the community, the graduates determined the community's priorities and interests despite the constraints they experienced. For example, participant 4 related how she approached an NGO that was working in one of the villages to accompany her on a community visit in order to complete a needs assessment of the village, as illustrated by the following quotation:

...it made things easier for me and I started going with them into the community...so I got a feeling of how things are in that community and I was speaking to the community members and the chief and also the committee...there's a committee in each...in every village...and I spoke to them and they would tell me of all the needs of the villages...that is how I got that relationship with the people in the villages (participant 4, initial I/V).

I indeed accompanied participant 4 on a visit to the chief in one of the villages where she gave a report to the chief on the groups she had been facilitating in the village. In this meeting, the chief expressed concern about the high level of illiteracy, unemployment and escalating crime in the village. In the discussion that ensued participant 4, together with the chief, explored possible ways in which the problem could be addressed in the village (field notes, 14/10/10).

By nature of their primary responsibility of being individual clinical therapists, the participants predominantly engaged in individual assessments. However, working within a community-based practice approach, they linked their individual clients' needs to broader community needs and then interpreted these needs from an occupational and social perspective rather than only from a biological perspective. This was illustrated when participant 7, although not expected of her in terms of her hospital role, made an effort to enhance her

understanding of her individual clients' context by attending a community meeting after hours. She selected to attend this particular meeting because many of her individual clients in the hospital presented with problems related to substance abuse. The meeting was called by concerned residents of the community to respond to the sale of drugs and alcohol in the community and to explore strategies to address the problem (field notes, 13/09/10).

Occupation-based practice at a community level also occured in response to individual client needs that were reflective of broader community needs. For example, having recognised that her three year old client's family could not afford to buy toys, participant 7 recommended to the client's mother the use of scrap material that was safe for her client to play with. She showed an understanding of the family context in that they did not have access to toys to promote child development and explored actions that could be implemented in the community to develop the mother's skills around play stimulation such as community-based workshops on using scrap materials to make toys for children (field notes, 13/09/10).

Similarly participant 2, after completing a DG assessment, concluded that her client seemed motivated to obtain employment but due to his disability had little chance of being employed. In reflecting on this, she explained why she considered the occupation-based approach to be relevant in the community, as follows: *Where occupation-based is very relevant for me is with the adults...especially when they come for disability grants...they are at home and they are able to work* (initial I/V).

In another example related to older adults, the need for occupational-based practice at a community level became evident when the participants implemented an education session on chronic diseases of lifestyle to a group of older adults at one of the clinics. The following quotation is relevant to this:

... when we suggested ideas...like...starting a garden in the community...or having a sewing project...they were all excited because...they said..."I would have the time to really interact with my community members, tell them about my problems"...there were so many things that we could start in those communities (participant 3, initial I/V).

Although occupation-based community development did not really feature in the participants' practice, some attempt was made by them to broaden the community-based practice approach to that of community development. This was mainly illustrated through the involvement of community members in various activities. These attempts were, however, hampered by constraints such as a lack of transport. For instance, after a process of consultation with the community, plans to start a mental health support group could not be followed through due to restrictions in transport, as illustrated by the following quotation:

...the available resources impact what we can do...like the mental health group...the people were ready to get involved...they had a venue...everything was in place...but then...it gets very difficult when you want to go out into the community but you don't have transport (participant 4, initial I/V).

In Theme 2 data that illustrates the approaches to occupational justice that the participants adopted, namely occupation-based practice and community-based practice was presented. In Theme 3 practice strategies, i.e. health promotion and CBR, utilised to facilitate occupational enablement will be portrayed.

5.3.3   Theme 3: Practice strategies utilised to address occupational justice

This theme describes the strategies that the graduates utilised in facilitating occupational enablement as a principle of occupational justice in practice. The categories that underpin this theme are Health promotion and CBR.

5.3.3.1 Health promotion

In response to the question: How do you incorporate occupational justice into your practice? health promotion was the first strategy highlighted by the

participants. The participants suggested that, for them, being involved with health promotion entailed a shift in their roles from that of clinicians to that of consultants, as illustrated by the following quotation:

I see myself more as a consultant...when I go to the clinic erm...and I see a patient and the patient...tells me what he or she presents with...because I don't have things with me like equipment or things to do...I can give advice, I can advise certain things, I can give a home program, although I can't implement it or show the patient in his or her home how to do it...we can go through it... (participant 1, initial I/V 2).

They expressed that, due to contextual factors, their implementation of health promotion as a strategy of occupational enablement was mainly aimed at developing the skills of individuals to enhance their well-being through occupation, or the skills of a particular group of people such as teachers. The following quotation is evidence of this:

...it's not so big like in policy, but it is something you can start with like to educate people and provide information on doing things from an occupational therapy point of view... educating is a very big thing...because erm like children play as their primary occupation...it's equipping the teachers with skills you know...developing personal skills so that they can at the end of the day deliver a better service to the parents and to the children (participant 1, initial I/V 2).

Health promotion as part of the participants' practice was rarely aimed at policy or strengthening actions of the broader community. The most frequent manifestation of health promotion was through educational initiatives. Here emphasis was directed at illness prevention or the prevention of complications post-illness as evident in those aspects of the graduates' practice that I was able to observe.

Participant 6 stated that "*...in many cases...we have a pamphlet and...we talk about what helps and what causes the problem*". The other participants also considered health education as integral to their practice, as illustrated by the following quotation:

...okay health promotion in my frame of mind is important but...you focus mostly on education about the pathology with the person but...you remember that that's not all ...there's many other things that affect the person but you are not always able to address that...and you always focus on that which is most important. So yes, I don't specifically go out to do a health promotion project...I do health promotion with a client or even when I walk past people and they need information I will share my knowledge with them...that is also where health promotion comes into practice (participant 5, initial I/V 1).

Educational activities were primarily related to early child development, diseases of lifestyle, mental illness and disability awareness, and mainly involved individuals and groups with the occasional involvement of communities. Examples of these activities are listed in Table 8.

Table 8: Examples of Health Promotion activities performed by participants
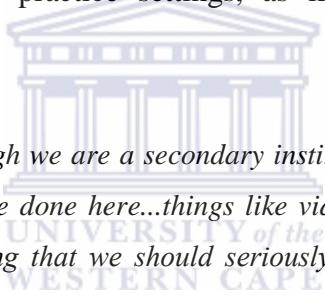
INDIVIDUAL	GROUP	COMMUNITY
Education on Pathology. Education on rights, options or choices.	Educating others about needs/rights, stigma i.e. teachers, mental health support groups. Educating parents on normal child development, school readiness and developmental stimulation. Educating grade 12 learners about support measures, study skills and career choices. Educating community-based youth group on constructive leisure time use, stress- and time management and study skills.	NGO/NPO/Dept of Health community-based health awareness campaigns on rights, needs, resources and opportunities i.e. ECD, AIDS, Mental Health, Abuse, Disability awareness, Road to health. Involvement in municipal wellness week. School education. Input at community meetings i.e. health forum, hospice.

Participant 4 contributed to the school health awareness programme that was organised by school health nurses in her community. Her role was to make presentations on learning disabilities and early childhood development. Her

presentations included characteristics of children with early childhood developmental challenges and pervasive developmental problems that become evident in the classroom (OT educational talk, script, reviewed 10/10/11).

Likewise, participant 2 implemented various health promotion groups at the CHC that focused on education related to diseases of lifestyle. Topics covered included healthy lifestyles, joint protection principles and energy conservation, and how these could be integrated into occupational performance. I was able to observe the arthritis group which was attended by 10 clients (field notes, 15/09/11).

The interviews seemed to increase the participants' perception that their efforts at health promotion were not exhausted as they identified strategies to further health education in their practice settings, as illustrated by the following quotation:

I do think that even though we are a secondary institution, health promotion or prevention should also be done here...things like videos in the waiting area...I really think it's something that we should seriously consider... (participant 7, initial I/V).

They were particularly concerned with the relevance of health promotion activities in relation to the needs of the people they worked with. Consequently, the issues of literacy and language, as they relate to health promotion, were also addressed in the interviews, as illustrated by the following quotation:

...posters make the place look nice, but how many of the population that comes here can actually read...whether it's English, Afrikaans or Xhosa...so I really think that it's something we should seriously look at in terms of creating awareness and looking at prevention... (participant 7, initial I/V).

5.3.3.2 Community-based rehabilitation (CBR)

CBR was the second strategy employed to address occupational justice in practice that was highlighted by the participants.

Examples of the CBR activities implemented by the participants are summarised in Table 9.

Table 9: Summary of CBR activities

CBR ACTIVITY	INTERVENTION
Training home-based carers	Consultation re functional problems, transfers, adaptations, assistive devices and positioning, assessing training needs.
Home visits	Family/caregiver education. Provision of psycho-social support. Assessment of social needs. Education re DG application.
Consultation	Visits to NGOs and CBOs. Input re programme development.

One example of CBR was the involvement of their clients' neighbours in OT intervention by the participants. They felt that in this way they, together with community members, could work towards achieving their clients' rehabilitation goals, as illustrated by the following quotation:

...my client's mother did not understand and she could not read so I asked her if there was someone at home who could read and assist her with her child...and then she brought her neighbours and they were very interested to learn...that is what happens, you understand? (participant 6, initial I/V 1).

Another example of CBR was the implementation of CP groups that focused on the transfer of skills to mothers and caregivers of children diagnosed with CP.

In this way, rehabilitation became more accessible to the community, as illustrated by the following quotation:

...an example is our CP group...we have changed our whole program totally this year, so it's more focused on the mothers...the quality of the care that the mothers can give...the mothers or the caregivers...need the skills (participant 1, initial I/V 2).

Another activity related to CBR was the community-based project at a disabled children's home that was implemented by participants 3 and 4 where the focus was on developing the caregivers' basic rehabilitation skills. The following quotation is evidence of this:

They had this idea of helping the mothers and caregivers in the community who have babies with disabilities, but they didn't know what to do with them...we gave them a description of what a rehabilitation centre is in Xhosa and we also presented to them about home-based care...and provided training...on what a rehab centre is so that everything that they do, it aim on that... (participant 3, initial I/V).

I accompanied participants 3 and 4 to the children's home that was situated on the far outskirts of town. The following field note extract provides a description of my observations:

The home was quite isolated from the rest of the community. It appeared dilapidated with cracked windows and paint peeling off the walls and doors. Inside the home was sparsely furnished and felt cold with no coverings on the floors. Some kids were severely disabled, while those who were mobile were just sitting in groups on the beds or floor with the care givers. The manager reported that there was very little community or parent involvement in the home and that the stigma of having a disability was a big problem in the community. She further reported that in her view the training the graduates provided to the caregivers improved the children's overall care. It was also her opinion that the children would be less likely to develop secondary complications with improved

care and therefore may require less frequent hospitalisation (field notes, 12/10/10).

Most participants, however, found expanding CBR services to the broader community challenging as there was no dedicated budget for CBR. According to a volunteer rehabilitation worker at one of the clinics, requests to make CBR more effective had been put forward to the clinic management but, due to the vast distances between the clinic and the villages, transport remained a major challenge (field notes, 28/07/10).

There were a few occasions where the participants accompanied volunteer rehabilitation workers on home visits or performed home visits themselves. These visits revolved around assisting PWDs in the community to do rehabilitation exercises, providing education on adaptive and safety techniques in performing ADL, sharing information regarding available community resources and counselling family members to provide assistance where needed. The following field note extract captures the typical nature of home visits done by the participants:
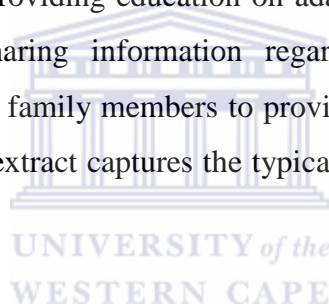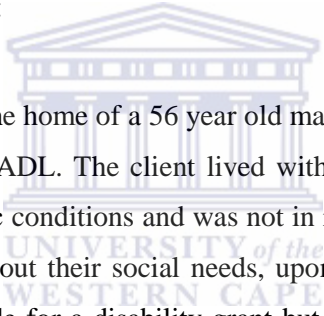
Participant 1 assisted the client's sister to transfer the client into the wheelchair that she was issued on a previous visit and reminded her about safety and back protection principles while they did the transfer. After addressing the client's positioning and seating in the wheelchair she made further enquiries about any form of assistance the sister might need in caring for her brother. Today, however, the sister just seemed pleased to have a supportive and listening ear and expressed her gratitude to participant 1 for taking the time to visit them at home (field notes, 4/08/10).

On other occasions the participants partnered with community-based disability organisations like APD where their role was that of skills development and consultation. I was able to accompany participant 2 on such a community visit, where her intervention was focused on transferring skills to home-based carers and family members. The visit took place at a health project that was housed in a trailer in the community with office space for the carers and a consultation

room for OT and PT. The role of the OT was to provide support and consultation to the home-based care workers, i.e. consultation on wheelchair positioning and exercises. This occurred at a weekly clinic for PWDs and other community members (field notes, 16/09).

While the participants seemed to be aware of the challenges that PWDs face in their communities, I found the full participation of PWDs lacking in identifying and addressing their needs (field notes, 27/07/10). The home visits appeared to be merely an extension of the participants' clinical role and did not necessarily reflect a social role (field notes, 2/08/10). This indicated that the participants needed to shift their understanding of their role as therapists who provide rehabilitation *in* the community, to that of CBR workers who provide rehabilitation *with* the community. The following field note extract provides an illustration relevant to this:

Our second visit was to the home of a 56 year old male who suffered a CVA and required assistance with ADL. The client lived with his wife in a shack under very poor socio-economic conditions and was not in receipt of a disability grant. Participant 2 enquired about their social needs, upon which they stated that an application had been made for a disability grant but that it was not progressing satisfactorily. In response, participant 2 explained the steps and time-line of the application process to them. She then proceeded to work with the client on bed mobility and adapted dressing techniques while his wife observed. She further motivated them to attend the stroke support group at the CHC. They, however, indicated that they do not have access to transport and therefore were not able to attend the group, upon which participant 2 just stated that she understood (field notes, 16/09/10).

Evidence that CBR was merely an extension of the participants' clinical role could also be found in the 'clinical' manner in which they responded to the needs of PWDs in the community, as illustrated by the following quotation:

...CBR is a priority...because we have seen what happened, what's going on, what the most prevalent illnesses are...for example we see a lot of stroke patients...I'm speaking about all the therapists...because we are all together...we talk a lot about our experiences...so we are actually in the process of motivating for a stroke unit because here are a lot of patients we have identified that can benefit from rehabilitation (participant 1, initial I/V 2).

While minimal reflection around CBR as a strategy of inclusive community development and social action occurred in the interviews, it was encouraging to note the participants' reflections on changes in their practice settings that needed to occur in order for CBR to be more effective. As illustrated by the following quote, they spoke about the need for change at a policy level that was required to address resources for CBR. They also addressed restrictions around the expectations for their practice as community service therapists:

We would like to have a rehabilitation centre...it gets very difficult for us because if you could see all those charts in the wards of the patients we are seeing and they want you to improve function on that person...you get...maybe an old CVA...he got this from when he was about fifty and now he's eighty... (participant 4, initial I/V).

In Theme two and three the approaches and strategies the participants implemented in their practice were described. Theme four captures the skills within these approaches and strategies demonstrated by the participants. These skills were applied as tools of occupational justice.

5.3.4 Theme 4: Skills applied as tools of occupational justice

This theme is presented at the hand of the following categories: Attending to power issues, Attending to diversity issues, Collaboration, Advocacy and Building capacity that reflect the specific skills and abilities utilised by the participants as embedded in the data.

5.3.4.1 Attending to power issues

During the interviews the participants were very clear that as new community service OTs entering practice, the locus of power and control was situated within the existing management and/or senior staff structures within their practice settings. They were strongly influenced, either positively or negatively, by the relationships they formed with colleagues in their practice settings. This contradicted the participants' understanding of working collaboratively with other professionals and did not only create tension within them but also between them and other staff members.

Each participant disclosed examples of being placed in a position where there was the potential for, or they experienced, actual conflict with other staff or management related to various aspects of their practice. This conflict mainly surfaced as a result of power issues related to professional boundaries, as illustrated by the following two quotations:

> *I'm gonna* (sic) *be very honest here...there's power between colleagues and then there's the power play between the therapist and the patient, so in terms of the colleague...I think in my hospital there's a lot of those...power issues...usually like it's... underlying...it's this underlying war between physio and OT* (participant 1, initial I/V 2).

> *…we had a huge fight with the doctors because they would just send people that came from the community that wanted disability grants, so they expected us to write a letter saying that this person is disabled and I told them "no, this is not how we work"...* (participant 3, initial I/V).

Power issues also revolved around existing professional hierarchies in the setting which was particularly evident during decision making processes, as illustrated by the following quotation:

When it comes to the hierarchy we are at the bottom...very very bottom...because it's almost like they don't want you to know too much...because you know...it's almost like a sense of power that they have over you...the thing about the hierarchy...if you go above them...your chances of actually getting what you want in the first place is less...because then that person they are upset because...they haven't been recognized in their power....yes...so...they just gonna (sic) *make it more difficult for you* (participant 6, initial I/V 2).

The role that power played around professional hierarchies in the process of decision-making was particularly evident in the influence that doctors had in decision-making around interventions with clients, as illustrated by the following quotation:

...people think that because they are doctors they have a more important role and so on...erm the doctors have so much say over who gets seen by an OT, what an OT does and whether a patient is a priority or not... (participant 1, initial I/V 2).

One challenge the participants experienced was that they were not always consulted or informed about a patient's impending discharge, as illustrated by the following quotation:

...you start working with a patient now and it's maybe Friday...'cause a lot of people just get discharged over weekends...there's no communication unless I go to the sister and I ask about this client...there's no way to just get the information (participant 5, initial I/V 2).

This was mainly related to an ineffective functioning of the multi-disciplinary team (MDT). In some settings, for instance, there were no ward rounds and the occupational therapists were thus not involved in the review of their clients, as illustrated by the following quotation:

...the MDT is very poor...they (the nursing staff*) do what they feel is right for the patient and when you go see them then they tell you that the doctor said they must do this and they don't understand...and then you explain to them that you feel that this has to be done for the client...they don't understand because we don't have ward rounds* (participant 3, initial I/V).

Power issues were also evident in the relationship between the health sector and other governmental sectors, as well as between the health sector and the NGO sector. For example, evidence of conflict related to professional boundaries with professionals from social development surfaced as the participants reflected on their work with other sectors, as illustrated by the following quotation:

...we also had a fight with the people from SASSA (South African Social Security Agency)*...they wanted to be the ones concluding if a client could work or not...and we thought they didn't respect our profession because if I assess the client...I can have results...they can't take on our work and decide on the...the assessments that we've done...* (participant 3, initial I/V).

Conflict related to professional boundaries was also evident when the graduates attempted to expand their practice on a community level. Examples of this were related by participant 4 in two instances. The first occurred when she requested permission to accompany a non-governmental organisation (NGO) on a community outreach visit, as illustrated by the following quotation:

...I had to ask staff from the NGO to write a letter for me...because they (hospital management)*...said that it's gonna* (sic) *benefit the NGO and not the hospital...so they won't allow me to go...so they* (the NGO) *wrote a letter for me...they explained their purpose of being in the community and what my role would be if I joined them...they looked at the fact that there was no transport...that when they are there, they could provide me with transport...so that helped me* (participant 4, initial I/V).

The second instance occurred when the school health nurses invited her to accompany them on a school visit, as illustrated by the following quotation:

...we had those politics...they (management) *said "you are employed by the department of health, you can't be part of department of education as well"...so I said..."I have to do community work and your excuse...is there's no transport...but now they* (the NGO) *come with transport, and offer to fetch us to go do these presentations"... we had to stand up again until they* (management) *allowed us (*participant 4, initial I/V).

The participants also identified factors like broader community dynamics that influenced their relationship with other people and, ultimately, their practice. The following quotation illustrates this:

...people who are in a more senior position...a position of authority...like my position as an OT, I can walk into a place and ask questions, but if I was just an ordinary person I might be chased away. This nametag that I wear makes a difference. So I use my position to access information because I know...my clients, cannot do it themselves (participant 2, initial I/V).

It was interesting to note that in attending to power issues, the participants showed an awareness of themselves as actors in the setting. This was evident in their reflections on their personal beliefs and the motivation behind their own occupational behaviour, as illustrated by the following quotation:

...okay, I'm taking it now to another level, but I'm also thinking that...even though you may have the knowledge of human rights...all of those things really depends on the type of person that you are at the end of the day...that also has an impact... (participant 5, initial I/V 2).

The participants showed an awareness of their own position of power and were cognisant of the importance of stepping down from that position, working with others and taking their clients' needs into consideration, as illustrated by the following quotation:

...you can't step on people's toes...because when you do that, there might not be transport for the rest of the year...you have to make sure that you engage with the people at the top and you have to charm them...if you want to help your client you must...make them feel that they are the only person that can help you at that moment (participant 6, initial I/V 2).

Stepping down from their power position also entailed acknowledging that they were not always in a position to assist their clients and being open and honest with their clients regarding this. The following two quotations are evidence of this:

...we saw people that we could not really do anything for...but then you also come to a point where you really don't know, you really have to say...I'm sorry, I'm not sure exactly what it is that I need to do with you...erm...so being honest and saying...but I will read up (participant 5, initial I/V 2).

...I usually do that where...where you say that this is what you gonna (sic) *do and this...so...when it's circumstances like that* (not knowing)*...I'll tell them that I'll try to provide you with all the information next time I come in...so I'm gonna* (sic) *go back...and then...you can actually see them feeling at ease, because now they know...okay you can't help, but you gonna* (sic) *try* (participant 6, initial I/V 2).

Respect for their clients' needs and upholding their dignity as a key value of their practice, was highlighted in the interviews and revealed attentiveness to the client-centred approach to OT practice. The following quotation is evidence of this:

...just giving your attention and just sitting down and chatting with the people...even if you cannot do anything for them...it's also just...touching their humanity...(participant 5, initial I/V 1).

The participants developed strategies to attend to power issues, such as consulting and utilising older staff members in decision making, as illustrated by the following quotation:

...if you have a proposal for the management they won't take you seriously because they think you're a child, so you have to consult someone who is older in order for them to listen to you so when we said that we wanted to call a meeting nobody wanted to come until we consulted the older mother...she's an Assistant Director, then they started to listen, but when she called the meeting she said " these two girls had this idea to do this" then they started to listen (participant 4,initial I/V).

While the rehabilitation staff conducted their own ward rounds where they screened clients to see which ones could benefit from OT and PT, the participants devised their own strategies to create bridges between themselves and the rest of the staff. For example, as the following quote illustrates, they reflected on strengthening the MDT approach by creating opportunities for meaningful engagement during the interviews:
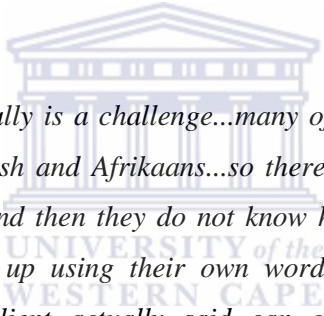
...we can still go on our ward round but what will work is if we go to maybe the staff members of each ward and ask them if we could maybe once a week sit down and discuss the patients that we are also seeing in the ward, just to ask the progress from their side...and I can also see that if we can just sit down or... discuss the clients or patients with the sisters and the doctors or even just the sisters, then it will also be easy for them to understand our role...what we are doing with the patients...then that understanding will also be better (participant 5, initial I/V 2).

5.3.4.2 Attending to diversity issues

Diversity issues were always at the forefront of the interviews with the participants. These revolved around cultural issues, religion, social practices and the behaviours a culturally competent person should engage in. The participants reflected on how they coped with cultural differences and on strategies they implemented in response to these issues. They identified several behaviours that they regarded as important for cross-cultural interactions. These included appropriate communication skills and responsiveness to the context. The purpose of these methods was to gain a greater understanding of their clients, to develop rapport and demonstrate respect in the therapeutic

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relationship. In communicating with their clients, some participants demonstrated what they wanted done, or, in trying to understand more clearly their client, would in turn ask the client to demonstrate what they meant. Participant 6 had her client teach her one new word of the client's language each time they met, while participant 5 stated that *"you begin to understand and also start using the gestures that they use together with a few Tswana words"* (initial I/V 1).

The participants also addressed the need for trained translators in their settings, as well as the proper way to use a translator. They talked about experiences where adult family members of the client were sought out to help with translation and indicated that a loss of meaning could occur when certain words were translated into another language. The following two quotations are evidence of this:

The language barrier really is a challenge...many of the Tswana words do not have a meaning in English and Afrikaans...so there are no words that can be used in the translation and then they do not know how to say it in English or Afrikaans and they end up using their own words. Therefore, much of the meaning of what the client actually said can get lost in the translation (participant 5, initial I/V 1).

You don't always have time to get professional people to translate because they are also busy...you will just get a cleaner or anyone else who speaks Tswana...and then a lot of the information gets lost...it's not always what the person said or it is the translator that decides what it is the client wants...so that can also affect the client-centredness... (participant 6, initial I/V 1).

In one session I observed, participant 6 had to do a first interview and assessment on a 10 year old girl who was referred to OT to address a range of barriers she experienced at school. The client was accompanied by her mother, who understood very little Afrikaans or English. After struggling for a while, participant 6 went into the passage to find someone to act as translator. One of the nurses obliged but it was difficult to tell how accurately she translated as participant 6 had to repeat a number of questions for the purpose of clarification

(field notes, 26/07/10). Later, she expressed concern that the people used to translate are not necessarily trained as translators and in some cases would give their own interpretation of what the clients said in the session.

Religion was another key diversity issue that the participants had to contend with. This was not just in relation to their clients but also in relation to their fellow staff members and the general ethos of some practice settings, as illustrated by the following quotation:

> *...one other thing that staff would do is...when the patient arrives they would just have a talk about their religion saying" you must pray...that's all you need to do is to pray and believe in God, that's all you need..."* (participant 4,initial I/V).

Some of the participants spoke about the relationship between cultural competence and client-centred practice. They regarded this as an important and ethical dimension of practice, as illustrated by the following quotation:

> *...we would go to the wards just to check if there are clients...so we'd get into the ward and she* (senior OT) *would ask "what are you doing here?" and the patients would say "we are sick" and then she would tell them "if you had Jesus in your life, you wouldn't be here". For me, that was really unethical...* (participant 4,initial I/V).

When they described how they employed cultural competence in their practice, the participants further showed an understanding of the value of client-centred practice in that they regarded it as important for the development of rapport and the demonstration of respect to their clients. The following two quotations are evidence of this:

> *The family believed that to be healed she needed to go and be a Sangoma…she didn't want that and she told me that she was frustrated and that she wants to go back to school…she just basically needed some advice from me…and then I told her that it's important for her to follow what she believes in...* (participant 4, initial I/V).

I don't believe in Sangomas, but I do get a lot of patients that do believe in Sangomas...so instead of saying "don't go to the Sangoma", I would involve the Sangoma. I would educate them about the things that I'm doing with the client...They (the clients) *would respond more positively...they would be more compliant and they would be really willing to work with me. They knew I respected them...* (participant 3,initial I/V).

Those participants who came from backgrounds where they had little experience of diversity articulated more enlightened perspectives that were in their attempts to understand their clients' context, as illustrated by the following quotation:

...it's always easy to see yourself above everyone else because the standard of living that you have...but once you in the community and you see...the hardships that they go through, you understand why there's always money for alcohol... (participant 7, initial I/V).

Their perspectives illuminated their beliefs that one should not try to change other people but compromise and adapt to the setting when one finds oneself in a diverse practice environment, as illustrated by the following two quotations:

...my male clients who had CVAs...they believe that their wives have to do everything for them. Even if he can bathe his upper body, the wife will do everything...and then I have to try to understand and meet them half way... (participant 2, initial I/V).

If I must compare how...the socio-cultural situation is by my house...we don't have young girls in our neighbourhood walking around with babies...and we don't have youngsters drinking...alcoholism is a very big thing here...so I had to adapt...not adopt it, just adapt to it and start getting used to it...and even language, their vocabulary is very different, the culture is different here, but it's not to the extent that I feel bombarded with too much, that I can't cope at all...(participant 1, initial I/V 2).

5.3.4.3 Collaboration

For most of the participants the skill of collaboration was demonstrated in their endeavours to informally build partnerships with community members, i.e. teachers, parents, caregivers, community-based organisations, the police, other health services and government departments. Table 10 outlines examples of partnering initiatives that were undertaken by the participants.

Table 10: Examples of partnering initiatives undertaken by participants

HEALTH SERVICES	Work with school health programme. Work with PHC programme. Work closely with physiotherapist.
OTHER SECTORS	Establish referral system. Involvement with police and municipal programmes. Work with social development on DG applications.
COMMUNITY	Consultation with community members i.e. community forums. Involvement with community organisations e.g. hospice. Contact with disability organisations e.g. DPSA.
NGO	Work with NGO's e.g. client education programmes.
PRIVATE BUSINESS	Partnerships with Shona Quip re W/C positioning and seating.

Some participants expressed frustration with the fact that they mainly fulfilled a clinical role and regarded building relationships with community members as an important path to living their vision of occupational enablement and working towards occupational justice. The following quotation illustrates this:

...the other thing that helped me was building a relationship with Mr X (a community researcher)*... Mr X knew a lot of people in town...he took me to social development to ask if they have any community projects that they are funding...so that I can have contact with those people who are part of the projects because I just wanted to do something else...I was getting frustrated!* (participant 4, initial I/V).

Networks appeared to be the main type of collaboration in which the participants engaged. The main purpose of the networks was for the members to exchange information, to share in one another's activities and to build a referral system, as illustrated by the following quotation:

I've heard about X (rehab centre) *and I was wondering, but who works there...I then phoned and I asked what kind of facilities do they have there...and, I didn't know much about APD...and then I phoned them and...if I want more erm...long-term intervention for a patient then I will refer to them...or I ask the social worker, which roots can I follow...especially with placement...from mainstream school to a special school* (participant 7, initial I/V).

Participant 2 established fairly successful collaborations with broader community organisations like APD and Hospice, as well as crèches that were situated on farms in her practice context. This was evident in a community newspaper article covering her involvement with the crèches (Newspaper article, reviewed,13/09/10) as well as the referral system that was established between her and other sectors (field notes, 13/09/10).

The participants regarded partnerships with NGOs as a valuable resource that assisted them to respond to occupational needs in their areas. This especially applied when they did not have access to transport and was not just the case for NGOs but for other Government sectors as well, i.e. the police, the municipality and social development. The following two quotations are evidence of this:

I said that if this transport thing is going to be a problem, and it's going to hinder me from doing community work then...I will ask the police because I'm sure the police go there once...maybe twice a month...I will speak to them and go with them...or with the people from the municipality or social development because I heard that they also do services there...so when they go, I will go with them...so that...worked for me... (participant 4, initial I/V).

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...social development, they are very involved with community projects...we went to them about three weeks ago to discuss a project that we want to start, a CP aftercare...there is some delay that is happening there, but social development is very involved (participant 1, initial I/V 2).

The participants also built relationships with other health professionals and promoted the MDT approach by working together as a unit with them. Participant 4 consulted a psychiatric sister that worked in a clinic in a remote village to assist her with a mental health project in the village. The sister agreed to be the co-facilitator of the project (OT staff meeting minutes, reviewed 14/10/10), and participant 3 sought out other professionals who worked in the community and formed an alliance with them, as illustrated by the following quotation:

...when I came here there was a regional speech therapist for the department of education and she told me that they do go to the communities once or twice a month...so I told her that I would love to go with them so that I could see how we could work together (participant 3, initial I/V).

It was also necessary for the participants to collaborate with each other, as this generated personal support and assistance in their practice in the community. The following two quotations are evidence of this:
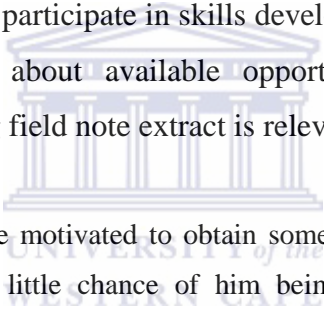
...I wrote this letter...we were trying to make this deal because X is from another district I said "this is how I want to deliver my services to this centre, but for me to be able to give them optimal services I have to have someone that's going to assist me and that person comes from another district...so if you going to allow me to have that person over...I would also assist them in their own community project"... (participant 3, initial I/V).

If I hadn't known Y and if we didn't have such a good working relationship...I wouldn't have known what is going on in the community...'cause if you are at hospital you can very much be in your own bubble...we have information, we have referral sources...so if you don't want to, you don't need to know the person at the CHC or the other therapist in the area (participant 7, initial I/V).

5.3.4.4 Advocacy

Advocacy was another key skill utilised by participants to address occupational justice in practice. Advocacy, i.e. working on behalf of others, occurred frequently where clients were unable to take action around particular challenges they faced and mainly involved efforts to secure resources for clients to engage in occupation. For instance, through their efforts to start a community-based mental health support group, participants 5 and 6 advocated for clients with mental illness to have opportunities for support and occupational engagement in the community (field notes, 27/07/10).

Bringing issues of social and occupational justice to the awareness of other professionals was part of advocacy work. I observed this when participant 2 advocated for her client to participate in skills development and contacted social development to enquire about available opportunities for PWDs in the community. The following field note extract is relevant to this:

> The client appeared to be motivated to obtain some form of employment but, being disabled, there is little chance of him being employed on the farm. Participant 2 seemed driven to advocate for resources and opportunities for him to engage in some form of employment and sustain his livelihood. By calling social development to enquire about skills development for PWDs in the community, she held them accountable for the services they provide. They responded by inviting her to meet with them to discuss the issues. That was advocacy in action because participant 2 spoke up on behalf of her client, who would otherwise not be able to direct this type of action himself, to ensure he receives the support and services for which he is eligible. She, however, also coached the client by raising his awareness of resources that are available for PWDs in the community. She further intends to address the lack of vocational services for PWDs at a broader health forum meeting and began to identify partners she could elaborate with to further address the issue (field notes, 14/09/10).

In another example related to advocacy, participant 4, together with the community service physiotherapist, embarked on a fundraising project to

address the lack of resources and to facilitate occupational opportunities for the mothers and children who attended the CP group at the hospital. The aim was to acquire educational activities and stimulating toys to enhance occupational engagement (field notes, 11/10/10).

Where clients were disadvantaged because their environment was not facilitating their participation the participants felt the need to uphold the clients' human rights and entitlement to equitable treatment. They valued advocacy to the extent that they were willing to address their clients' adversity despite experiencing constraints in doing this. For instance, participants 3 and 4, when working in the children's home, engaged in advocacy work for children with disabilities. They advocated for the children to have the resources they needed to engage in occupations, i.e. toys for play and opportunities for education such as attending a special school. The following two quotations are evidence of this:

...we wanted to highlight some of the things they need to consider when they are funding the centre...we wanted social development to make a difference...to offer transport and to pay for the fees of those kids so that they could attend that special school... (participant 3,initial I/V).

...so if they could build that relationship with the school...even if they are not allowed to attend every week...maybe twice a week...that would make a difference because we explained to them the importance of occupation...of the children...that it's play and education... (participant 4, initial I/V).

In their endeavours to work for the children to attend a special school, they advocated for the rights of children with disabilities to receive an education. This advocacy work also involved mediating between the home and social development to address communication between the two parties, as illustrated by the following quotation:

...on that day we saw that advocating is really not helping, we need to mediate because when we are there at the centre they would say something about social development and then when we are at social development, they would tell us something about the centre...they didn't really interact, so then the meetings that we planning now...we will have the people from the centre and social development and the board members all together in one room, so that we will get consistent answers and we would mediate (participant 3, initial I/V).

5.3.4.5 Building capacity

Building capacity as a tool of occupational justice occurred at three levels: individual, group and community. This was informed by the values of experiential learning, peer learning and meaningful engagement. The roles that the participants adopted in capacity building initiatives were that of consultant, facilitator and enabler. They built capacity through client, family and caregiver education, training home based carers, training teachers, running life skills groups and running support groups for mothers of children with disabilities.

A key skill that was evident in the participants' practice was that of enabling. To this end their intention was to build people's capacity to perform occupations meaningfully and functionally, as illustrated by the following quotation:

I like to ask for the family to be there a lot because you don't know when that person will be discharged...if the family is there they see what you doing...and then I would like to ask the family to do it also...so I know that when they get discharged they at least know how to do it at home... (participant 4, initial I/V).

At an individual level, capacity building was directed at the facilitation of personal agency, particularly with regard to clients' participation in their intervention. As clients were often not informed about their diagnosis the participants fulfilled the roles of educator and consultant, in which they demonstrated values of respect and upholding their clients' dignity. The following two quotations are evidence of this:

...the doctors don't speak to the patients about their condition and the patients will come back to us with x-rays or a letter...we will try and sit with the patient and say "okay so this is what the doctor means this is what the x-rays say"...I think that ...even though it's something negative (client not being informed)*...it can be a positive as well in order for us to actually educate people* (participant 1, initial I/V 1).

...to come here and to have somebody listening...and explaining...yes, that's very important...if you just sit down and explain to them, what is wrong...if you take the time to listen to their stories erm...even just ten or fifteen minutes... (participant 5, initial I/V 1).

At a group level one successful initiative was the life skills group that was facilitated by participant 2 at the CHC. The group was attended by 15 community members and focused on stress management skills. In an informal discussion with the group members afterwards, they all reported having benefitted from the group as they developed their coping skills in daily life-situations and found the group to be a support system as a result of their participation (field notes, 15/09/11).

Another successful capacity building initiative was the CP groups for mothers and children that were facilitated by several graduates. In one CP group I observed, in which participant 4 was involved, ten mothers from the surrounding community were present despite having to pay high transport costs. The aim of the group was to enhance the mothers' skills and support, i.e. by showing each other how they handle their children at home. Participant 4 gave educational input and demonstrations on positioning and developmental stimulation and allowed the mothers to practise their skills in the group. The mothers were very engaged in the group and seemed pleased with the assistance they received (field notes 13/10/10).

At a community level capacity building around child development featured predominantly in the graduates' practice. One example of this was observed when I accompanied participant 2 on an outreach visit to a crèche that was run

by APD as well as a crèche that was situated on a farm. On both visits she trained the crèche teachers in developmental stimulation, positioning and involving parents in their children's care and education. In addition, she introduced the teachers to appropriate classroom activities for children who presented with learning difficulties, and developed their skills in utilising these activities in terms of the actual application of specific structuring and handling principles with the children (field notes, 16/09/10).

In another example participant 4 related how she facilitated a workshop with teachers to develop their skills in child development, as illustrated by the following quotation:

...I explained first the most common disability and the pervasive developmental disorders and then after that I highlighted the role of the teacher in the classroom...what adaptations can they make in the classroom... (participant 4, initial I/V).

In the disabled children's home project, participants 3 and 4 facilitated workshops with home-based carers to develop their skills in caring for the children. This is an example of how the participants brought their services as a resource to the caregivers who had little or no access to opportunities for skills development. They assisted them to clarify their mission, worked with them to establish processes for the project and then shared these responsibilities with the manager and caregivers, who gradually took over. The following two quotations illustrate this:

We educated them on how to handle the child with disability...do positioning...how to stimulate them and help them to be independent and we also...presented the children's rights and they were very happy because they said that most of the people when they come visit the centre, they ask them "What are the rights of the children with disabilities?"; and they only knew a few (participant 4, initial I/V).

...they have the morning staff and the evening staff, we saw the morning staff and we educated them on how to handle the child and how to protect their back...but then because we wanted them to sustain that education...we told them to train the night staff in turn... (participant 3,initial I/V).

In Theme 4 the skills that the participants applied as tools of occupational justice, i.e. attending to power and diversity issues, collaboration, advocacy and capacity building were described. In Theme 5 the contextual constraints to occupational justice as identified by the participants are presented.

5.3.5   Theme 5: Contextual Constraints to Occupational Justice

This theme describes the practice constraints that the participants encountered in their practice setting. The theme further centres around their expectations on entering the practice setting as a community service OT. During the interviews the participants were asked to describe what they considered to be factors that hindered their ability to work within an occupational justice framework. This question was crucial in gaining an in-depth understanding of the participants' perceptions about the constraints they experienced in their practice and how they responded to them. The participants were very vocal about the constraints they experienced and readily identified issues that they thought limited their practice. Consequently this theme captures systemic, personal and educational factors as revealed in the data and is supported by several categories: Lack of OT awareness, Resource constraints, Complex process of bureaucracy, and OT Vision do not fit system and Practice-education gaps.

5.3.5.1 Lack of OT awareness

In describing the constraints they experienced in their practice, the participants consistently referred to the lack of OT awareness with which they were confronted on a daily basis. They claimed that the management, staff and clients did not understand OT and therefore did not appreciate its value. The following three quotations are evidence of this:

...people didn't know what OT is...people call you doctor because you wearing a lab coat...they call you doctor they don't understand... (participant 4, initial I/V).

...they have poor understanding of what it is...the service that we are providing...and I think that is also a very big barrier for us... (participant 1, initial I/V 1).

Wherever you go here they always talking about the physio...it's never about OT...so we always...always need to go up and say, but this is actually OT (participant 6, initial I/V 2).

Referring to the way in which OT was already perceived at the hospital prior to her arrival, participant 4 expressed dissatisfaction with the way in which it contributed to the lack of understanding of OT, as illustrated by the following quotation:

...the message that they were getting based on what OT is...that was even more frustrating for me because they also couldn't figure out what OT is exactly in terms of what was being done at the hospital...so that was even more frustrating for me... (participant 4, initial I/V).

The participants felt that there was also a lack of understanding about the policy of community service, particularly at a management level. The following two quotations are evidence of this:

...I don't think they really understand...the role of community service and why there is community service...they don't really understand (participant 1, initial I/V 2).

...when I came here they didn't have anything arranged for me as a comserve (community service OT)...I had to write a letter to the hospital manager and tell him about my role and what I'm supposed to do...cause when I came here...they thought...I was...an assistant...and I told them...I'm supposed to spend sixty percent of my time going around the community, giving my services to people (participant 3, initial I/V).

The participants maintained that they were not appreciated by other professionals and in particular by the management of the settings where they were deployed. They also felt that their skills were not being fully utilised and that this disregard of their professional role was a confirmation of the lack of awareness of OT in the setting. The following two quotations are evidence of this:

I don't think that they (management) *see my role as being vital...they see you as a community service worker and that is all you will be for the time being that you are here...so you constantly have to fight for this is what I want to do and stop seeing me as just a community service worker* (participant 1, initial I/V 2).

...if there's some shortage somewhere...like when there was the strike...they needed more clerks, they needed people to help in the kitchen...they came to the rehab...you must go help...without even asking what our role is, what's our plan for the day...because they have the idea that we not doing anything, but when we want to go into the community to do home visits then that's an issue again.... (participant 4, initial I/V).

The participants reported that most referrals for rehabilitation were for physiotherapy and that referrals for OT were "*just about issuing wheelchairs and for disability grants*" (participant 5, initial I/V 1). They further claimed that lack of OT awareness was a contributing factor to the low number of referrals that they received; hence they regarded it is as a key constraint in their practice. Participant observation confirmed the low number of referrals that OT received as, throughout the data collection period, it was observed that the participants only saw one client on some days. Low client numbers were, however, not only observed in the case of the OTs but in relation to other rehabilitation staff as well. The following field note extract is relevant to this:

I'm looking out on a fairly large gym area, it's mid-afternoon and there is no therapist or client in site. It has been like this for most of the day. I observed one intervention session with the community service OT. The rest of the day she has spent at her desk doing administrative tasks. The rest of the rehabilitation staff are also sitting at their desks, appearing to be busy, with some just chatting to

one another. It has been like this for most of the day and I'm wondering: where are the clients? (field note,11/10/10).

When they were able to conduct clinic visits, intervention was also limited due to the low number of clients that were booked for OT at the clinics. In one instance we drove for 200km on a sub-standard gravel road to a remote town to find that only two clients arrived for OT appointments at the clinic (field notes, 29/07/10). In another instance, we drove for 280 km with the journey lasting approximately 2 hrs and found that there was only one client booked for OT (field notes, 2/08/10).

The incidence of low number of referrals also emerged from practice documents I reviewed. For example, in one practice setting the OT stats form (reviewed, 11/10/10) indicated that a total number of 14 patients (in- and out-patients combined) were seen by the two OT staff (senior OT and community service graduate) at the hospital over a three month period. These low stats were not consistent with the demographics of the area in terms of its population and disability profile.
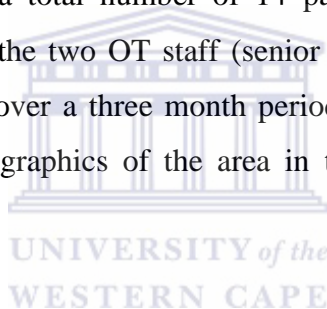
Additional factors that emerged from the document review that could be related to the low number of referrals that OT received include the following:

- Clients did not have money to travel to the hospital (NGO letter to Medical superintendent, reviewed 12/10/10);
- Patients attend OPD poorly due to lack of transport (OT Quarterly report, reviewed 13/10/10);
- Reason for referral left blank. (OT referral from, reviewed 28/07/10); and
- Health workers' strike (OT Quarterly report, reviewed 13/10/10).

It was, however, interesting to note that where the participants were able to address the lack of OT awareness in their practice settings, the number of OT referrals increased and other health professionals, for example the doctors, had a good understanding of the role of the OT, as participant 7 (initial I/V) explained:

"*...in the referrals that the doctors sent...you can clearly see the difference between the referrals that that they send to physio and that they send to OT.*"

5.3.5.2 Resource constraints

The second constraint to occupational justice cited by the participants was a lack of resources. With regards to resource constraints the challenges that they faced included budget restrictions resulting in a lack of materials, equipment, basic resources such as space and a lack of transport.

While the participants that were placed in the Western Cape appeared to be managing with the resources they had, the participants in the Northern and Eastern Cape claimed that the resources in their settings were grossly inadequate. They attributed this to the failure of the Department of Health to provide an adequate budget for rehabilitation services in their settings. In cases where there was a budget the participants claimed that they were "*restricted in terms of finance*" and where they were under the impression that there was a budget for OT, they felt frustrated as they were "*told that we have a budget but we never have access to the money*" (participant 1, initial I/V 2).

The availability and quality of resources varied from therapy areas that appeared to be well-stocked to not having any equipment at all, while the workspace allocated to OT ranged from adequate space to a very small office, to no designated therapy space at all. A lack of financial resources meant that the participants encountered challenges such as having an almost non-existent budget for community outreach, lack of materials for occupational engagement and long waiting lists (up to a year) for basic materials such as splinting and seating materials, as well as for equipment such as wheelchairs, buggies for children and crutches or standing frames (field notes, 14/10/10).

Table 11 provides a summary of the resource constraints the graduates experienced.

Table 11: Summary of resource constraints

RESOURCE CONSTRAINT	PRACTICE CONSTRAINT
No budget for OT.	No dedicated transport for rehabilitation services.
Lack of equipment.	Shortage of wheelchairs. Shortage of splinting equipment. No assistive devices, rollers, wedges, or adaptive equipment available for effective positioning, W/C seating and adapted occupations. Restricted or no access to computers and printing materials.
Shortage of materials.	Unable to do activities.
Lack of space.	No room for OT. Small OT office.
Lack of transport.	Home visits restricted. Community outreach restricted. Health promotion and CBR restricted.
No budget for professional support.	Unable to participate in continuing professional development opportunities.

Community outreach services were often erratic as the therapists depended on hospital transport to perform clinic visits. Hospital transport was not always available as there were not enough vehicles and rehabilitation services appeared to have low priority when requests for transport were made. Where transport was available, it was mainly used for patients. In the case of staff, the shortage of transport presented a serious challenge as in some cases available transport had long exceeded its maintenance budget and therefore the vehicles were not roadworthy. As a result, the staff had to compromise many meetings, workshops and CPD activities in addition to community outreach activities and clinic visits (field notes, 28/08/10).

With regards to a lack of equipment, the hospital equipment budget often did not satisfy the need for rehabilitation, as medical equipment received priority (field notes, 27/08/10). Equipment or materials were also not readily available for OT. In relation to this participant 1 (initial I/V 2) explained: *"...when I go to the clinic, I don't have things with me like equipment or materials to work with"*. Where materials were restricted the participants considered using basic materials, i.e. foam to modify seating and wood to make assistive devices, but even these materials were not available (field notes, 13/10/10).

The participants also had to be creative in improvising with what was available as the following quotations illustrate:

...a lot of the times...I will use the little things in the office...or I will go buy or make...I will go out of my way to get things done because...I just...I get along with what...I have... the little that there is... (participant 1, initial I/V 1).

...we use our own money or...the other day, we were in this...mobile...(giggles)...we just said...as long as it's gonna (sic) *take us from point A to point B...we just gonna* (sic) *sit there at the back...we just don't really care...* (participant 4, initial I/V).

According to the participants, resource constraints were also linked to the broader socio-economic status and geographical location of people, as well as the lack of access and/or high cost of transport in these contexts. For instance, due to the social problems that many clients experienced, follow-up of therapy was a major challenge as the clients often missed appointments because of a lack of access to transport to the hospitals or clinics. The following three quotations are evidence of this:

Transport also impacts on the time that we can spend with the clients...because sometimes they come late and they say that their transport will only wait for them until a certain time...then I have to do my session in that short period of time... (participant 6, initial I/V 1).

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...and the geographical location of people...sometimes there is transport available...but because it takes so long...the people just don't come or the ambulance gets stuck half way along the road or the ambulance drops the people, but they take very long to fetch them and people don't want to wait (participant 1, initial I/V 1).

5.3.5.3 Complex process of bureaucracy

Another key constraint to occupational justice cited by the participants was the complex process of bureaucracy to which they were subjected in their practice settings. This refers to various rules related to accessing resources, establishing community projects and obtaining permission to do community outreach. The participants considered these rules a hindrance as it did not allow them to practice as they saw fit. For instance, intersectoral relationships were discouraged as they were told that *"you are employed by the department of health; you can't be part of education as well…"* (participant 4, initial I/V). Another example where intersectoral relationships were discouraged occurred when participant 1 took the initiative to establish a referral system with teachers at schools in her district, as illustrated by the following quotation:

...there's that barrier between the health profession and the education department...you don't have connections with each other...in the beginning of the year...we went to the schools...to get referrals for ourselves...and then I was told that we are not allowed, that's not our field...that's not our playground...we are not allowed to go to the schools and render services to the children that have learning difficulties (participant 1,initial I/V 2).

In another example, participant 4 was approached by the police to assist them with the trauma that rape survivors endured in the community. Participant 4 was keen to facilitate a support group with the rape survivors in partnership with a community social worker. The idea was for these groups to be community-based as the members' privacy would not be protected if the group was held at the hospital. This was, however, discouraged by the hospital's management as they felt that as participant 4 was not employed by the police, she could not facilitate the groups in the community. They suggested that the victims should

come to the hospital but the prospective members were not willing to do so for fear of exposure (field notes, 11/10/10).

The participants further claimed that the hospital policies, for instance around accessing resources and addressing problems, were complex and time consuming. The following two quotations are evidence of this:

...we are told that we have a budget erm but we never have access to the money and if we want to have access to the money it has to be recognition, recognition after recognition and channels that you have to follow...and it's just a whole tiring process... (participant 1, initial I/V 2).

...Ms W will tell us you have to first write a letter to Mrs X...if she's not replying...then she will say we have to go to Mr Y...and then also erm...telling Ms Z and...the Department of Health...people on top of us...the people that we should contact...so I cannot go straight from this point to the Health Department...you need to go through the specific channels... (participant 6, initial I/V 2).

Likewise, the participants found it challenging to develop OT services as there were no clear guidelines regarding the procedures to do this, as illustrated by the following quotation:

...we don't have guidelines to what the exact steps are for starting a project...we always have to fall around our feet...you know looking for resources and networking with other departments...here is no set process model for establishing a project like for a community centre or a service centre or something like that...(participant 1, initial I/V 2).

They further claimed that when they followed the necessary procedures it took several months for their requests to be addressed. The following two quotations are evidence of this:

...you do all the things that...you supposed to...the procedures that you supposed to follow...but they never come back to you...you never see changes...yes, they say they hear you...but you never see changes happening...(participant 6, initial I/V 2).

...change never happens...the problems...it's just a little piece of paper...on their desk...you have to constantly phone them...phone them...over and over again...and they will only focus...if you don't have a pen...and you phone them all the time...all the time...all the time...then you...then, maybe in a couple of months' time then you will get your pen...but then there's no paper...you know what I'm trying to say? (participant 5, initial I/V 2).

At times the rules that they were subjected to as community service therapists left them confused, especially when they did not receive any encouragement to explore alternatives. The following reflection from participant 1 around her request to attend a professional development opportunity is evidence of this:

...there are certain rules...doesn't make sense...I want to go on a hands course...I am willing to compensate...but...they don't wanna give me study leave to attend the course and every time when I ask about it I am told that I am a community service worker and the government does not want to invest in educating or training employees if they not guaranteed that the employee is gonna (sic) *work...next year...but I just feel regardless of the fact that I'm a community service worker, I am a health professional...I want to be equipped...they don't look at the context that I'm working in...* (participant 1,initial interview 2).

5.3.5.4 OT vision does not fit the system

From the description of their roles and responsibilities (see Section 5.2.3), the participants appeared to be practising within a traditional medical model, i.e. intervention predominantly directed at addressing an individual's illness and its related symptoms. When posed the question: What have been some constraints or challenges you experienced in practicing in this setting? the participants indeed reflected on the dominance of the medical model during the interviews.

They seemed concerned with being confined to the hospitals and clinics and stated that almost every referral they received put medical conditions at the forefront. The following two quotations are evidence of this:

...our role is to implement interventions to in-patients and out-patients at the hospital...we have to go to the wards and see the in-patients...we have to book patients if they are coming for out-patients...my job description...it just focused on the hospital setting (participant 4, initial I/V).

We are told that the clinic is our primary erm ...that is where we are...to focus our work...it is very medically orientated...very clinical like erm they expect you to...work with kids who have learning problems or you work with hands patients or strokes...or disability grants...(participant 1, initial I/V 1).

For the participants this implied that the social and occupation-based goals they set for their clients assumed a lower priority as "*the focus here is very medical...you focus on the pathology of the person*" (participant 5, initial I/V 1). When they did address occupational goals it often resulted in conflict situations, in particular with medical doctors, as illustrated by the following quotation:

...you will have a client where you have to do a work evaluation...and then...the doctor seems very medical like, what is the emergency...medical emergency...they don't look at what the work assessment can do for the patient...they don't look at other issues (participant 1, initial I/V 1).

Likewise, the participants found that community members, for example older adults, felt that they would not get well if they did not get medication and thus saw no point of rehabilitation (field notes, 14/10/10).

Another example of how the medical model dominated was the statistics forms completed by the participants to report on the services they provided. In reviewing the statistics documentation in the various practice settings, it became evident to me that the statistics forms issued by the Department of Health did

not allow for an accurate reflection of the participants' services due to its curative focus. For example, the statistics forms only accounted for medical conditions treated, number of patients seen and number of sessions done. There was no room for the recording of health promotion and community outreach services (OT statistics forms, reviewed 2/08/10). Participant 1 acknowledged this when she responded to my query regarding how she would record the workshop she had conducted with crèche teachers that I was able to observe:

> ... *if I must ask...where this workshop fits in...she* (senior OT) *will say admin and it is not really admin because it is community outreach...at the end of the day...management...they don't know what is going on here...but they want stats...they want to see are you seeing your patients, what are you doing with the patients, how many are you seeing* (participant 1, initial I/V 1).

It was further evident that while millions of rand were spent to build modern, state of the art new hospitals in deep rural areas, the majority of people were not able to access the hospitals due to a lack of transport. It seemed that all the resources for health went into providing a curative service which appeared to be underutilised (field notes, 14/10/10).

Despite their dedication, the interviews and observations uncovered frustration, despondency and low morale amongst the participants. Their reflections suggested that the fundamental reason for this was that they were not able to live out their OT vision and to provide appropriate services as indicated by local needs. Participant 3 (initial I/V 1) expressed frustration when she stated: "*…there were so many things that we could start in those communities...we got so frustrated...*" while participant 4 (initial I/V 1) felt that: "*they* (management) *have the idea that we not doing anything, but we want to go outside into the community*".

The interviews seemed to allow the participants to ventilate their frustrations, especially with regards to their views that the system was not accommodating their vision. The participants regarded this as mainly due to the influence of contextual factors on their practice and not with regards to how they saw the

value of OT or the OT profession itself. They articulated that they felt constrained in living out the professional philosophy, values and conviction they held about OT and expressed that they felt frustrated with their job descriptions that limited them to seeing individual in- and out-patients only. The following two quotations are evidence of this:

...there are days when I feel like...what am I doing here?!...what is my role actually?...this is what I see...this is what I expect from myself and theoretically if I'm placed...within this context this is what...my role should be...but realistically it is not always like that...I'm expected to see patients, I'm expected to run groups, I'm expected to erm...go to the schools or see children...that's not always...like that's not my role...so I see myself...not as being that specific OT that is within that context...I see myself as being someone different... (participant 1, initial I/V 1)

...I felt like I wasn't really giving the people...I wasn't giving them the skills...I wasn't showing them the skills, they weren't getting what they deserved to get... (participant 3, initial I/V 1).

The lack of follow up that occurred after clients were discharged form hospital was a key concern expressed by the participants. This seemed to heighten their awareness that what they had to offer in making a difference in their clients' lives was so much broader than what they were expected to do in practice. The following two quotations are evidence of this:

...because most of them...were not able to come to the hospital after they have been discharged because they live far away...I would see a client today and never see them again...and I didn't even know, I wouldn't even know if my services made a difference in that person's life...(participant 3, initial I/V).

*...sometimes, I feel like I'm an outsider to therapy...therapy is happening and I'm seeing the patient and I'm doing everything OT orientated, but I'm not there...I don't see the processes happening...the patient is here now and in a month's time I see him again and I don't know what happens between that time and it becomes frustrating...it becomes very frustrating...* (participant 1, initial I/V 1).

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These challenges occurred whilst the participants worked in an environment where there was limited professional support and was evident in their perception that "*...the whole view of community involvement is very negative*" (participant1, initial I/V 1) and that staff members were resistant to community approaches, as illustrated by the following quotation:

...I went...I visited...but it was a struggle because the staff members were like "you want to go there...it's dirty, the kids don't get washed...it's very far" but that's why I was like "but that's what community is all about", I have to go there and see... (participant 3, initial I/V).

The participants further struggled to get hospital management to support their social and occupational role in addition to the medical, as illustrated by the following quotation:

...there's very, very little support...from I would say management...look we have tried numerous times to approach people and say what we wanna (sic) *say and say the importance in why we wanna* (sic) *do stuff...even management does not give us the opportunity to do anything about it...*(participant 1, initial I/V 2).
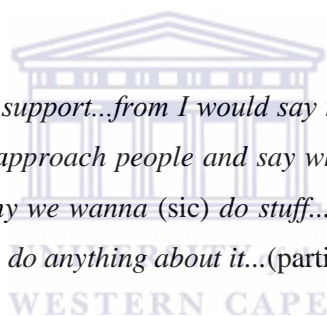
Because the medical model was the dominant paradigm within their practice settings, the participants found themselves in an environment that did not hold the same understanding of OT as they did. It was as if they were speaking a different language to everyone else. This was supported by my observations as illustrated by the following field note extract:

It would appear that senior OTs who supervised the community service graduates and who had been part of the system for a number of years, had not shifted their practice to embrace a more socio-occupational focus to OT. For example, the difference in occupational therapy language used by the graduates and that used by their supervisors was noticeable in their interactions. Where the supervisor would talk about function and refer to pathology only, the graduate would speak about occupation and related issues, i.e. occupational engagement in explaining their role in their settings. Where the graduates would speak about client-centred practice, the more senior therapists would speak about asserting

their power in the client–therapist relationship. Where the graduates raised possible strategies they could employ to address challenges they faced in fulfilling their role as OTs, the senior therapists raised concern about how they would justify such non-medical interventions to hospital management as the stats form did not accommodate this, thus their productivity would be perceived in a negative way (field notes, 28/10/10).

Low morale amongst the participants was also evident when they expressed concern at not being able to practice OT in the manner in which they were taught at UWC. In line with what they learned in the UWC curriculum they wanted to address not just the medical but also the social and occupational problems that impacted on their clients' occupational functioning. To this end, they expressed emotions that ranged from depression to guilt during the interviews. The following two quotations are evidence of this.

...we come into community service with an open mind...that you're gonna (sic) *experience a lot of things...but...I still got depressed...I just needed you here to come...to...witness that yes...what you are doing is on par with...what you were taught...even though it is not everything that you're implementing and doing, but at least you are doing as much as you can...* (participant 5, initial I/V 2).

... I don't really use much activity...and I tell you this because of how we were taught and the importance of using occupation as a means to an end...I really did feel guilty and sometimes I still feel that I can do more in terms of occupational rehabilitation and functional rehabilitation...really (participant 7, initial I/V).

The participants' sense of low morale was perpetuated by their lack of hope for future change. For example, participant 1 thought that in the event of her staying on at her placement post after her community service year, attempts to live out her vision would still be restricted by the sytem, as illustrated by the following quotation:

...if I should stay on next year...I think that I would still be restricted because...I wouldn't have the support of the people at the Department of Health...I would have to find my own way to do my own thing... (participant 1, initial I/V 2).

5.3.5.5 Practice-education gaps

The participants also identified gaps in their education that impacted on their practice. This was in response to the question: In your opinion has UWC OT education prepared you for practice? They raised the issue of professional identity and stated that they struggled to maintain this at times. At the hospital where participant 6 was placed there was a longstanding history of conflict between the OTs and physiotherapists that worked at the hospital. It was difficult for a new graduate to enter this situation. She appeared to be vulnerable in the situation and felt that it impacted on her sense of professional identity, as illustrated by the following quotation:

...of course I also have erm...professional identity issues erm...especially with the physios...especially with the...the whole (hospital) *situation...cause I can remember working at* (the hospital) *where I wouldn't feel comfortable with working in front of the physios and it would really like make me nervous doing my thing in front of them...* (participant 6, initial I/V 2).

Participant 5 felt that she struggled with her professional identity because she did not always have the requisite knowledge of some aspects of pathology, as illustrated by the following quotation:

...what is currently making me struggle with my professional identity is because they always come to you with this...a lot of knowledge...and you must just pray because we don't always have that knowledge of some pathologies (participant 5, initial I/V 2).

She, however, acknowledged that when she has adequate knowledge of pathology, her personal level of confidence influences her ability to explain the theory. She further stated that she sometimes feel intimidated by other

professionals, and related this to a general trend in the OT profession, as illustrated by the following quotation:

...not always advocating for OT erm...when I'm talking about government professionals now...is erm...not first of all...knowing myself and...our profession...not knowing how to really explain things in terms of theory...that is where it stems from...that is from my own insecurity...(participant 5, initial I/V 2).

The other graduates mainly felt that their theoretical knowledge was adequate. They, however, thought that the UWC OT curriculum should allow more diverse fieldwork opportunities for students to develop their skills in a practical manner, as illustrated by the following quotation:

...clinical work only prepared me in those... fieldwork experiences that I had...I was placed in burns...then it prepared me for that, but for CVA, spinal cord...just that practical experience in class only, it's not enough...when seeing the real patients (participant 4, initial I/V).

They suggested that students be more exposed to OT in practice as it would assist them to develop their problem solving skills. The following two quotations are evidence of this:

...as a student I struggled to think out of the box...but every year...if one could spend time in the holidays shadowing OTs then maybe it will help you to think out of the box...like none of us students were placed at a community centre (participant 2, initial I/V).

...we only had one opportunity to make a pop-up splint and a wrist extension, but that's it...and it was fun at the time and you know like a student it's fun messing around and stuff...but now... I'm in an environment where I constantly have to look for materials and you know I don't know where to start in terms of what can I use in place of that and I think that would have been very much helpful to do that... (participant 1, initial I/V 2).

They called for exposure to real-life clients in particular, as they thought that this would enhance their preparedness for practice. The following two quotations are evidence of this:

I think we needed more erm...practising...implementing skills, not only on one another...because it's easy to test range of motion on a fully functional person...but then when you get your stroke or you get your spinal or your burns...it's much harder... (participant 7, initial I/V).

...we are introduced to all the neurology and mental health...and then you don't get to have that practical experience in all of them...most of the things that we are taught, are not easy to be done on the patients...things like transfers, bridging, rolling...they are not easy because in class we were just demonstrating them on ourselves which is easier...we don't have...yes...we don't have high tone...when you get to the real patient... then it gets tricky (participant 4, initial I/V).

Another key focus area that was identified as a gap in their education was that of conducting home visits. Participant 1 felt that if home visits were a compulsory component of fieldwork she would be more prepared for practice, as illustrated by the following quotation:

*...the first time I remember going (*on a home visit*) I was totally like oh my word I don't remember what to do and I thought...why don't you* (UWC) *make home visits like a must...I think I would have learnt much more if I had to go on an actual home visit...for us to write reflection from that I think that would have been very nice* (participant 1, follow up I/V 1).

With regards to activities, the participants felt that the activities they were taught at university were not always appropriate or meaningful to the cultural context in which they practised. The following two quotations are evidence of this:

I think I have experienced cultural differences in terms of most things we were taught to do...it's not applicable, most of the things we were taught to do its not applicable to them...the activities (participant 4, follow-up I/V 3).

...if I would ask someone dying of cancer and I tell them to make a memory box, they would think I'm crazy...there are so many other important things for them to do... (participant 3, follow-up I/V 3).

In relation to community development, the participants identified a gap in the curriculum with regards to building collaborations, as illustrated by the following quotation:

Maybe a recommendation could be that the OT curriculum includes training students to work with different sectors...especially at a community level because I think...I think we lack a lot there. This could prepare comserves to know about different systems be it health, traditional, religious systems, local government etc. (participant 7, follow-up I/V 1).

With regards to power, as professionals we need to be confident in building collaborations...build alliances with the most influential groups in the community who can support us. In that way it will be easier to raise awareness to the rest of the people because we would be having the dominating groups already on board. That should get more focus in the curriculum. (participant 3, follow-up I/V 3).

As described earlier, the constraints they were subjected to in their practice settings were overwhelming for some participants and impacted on their morale. This also seemed to be linked to a lack of coping skills and preparedness in this regard, as illustrated by the following quotation:

...I feel so like I don't know what to do...I don't know what to do in a situation where there's a barrier and I'm like oh my word!...I don't really have a way of coping, I don't know what to do (participant 1, initial I/V 2).

It further became apparent that the participants experienced a disjuncture between their academic training expectations and the actual realities within the public health service. They expressed that due to the expectations around the projects they implemented during community fieldwork as students, they now held unrealistic expectations. For instance, participant 5 explained how she expected health promotion and community development only to be effective when they occurred on a larger scale, i.e. involving whole communities, and consequently felt that she failed when this did not happen, as illustrated by the following quotation:

I've gone through a little depression...because I feel I don't do enough because I was thinking of everything that we were taught and how passionate we were...when you leave varsity...you really have this perception that community development means reaching as many people and getting that entire community working...(participant 5, follow-up I/V 1).

Theme 5 captured describes the practice constraints that the participants encountered in their practice setting. The theme further centred around their expectations on entering the practice setting as a community service OT. In Theme 6 the participants' perceptions about factors that facilitated their practice will be presented.

5.3.6   Theme 6: Contextual Facilitators of Occupational Justice

This theme captures the participants' perceptions about factors that facilitated their practice. The participants were asked to describe what they regarded as successes in their practice and to explain how those factors influenced their practice. Posing these questions to the participants was instrumental in gaining an understanding of their perceptions about contextual factors that facilitated occupational justice in their practice. Therefore, this theme highlights systemic, personal and educational factors as revealed in the data and is supported by several categories: Living OT vision, Context supports practice, Education guides practice and Graduate attributes.

5.3.6.1 Living OT vision

As presented in the findings earlier, the participants experienced many challenges and constraints in their respective community service settings. They, however, appeared to have embraced these challenges as they remained steadfast in their vision for OT and in the fundamental values of the OT profession. They seemed motivated to provide relevant OT services and to act as agents of change in their practice settings. For the graduates this meant living their OT vision. The following two quotations are evidence of this:

...I think for me...being able to go out and actually being an OT...for me it's very rewarding to think afterwards that I've actually taken that client's context into consideration... (participant 6, initial IV 2).

...at the end of the day erm…like this baby that I've been seeing since the beginning of the year...I just didn't think that progress was gonna (sic) *come...only a little bit every time I see him...little bit every time...erm...then all of a sudden this child started...blossoming after nine months of therapy...so for me to see...the patient getting better…for me that is something that is a positive and that is boosting my erm…confidence and also my erm…my passion and my belief for OT* (participant 5, initial IV 2).

The participants' endeavours to live out their vision for OT were further elucidated when they related their attempts to influence their practice settings so that they would become more accommodating of their vision for OT. This involved working to convince management to support community development initiatives. For example, participants 3 and 4 explained that they had to 'stand up' for OT by clearly articulating their vision to management and to those with whom they were practising, as illustrated by the following two quotations:

...I wrote this letter to the previous hospital manager that we had...I said that this is how I want to deliver my services to this centre…that we have this vision, I have this vision so he thought it was a wonderful idea because they never did anything for the community… (participant 3,initial I/V).

I think the challenges we had to go through, they made us even more confident because we had to stand up for OT and explain to the people what OT is, what is our role and what we can do…in…in the hospital and also in the community… (participant 4, initial I/V).

Living their OT vision further implied that the participants had to advocate for OT. They claimed that being able to do this increased their level of confidence and ability to cope with the challenges they experienced. The following two quotations are evidence of this:

….I felt so proud at the end of the day that I could explain to the people what…OT is…I felt so very proud and just the people coming up to me afterwards and talking and saying... they're so interested and now they know that we have a role... (participant 5, initial IV 1).

In other instances they advocated for OT by educating staff about OT through the implementation of in-service training. Also, in the absence of ward rounds, some participants started their own ward rounds where they went around to the wards to screen clients for OT, thereby enhancing the staff's OT awareness. Participant 5 (initial IV 1) stated that: "*with our own ward rounds where we got such a lot of clients...they actually become aware...the sisters",* while participant 6 (initial IV 1) claimed that "*the sisters...are very interested…coming to our ward round and seeing the patients that we choose.*"

 At other times the participants advocated for OT by devising ways to build a referral system. For instance, participant 1 advocated for OT by encouraging teachers to refer children to OT via the clinics. Some teachers did not know about the service and many teachers questioned why she (the participant) could not come to the crèches. It was evident from the teachers' reaction that they were interested in what participant 1 presented; many asked questions related to difficulties they experienced in the classroom and thanked her for the practical input she gave (field notes, 3/08/10).

Despite their frustrations, all the participants felt that they developed professionally by living their vision for OT. They thought that their sense of professional identity was enhanced and that it allowed them to assert their role with other professionals. This was evident in the confidence they demonstrated in their practice. In one example relevant to this, participant 1 related an incident where she wanted to perform a work assessment on a client and had to assert herself in order for the doctor to supply the necessary documentation she required to proceed, as illustrated by the following quotation:

...I called the doctor...and I asked him...why didn't he see my patient and he said no...it's not an important case...and I said I need...documentation to say that he (the client) *has seen a doctor and I just felt he was impacting on my work...and I told him I'm an occupational therapist and I look at occupation and this guy is struggling at work...* (participant 1, initial IV 1).

The participants' sense of professional identity was also evident in their expressions of confidence in their own abilities and the value of OT. The following two quotations are evidence of this:

...what we doing is actually just erm...little, very little...but does have an influence and....it also has an impact on us because through that we can all grow...we do grow erm...professionally (participant 5, initial IV 2).

...I feel like I know what I am doing....(laughs)...and I feel comfortable actually going, approaching somebody....I think it makes me more secure...it makes me more secure about myself and who I am in OT...knowing that I don't have to feel insecure... (participant 1, initial IV 1).

5.3.6.2 Context supports practice

The participants' attempts to address occupational injustices in their practice were significantly enhanced by the degree of support they experienced in their respective practice settings. This was a key issue that the participants identified when they reflected on factors they regarded as facilitators of occupational justice. They identified various levels of support in their practice context that

influenced their practice. For example, support from the community was regarded as a motivating factor by the graduates. This relates to people's positive attitudes towards them. The participants felt that the degree of acceptance and co-operation they experienced from community members assisted their practice as well as their adaptation to community service, in that they "*felt very welcome...and accepted by the community* (participant 6, initial I/V 1). The following quotation is further evidence of this:

> *...firstly a positive for me, that really helped me here as well, is that the people are really just so friendly and so trusting and erm...many, most of them are so cooperative and they so willing to try new things...even though we are from two different cultures and backgrounds, so for me that was really something that was positive...that also gives your self-esteem a boost...* (participant 5, initial I/V 1).

Generally, the participants felt that the availability of support had a positive impact on their professional practice. Key factors relevant to this were having resources available to practice, and being supported to explore opportunities for OT. The following two quotations are evidence of this:

> *...I also make use of the available resources...when patients have difficulties at home, I can do a home visit because we have access to transport...* (participant 2, initial I/V).

> *...she (participant 2) is at a CHC...so she is in a better position to do community outreach...the CHC would assist...in terms of training, creating awareness, prevention, education...things like that but like...we don't* (participant 7, initial I/V).

Another factor related to available support was having opportunities for professional development, as illustrated by the following quotation:

> *What also assisted was...we had a workshop...on CP...and one on splints...and one on wheelchairs, how to fill in the wheelchair forms and how to assess for fittings* (participant 6, initial I/V 1).

For the participants the recognition of OT as a valuable resource in their settings was a significant indicator of the level of support they achieved in their practice and motivated them to explore further opportunities for OT. The number of referrals that they received from other professionals, as well as those received from the community through word of mouth, were regarded as positive indicators of the perceived value of OT in their settings. The following two quotations are evidence of this:

...when you start working with them they see...they are able to understand and when they get into their community they tell others about the OT services and we've got a lot of referrals...like clients from communities who have heard of OT from other clients, so the word of mouth has really worked (participant 4, initial I/V).

...the message goes out through word of mouth because you get clients coming in and telling you that "no but this person was here and you helped them...so now I'm also coming in because I also got this problem" and I actually found that a lot of the clients make appropriate referrals...more so than...the doctors (participant 6, initial I/V 1).

Although none of the participants reported being involved in formal, structured supervision with another OT, some of them regarded having the support of senior OTs as a contributing factor to practice success. The following quote is evidence of this:

...in the beginning, when we came here...erm...they were very supportive...they never said anything about mentor...no, they took us to the OT department and we just learned...okay this is the head OT...I think she took it on herself...the first few sessions...she would sit in, we would have a discussion afterward and...like going on my first clinics erm...she would also go with...to like just get me more comfortable... (participant 6, initial I/V 1).

The participants also discussed the importance of developing their own support networks. For example, those graduates who were placed in close proximity to another graduate acted as each other's support system. Contact with their peers

provided the graduates with a sense of support and reassurance around issues related to their practice, as illustrated by the following two quotations:

...the fact that we were placed...nearby each other...I think that also helped...because we got that support from each other and we also encouraged each other...(participant 4, initial I/V).

...when we had...the OT forum uh...that's where I met participant 4 for the first time after we have been placed here...so we had time to reflect about how we were performing our tasks...it was like seeing erm...my mother, you know when you from far away and you didn't know how to cope... (participant 3, initial I/V).

Others kept in contact through social networks as illustrated by the following quotation:

...I think we also draw on each other...because... it was a very close knit department (UWC OT Department)*...so we still have that erm...connection with our peers and everything...so if you go on mxit or facebook...they try to give you the best information that they can...if not information then at least a four day session discussing...* (participant 6, initial I/V 2).

Participants 7 and 2 established their own independent working relationship which stemmed from a conviction that the OT that works on level two should have a close relationship with the person on level one, hence they set an example of how this relationship could work in practice, as illustrated by the following quotation:

Z and I are informal...if I go to her or if I have a problem...then I go to her and I say "please help me"...or she will phone me and ask me "I have this patient...erm this is what I think, do you agree...is there something else that we can do?" (participant 7, initial I/V).

5.3.6.3 Education guides practice

In order to explore what influence their education had on their practice, I posed the following question to the participants: How has UWC OT education prepared you for practice? In reflecting on these questions they offered some insights into the value that they placed on their education. Curriculum content around theory and practice skills in OT was at the forefront of these reflections. These included theoretical models, pathologies and the practice principles and skills that they were taught, as well as their application to OT practice. The following two quotations are evidence of this:

> *...a lot of what UWC and especially what you gave us is a lot of theory...it's about understanding it...sometimes I forget about the model...but when I'm thinking through it myself then I will actually realize...I'm thinking through the pathology and what I want to do with this person...then I would realise...oh, but this is actually in this model...* (participant 5, initial I/V 2).

> *...with regards to skills I think that the type of knowledge that we got, we got all the right knowledge, we got the correct assessment tools, we got the pathologies...there was nothing wrong with the type of information that we got...* (participant 7, initial I/V).

Fieldwork subjects in the curriculum were the most frequently perceived by the participants as having best prepared them for actual practice. They reported that they were well equipped to work in their practice settings as the rural nature of their fieldwork placements as students prepared them to cope with the diverse and under resourced nature of their community service settings. The following two quotations are evidence of this:

> *...we were prepared...for the diversity of the placements and also for the fact that not all of the placements that we were sent to had a lot of resources, where we also had to like come up okay...this is what you want to do with the patient...and this is not there erm...so think of other ways that you can do the same thing...erm that you would have done if you had the resources...so in that sense we were prepared* (participant 6, initial I/V 2).

...obviously at the moment udubs (sic) (UWC) *is over-resourced compared to* (the hospital), *but it still...it did open you to...to thinking of other ways of doing...so that for me... did prepare us for erm...for community service* (participant 5, initial I/V 2).

The curriculum content on community-based practice was another key subject area that the participants perceived as valuable in preparing them for practice. They felt that the curriculum's focus on the social aspects of OT assisted them to "*think out of the box*", as illustrated by the following two quotations:

I think the whole social model of community development...that was the times it made you think out of the box...think about more than just your goals (participant 1, initial I/V 2).

...really understanding the context and also understanding the theory that supports the context of community...for me I think that was really a big help... (participant 5, initial I/V 2).
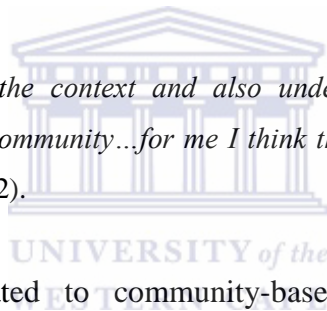
Curriculum content related to community-based practice surfaced as a motivation for decisions the participants made regarding possible interventions they needed to embark on, as illustrated by the following quotation:

...we would reflect on all the things that we studied at UWC and how we see these things in the community...and how we could use our skills to make a difference... (participant 3, initial I/V).

Their fieldwork experiences, combined with curriculum content on cultural diversity and a political practice of occupational therapy, surfaced as additional factors that the participants regarded as facilitators of occupational justice in their practice, especially in relation to the nature of their community service practice settings. The following two quotations are evidence of this:

...the module on culture...that was meaningful, it opened our eyes...to be here...to be part of another culture...is totally different...but that part of the curriculum

made me think...I came to realise that those are the things you have to look out for and erm...that is how I really try to respond to it (the culture) (participant 5, initial I/V 2).

I think it (the curriculum) *did prepare us...for all these challenges because when we went to Grabouw...the political issues that we had to go through when we wanted to establish the projects...are the political issues that we facing here with the staff...and other people that we are interacting with...that is why we are also very firm and assertive and we are able to stand for what we believe in...because those community projects really did erm...prepare us for this* (participant 3, initial I/V 2).

Another subject area the participants perceived to be useful in preparing them for practice was ethics. They related how it guides their practice and stated that they continuously reflect on this, as illustrated by the following two quotations:

...while we were driving one of the colleagues just said "you know what, let's just go for an extra drive"...I said I can't I have a patient...I really can't and we not suppose to drive around...it reminded me of the cases that we discussed...the whole ethics behind all of that... (participant 1, initial I/V 1).

...we think about ethics...we think about it every time we about to do something we think ok...theory was saying this and this and this, we should have done this and this and this...it's wrong to do it like this, from now on we do it like this and this and this...(participant 4, initial I/V).

The participants also reflected on the teaching and learning strategies employed in the UWC OT curriculum. They emphasised that the utilisation of the UWC process models as tools to facilitate their clinical reasoning was helpful, not just in terms of community-based practice but also in terms of practice with individuals and groups. They found the process models particularly useful as they developed their understanding of the person-environment-occupation relationship and their clinical reasoning skills in practice, as illustrated by the following quotation:

...the UWC process models...in terms of the individual, the group and the community...having that as your foundation is something very good...so I think in terms of that the curriculum and the process models that we use actually guided and facilitated practice for me...(participant 1, initial I/V 2).

Also, with regards to the facilitation of clinical reasoning, the participants found the methods used by their lecturers and fieldwork supervisors to be very useful. This emerged in their reflections on the interventions in which they participated that exemplified how they integrated their education with what they did in practice. The following two quotations are evidence of this:

...the 5W-H was something that is still instilled in me and I do it now...basically automatically...as well as the clinical reasoning process (participant 7, initial I/V).

I think that in terms of clinical reasoning being placed at a block...and having supervisors there to show you and guide you through the various principles...that's very helpful... a lot of times when I see patients...I think back...they (the lecturers) *said this...* (participant 1, initial I/V 2).

They furthermore regarded reflective writing as an important aspect that facilitated their ability to engage in reflective practice, particularly with regards to theory-practice integration and the development of their professional practice. The following two quotations are evidence of this:

...something that helped really a lot, or helped me a lot was the journaling and the reflecting on the events and especially putting your theory into practice and integrating it... (participant 7, initial I/V).

...when you reflect and you think about what you've done, about what you have learned, how you have done things, what you could have done better, and...it actually helps you like I don't think my clinical reasoning would have grown to the extent it did if I didn't exercise it (reflective writing)... (participant 1, initial I/V 2).

Other issues related to teaching and learning strategies that the participants appreciated were the supportive relationships they had with their lecturers, being able to freely engage in discussions with them, and learning from the example that they set. The following two quotations are evidence of this:

...the set-up at UWC, the relationship between the lecturers and the students is perfect...if I must think back to the support we got in the university and if you didn't understand...you work through it with your lecturer and I think that is what makes it easy for me...if I don't know something here, I feel free to go to someone and ask "listen here, this is what I'm seeing" because I'm used to that (participant 1, initial I/V 2).

I think...compassion was something that was very nicely displayed, if I can put it that way, or portrayed or reflected at UWC and it wasn't only in working with our patients or clients during fieldwork practice...it's also the type of relationship that the lecturers have with their classes or with their students and it's through small things like that you really learn...it's like monkey see, monkey do... (participant 7, initial I/V).

Student centred learning and the case study method of learning were the other teaching and learning methods that the participants claimed had a positive influence on their practice as it equipped them with the necessary critical thinking and problem solving skills that they were able to demonstrate in their practice. The following two quotations are evidence of this:

...I think udubs (sic) (UWC) *taught me...they taught you techniques to at least adapt to a situation...so...so...yes, you do go in unprepared, but because of the way that we had fieldwork especially...you didn't have all the knowledge of your client, but you knew that you have to go research for that, you have to go look for other methods...so that also in a way helped us...because we weren't over-prepared, but we knew how to compensate for that* (participant 6, initial I/V 2).

I always used to complain...why must we always give a thick intervention program or whatever, it's so unnecessary...because it's like we have half an hour...and we can't think of an activity...and then you always explained to us...when you placed in the boendoes (rural areas) *somewhere you gonna see the*

patient now and you gonna have to think of all those things...(chuckles) but now I see the value of that...like in thirty minutes time I must come up with a plan...(participant 5, initial I/V 2).

In further reflections on their experiences on teaching and learning aspects of the curriculum, the participants acknowledged that their education enhanced their professional identity, thereby assisting them to advocate for OT in their practice settings. The following three quotations are evidence of this:

...I think that I do understand what occupational therapy is and...I think that it's not only about the curriculum, it's about the people that are getting it through as well...it plays a very big role or important part in how you feel about the profession you are in...(participant 1, initial I/V 2).

...being new as a practising occupational therapist...I think that for me what really prepared us...is understanding and having a passion for occupational therapy (participant 5, initial I/V 2).

...I always speak about advocating for OT...'cause I always remember you going on and on about advocating for our profession and nobody else can do that...we need to do it for ourselves... (participant 4, initial I/V).

5.3.6.4 Graduate attributes

In exploring the relationship between education and practice in this study, certain attributes of the participants that contributed to the facilitation of their practice came to the fore. For instance, when asked if they were able to cope with their situations the sense of perseverance held by participant 6 (initial I/V 1) was highlighted in her response: "*...it's not a matter of being able or not able...you have to do it*". She continued by explaining how, in the absence of available resources, she would improvise and use any object or material available in the room in her intervention sessions, indicating adaptability and creative problem solving as illustrated by the following quotation:

...the fact that I'm using...just anything in the room, helps the client also...cause they can also go home and just take anything in the room...because the people don't have money...so that is also like one plus point...seeing that I can still do OT (participant 6, initial I/V 1).

On one of her clinic visits to a remote town I indeed observe how participant 6 used empty paper towel holders and pieces of clothing to demonstrate to a mother how she could position her child at home (field notes, 27/02/10). The other participants also seemed to engage in particular critical thinking and reasoning processes when they made practice decisions, as illustrated by the following two quotations:

...If I must think about today's session my...idea that I had for this thing that I made, I didn't have the material obviously...but the idea that I had or the vision that I had in my head was totally different to the end product and that is where it comes...when you think oh my word, what can I do to change this? (participant 1, initial I/V 1).

...I know, like a light bulb moment, I'm realising that I do reason to what I see and what I want and where I want that person to be (participant 5, initial I/V 1).

They were organised but flexible around time constraints and open to new ways of working, as illustrated by the following quotation:
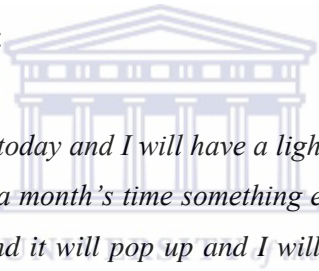
...I'm actually able to treat clients in the little time that there is...you know in the time that you have you must get everything and you must get the information and you must...and you must also do it in such a way that the client can take some knowledge home...I've grown a lot in that way...by doing that...half an hour...shifts (participant 6, initial I/V 1).

They further showed openness to learning and took initiative to acquire new knowledge by consulting relevant sources. They also showed that they were capable of individual learning and critical reflection for the purpose of furthering their practice, as illustrated in the following two quotations:

I don't have to feel insecure if I don't know something...so I can go and say I'm struggling with this, so is there any way that you can help because I know this is just not working...so I think it's what you make of it...I mean I don't know everything and I know I still got a lot to learn, but I'm like an open book and if you feel you want to write something in me...then write (participant 1, initial I/V 2).

...I am able to like think about okay – this is what the client is presenting with, this is what I can give them so long - maybe I still do need to...I still need to do some other research... (participant 5, initial I/V 1).

Engaging in reflective practice was an attribute that appeared to facilitate new ways of thinking about their practice in that they considered strategies they could employ to address some of the challenges they experienced, as illustrated by the following quotation:

... something will happen today and I will have a light bulb moment and I'll jot a few things down...and in a month's time something else will happen that relates to what happens today and it will pop up and I will think –why didn't I reflect better...and so reflection just keeps on happening and you adapt and you change and you learn like that... (participant 1, initial I/V 2).

One important attribute that was evident in the participants' practice stories was that of cultural sensitivity and they appeared not to be intimidated by the different cultures they experienced, as explained by participant 6 (initial I/V 1) who stated: *I'm not afraid of a different culture...for me it was okay…it was different, yes, but…I never had issues with it.*

Attributes such as a genuine interest in other people's viewpoints, a willingness to learn from other cultures and showing respect were also evident in the participants' reflections. The following two quotations are evidence of this:

I know that my role is to consider all the things that make up the client, like their cultural beliefs. I have to respect their background and I have to work with that… (participant 3, initial I/V).

...with cultural competence, one thing that is very, very, very important is how you approach the community and the impression that you give the community of yourself (participant 1, initial I/V 1).

Another important graduate attribute evident from the interviews was the conscientiousness the participants showed about providing the best care possible to their clients, as illustrated by the following two quotations:

...its how we care about our patients...none of the senior therapists told us we could contact OPD or social development...its our own doing...so we care about the people (participant 1, initial I/V 2).

...the people are watching you with this eye and they are really trusting you and you must get something that will really help them because you want to help...I don't know, for me it's almost like a motivation...because you know you need to help them (participant 6, initial I/V 1).

Lastly, the participants showed a desire to contribute to social justice by defying certain rules they were subjected to. This was evident in the manner in which they stood up for their beliefs in terms of the relevance of the service they could provide – relevant to the context in which they practised, as captured by participant 5 (initial I/V 2) when she stated: "*...one thing that I've learnt personally from doing occupational therapy is being assertive and standing up for what I believe in and what is right*".

In Theme 6 the participants' perceptions about factors that facilitated their practice, i.e. living OT vision, context supports practice, education guides practice and graduate attributes, were described.

5.4   CONCLUSION

In this chapter the study findings were presented as six themes. Theme 1 described the participants' understanding of the meaning of occupational justice as that of enhanced health and well-being through social change and occupational enablement. Theme 2 described the approaches to occupational justice that the participants adopted, namely occupation-based practice and community-based practice. In Theme 3 practice strategies, i.e. health promotion and CBR, utilised to facilitate occupational enablement as a principle of occupational justice, were portrayed. Theme 4 described the skills that the participants applied as tools of occupational justice, i.e. attending to power and diversity issues, collaboration, advocacy and capacity building. In Theme 5 contextual constraints to occupational justice, i.e. lack of OT awareness, resource constraints and the complex process of bureauocracy, OT vision does not fit the system and practice-education gaps were described. Finally, in Theme 6 the participants' perceptions about factors that facilitated their practice, i.e. living OT vision, context supports practice, education guides practice and graduate attributes, were described. In the following chapter the conclusions that were derived from the findings are discussed by drawing together threads from the study-context and the literature review.

CHAPTER 6
DISCUSSION

6.1   INTRODUCTION

In the previous chapter I presented the findings of the study. In this chapter, I present a discussion of the findings. I begin the discussion by presenting a model to illustrate how the participants conceptualised occupational justice in practice. I then address the ways in which the participants were able to draw on their university education to make sense of their role within their practice settings. I also discuss the extent to which the community service practice settings provided the participants with opportunities to work within an occupational justice framework. Following on this, I address some of the specific challenges that these settings raised from the perspective of participants and how these were addressed. In the last part of the chapter, I explicate important lessons derived from the findings for the development of UWC OT education to better equip graduates of the future to address the structural realities that shape the lives of people as occupational beings, including people with disabilities.

6.2   CONCEPTUALISATION OF OCCUPATIONAL JUSTICE

The participants were not specifically asked to provide a definition of occupational justice. However, through their articulation of their vision for OT, their understanding of occupational justice was revealed. A model of how the participants understood and conceptualised occupational justice in practice emerged through data analysis and is presented in Figure 3.

Figure 3: Participants' conceptualisation of occupational justice
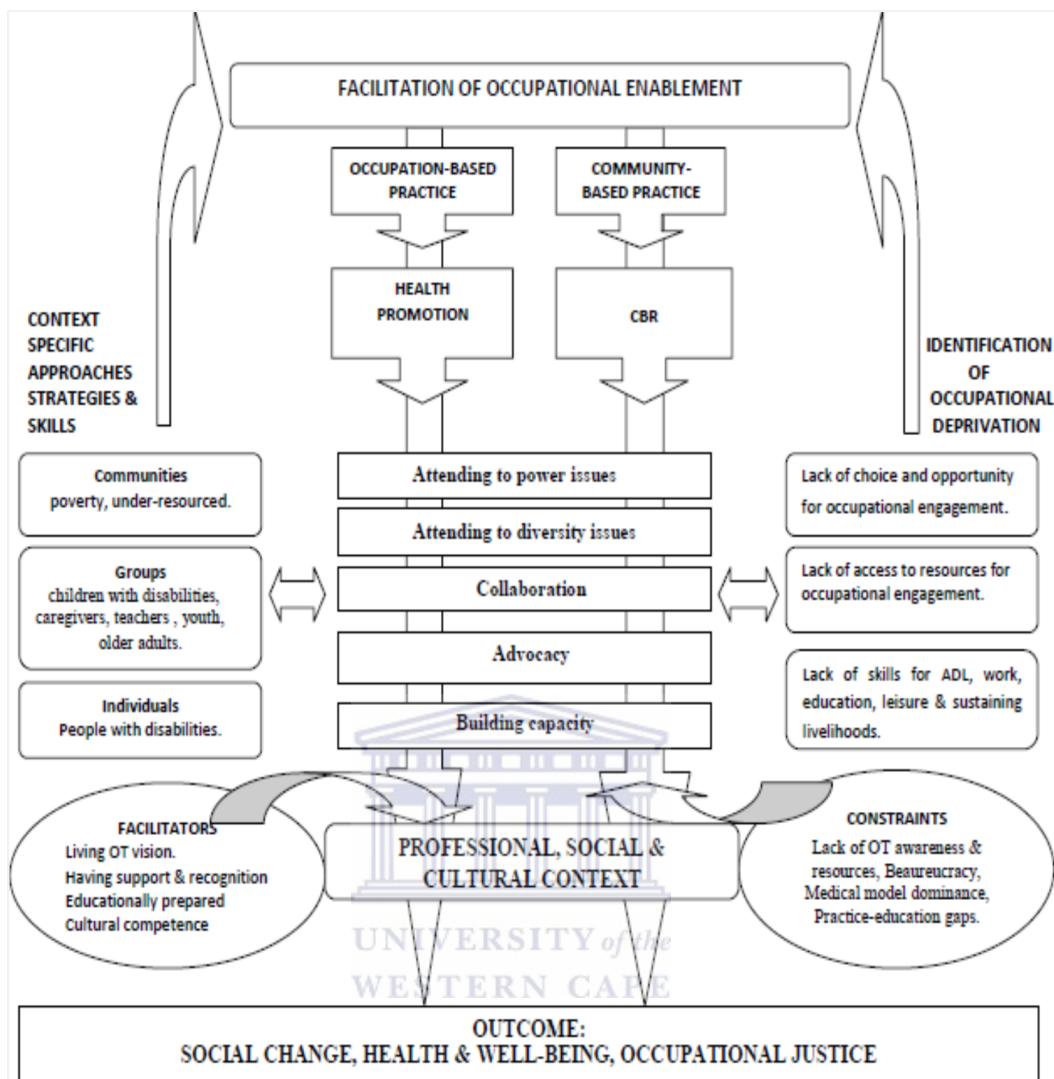
The model indicates that the participants held the belief that there is a relationship between health, well-being and occupational engagement and that occupational participation is contextual. Informed by this belief they worked to advance occupational justice, which they conceptualised as enhanced health and well-being, and broader social change as an outcome of the facilitation of occupational enablement. This vision of the participants is in line with that of the UWC OT education programme that envisions graduates who regard social change as a dimension of practice and also act as agents of change.

Although the participants' practice centred on the facilitation of occupational enablement, it is depicted in the model through the specific practice processes adopted by the participants. These practices are representative of the

participants' held beliefs and professional preparation associated with occupational justice. The participants' practice commenced with the identification of occupational injustices - in particular occupational deprivation experienced by individuals, groups and communities. At the centre of the model lie the context-specific practice approaches, strategies and skills demonstrated by the participants. It is through a combination of these practices that the participants worked to improve occupational justice. The context of the model represents the professional, social and cultural environments in which practice occurred. Linked to this context are practice facilitators and constraints that are connected to contextual influences that either assisted or hindered practice. The outcome arrows represent the primary goal of practice, namely occupational justice understood by the participants as social change and enhanced health and well-being through occupational enablement.

6.3   OT CORE KNOWLEDGE VALUES AND SKILLS

In the previous section I presented how occupational justice was conceptualised by the participants. In this section I address the ways in which the participants were able to draw on their university education to make sense of their role within their practice settings and discuss the extent to which these settings provided the participants with opportunities to work within an occupational justice framework.

The participants share a professional value and knowledge base by virtue of their status as UWC OT graduates and by being guided by the philosophies of the profession. The findings indicated that occupational justice held considerable value for the participants. Their practice commenced with the identification of occupational injustices and was informed by the OT profession's philosophy that people are occupational beings and that their health and well-being are compromised when occupational needs are not met (Wilcock, 2006). This was evident in the manner in which they connected occupational engagement to people's well-being. It can therefore be inferred that the participants understood occupation as a fundamental human need and that they regarded occupational well-being as essential to people's overall

health and well-being. Hence, in identifying occupational injustices, the participants considered whether people were able to participate in meaningful occupation and, if not, identified factors that restricted their ability to do so.

It is noteworthy that the participants regarded the identification of occupational justices and, by implication, their clients' needs, a priority. The findings showed that the participants believed that they not only needed to see people as individuals with biological needs but also with particular social needs. This location of people's needs in the broader social context indicates that the participants conceptualised occupational participation as contextual (Townsend & Wilcock, 2004a). This was illustrated in the manner in which the participants endeavoured to obtain an understanding of how people's occupations were influenced by the social and physical environment in which they lived, worked and played (Watson & Fourie, 2004). This demonstrates a theory-practice integration of Wilcock and Townsend's (2000:84) theorising of occupational justice as addressing "what people do in their relationships and conditions of living". This is significant as the UWC OT education programme aspires to produce graduates who are able to implement occupational therapy interventions that are relevant to people's context and health needs.

Some of the participants conducted appropriate community entry processes to conduct needs assessments to identify occupational injustices. Other participants made an effort to enhance their understanding of the social context by attending community meetings after hours in order to identify how they could integrate their clients into the community. Given the conditions of poverty and the related under-resourced nature of their practice contexts, the prevalence of occupational injustices was confirmed by the needs assessments that several participants conducted. The predominant occupational injustice revealed by the findings was that of occupational deprivation. This relates to a lack of occupational choice (Wilcock, 2006) and being denied resources and opportunities to engage in occupations (Townsend & Wilcock 2004b) as experienced by older adults, who felt frustrated because there were no recreational activities in which they could engage.

All the participants indicated that they felt adequately prepared for community service by the curriculum. The participants mainly related this preparedness to the social orientation of their education. Predictably, several participants made reference to the importance of the community work skills they had been taught. The findings showed that the participants' highly valued fieldwork combined with curriculum content on theory and practice skills in OT, community-based practice, a political practice of OT, cultural diversity and ethics. It emerged that it was through diverse experiences of fieldwork that the participants came to appreciate the meaning of occupational justice due to their exposure to real-life occupational injustices. This confirms the important role that fieldwork plays in the curriculum in preparing students for practice.

It did, however, emerge that some participants felt a lack of preparedness in relation to their competence with regards to clinical skills, i.e. knowing how to handle pathologies. The participants felt that the curriculum did not allow enough diverse fieldwork experiences thus they had difficulty dealing with pathologies which they were not exposed to as students. This finding was not surprising as it was a common finding in studies that addressed graduates' preparedness for practice as highlighted in the literature. The researchers of these studies suggest that, as the OT role is continually expanding, it is not possible for OT education programmes to teach students all the specific knowledge and skills they require (Trysenaar & Perkins, 2001; Doherty, Stagnitti & Schoo, 2009). This draws attention to the notion of life-long learning which Duncan and McMillan (2006) emphasise as a vital aspect of contemporary OT practice. It is therefore noteworthy that the participants initiated their own support networks, and conducted their own research to acquire the necessary knowledge when they struggled with specific issues such as handling different pathologies, thereby portraying life-long learning, which is also a UWC graduate attribute.

A significant finding that emerged was the professional identity of the participants evident in the manner in which they expressed confidence in the value of OT (Duncan & McMillan, 2006; Creek, 2011) and in their desire to contribute to occupational justice. Another important attribute that surfaced was

the cultural sensitivity they displayed, as illustrated by a genuine interest in other people's viewpoints, willingness to learn from other cultures and demonstrations of respect (Buchanan & Cloete, 2006; Thomas & Clark, 2007). The findings showed that the participants demonstrated sensitivity to their clients' culture, as illustrated in the manner in which they attended to diversity issues in practice. Consequently, attending to diversity, in particular through cultural competence, revealed a dimension of client-centred practice as part of an overall range of occupational justice promoting strategies in the findings.

The principle of empowerment through occupation, which supports equality in power sharing (Townsend & Wilcock, 2004a), was illustrated by the participants' cognisance of the importance of stepping down from their own position of power and taking their clients' needs into consideration. Accordingly, the manner in which the participants adopted the client-centred approach involved the generation of clients' participation in intervention programmes. For instance, when clients were not informed about their diagnosis, the participants fulfilled the role of educator and thereby demonstrated values of respect and upholding of clients' dignity. These examples illustrate listening, communication and respect, which are core elements of client-centred practice as outlined by Sumsion and Law (2006).

The attributes that the participants exhibited concur with those of the UWC OT education programme and those derived from the Department of Health's objectives for community service (Reid, 2002). These attributes are also identified by several authors as important for the facilitation of socially responsive practices. For example, the participants portrayed critical thinking and creativity in obtaining knowledge of community resources (Alsop, 2006; Duncan & McMillan, 2006) in identifying how they could contribute to the health and wellbeing of communities. They also engaged in reflective practice (Duncan & McMillan, 2006) and took initiatives to acquire new knowledge by consulting relevant sources when needed (Alsop, 2006; Duncan & McMillan, 2006). They further showed adaptability, creative problem solving and flexibility (Buchanan & Cloete, 2006; Creek, 2011), by demonstrating an openness to new ways of working (Duncan & McMillan, 2006) and by their

resilience (Thomas & Clark, 2007) in coping with the realities of practice. Figure 4 presents a comparison of the attributes portrayed by the participants with those outlined by UWC and the Department of Health.

Figure 4: Participant attributes compared to UWC attributes and community service attributes
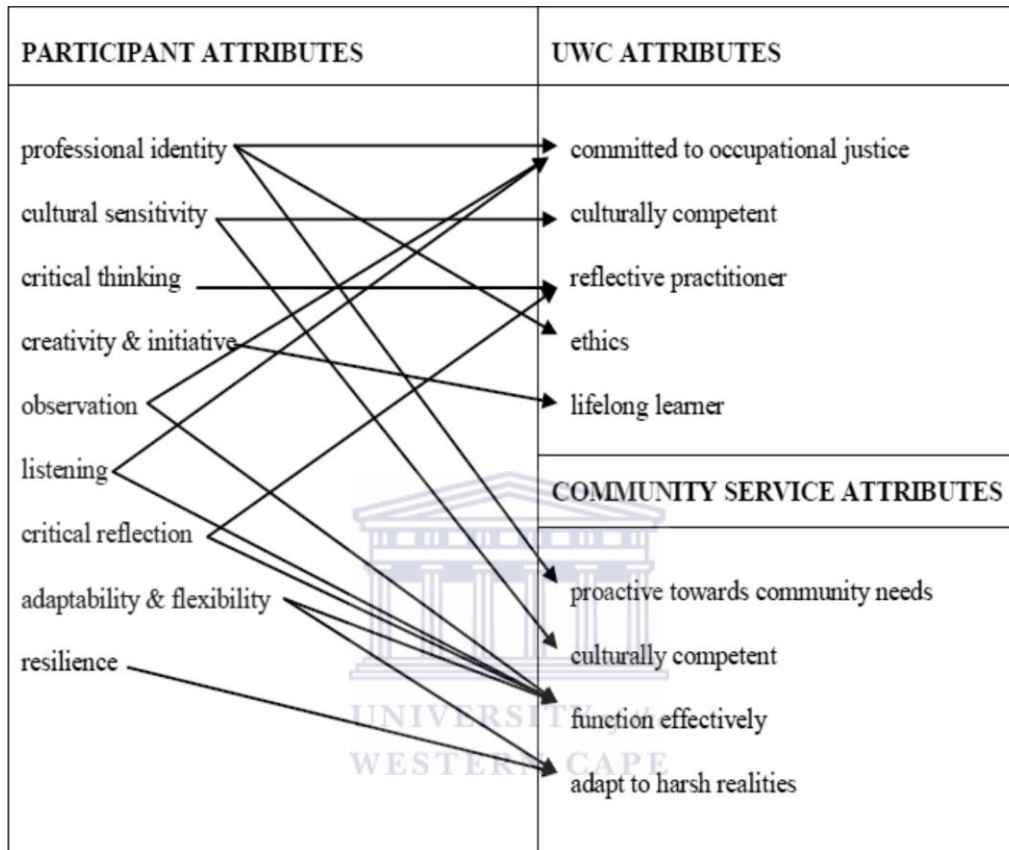
In applying their conceptualisation of occupational justice in practice, the principle of occupational enablement (Townsend & Wilcock, 2004a) was the central link between the various practice approaches and strategies that the participants implemented in practice. They did this through the occupation-based practice approach which they regarded as their professional responsibility. This is noteworthy as the participants seemed to regard occupation-based practice as the definitive basis of the OT profession , thus underpinning their professional identity and setting them apart from other team members. For instance, the participants felt it important that their practice demonstrate what is unique to what an OT does, i.e. by adopting an occupational perspective, in comparisson to what other professionals do.

A key dimension of the participants' practice highlighted by the findings was their endeavours to work towards having people's occupational rights met. In describing occupational rights, the participants spoke of the right to information and self-determination, the right to income generation, the right to practise cultural and religious beliefs, the right to appropriate education, and the right to engage in diverse and meaningful occupations. It emerged that the participants attempted to transform occupational injustices in line with the occupational justice practice framework proposed by Stadnyk (2007) wherein outcomes of occupational justice are conceptualised as having people's occupational rights met by transforming occupational injustices through occupational enablement. The above mentioned dimensions of the participants' practice further links with the LEO Model (Townsend, Polatajko, Craik, & Zweck, 2011) that describes effective enablement as real life engagement, where OTs are flexible and responsive to client needs and collaborate with them in an environment that fosters equity and citizenship.

While the findings showed that the participants predominantly focused on occupation as an end, i.e. meeting clients' goals for occupational engagement, with little evidence of occupation as means, i.e. the actual use of activities during intervention, the participants understood that occupational enablement requires approaches that support people in developing their occupational potential through relevant means. Relevance for the participants implied being responsive to client needs and allowing people to choose occupations they considered to be most meaningful to them. These practices by the participants demonstrated what Kronenberg, Pollard and Ramugondo (2011) imply when they state that people's experience of health and well-being are influenced by the opportunities they have for occupational engagement.

Through the various interventions implemented by the participants to further occupational enablement, it emerged that they considered health promotion as an integral feature of their practice. In the UWC OT curriculum health promotion is covered as part of an interdisciplinary faculty foundation course and is further integrated in profession-specific modules through first to fourth year. It is therefore not surprising that the participants appreciated the value of

health promotion to occupational enablement. Even so, health promotion as demonstrated in the participants' practice was rarely aimed at strengthening health-enhancing actions of the broader community. Instead, their practice focused on health education aimed at providing information regarding prevention of illness and complications post-illness. In addition, health promotion was directed towards developing the skills of individuals or groups to enhance their well-being through occupation. While this indicates an occupation focus as a unique feature of OT, health promotion is not only health education.

What is concerning is the lack of skills that the participants portrayed in implementing specific health promotion strategies as elements of practice. The Ottawa Charter (WHO, 1986) cites enabling, together with advocacy and mediation, as key strategies of health promotion. Besides advocacy actions to address resources for occupational engagement and enabling occupation at an individual level, the strategies of enabling and mediation at a broader community level were, however, not visible in the findings. For instance, none of the practice examples related to health promotion involved the facilitation of people's agency to enable them to take control of their health, or mediating between different stakeholders to collaborate in creating opportunities for occupational engagement in the community. This may indicate that more attention needs to be given to developing students' skills in the planning, design and implementation of health promotion programmes in the curriculum, particularly around advocacy and mediation.

The occupational justice principles of social inclusion and empowerment through occupations (Townsend & Wilcock, 2004a) did, however, manifest in some participants' attempts to adopt a community-based approach to practice. Community-based practice, i.e. participants themselves identifying occupational needs in the community and developing strategies to address those needs, is differentiated from community development, i.e. involvement of community members in identifying and developing actions to address their needs (Labonte, 1993). Community-based practice by the participants was characterised by community consultation and outreach programmes through which people were

involved in various activities. Examples of the participants' attempts at initiating community development are consultations with a village chief, the police and victims of abuse.

Although the participants spoke about promoting empowerment in relation to these examples, they were more concerned with creating opportunities for meaningful occupational engagement at a community level than with supporting communities to address their own particular occupational needs through social action. Furthermore, strategies for community development, such as nurturing community partnerships, building capacity at a community level, influencing health services and intersectoral collaboration, as proposed by Lauckner, Krupa and Paterson (2011), were noticeably absent from the participants' practice. From this I conclude that the link between their conceptualisation of occupational justice and actual practice was weak.

As noted in the literature (Labonte, 1993; Lauckner, Krupa & Paterson, 2011) factors critical to the success of empowerment involve community ownership of problems and solutions and people taking action on problems. In community development, participation is valued both as a means and as an end. Participation as means refers to the community's involvement in indentifying needs and setting objectives, while participation as an end implies the empowerment of the community to take responsibility for their development. The framework for occupation-based community development (Galvaan & Peters, 2013) is particularly relevant for OT practice in terms of promoting participation. For instance, instead of only focusing on educating youth on constructive leisure time use, working with them presented an opportunity for the participants to facilitate the youth's reflection on how structural issues in their rural context influenced their leisure participation and then enabled them to develop and implement actions to remove identified occupational injustices. The above shortcomings in the participants' practice illustrate that they lacked specific tools with which to work within a community development approach, highlighting another shortcoming in the curriculum.

Their growing integration of core occupational therapy skills and attributes such as observation, listening and reflection, underpinned by an empathic and nonjudgmental approach, allowed the participants to engage with people whose world was often very different from their own. For example, the participants stressed the importance of demonstrating respect for others regardless of social status, religion or culture. They showed respect for those clients who had different belief systems than theirs, and they learned culturally appropriate communication skills to gain a greater understanding of their clients. In this way, they worked for occupational justice by acting out some of the values that define it, i.e. diversity, inclusion and shared advantage of occupational participation (Townsend & Wilcock, 2004b). However, in attending to issues related to culture, none of the participants paid consideration to the interdependent nature of occupation in the African context. The fact that the participants did not regard collective consciousness as an important feature of people's occupational enablement indicates a weakness in the link between their beliefs and practice.

The Afrocentric worldview is collectivist and observes people and life events as mutual and interacting with one another. Therefore, from an African cultural perspective, collective occupational well-being should be a principal focus of practice when adopting an occupational justice approach and requires a conceptualisation of human agency as collective (Ramugondo, 2012). This means that within a South African context we have to consider the possibilities of a more relational focus of enabling occupational justice and indicates the need for African indigenous knowledge systems to be included as a content area in the curriculum. The critical issue is for students not just to understand African knowledge systems but also to be equipped to implement African-centred occupation-based interventions to empower people and to advance occupational justice in local contexts. This implies that OT education should prepare graduates to be able to effect transformation in a way that reflects an African conceptualisation of human occupation, occupational justice and occupational therapy practice.

Although the three occupational justice practice frameworks noted in the literature (Stadnyk, 2007; Whiteford & Townsend, 2011; Townsend, Polatajko, Craik, & Zweck, 2011) emphasise participatory processes for advancing occupational justice, it is permeated by concepts in line with a Western worldview, such as independence and the right to autonomy. These practice frameworks predominantly inform OT curriculum content related to advancing occupational justice in practice. In addition, the Western worldview, through its dominance in occupational therapy professional literature, generally continues to inform practice interventions by South African occupational therapists. This also appeared to be the case with regards to the practice interventions implemented by the participants in this study.

The theoretical implications of the issues discussed here are significant in terms of conceptualising occupational justice in the South African context. While existing professional literature provides a solid theoretical basis for occupational justice, it should be deconstructed and re-formulated with due consideration of the values, beliefs and practices of local people. It is imperative that the curriculum provides experiential learning opportunities for OT students to do this. In addition, the curriculum should provide opportunities for students to engage in critical reflection on ways in which indigenous knowledge and local understanding of occupational justice, in terms of inclusion, human agency and critical consciousness, can be made more explicit in everyday practices. By adopting these teaching and learning practices, OT educators will effectively frame occupational justice not just in terms of social change but also in relational terms.

Another approach to practice that links with the occupational justice principles of social inclusion and empowerment through occupations (Townsend & Wilcock, 2004a) highlighted by the findings, was that of CBR. In one example related to CBR, two of the participants assisted the staff of a disabled children's home to clarify their mission; build their capacity to establish processes to implement a project around child development; and developed the skills of the manager and caregivers, who gradually passed on their acquired skills to others, thereby themselves becoming educators. Through advocacy initiatives they

further spoke on behalf of the children, who were unable to take action around particular challenges they faced, and advocated for them to attend a special school. In another example, a participant advocated for the implementation by the Department of Social Development of skills development programmes for people with disabilities and arranged a meeting with community-based organisations to address the issue.

Other examples uncovered in the findings that illustrated the participants' practice of CBR include:

- home visits to people with disabilities;
- involvement of neighbours and home-based carers in rehabilitation;
- support groups for mothers of children diagnosed with CP;
- running workshops on disability rights;
- developing caregivers' basic rehabilitation skills;
- raising disability awareness;
- providing wheelchairs;
- development of teachers' skills around learning disabilities; and
- support groups for people suffering from mental illness and stroke survivors.

While these efforts indicate that the participants paid some attention to the health (promotion and prevention, rehabilitation for independence, provision of assistive devices) and education (early childhood, primary, life-long learning) components of CBR, the participants' practice mainly portrayed CBR as the provision of more accessible rehabilitation services to the community. For example, rather than engaging in CBR, the home visits conducted by the participants were for the purpose of rehabilitation in the home. Their practice indicates that the participants predominantly focused on the medical aspects of rehabilitation that have traditionally neglected empowerment of people with disabilities.

CBR within an inclusive development framework for the poverty reduction, equalisation of opportunities and social inclusion of all people with disabilities

(WHO, 2010), was relatively absent. It is noteworthy that the participants did not address the social inclusion of people with disabilities, despite acknowledging their experiences of occupational injustices. For example, in their work with the disabled children's home, the participants raised awareness of disability and disability rights through education and capacity building initiatives but did not involve people with disabilities, i.e. parents, in advocacy initiatives aimed at the removal of barriers to social inclusion. Moreover, practice examples did not illustrate the social (equal opportunities for social participation) and empowerment (promotion of self-reliance, community action) components of CBR. The livelihood component of CBR (poverty reduction and skills development for income generation) was also absent from the participants' practice.

Although CBR, as represented by the joint position paper (ILO, UNESCO & WHO, 2004), which adopts equalisation of opportunities, social inclusion, and partnerships with people with disabilities as strategies of CBR, was covered in the curriculum, these findings illustrate that the participants have not been able to make a shift from working for people with disabilities (providing services) to working with (participating in CBR) people with disabilities. This again indicates a weakness in the link between the participants' conceptualisation of occupational justice and their actual practice.

Perhaps the weakness in the link between the participants' conceptualisation of CBR as being imperative to advancing occupational justice and their actual practice, can be attributed to the lack of CBR fieldwork opportunities available to students in the curriculum, as students are placed mainly in institutional rehabilitation programmes for fieldwork. Bearing in mind that the participants are 2009 OT graduates, the blueprint CBR guidelines (WHO, 2010), which inform the actual implementation of CBR, were not covered by the educators. This indicates a lack of awareness and vision about global developments around CBR on the part of UWC OT educators and may further explain why the participants lacked the tools to work within an inclusive development framework of CBR.

Literature has shown that people with disabilities in rural areas are subjected to institutional and environmental exclusion (Duncan & Watson, 2009), emphasising the importance of eradicating social, economic and institutional barriers if the empowerment of people with disabilities is to be facilitated. With current developments in the health system around the re-engineering of PHC, rehabilitation professionals would have to be more competent in CBR and thus need extensive knowledge and skills regarding CBR and its implementation. With regards to addressing students' attitudes toward people with disabilities, consulting disabled people's organisations (DPOs) and involving people with disabilities in curriculum development and teaching around disability and CBR would be beneficial in terms of students learning more about social inclusion and empowerment from the perspective of people actually living with disabilities.

Furthermore, although the medical model of disability, which sees disability as individualised and draws attention away from the oppression of people with disabilities, prevails in the settings where the participants practised, the situation presented the participants with an opportunity to respond by engaging in policy processes as a dimension of practice for occupational justice. However, the lack of evidence in the findings related to this point to another shortcoming of the curriculum. As such, OT practice necessitates that occupational therapists are able to analyse and interpret policies in terms of their contents, lobby for their implementation and monitor their targets and process of implementation. Yet, while the participants' in various instances articulated their frustration with the lack of policy development and processes in their practice settings, they seemed ill-equipped to address the issue. The curriculum should therefore not only orientate students to policies relevant to OT practice, but also address social policy processes in terms of interpretation, analysis, implementation and monitoring. In short, OT graduates must have the skills to engage in policy processes in order for them to share this expertise with people with disabilities and community members so that together they may lobby for effective policies to be implemented. This is a major content area that needs to be developed in the UWC OT curriculum.

6.4 THE CHALLENGE OF USING OCCUPATIONAL JUSTICE AS A FRAMEWORK FOR PRACTICE

The previous section explored the ways in which students were able to draw on elements of their university education to make sense of their role within their community service placements. The next part will address some of the specific challenges that the participants encountered in these settings and how they responded to these challenges.

As described in Chapter Four, Section 4.7, graduates who were placed in under resourced rural communities for community service were selected to participate in this study. The findings showed that the participants practiced in settings where health problems were described as typical of a developing context as it was characterised by poor socio-economic conditions and lack of access to health services. Although the Western Cape appeared to be better resourced in comparison to the Northern and Eastern Cape, available resources still appeared to be incongruent to the health disparities that were noted in the practice contexts of those participants who completed community service in this province.

Six of the seven participants in this study were placed in practice settings that provided community-based services i.e. clinics and CHCs, and Level 1 services i.e. district hospitals. In line with the DHS and PHC approach it is expected for community outreach and support to occur at the levels of community-based services, also referred to as PHC services, and district hospital services (South African Government, 2004). It however emerged that this was not the case in the participants' practice settings as resources were mainly dedicated to the provision of curative services (medical model approach) with little thought given to preventative work (social approach). This was illustrated in the manner in which the emphasis of health services in the participants' settings fell on medical intervention rather than on CBR as emphasised by the UNCRPD (UN, 2006) and WHO guidelines (2010).

The nature of their community service practice settings posed several challenges for the participants. The participants reported that they experienced many constraints to practice including a lack of OT awareness and difficulty collaborating with other professionals. Newton and Fuller (2005) assert that when occupational therapists find themselves in situations where other professionals do not appreciate their role and skills due to a lack of OT awareness, practice becomes challenging. In this study this was indeed the case for the participants. The findings showed that the participants' professional role was not appreciated and that their skills were under-utilised as was evident in the lack of OT referrals they received. Without exception, power dynamics related to professional boundaries and the hierarchy of professionals startled the participants.

These power dynamics involved the claim of professional boundaries for example during decision-making processes. In response to this, the participants established bridges between themselves and the rest of the staff by creating opportunities for meaningful engagement with the MDT. They also harnessed support for their interventions from older staff members as they were respected in the setting, and utilised them to advocate for OT during decision making processes. Where they asserted their role in their attempts to perform community-based interventions, the resultant degree to which OT was recognised as a valuable resource emerged as a key facilitator of practice. The participants were however not able to influence teamwork so that it could become more fully interdisciplinary. In most instances the various disciplines continued to practice in professional silos thereby perpetuating a lack of team spirit and tribalism among professionals (Julio, Chen, Bhutta, Cohen and Crisp et al., 2010).

From the perspectives of the participants, the dominance of the medical model, lack of resources and system of bureaucracy appeared to be the biggest challenges raised by their practice settings. For instance, the findings illustrated how the various rules and policies around accessing resources, establishing community projects and obtaining permission to do community outreach undermined the participants' practice. These red tape issues hindered

the implementation of an occupational justice framework and particularly an integrated rehabilitation service.

The findings further revealed that the statistics forms issued by the Department of Health did not allow for the recording of OT services that addressed occupational injustices through health promotion and community development interventions. As a result the participants' actual practice outputs were obscured, thus increasing the difficulty to motivate for resources to increase the relevance of their services. This strongly resonate with the view of Townsend, Polatajko, Craik, and Zweck (2011) who state that documentation completed by occupational therapists in practice does not link OT with participation, citizenship and human rights. They therefore assert that an opportunity for occupational therapists to take ownership of occupational justice in practice lies in designing and negotiating the use of accountability documents that are relevant to occupational justice issues. The participants were however discouraged by their supervisors to do this and thus did not further pursue the issue.

It further emerged from the findings that the participants perceived protocols, for instance around accessing resources, to be complex and time consuming with no clear guidelines regarding actual procedures that needed to be followed. Managers often had little understanding of the community service policy or the different roles of community service graduates. Hierarchical management systems contributed to the power dynamics as health managers appeared to follow traditional management practices like holding the power in confirming or denying requests and having the final say in making decisions. As a result, power struggles between the participants and management appeared common. This was particularly evident when it came to the allocation of resources such as transport for rehabilitation and adhering to the community service policy of graduates having to do community work. In this way, the placements did not provide the participants with sufficient opportunities to meet community service policy objectives.

There were, however, some instances where the participants made concerted efforts to address the community service policy with management. For example, Participant 3 and 4 wrote a letter to management to explain the policy in terms of the requirement for community service graduates to do community work and were subsequently allowed to perform community outreach. They were however not allocated any transport to do this which curtailed their efforts to engage in community work. As suggested by Townsend, Polatajko, Craik, and Zweck (2011) this challenge presented the participants with the opportunity to join with communities to work for occupational justice but health managers were perceived to be resistant to community approaches. Consequently the participants struggled to obtain support for their social and occupational role, other than the medical.

It came to view that a lack of resources like transport affected the participants' practice in various ways. For instance, the lack of follow-up characterised by people defaulting on appointments due to their inability to access transport, was a key concern expressed by the participants. They were however unable to perform follow-up of clients in the community due to a lack of transport. According to the Batho Pele document (Department of Public Service & Administration, 1997), all people have the right to equal access to services to which they are entitled. This especially applies to people with disabilities and rural people who may have difficulty accessing services. The lack of transport for community work, however, meant that people who needed OT services most remained confined to their homes thereby entrenching the injustice of occupational marginalisation people with disabilities.

Some participants responded to this challenge by approaching the police or an NGO to obtain transport. Other participants responded to the challenge of a lack of transport by using available resources in the community as materials for activities, while others utilised their own money to pay for materials and transport. The participants were however not able to sustain these efforts, thus the potential for community trust to be compromised as a consequence of a lack of resources surfaced in the findings. For instance, when some participants were unable to follow through on plans to implement community-based mental health

and support groups for abused women due to a lack of transport, they felt that they might have let the community down.

The findings further indicated that the participants networked with organisations and other sectors for the purpose of information sharing, but were not effective in establishing strategic collaborations to address meaningful social change. The lack of intersectoral collaboration appeared to be underlined by unclear directives from the Department of Health around addressing the needs of children with disabilities as well as a lack of clarity regarding which department is responsible for the provision of OT services to school children. This is regrettable as a lack of inter-sectoral collaboration may perpetuate the understanding of rehabilitation as a medical issue only.

In reflecting on the constraints posed by the medical model dominance in their practice contexts, the participants acknowledged the consequences of the absence of CBR for people's health and well-being. For instance, they recognised that a lack of disability prevention and rehabilitation at a community level could lead to people developing complications which would necessitate admission and having to remain longer in hospital, thereby increasing overall health costs. To compensate for the constraints related to doing community work and because they perceived the hospitals to be underutilised, some participants envisioned the establishment of dedicated rehabilitation centres where clients could receive adequate rehabilitation inclusive of disability prevention. This prospect, however, seemed daunting to the participants due to the health system's prejudice towards the medical stabilisation of clients evident in the resistance that the participants encountered when they explored this option with management.

While this challenge also presented the participants with the opportunity to join with communities to address the needs of people with disabilities, health managers were again perceived as resistant. In some instances this lead the participants to comply with managers' expectations of them even if it meant that they had to practice in ways they did not fully agree with, leaving them with feelings of guilt and despondency in turn. In fact, some participants held

the view that confronting the system might compromise their relationship with health managers, thus having a negative impact on OT services. From my observation, the participants' appeared to experience pressure to conform to their health managers' expectations of them. This highlights the issue of hegemony and lends support to Whiteford's (2007) view that OT practice often occurs in a time of managerialism in which economic considerations dominate practice thereby forcing it to become homogenised and formulaic despite complex needs.

The challenges encountered by the participants concur with those encountered by occupational therapists who worked in rural and remote areas of Australia as identified in a study conducted by Newton and Fuller (2005) namely isolation, resource constraints, and limited professional support and opportunities for professional development. As the participants in Newton and Fuller's (2005) study, the participants of this study also experienced the placements as personally challenging, raising issues of appropriate support. While none of the participants reported that they had formal support i.e. mentors, the senior occupational therapists that supervised them appeared to be supportive particularly in terms of orientating participants to their placements and clarifying role expectations. However, it was evident that what senior occupational therapists intended as support became a point of conflict for the participants as they experienced a dissonance between the professional values held by them and those held by the more experienced senior occupational therapists who supervised them.

This dissonance was evident in the discrepancies between the approaches adopted by senior occupational therapists and those adopted by the participants. It seemed that the senior occupational therapists who supervised the participants, and who had been part of the system for a number of years, had not shifted their practice to embrace a more socio-political and occupational focus of OT. In the absence of appropriate role models for practice, it is therefore not surprising that the participants at times felt overwhelmed by the difficulty that they experienced in being able to practice OT in the way that they were taught at UWC.

If one considers that the OT profession only recently adopted a more socio-political approach to practice (Hocking & Ness 2002; WFOT 2004; WFOT 2006; WFOT 2010) this differentiation between the values held by new graduates and those held by occupational therapists who graduated a while back is understandable. These findings highlighted the need for senior occupational therapists who supervise new graduates to be oriented to developments in the profession.

In her study on occupational therapists' experience of hegemony in a hospital setting, Wilding (2011) found that the dominant discourses of financial rationalization and medical epistemology act as hegemonies that manifest in occupational therapists' unconscious compliance with the processes and protocols of the hospital. As in the case of the participants of this study, Wilding (2011) identified that rather than questioning whether they ought to do what others wanted them to do, occupational therapists experienced guilt at not being able to meet the demands placed upon them. Consequently, Wilding (2011) proposes that the challenge of hegemony can be overcome when occupational therapists engage in ongoing reflection around the impact that a dominant medical discourse have on their practice as well as on their own attitudes and behaviours.

While the participants in this study recognised that it was the system that needed to change, they did not really consider how they could develop and implement actions to address the system in order for their practice to become more facilitative of occupational justice. Also, while some participants began to take the initiative to affect change they lacked the confidence and the agency to follow through on it. It seemed that their efforts to shift mindsets proved to be difficult as they themselves were struggling with their own sense of powerlessness when it came to effecting change within their practice settings.

The participants did not appear to be empowered to address the challenges they encountered through influence or collective action, alerting to their own level of human agency and ability to respond to the complexities of community service practice. In fact, the sense of powerlessness that the participants experienced

mirrors that of occupational deprivation (Townsend & Wilcock 2004b) as a result of restrictions confining them to hospital settings despite the community service policy requiring them to do community outreach. As the participants expressed feelings of frustration, despondency and low morale due to their inability to bring their OT visions to reality, it could also indicate that they experienced occupational alienation (Thibeault, 2007).

In interpreting the participants' responses to the challenges they experienced in their practice settings, Rowland's (1997:13) categorisation of 'power over' (ability to coerce), 'power within' (power from individual critical consciousness), 'power to' (change existing hierarchies) and 'power with' (power from collective action) is helpful. The most commonly recognised form of power, *power over*, has many negative associations for people such as coercion. In this form, power is seen as a possession, usually taken from someone else and used to dominate, and control resources and decision making processes. For example, the health managers and senior occupational therapists exercised power over the participants leading to their experience of hegemony in their practice settings. The other three categories of power offer positive ways of how power could be generated and expressed in response to experiences of hegemony.

Figure 5 illustrates these three forms of power as applied to the participants. The arrows reflect the inter-relationships between the different forms of power and the participants' response to the challenges they encountered in their practice settings.

	Power within	**Power to**	**Power with**
Forms of Power	Decreased confidence and agency. Sense of powerlessness. No capacity to influence decision-making processes.	Decreased awareness of strategies to change existing hierarchies and power dynamics.	Lacks power derived from being part of a collective.
Parrtic. responses to	Position at bottom of hierarchy impacts practice choices. Lack of political/power analysis. Lack of critical reflexivity.	Unable to respond to occupational injustices in a critical way. Not acting to change existing hierarchies. Lack of policy analysis, negotiation and advocacy skills.	Partnerships and intersectoral collaboration not facilitated. Do not work collaboratively.

In the case of the participants, their *power within* appeared to be limited as illustrated by their perceived sense of powerlessness as described above. Due to this sense of powerlessness combined with their position at the bottom of the professional hierarchy, the participants lacked *power to* influence decision-making processes in various ways. Lastly, due to their inability to effect community partnerships and intersectoral collaborations, they lacked *power with* stakeholders and were thus unable to facilitate collective action to address any of the challenges they experienced.

These findings are significant as it illustrate that the participants lacked the skills to respond to power dynamics. The fact that the participants were novice therapists at the time of the study might aid an understanding of this

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phenomenon, but it is a concern that they appeared to lack an understanding of power dynamics and its relationship with empowerment. This indicates incongruence between their theoretical knowledge and their ability to translate this knowledge into practice.

In reflecting on the participants' responses to the challenges they encountered in their practice contexts, the inevitable question that comes to mind is: Were the participants actually able to advance occupational justice? The issue of how much power students perceived they had to address the challenges they encountered and effect change in their practice contexts is an important factor in exploring this question. It can be argued that the complexities of community service practice requires graduates who are able to recognise the dynamics that operate within this context and to identify and implement strategies to work proactively within the limitations or opportunities imposed by these dynamics. A lack of reflection on types of power and appropriate strategies to address power dynamics can mean that OT interventions aimed at occupational empowerment may fail to explicitly address the issue of power.

In community work in which processes of critical conscientisation and empowerment should be pursued among the people that OT graduates work with in order to advance occupational justice as well as within the graduates themselves, reflexivity and praxis is of the essence (Freire, 1972). Inferred here is the importance of critical reflection to stimulate awareness of self and awareness about a situation which in turn allows people to act upon that situation (Frere, 1972). While the findings showed that the participants understood occupational justice as a dimension of social change, they lacked the conceptual and analytical tools to make sense of the complexities of community service practice. Engaging in critical reflexivity on these complexities for example power struggles, might have aided the participants to identify strategies needed to shift unequal power dynamics and in so doing, be better able to work towards occupational justice. Therefore, I conclude that the inability of the participants to do this impeded their efforts to actually advance occupational justice in practice. This implies that the role that critical reflexivity plays in the UWC OT curriculum needs to be revisited.

In the last part of this chapter, I explicate these and other important implications derived from the findings to inform the development of the UWC OT curriculum to better equip graduates of the future to address challenges and constraints related to the complexities of community service practice in South Africa.

6.5   OT EDUCATION FOR TRANSFORMATION?

As described in Chapter Two, the development of the UWC OT curriculum around the inclusion of occupational justice as one of its tenets were influenced by various contextual factors i.e. the shift in emphasis from a bio-medical to a more socio-political approach to health, the introduction of compulsory community service for health professionals, and developments in the OT profession around the redefinition of its role in health care. Accordingly, Paulo Freire's (1972) emancipatory curriculum orientation and critical education approach are key features of the UWC OT curriculum. The curriculum places an emphasis on student centred learning and facilitating the political consciousness and empowerment of students.

In relation to the value of the curriculum in preparing them for practice, reflective practice was highlighted by all the participants. According to Schon (1983) reflection is a critical underpinning of growth and learning, and therefore reflection in action could be used by professionals as a tool to improve their practice. Reflective practice can thus be understood as the process of learning through and from experience geared to gaining new insights of self and/or practice. In the UWC OT curriculum, this form of reflection is generally facilitated through the use of Kolb's (1984) learning cycle, which guides students' reflection on how their accumulated body of knowledge from theory and experiential learning can be used to improve practice through retrospective analysis of practice incidents.

In reviewing models of reflection, Ghaye (2005) suggests that an emphasis on self-reflection may be limited and fail to broaden the lens for practitioners to

take into account wider issues of power and inequality. Therefore, a concern that arises with UWC OT students' use of the Kolb's learning cycle is to what extent wider issues of power in respect of the role and professional status of students, service users and related issues such as gender or ethnicity are included in the students' reflections. This then raises the question: What form of reflection is being taught in the UWC OT curriculum? Is it reflection that looks back on practice for the purpose of analyses, rather than critical reflexivity that engages one in critically examining and reflecting on both personally held and professionally embedded values? In other words, is it reflection that moves beyond the individual level to include a critical perspective that takes into account issues of power?

Although none of the participants directly reported that they felt ill-prepared by the curriculum, it was clear that they were not fully able to respond to the realities of their community service practice settings. While active discussions and reflection as teaching and learning methods in the curriculum seem to have fostered a deeper understanding amongst the participants about people's occupational rights, the negative experiences they encountered impacted on their sense of self-efficacy to engage in occupational justice-promoting actions. There however appeared to be a strong desire on the part of some participants to sustain themselves within what Freire (1972) would describe as an oppressed environment. For example, while some participants felt the need to address change despite the difficulties they experienced, others stopped fighting the system for fear of victimisation and their clients' suffering the consequences as a result. Faced with this difficulty and believing that they had little ability to instigate changes in the health system, the participants fell silent and experienced a sense of guilt as a result.

The reasons behind the participants' experience of powerlessness within their practice contexts are complex. It can be argued that the participants conceptualised power as a possession, rather than a process that operates in all interactions. This conceptualisation of power may be associated with the participants' experience of the health system, in which managerial authority was the most evident form of power, as bureaucratic. It could, however, also be

associated with their individual life experiences and the socio-political history of South Africa and how this influenced the existing health culture.

Although each participant may have had similar educational experiences, their interpretation of these experiences would be different for each person due to their individual life experiences, their culture, and variations in their own world. Furthermore, the participants left the educational setting in which their particular knowledge relating to OT was constructed, and entered a health service that portrayed its own socially constructed knowledge. Consequently, the participants experienced value discrepancies between the knowledge constructed through their education and the knowledge system they encountered in their practice contexts. The discrepancies between what they came to understand about occupational justice through their education and what they experienced in the real world of practice left the participants with a sense of failure with regard to fulfilling their professional roles.

Therefore, the findings of this study raise questions about the effectiveness of the UWC OT curriculum as an emancipatory curriculum. A curriculum as emancipatory can also be understood as a curriculum for transformation, as its key focus is equipping students to participate in critical or transformative action through building their critical consciousness (Grundy 1987). Such an OT curriculum would facilitate critical reflexivity and develop the participants' capacity for questioning and challenging the status quo with regard to the occupational rights of individuals, groups and communities. Critical reflexivity is pro-active, as its focus is on providing practitioners with a tool that will make them aware of the assumptions that shape their interaction with others (Jones, 2009). In this sense, critical reflexivity involves the ability to recognise that all aspects of the self and its context influence the way that knowledge is created. This is important in terms of the implications for the curriculum: in order for students to become more critical, they must understand what is meant by reflexivity or critical reflection in action.

Freire (1972) stresses the importance of allowing students to recognise connections between their individual problems and the broader social contexts

in which their experiences are embedded, through the deconstruction of relations of power. To this end, critical pedagogy fosters understanding of power relations and the development of critical consciousness (Freire, 1972). It can therefore be argued that the type of reflection utilised in the UWC OT curriculum, and that subsequently portrayed by the participants, is different to that espoused by critical pedagogy in that they did not fully acknowledge their own positioned subjectivities in the process. The findings show that the participants portrayed consciousness in reflecting on the underlying structural factors that impacted on people's occupational well-being, but reflection did not develop an ability to address those factors.

Reflecting on power and power structures further offers the potential for a transformational approach (Mezirow, 1991). According to Mezirow (1991), the gateway to the development of critical consciousness is transformative learning, which involves a process through which the assumptions individuals use to interpret experience are brought to light, challenged and reformed. Like Freire, Mezirow (1991) views knowledge as constructed in relation to others, with reflection and dialogue being key elements of the learning process for both. Mezirow, however, emphasises that it is through critical reflection that we come to identify, assess and possibly reformulate, key assumptions on which our perspectives are constructed. From the findings of this study it is apparent that utilising transformational learning as a teaching and learning approach could provide students with a more in-depth approach to reflection.

Utilising transformational learning as a teaching and learning approach in the UWC OT curriculum could develop critical OT students who will adopt a questioning and acting approach in order to bring about change in their practice and carry it on to professional practice once qualified. Educators would have to portray to students a level of reflection that goes beyond that of analysing practice incidents, requiring them instead to move to deeper levels of reflection in which they interrogate their own values. In facilitating this process, educators should encourage students to reflect on questions such as: How do my own value systems influence my practice? How might my practice change as a result of reflections on my value systems? How do different forms of power in my

practice context influence my practice? and What processes could I use to challenge different forms of power?

Furthermore, although the curriculum does include the philosophy of PHC and how this evolved in relation to the history of healthcare in South Africa, there seems to be a shortcoming in relation to looking critically at the socio-political history of South Africa and how this may influence the existing health culture (Giroux, 1983). Through the use of this critical lens, actions leading to the emergence of new opportunities for transformation could be identified. Hence, by taking a critical reflexive stance emphasis would be placed on how the reflection process can bring about change through action.

As discussed earlier, a traditional rehabilitation perspective on disability receives more attention in the curriculum, neglecting the role of activism around disability rights and inclusion.While the inclusion of the WHO (2010) CBR guidelines in the curriculum became apparent through this study, it would be important that the curriculum speaks to the link between poverty, human rights and disability. One way in which the curriculum could address this link is to embrace the academic discipline of disability studies to provide students with an opportunity to engage with disability as a human rights and development issue. A core premise of disability studies is that it challenges the view of disability as an individual deficit that can be remedied by 'experts' such as occupational therapists through medical rehabilitation. Disability studies contribute substantially to the examination of political strategies of intervention that can confront barriers to disabled people's occupational engagement and social inclusion. This latter aspect is poorly defined in all of the occupational justice practice frameworks noted in the literature.

Young (1990) asserts that only in examining power as a social relations issue can we understand how injustices that oppress the everyday life of people with disabilities persist in society. The inclusion of disability as an issue of diversity in the UWC OT curriculum can enhance students' understanding of how difference is understood in society and thus inform practice on occupational justice. Besides teaching and learning methods employed in the curriculum, the

educational environment also refers to the hidden curriculum, i.e. the values, attitudes and norms that underlie interactions in the school (Miller & Seller, 1990). As the findings revealed the participants' inability to engage with disability as an issue of difference, the inclusion of people with disabilities in curriculum development as well as teaching and learning (see section 6.3), would foster values of inclusion as part of the UWC OT educational environment.

Critical reflexivity also needs to be incorporated into practice learning and fieldwork opportunities. Areas for the development of fieldwork in the curriculum relate to the opportunity that they pose for power analysis and critical reflection. With regards to fieldwork, this would entail that students do not merely perform an assessment of the practice context by means of a needs assessment, but that a deeper analysis of power dynamics be conducted. Fieldwork should begin and end with a reflection on the power dynamics present at fieldwork sites with journals and discussions in class being utilised to reflect upon the changes related to these dynamics which have taken place over time. Such exercises might also facilitate reflection on the ways in which occupational therapists could utilise collective resources to challenge systems that oppress marginalised members of communities, for example people with disabilities and the elderly. As discussed earlier (see Section 6.3), reflection on indigenous knowledge systems and how it relates to occupational justice, is imperative. With this understanding, critical reflexivity on occupational justice can be advanced through the facilitation of the collective agency of local people.

Fieldwork further presents an opportunity for students to actively engage in 3P archaeology to enable them to understand the influence of politics on human occupation and on the practice decisions that they make (Kronenberg & Pollard, 2006). In relation to their fieldwork experience, educators could facilitate a process whereby students explore interrelated personal, professional and political perspectives of who they are and what they do, i.e. encouraging them to investigate assumptions underlying that which drives them personally and as professionals (Kronenberg & Pollard, 2006). Fieldwork could also facilitate

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students' political reasoning more explicitly through the use of the pADL questions (Kronenberg, & Pollard, 2006) to advance their understanding of identified political realities and how to develop critical actions to address them. The importance of political reasoning is that it could advance emancipation and empowerment in practice by facilitating the development of actions such as advocacy to uphold client rights (Galheigo, 2005; Dhillon, Wilkins, Law, Stewart & Tremblay, 2010).

Engaging in a process of political reasoning could further facilitate visions of possibility amongst students. This is supported by critical pedagogy as a teaching and learning approach that aims to facilitate visions of possibility amongst students and to support their development of critical actions towards realising those possibilities (Freire, 1972; Giroux, 1985; Simon, 1987). To further students' ability to engage in a possibilities-based practice, Griffin (2001) suggests the development of skills such as negotiation and conflict resolution, as well as skills to influence decision making within the health care system. Additionally, Kronenberg, Pollard and Ramugondo (2011) name skills such as creative networking, writing proposals, and political lobbying as requisites for occupational therapists to shape and influence the face of health care in South Africa. Other examples might be teaching students how to write submissions for change or participating in action research projects that deal with occupational justice issues (Mace, Wright-St Clair, Thomas & Burnett, 2011). In relation to the participants' ability to address any of the challenges they encountered in their practice settings, none of these practice skills were evident in the findings that this study raised. Therefore developing students' practice skills to engage in a possibilities-based practice requires attention in the curriculum.

Another implication for the curriculum that emerged from the findings of this study is that OT graduates need to be equipped with the skills to facilitate collaboration in order to work collaboratively. The findings showed that the participants mainly engaged with other sectors with the aim of forming partnerships to network and share information, for instance with disability organisations, schools and social service agencies. While this indicates that the

participants conceptualised that collaboration is an important feature of occupational justice, it is of concern that their efforts stopped short of devising and implementing deliberate collaborative actions to address locally identified needs.

According to Julio, Chen, Bhutta, Cohen and Crisp et al. (2010), engaging stakeholders is crucial to ensure that partnerships reflect mutually negotiated objectives and community needs. They call on education programmes to form networks and alliances with relevant stakeholders in order to harness educational content and teaching resources. This implies that UWC OT education should establish partnerships with the Departments of Health, particularly PHC services, Social Development, Labour and the NGO sectors respectively, so that training students to work across sectors, especially at a community level, may be advanced. In this way, students may develop their knowledge around different sectors, identify other areas that are already prepared for particular challenges, and develop confidence to build alliances and collaborations with groups which can support their interventions towards occupational justice.
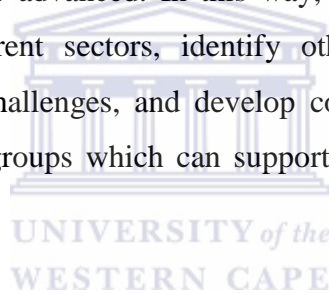
The findings of this study further raised the importance of facilitating interprofessional and interdisciplinary practice in the curriculum. Most participants reflected on the impact that a lack of interdisciplinary practice had on their ability to facilitate occupational justice-informed interventions. In relation to this, the findings highlighted the need for UWC OT education to consider how interdisciplinary and interprofessional education could be advanced in the curriculum. In line with the call made by the Lancet commission (Julio, Chen, Bhutta, Cohen and Crisp et al., 2010), the implication of these findings for UWC OT education is to form alliances within the university to promote interdisciplinary and interprofessional education.

The main objective of compulsory community service for all the different categories of health professionals is to ensure improved provision of health services to all South Africans. As UWC OT education is committed to the training of contextually relevant occupational therapists, UWC OT graduates

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are trained to work within and beyond the medical model of rehabilitation. Allowing the graduates to provide community-based services (in addition to clinical services) would increase their productivity and job satisfaction, and would advance the optimal utilisation of the scarce resource of OT in underserved areas, as intended by the community service policy. Hence, the findings of this study make a strong case for the strengthening of rehabilitation services within the re-engineering of PHC, which places a greater emphasis on outreach into communities and households, and greater interaction with communities to engender their support for improving their own health and well-being.

This indicates the need for UWC OT education, in partnership with the Occupational Therapy Association of South Africa (OTASA), to interface with the HPCSA and relevant government departments concerning the difficulties that OTs experience in delivering services at a PHC level and to explore with them how these difficulties could be addressed. It is further necessary for the UWC OT education programme to interface with the Department of Health and other relevant role players around the development of rehabilitation services at a district level.   In addition, as discussed before (see section 6.4), the implementation of continuing professional development opportunities would be beneficial in orienting senior occupational therapists to a political practice of OT and supporting graduates to advance occupational justice in practice.

Additional considerations that became apparent from the findings relate to the need for community service graduates to have better access to professional resources and support. In addition to developing curriculum content to prepare students for the challenges of practice, UWC OT education should consider how it could support and enable new graduates to access mentors and opportunities for continuing education.

6.6   CONCLUSION

I began this discussion by presenting a model to illustrate how the participants' conceptualised occupational justice in practice. The model indicated that the participants held the belief that there is a relationship between health, well-being and occupational engagement and that occupational participation is contextual. Informed by this belief they worked to advance occupational justice, which they conceptualised as enhanced health and well-being and broader social change as an outcome of the facilitation of occupational enablement.

In the second part of the discussion I addressed the ways in which the participants were able to draw on their university education to make sense of their role within their practice settings in terms of the core OT knowledge, values and skills they portrayed. I also discussed the extent to which the community service practice settings provided the participants with opportunities to work within an occupational justice framework. I highlighted instances where there was a weak link between the participants' conceptualisation of occupational justice and their actual practice. In relation to these instances, I highlighted that more attention needs to be given to developing students' skills in the planning, design and implementation of health promotion programmes in the curriculum, particularly around advocacy, mediation and strategies for community development, such as nurturing community partnerships, building capacity at a community level, influencing health services and intersectoral collaboration. In addition, I argued that the curriculum should provide opportunities for students to engage with indigenous knowledge systems, CBR as inclusive development, and social policy processes.

In the next part of the discussion I addressed the challenges the participants encountered in their community service practice settings and how they responded to these. I addressed how the participants responded to the main challenge they encountered, namely power dynamics. In relation to this, I argued that the participants lacked the conceptual and analytical tools to make sense of the complexities of community service practice and thus were unable to actually advance occupational justice in practice.

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In the last part of the chapter, I explicated important implications derived from the findings for the development of the UWC OT curriculum, to better equip graduates of the future to address challenges and constraints related to the complexities of community service practice. These implications revolved around the need for the UWC OT curriculum to address critical reflexivity, disability as a human rights issue, a possibilities-based practice, intersectoral collaboration and advancing interdisciplinary education.

In the following chapter the main conclusions and recommendations derived from this study are presented.

CHAPTER 7

MAIN CONCLUSIONS AND RECOMMENDATIONS

7.1   INTRODUCTION

In this final chapter of the thesis, I present a summary of the study and the main conclusions drawn from it. I further formulate recommendations to advance the UWC OT curriculum to equip its graduates to act as agents of change. Finally, I discuss the limitations of this study and provide considerations for future research.

7.2   SUMMARY

The focus of this qualitative interpretive study was occupational justice, as conceptualised by occupational therapy (OT) graduates from the University of the Western Cape (UWC) who underwent compulsory community service in three provinces of South Africa. The aim of the study was to explore how UWC OT graduates' conceptualisations of occupational justice, as instilled by the UWC OT curriculum, manifest in their practice of community service. The objectives of the study were: i) to explore how UWC community service OT graduates embody occupational justice in their practice; ii) to explore how the educational processes and content of the UWC OT curriculum support UWC community service OT graduates to embody occupational justice in their practice; and iii) to reflect on strategies that can be employed to address constraints faced by UWC community service OT graduates in incorporating occupational justice into their practice.

In the rationale of this study (see Chapter One, Section 1.2), I portrayed how developments around health reform in South Africa and the OT profession's redefinition of its role in health care, contributed to the evolution of this study. In Chapter Two, I emphasised that these developments had implications for OT education with regard to the structure, content and delivery of OT curricula in

South Africa. I further described how curriculum transformation led to the inclusion of occupational justice as a tenet of the UWC OT curriculum to reflect its mission to produce socially responsive and politically conscious graduates.

Underpinning this study was the assumption that OT education informs professional practice and that uncovering new graduates' practice experiences can inform the development of the UWC OT curriculum to support its graduates to enact occupational justice in practice. I located the study within the framework of occupational justice and critical pedagogy. The theory of occupational justice offered a lens for interpreting how the concept is understood by the participants, while critical curriculum theory and critical pedagogy aided an understanding of how the curriculum influenced the participants' conceptualisation and practice of occupational justice. The literature in Chapter Three indicated the importance of OT educators and practitioners embracing a critical stance if the values of the profession are to translate into meaningful contributions to occupational and social justice.

An interpretive and descriptive single case study that was generated and analysed through qualitative methods, as described in Chapter Four, was used. This included participant observation that was utilised to gain an understanding of the participants' practice context, semi-structured dyadic interviews that allowed the participants to reflect on their understanding and practice of occupational justice in pairs; and review of practice documents that provided a description of the ways in which the participants enacted occupational justice in practice.

Seven participants were selected from the UWC OT students who graduated in 2009 and completed compulsory community service in 2010 in under-resourced rural communities in South Africa. Two participants practised in the Eastern Cape, three in the Northern Cape and two in the Western Cape Provinces respectively.

7.3   MAIN CONCLUSIONS

The findings of the study presented in Chapter Five and discussed in Chapter 6, demonstrated that the participants practised in settings that were characterised by poor socio-economic conditions and lack of access to health services. The participants understood occupation as a fundamental human need and regarded occupational well-being as essential to people's overall health and well-being. In identifying occupational injustices the participants considered whether people were able to participate in meaningful occupation and, if not, identified the factors that prevented them from doing so. Occupational justice held considerable value for the participants, as reflected in their high regard for social change in enhancing health and well-being. They conceptualised as enhanced health and well-being, and broader social change as an outcome of the facilitation of occupational enablement. Occupation-based practice was a key dimension of the participants' professional identity and they supported people in developing their occupational potential through the facilitation of occupational enablement.

The nature of their community service practice settings, however, posed several challenges for the participants. They experienced a lack of OT awareness, resulting in difficulty in collaborating with other professionals and the consequent under- utilisation of OT services due to a lack of appreciation of the OT role. From the perspective of the participants, the dominance of the medical model, lack of resources and system of bureaucracy appeared to be the biggest challenges they encountered. The bio-medical approach dominated in their practice settings with resources mainly dedicated to the provision of curative services, with little thought given to the socio-political approach to health. As a result, the participants appeared to encounter hegemony in practice.

In encountering hegemony, however, the participants displayed an attitude of defeatism, leaving them with feelings of guilt, despondency and powerlessness. They lacked the skills to respond to power dynamics and to interact with people in positions of power. Power dynamics also involved the claim of professional boundaries but the participants were not able to influence teamwork so that it

could become interdisciplinary. In most instances, the various disciplines continued to practice in professional silos.

The participants predominantly focused on the medical aspects of rehabilitation that have traditionally neglected empowerment of people with disabilities. CBR within an inclusive development framework was relatively absent from practice. Moreover, in attending to issues related to culture, none of the participants paid consideration to the interdependent nature of occupation in the African context. The Western worldview appeared to inform practice interventions.

The participants were more concerned with creating opportunities for meaningful occupational engagement than with supporting communities to address their occupational needs through social action. In addition they did not always consider what occupational justice means for individual clients. Health promotion was rarely aimed at strengthening health-enhancing actions of the broader community but focused more on health education. Strategies for community development, such as nurturing community partnerships, building capacity at a community level, influencing health services and intersectoral collaboration, were noticeably absent from the participants' practice. They further lacked the skills to engage in policy processes and a possibilities-based practice such as political lobbying.

While the participants' education was geared towards equipping them to provide appropriate services as indicated by local needs, the health system was not ready to accommodate their practice. Consequently, the discrepancies between what they came to understand about occupational justice through their education, and what they experienced in the real world of practice, left the participants with a sense of failure with regard to fulfilling their professional roles.

In reflecting on these findings, I have asked two questions: (1) To what extent were the participants actually able to advance occupational justice in practice? and (2) How effective is the UWC OT curriculum as an emancipatory curriculum? Consequently, the main conclusions drawn from this study were:

- The link between the participants' conceptualisation of occupational justice and actual practice was weak.

- They lacked specific skills to advance occupational justice as agents of change, indicating incongruence between their theoretical knowledge and their ability to translate this knowledge into practice. This impeded their efforts to advance occupational justice in practice.

- The participants portrayed consciousness in reflecting on the underlying structural factors that impacted on people's occupational well-being, but did not seem to view critical reflexivity as a fundamental part of their professional practice which further hindered their efforts to advance occupational justice.

In summary, the study highlights important areas that need to be addressed to develop the UWC OT curriculum to better support its graduates to enact occupational justice in practice. A diagrammatic presentation of the UWC OT curriculum (see Figure 1) was presented in Chapter 2, Section 2.5. Based on this diagramme, Figure 6 provides a diagrammatic illustration of specific curriculum content areas that will support UWC OT graduates to work as change agents in practice. The arrows point to the link between these content areas and specific components of the curriculum namely policy frameworks, teaching and learning approach, core pillars and graduate attributes. In relation to the development of the curriculum, the link between these curriculum components and content areas is explicated in the recommendations derived from this study that are presented below.

Figure 6: Areas for development of the UWC OT curriculum
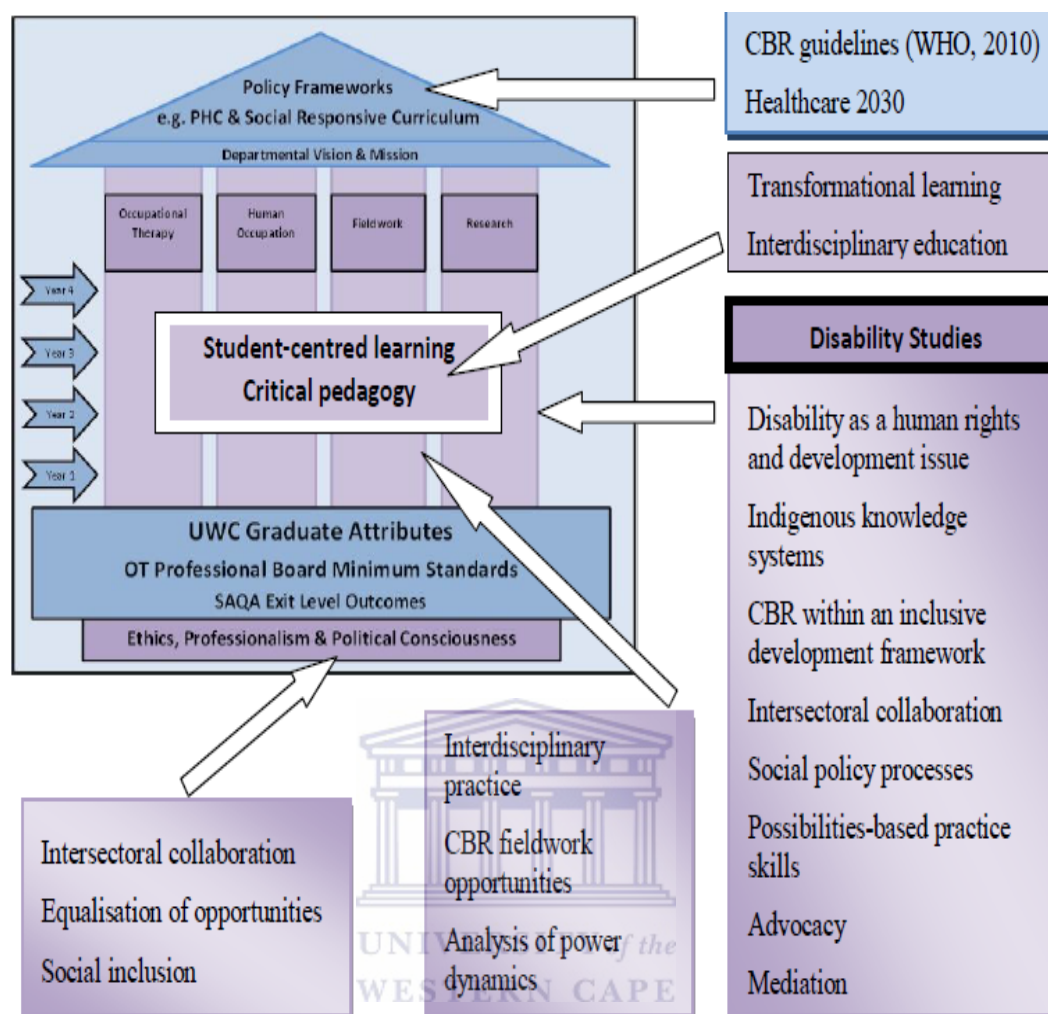
7.4 RECOMMENDATIONS

Based on the findings of this study, the following recommendations are made in respect of:

7.4.1 The UWC OT Curriculum

Attention should be given to how occupational justice is framed by educators. In addition to thinking about occupational justice in terms of broader social issues, educators should encourage students to consider what occupational justice means for individuals, particularly when working in settings such as hospitals, where the focus of practice is on individualised care.

Through transformational learning, different forms of power and power dynamics should be addressed. Educators should facilitate reflexivity on the social conditions under which knowledge is generated. Student life experiences and the influence of South Africa's socio-political history on the health system should be explored with them. Through this process, assumptions related to power that students use to interpret experience, should be brought to light, challenged and reformed.

It is recommended that a disability studies module that addresses disability as a human rights and development issue should be developed and incorporated as a core pillar of the curriculum. The CBR guidelines (WHO, 2010) should be included in this module. Students should also be equipped with the skills to facilitate collaboration in order to work collaboratively. Attention should be given to the design and implementation of health promotion programmes and the development of students' advocacy and mediation skills.

Policy frameworks related to the development of the health system such as Healthcare 2030 should be utilised to inform curriculum content and students should be given an opportunity to engage with the policy. In addition, the module should address social policy processes in terms of interpretation, analysis, implementation and monitoring in order for students to develop these skills and share this expertise with people with disabilities and community members.

Indigenous knowledge systems should be included in the curriculum. In addition, the curriculum should provide opportunities for students to engage in critical reflection on ways in which indigenous knowledge and an African understanding of occupational justice, in terms of collective agency and critical consciousness, can be made more explicit in everyday practices. The critical issue is for students not just to have an appreciation of an African conceptualisation of human occupation, but also to be equipped to implement African-centred occupation-based interventions to advance occupational justice in local contexts.

An increased focus on the facilitation of counter-hegemonic strategies in the curriculum is necessary. It is recommended that curriculum content that addresses skills such as advocacy, negotiation, ability to influence decision making and conflict resolution. The emphasis should be on developing students' application of these skills. Therefore it is recommended that educators partner with government departments, i.e. health services, in order for students to develop and present proposals for practice possibilities to these departments. In this way, forums will be created to allow students to practice and develop acquired skills in real-life situations.

The development of skills such as writing proposals and political lobbying should also be addressed. In addition, students should be taught how to write submissions for change, for example, parliamentary hearings, and to participate in action research projects that deal with disability issues. DPOs should be consulted in the development of this module and be involved in teaching and learning around disability and CBR. The probability of offering this module as an interdisciplinary module in the Faculty of Community and Health Sciences should be explored, as all students should acquire competencies of equalising opportunities and creating an enabling environment by removing barriers to social inclusion.

7.4.2   Fieldwork

It is recommended that fieldwork in the curriculum be expanded around practice learning opportunities for CBR and the facilitation of disability-inclusive development.

Students should learn to view reflexivity as a fundamental part of their professional practice. In order to facilitate this, fieldwork should begin and end with a reflection on the power dynamics encountered in fieldwork. The purpose of this process is for students to examine the political, social and cultural contexts in which they perform fieldwork, as well as how this impacts on their practice. Discussions that foster reflexivity should be utilised to reflect upon the dynamics and changes that may occur over time.

It is recommended that fieldwork expectations include the application of 3P archaeology and the pADL questions, and that it is assessed accordingly. Emphasis should be placed on students' identification of barriers to the implementation of their visions for practice in fieldwork and how these could be addressed. Here, educators must be instrumental in facilitating critical reflexivity and political reasoning alongside other forms of professional reasoning in OT. In this way, students will experience reflexivity in relation to real experiences. It is further recommended that students incorporate their experience of 3P archaeology in their fieldwork reflective journals and learning portfolios. The same applies to the application of the pADL questions.

7.4.3 Graduate attributes

It is recommended that equalisation of opportunities; social inclusion and intersectoral collaboration are added to expand the list of graduate attributes for the UWC OT education programme. In this way these attributes will become embedded in the curriculum from first to fourth year.

7.4.4 Interdisciplinary education and practice

It is recommended that efforts for students to engage in interdisciplinary education and practice be enhanced, and alliances within the university to promote interdisciplinary practice be strengthened. To this end, it is recommended that existing structures within the UWC Faculty of Community and Health Sciences, such as the service learning unit, be approached to explore how senior OT students could have more exposure to interdisciplinary practice.

7.4.6 Intersectoral collaboration

In order to advance student preparation for collaborative practice, it is also necessary to explore alliances with the Department of Health as well as sectors such as the Departments of Social Development and Labour. It is recommended that these stakeholders be invited to engage with educators and students on how

they can work collaboratively with OTs in practice. In this way, coordination between different sectors to create stronger links affecting service delivery will be fostered.

7.4.7 Academic development

Educators play a key role in the facilitation of critical practice. It is recommended that opportunities be created for educators to reflect on how they can more fully embrace an emancipatory curriculum be incorporated into the departmental academic development programme.

It is recommended that opportunities be established for educators to enhance their understanding   and skills around critical pedagogy and transformational learning in order for them to assist students to respond to the complexities of community service practice. In addition, academic development sessions that address 3P archaeology, political reasoning and how these could be facilitated in OT education, should be addressed.

The academic development programme should further address concepts related to a critical practice of OT and how these concepts could be incorporated into the repertoire of teaching and learning strategies that are utilised in the programme. The concepts are: critical reflexivity, the phenomenon of hegemony and a possibilities-based practice approach.

7.4.8 Support for community service graduates

In order to generate support for community service OT graduates, UWC would have to establish partnerships with the Occupational Therapy Association of South Africa (OTASA), the Health Professions Council of South Africa (HPCSA) and the Department of Health to address the constraints that OTs face in delivering services when completing compulsory community service. It is recommended that these stakeholders, together with representatives from other

OT education programmes in South Africa, be invited to a meeting where these issues could be tackled.

Such a meeting could provide an opportunity for input to be given on the curriculum to increase awareness of how students are prepared for community service and the role of OT in PHC. Presentations of students' community projects should also receive attention in raising stakeholders' awareness of graduate competencies developed around practice for community service.

At such a meeting it should be discussed as well how health managers and relevant stakeholders, particularly those in rural areas, could be made aware of the community service policy and the contribution that community service OT graduates could make to health services. To this end, consideration should be given to the presentation conduction of a road show to be undertaken with the UWC OT education programme together with other universities and OTASA.

In addition to interfacing with relevant stakeholders, publications on the role of OT in PHC, particularly in journals covering a wider field than that specifically of OT, such as the South African Medical Journal, should also receive attention.

7.4.9   OT continuing professional development

In order to provide support to new graduates it is recommended that a UWC OT blog be created with the aim of creating a virtual space where graduates can engage in joint reflections and dialogue around various practice issues. This will lend support to graduates, particularly when it comes to addressing systemic issues they may encounter in practice.

It is further recommended that CPD opportunities around a political practice of OT be implemented to orientate senior occupational therapists, who supervise new graduates, to the notion of occupational justice. An eclectic approach to OT, wherein the occupational and social orientations of practice in addition to the medical role, are emphasised, should be awarded a particular focus in CPD.

7.5   LIMITATIONS OF THE STUDY

Case studies facilitate the gathering of information about a particular situation and involve detailed study of an individual or a group. This case study involved seven UWC graduates who graduated in 2009 with six to ten months' practice experience in under-resourced rural settings. Consequently, the findings of this study were specific to these participants and these particular settings.

The primary research issue in this study was the influence of UWC OT education on the participants' conceptualisations of occupational justice in their community service practice. Therefore the participants selected for this study were graduates from UWC and reflected their experiences and perceptions, as related to the UWC OT curriculum.

The findings of this study relate only to the participants' reflections on their community service practice experiences. It is a limitation that I did not seek formal feedback related to the participants' role in practice from their respective employers, managers, colleagues and users of OT services. Such feedback is indeed worthy of future research.

7.6   RECOMMENDATIONS FOR FUTURE RESEARCH

In consideration of future research it is recommended that a follow-up study to generate an understanding of the professional development of the participants of this study over time, particularly in relation to their development of critical actions around occupational justice be conducted. Feedback should also be obtained from employers, health managers, colleagues and service users about the role that OT graduates play in practice from their perspective.

It is further recommended that an investigation be conducted that explores how occupational therapists transcend barriers to practice in order to generate a better understanding of how students may be empowered to apply critical reflexivity in everyday practice. A participatory action research study that engages reflexivity and dialogues, through which occupational therapists may

be invited to explore how occupational justice could be made more visible through critical practice, would be beneficial in empowering participants to take actions that would lead to change in practice.

Finally, it is recommended that an action research project be conducted by UWC OT educators to determine how the adoption of transformational learning may influence students' preparedness for practice.

7.7   CONCLUSION

The purpose of this study was to identify ways in which the UWC OT education programme could better support and enhance the educational preparation of OT graduates to work towards occupational justice in community service practice. Occupational therapy curricula require regular review for development but graduates' involvement in this is usually restricted to perspectives on satisfaction with OT education. While newly graduated community-service occupational therapists would be an appropriate source to determine enhancements needed in the undergraduate OT curriculum, this is the first study conducted in South Africa that explored the influence of an OT curriculum on graduates' preparedness for occupational justice-informed practice. The illustrations of graduates' conceptualisations of occupational justice (Figure 3); inter-relationship between the participants' sense of powerlessness and responses to challenges (Figure 5); and areas for development of the UWC OT curriculum (Figure 6) could be highlighted as key contributions of this study in terms of knowledge generation around the development of UWC OT education for occupational justice.

The knowledge that this study generated is not just valuable for the development of the UWC OT curriculum. The study highlighted that for OT graduates to impact the contexts in which they practice in South Africa, OT education must ensure that students not only accumulate core OT knowledge, values and skills, but also that they are equipped to apply tools to advance occupational justice in challenging practice environments. To reach this goal, transformational learning as pedagogical practice is of the essence, as it frames

student preparation not just as learning but as a process that equips students to understand and intervene in matters of occupational justice as active agents of change. Critical reflexivity and specific strategies for social inclusion must be emphasised in OT curricula for students to develop the competence to deal with the complexities of community service.

Much discussion in the profession has taken place on how the theoretical understanding of occupational justice translates into practice. This study has contributed to this knowledge base, in particular from an educational and curriculum development perspective. In relation to this, the study highlighted that it is imperative that OT curricula in South Africa provide opportunities for students to engage in critical reflection on ways in which indigenous knowledge and a local understanding of occupational justice, in terms of collective agency and critical consciousness, can be made more explicit in everyday practices. This implies that OT educators also frame occupational justice in relational terms and facilitate opportunities for students to reflect on the theory of occupational justice in terms of the values, beliefs and practices of local people.

Moreover, the study highlighted that a lack of reflexivity on different forms of power and appropriate strategies to address power dynamics can mean that OT interventions aimed at occupational empowerment may fail to explicitly address the issue of power. Whereas political strategies of intervention that can confront barriers to people's occupational engagement and social inclusion are poorly defined in the occupational justice practice frameworks noted in the literature, this study highlighted the importance of OT curricula developing graduate attributes such as intersectoral collaboration, equalisation of opportunities and working in partnership with people with disabilities to address social inclusion.

Finally, in line with the Healthcare 2030 policy and developments in the South African Health system, CBR and interdisciplinary practice are poised to constitute the basis of rehabilitation services in South Africa. Future graduates would have to attain the aforementioned competencies and therefore need to be adequately prepared to deliver contextually relevant services. In line with its purpose to inform the development of the UWC OT curriculum to support its

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graduates to enact occupational justice in practice, this study has significantly contributed to the UWC OT education programme's undertaking to respond to these developments.

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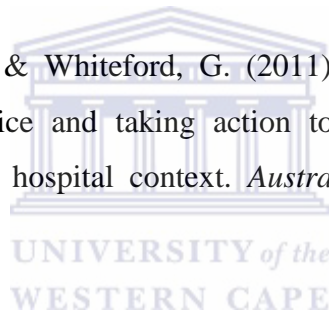
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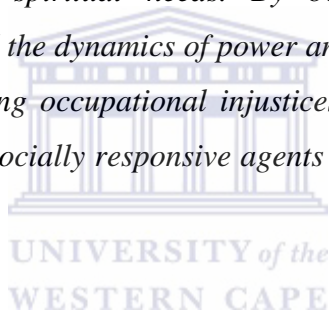
APPENDICES

APPENDIX 1
UWC OT MISSION STATEMENT

The occupational therapy department is an integral part of the Faculty of Community and Health Sciences at the University of the Western Cape. The department is committed to producing graduates who value people as occupational beings who have the right to choose and engage in meaningful and purposeful occupations. Graduates will understand the link between occupation, wellbeing and health in context. Promoting health and wellbeing is understood as addressing people's physical, emotional, psychological, economical, social and spiritual needs. By being politically conscious, graduates will understand the dynamics of power and their role as advocates as being central to addressing occupational injustices and human needs. By so-doing, graduates will be socially responsive agents of change (De Jongh, Hess-April & Wegner, 2012)

APPENDIX 2

DATA COLLECTION GUIDE

INFORMATION	DATA COLLECTION SOURCES & METHOD
WHAT IS THE CONTEXT OF PRACTICE? *What is the social context of the service?* *What are the main features of the service?* *What is the role of the OT?* Occupational Deprivation Occupational Alienation Occupational marginalisation	Document Review: Program documents (description, brochures, meeting minutes) Observations/interactions: community Community members Service Service users Manager Staff Interviews: Participants
HOW DO GRADUATES EMBODY OCCUPATIONAL JUSTICE IN THEIR PRACTICE? *What inform graduates' practice?* *What are graduates interpretations of occupational justice?* *What is actually accomplished by graduates?* occupation based practise community development CBR health promotion cultural competence reflective practice	Interviews: participants document review: intervention protocols progress notes meeting minutes observation: OT program Service users Community interaction

Professional identity /identification of roles identifying what motivate practice identification of resources or lack of resources for occupation reflecting on power relationships & impact on occupation letting go of "power transfer of skills focus on health promotion/wellness ability to work with available resources advocacy for occupation opportunities and resources addressing opportunities for occupation skills development/ capacity building/ facilitation of agency	participants, interactions/ meetings
WHAT STRATEGIES CAN GRADUATES EMPLOY TO ADDRESS CONSTRAINTS THEY FACE TO INCORPORATING OCCUPATIONAL JUSTICE INTO THEIR PRACTICE? *What are the constraints that graduates' experience in their practice?* *What underlying factors contribute to these constraints?* Resourcefulness: drawing on previous experiences i.e. student fieldwork Policy supporting practice Professional identity Generating support/ Interface, team, policy makers etc.	Interviews: participants observation: interactions/ meetings
HOW DO THE EDUCATIONAL PROCESSES AND CONTENT OF THE UWC OT CURRICULUM SUPPORT GRADUATES' TO EMBODY OCCUPATIONAL JUSTICE IN THEIR PRACTICE? *What teaching and learning processes facilitate values, knowledge and attitudes necessary for graduates to engage in occupational justice action?* *What opportunities could be created to develop education on occupational justice?*	document review: curriculum documents Interviews: participants

APPENDIX 3

SUMMARY OF OBSERVATIONS

PARTICIPANT 1 (NORTHERN CAPE)

Activity	Observation
Individual client at clinic	Household activity, making a sandwich Provide and practice with assistive device
Child with tendon injury	Making soft splint Educate mother re splint
Child with developmental delay	assessment
Crèche teacher's workshop	Education re occupational difficulties that children with special needs may experience.
Home visit, 32 yr old client with CVA	family education re transfers

PARTICIPANT 2 (WESTERN CAPE)

Activity	Observation
25 yr old male- unemployed Brachial Plexus Injury	Vocational counseling Referral to ACVV/ Social Development programme Teleph conversation with social development re services offered for PWD's who reports that there is none but invite OT for input re comm. programme Advocacy for opportunity for occupational engagement Educate pt on community citizenship and raise pt awareness about rights of a PWDs Schedule meeting with social development to discuss partnering re developing programme for PWDs
Mother with 5 yr old girl Presents with perceptual & behavioural problems Sturge weber syndrome → epilepsy	Home programme for perceptual and devlpt stimulation. Demonstrate various activities to mother. Perceptual stimulation: colours, puzzles etc.
21 yr old female with Mental retardation who has a 1 yr old baby.Attended class for remedial teaching for learners with special needs but dropped out at an early age ++alcohol abuse & violence in family	Input re life skills, coping skills, stress management, caring for child→ client reports much improvement in these areas. Complete disability assessment and educate client re disability application process. Encourage client to continue attending OT for support in future.
Boy with FAS presents with developmental delay, Child in Care of grandmother who attends session	Involve grandmother in session re developmental stimulation and home programme.
Meeting/training with home based carers	Informal meeting in trailer, discuss referrals for OT, Feedback on patients seen by carers and consultation re functional problems, assistive devices and positioning,

Home visit: 56 yr old male, CVA R hemi – requires assistance with ADL, W provides care. Lives in a shack under very poor socio-economic conditions.	Spend time discussing client progress with wife – enquire re social needs and progress re DG application. Work w pt re bed mobility and adapted dressing. Discuss/ motivate attendance of stroke support group at CHC
Home visit: 68 yr old female R hemiplegic	Work with daughter and pt re safety issues at home when doing ADL's and transfers. Discuss/motivate rehabilitation at CHC.
Home visit: 50 yr old male, CVA, hemiplegic	Issue wheelchair – discuss safety issues with daughter, motivate rehab attendance at CHC. Education re DG application. Provide emotional support
APD Crèche	Play session with kids, Input to carers re approach at child's developmental level. Input re correct positioning. Discuss ideas for toys, structure of programme and group stimulation with carers.
Farm creche	Speaker at parent meeting on normal child development--. Input re school readiness, developmental stimulation

PARTICIPANT 3 AND 4 (EASTERN CAPE)

Activity	Observation
Individual session	W/C to bed transfer & adapted dressing with elderly female who is a L-hemi after a stroke about 2mo before. Now an outpt. accompanied by her two daughters, both unemployed. Focuses much on family educational input on safety at home. She uses non-slip material for transfer, however cannot give to them to take it home, alternatives discussed.
CP group	Education/ demonstration re positioning and developmental stimulation. Mothers very involved and participative in group.
Meeting with chief	Report back re mental health support group. Discussion of social needs in village.
Visit to children's home	Meet with board members to plan meeting with social development re funding. Needs assessment re future skills training for care givers and home based care workers. Play stimulation with children.

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PARTICIPANTS 5 AND 6 (NORTHERN CAPE)

Activity	Observation
10 yr old girl in grade 4 referred by teacher for learning difficulties	Initial interview and standardized assessment commenced. Unable to complete. ++ language an d translation difficulties
2 yr old boy and grandmother, suffers from epileptic fits, presents with low tone and developmental delay. Seen as outpt. but inconsistent attendance	Normalization of tone, stimulation of trunk control→ input to mother re home programme.
4 yr old girls with CP and mother.	Educating mother on positioning, stimulating head and neck control and transitional movements from laying prone into crawling. Mother given opportunity to practice skills learnt. And activities suggested in home programme.

PARTICIPANT 7 (Western Cape)

Activity	Observation
Upper Limb burns	Maintain and improve range of motion of upper limb Educate and train care-giver Home exercises given Encouraged bilateral hand use through activity Gait re-education
Burn-Hand	Maintain and improve hand function
Surgical Ward round	Discussion of clients' progress and discharge plans
Proximal inter phalangel fracture	Re-assessed range of motion Re-assessed hand function Interviewed client about social and vocational circumstances
Burn-Hand	Removed bandages to assess hand function Maintain and improve hand function Educated client about the importance of maintaining ROM Encouraged bilateral hand use
Fetal Alcohol Syndrome	Interview care giver Interview client Educate client Write report to social worker
Above knee amp.	Passive stretches and movement of stump through full range of motion Contacted patient's family to arrange family training session Transferred to wheelchair

Below knee amp.	Assessment of range of motion of stump
	Assessment of mobility
	Functional assessment
	Amputation home programme given
	Stump exercises demonstrated and done with the patient
	Educated and trained caregiver and patient abut foot care

GUIDE FOR FIELD NOTES

Observation	Reflection
Community context	What physical and social structures are evident?
Practice setting	What physical and social structures are evident?
Events Meetings Activities Interventions Interactions	What are the main activities? What are the reasons for the interactions observed? What constraints/ challenges are encountered? How are constraints/ challenges addressed?
OT intervention Principles evident in practice	What are the intended and actual outcomes of practice? What theory is draw on and how is it used?
Occupational justice values & concepts	How are key concepts, values and approaches of occupational justice integrated into practice? How do contextual factors enable occupational justice?

INTERVIEW GUIDE

Can you give a general description of the practice context?

What are the priorities the health service aim to address?

What is the role of the OT in the setting?

Can you describe the kind of OT you are, or the kind of OT that you could identify with?

Why are you thinking in this way?

What is your particular vision for the role of OT in the setting?

How have you come to this vision?

If it is different from what your current role expectations are how is it different and why?

How have you incorporated occupational justice into your practice?

What have been some constraints or challenges, if any, you experience in practicing in this setting?

How have you responded to these constraints/ challenges?

In your opinion has UWC OT education prepared you for community service? Please motivate your answer.

Can you describe some interventions you've participated in that you would say exemplify how you integrate your education with what you do in practice?
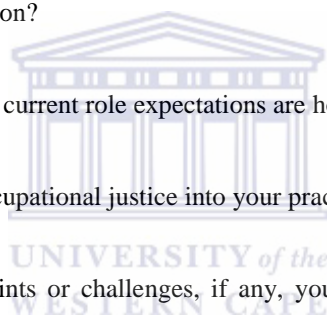
APPENDIX 6

DOCUMENTS REVIEWED

UWC OT Department Statement of approach.

UWC OT curriculum module descriptors and course outlines, 1st to 4th yr.

Hosp Vision and Mission.

OT Dept Quarterly Report (July – Sept '10).

Letter to Dept of Health rehab manager.

Cake sale advertisement.

OT monthly statistics.

Script, OT educational talk.

Patient monthly stats form.

Letter from research NGO.

Early childhood development (ECHD) Campaign- teacher's educational pamphlet.

Dept of OT General meeting- agenda and minutes.

OT job description.

Hospital Quarterly statistics.

OT Monthly statistics forms.

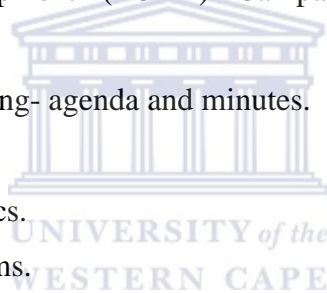OT – newspaper clip.

OT case descriptions.

W/C protocol & procedure.

Out- patient procedure policy: rehabilitation.

Hospital vision & mission.

OT referral forms.

Work evaluation protocol.

APPENDIX 7

UWC ETHICS CLEARANCE

**OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH
DEVELOPMENT**

Private Bag X17, Bellville 7535
South Africa
Telegraph: UNIBELL
Telephone: +27 21 959-2948 2949
Fax: +27 21 959-3170
Website: www.uwc.ac.za

18 May 2010

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and the ethics of the following research project by: Ms L Hess-April (Occupational Therapy)

Research Project: South African occupational therapy graduates' conceptualizations of occupational justice in community service practice: a case study

Registration no: 10/4/25

Peter Syster
Manager: Research Development Office
University of the Western Cape

UNIVERSITY *of the*
WESTERN CAPE
A place of quality, a place to grow, from hope to action through knowledge

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APPENDIX 8

EASTERN CAPE ETHICS APPROVAL

Eastern Cape Department of Health

Enquiries:	Zonwabele Merile	Tel No:	040 608 0830
Date:	22nd September 2010	Fax No:	043 642 1409
e-mail address:	zonwabele.merile@impilo.ecprov.gov.za		

Dear Ms L Hess-April

Re: South African occupational therapy graduates' conceptualizations of occupational justice in community service practice: a case study

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health.

2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.

3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.

4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.

5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

DEPUTY DIRECTOR: EPIDEMIOLOGICAL RESEARCH & SURVEILLANCE MANAGEMENT

Ikamva eliqaqambileyo!

APPENDIX 9

NORTHERN CAPE ETHICS APPROVAL

	Office of the Deputy Director General
DEPARTMENT OF HEALTH	Executive Offices Kimberley Hospital Complex Private Bag X5049
LEFAPHA LA BOITEKANELO	KIMBERLEY 8300
ISEBE LEZEMPILO	
DEPARTEMENT VAN GESONDHEID	

Enquiries **DR DG THEYS**
Dipatlisizo
Imibuzo   **Tel: 053-8302102**
Navrae   **Fax: 053-8334394**

Date   **30 JUNE 2010**
Letlha :
Umhla :
Datum :

Reference :
Tshupelo :
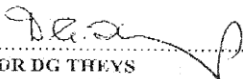Isalathiso :
Verwysings :

Ms Lucia Hess-April
Private Bag x1
Belville
7535

RE: **PERMISSION TO CONDUCT RESEARCH**
Subject: South African occupational therapy graduates' conceptualizations of occupational justice in community service practice: a case study

Your letter dated 24 June 2010 bears reference.

Authorization is hereby granted to Ms L Hess-April (registration number 10/4/25) to conduct a research on Occupational Therapy Community Service in the Northern Cape.

Thank you,

DR DG THEYS
ACTING HEAD OF DEPARTMENT

We are committed to achieving our vision through a decentralized, accountable, accessible and constantly improving health care system within available resources. Our caring, multi-skilled, effective personnel will use evidence-based, informative health care and maturing partnerships for the benefit of our clients and patients.

APPENDIX 10

WESTERN CAPE ETHICS APPROVAL

DEPARTMENT of HEALTH
Provincial Government of the Western Cape

REFERENCE: 18/19/RP88/2010
ENQUIRIES: Dr A Dearham

Occupational Therapy Dept
University of the Western Cape
Private Bag x17
Bellville
7535

Fax: (021) 959 1259

For attention: Dr L Hess-April

SOUTH AFRICAN OCCUPATIONAL THERAPY GRADUATES' CONCEPTUALIZATIONS OF OCCUPATIONAL JUSTICE IN COMMUNITY SERVICE PRACTICE: A CASE STUDY

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following members of staff to assist you with access to the facilities:

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (healthres@pgwc.gov.za).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

DR J CUPIDO
DEPUTY-DIRECTOR GENERAL
DISTRICT HEALTH SERVICES AND PROGRAMMES
DATE: 13-08-2010

CC: DR L PHILLPS   DIRECTOR: CAPE WINELANDS

INFORMATION LETTER

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959, Fax: 27 21-959

<u>INFORMATION SHEET</u>

Project Title:

South African occupational therapy graduates' conceptualizations of occupational justice in community service practice: a case study.

What is this study about?

This is a study conducted by Lucia Hess- April lecturer at the University of the Western Cape Occupational Therapy Department. I am inviting you to participate in this study as you have completed the new UWC curriculum that integrated the concept of occupational justice into your training as an occupational therapist. You have been selected because you are a 2009 occupational therapy graduate from UWC who is currently completing your community service year in an under-resourced, rural practice setting.

The purpose of this study is to critically reflect on how occupational justice may be guiding your practice and how this relates to the education you received at UWC. As our profession is still developing an understanding of occupational justice, the study will allow me and you together to reflect on the challenges you may be facing in advancing occupational justice and on how these challenges could be addressed in practice. Ultimately, the study will help us to understand the practice of occupational justice in an under- resourced, rural context and how the UWC OT curriculum can better support graduates to practice in community service.

What will I be asked to do if I agree to participate?

I would like to visit you in your practice setting in order to get a better understanding of your practice context. I will do this through participant observation. I would therefore need to spend some time shadowing you as you go about your daily routine while I learn more about your practice context. To enable my understanding of your practice you will be asked to provide me with any relevant documentation for example practice protocols, reports and/or portfolios. I will spend a minimum of three intermittent periods of one week in your practice area before the end of your community service.

You will further be required to participate in an in-depth interview each time that I visit you in your practice setting; therefore the interviews will occur in conjunction with each period of participant observation. During the interview we will together reflect on your community service. The interview will occur in an interactive, conversational and informal manner. As I want to analyse how the UWC OT curriculum assisted in your understanding of occupational justice, you will be asked to reflect on how the curriculum impacted your knowledge and practice of occupational justice. During the interviews an audio tape recorder will be used to record our conversation for later transcribing and analysis.

Would my participation in this study be kept confidential?

I will do my best to keep your participation confidential. This study involves making audiotapes of our interviews so that it can be transcribed for analysis. I will ensure that the person who transcribes the interviews maintains confidentiality. The audio tapes will be stored securely in a locked drawer and only I will have access to the drawer. Your anonymity will be maintained as I will use a pseudonym instead of your name to label the data. Issues that arise from the data will not be discussed with others in ways that might identify you. You have to remove any personal identifying information and that of persons involved in your practice, from the documents that you submit for utilization in the study. I will also ensure that the research report and publications that result from this study do not contain information that may identify you, your practice setting or persons you interact with in practice.

What are the risks of this research?

There are no foreseen risks as a result of your participation in the study.

What are the benefits of this research?

As the interviews will provide you the opportunity to engage in reflective practice, it may lead to the development of your practice. Your reflections will also inform the development of the OT curriculum at UWC.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalised.
What if I have questions?

This research is conducted by **Lucia Hess- April** from the University of the Western Cape Occupational Therapy Department. If you have any questions about the study itself, please contact her at:

The Occupational therapy Department
University of the Western Cape
Private Bag X17
Bellville
 7535

Tel. 021 9593929
Fax 021 9591259
E-mail: lhess@uwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Prof. J. Smith
Faculty of Education
University of the Western Cape
Private Bag X17
Bellville 7535
Tel. 021 9592936
Fax*: 021 9592647
E-mail: jsmith@uwc.ac.za

OR

Dr. J. De Jongh
Occupational Therapy Department
University of the Western Cape
Private Bag x17
Bellville 7535
Tel. 021 9592544
Fax: 021 9591259
E-mail: jdejongh@uwc.ac.za

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

CONSENT FORM

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959, Fax: 27 21-959

CONSENT FORM

Title of Research Project:

South African Occupational Therapy graduates' conceptualisations of occupational justice in practice: a case study.

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name………………………...

Participant's signature……………………………….

Witness……………………………….

Date………………………

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study supervisors:

Prof. J. Smith
Faculty of Education
University of the Western Cape
Private Bag X17
Bellville 7535
Tel. 021 9592936
Fax*: 021 9592647
E-mail: jsmith@uwc.ac.za

OR

Dr. J. De Jongh
Occupational Therapy Department
University of the Western Cape
Private Bag x17
Bellville 7535
Tel. 021 9592544
Fax: 021 9591259
E-mail: jdejongh@uwc.ac.za