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EXPERIENCES OF SOCIAL WORKERS IN SERVICE DELIVERY DURING COVID-19

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ABSTRACT

During COVID-19 social workers encountered numerous challenges in rendering services to clients. The national lockdown and working from home worsened the situation. COVID-19 instilled fear to the global population, including social workers who were offering services during this pandemic. The current study aims to explore social workers' experiences of service delivery during COVID-19 to determine the extent of damage caused by COVI D-19. Exploring these challenges will assist in developing strategies for addressing further damage, while enhancing social workers' well-being. This is a qualitative study that uses a case study research design to explore social workers' experiences. Participants were 15 social workers from the Department of Social Development in Waterberg District, Limpopo Province. The study used one-on-one interviews with semi-structured interviews for data collection. Participants were selected using purposive sampling. Data was analysed using thematic data analysis. The findings indicate that services were rendered telephonically and face-to-face. Some participants were unhappy with rendering services during COVID-19 due to fear of contracting the virus and spreading it to their families, while others were happy to offer their services and had minimal fears. Some participants were affected by poor work-life balance. Most work that social workers did during COVID-19 concerned the dispatching of food parcels. Resources were limited which resulted in participants using their own expenses. The study recommends the Department of Social Development to provide enough resources to employees for rendering services. This was done from the bigger research study which was ethically approved by WITS which ethics number is SW22/07/04.

Keywords: *Case Management, COVID-19, Experiences, Service Delivery, Social Workers, Work-Life Balance*

INTRODUCTION

The coronavirus disease 2019 (COVID-19) is an infectious disease that spreads from one person to another through droplets released when an infected individual coughs or sneezes. Its common symptoms include fever, dry cough, fatigue, and shortness of breath (Ishrath et al., 2021). To reduce the spread of COVID-19, the lockdown was strategically introduced on the 27th of March 2020 by different governments globally, forcing millions of employees to work from home (Al-Habaibeh et al., 2021). The COVID-19 pandemic brought many changes in the workplace since the beginning of the year 2020. Social workers are recognised as essential

workers; hence they were expected to continue offering services during the South African national lockdown. The COVID-19 pandemic resulted in loss of life (Okafor, 2021).

Therefore, social workers, as essential workers, were expected to ensure their clients' wellbeing. They were expected to work with the infected clients and their populations (Isangha et al., 2020). Alongside providing services, there was immense anxiety and fear among social workers and clients, as COVID-19 was a deadly and unfamiliar pandemic (Okafor, 2021). A study conducted by Holmes et al. (2021) in the United States (US) revealed that most social workers were diagnosed with post-traumatic stress disorders (PTSD), severe grief symptoms, burnout, and secondary trauma. However, strategies designed to address anxiety and fear among social workers were neglected. The focus was on addressing fear among clients (Okafor, 2021). Yet, in the US, the recommendations that were made by Holmes et al. (2021) indicate that social workers need organisational support, as they experienced trauma. In addition, this support must have been continuous to ensure their emotional well-being.

Although both social workers and their clients experienced anxiety and fear, services were only provided to clients. As a result, social workers encountered several challenges regarding service delivery, including the way cases were managed, how they were strained emotionally, limited resources, and the issue of balancing work and life. Based on observations in the Waterberg District, extensive planning was undertaken to develop strategies for service delivery and to ensure social workers could protect themselves from contracting the virus. This was guided by the departmental circulars, which addressed work-from-home arrangements and staff rotations. Certain measures were taken to enable social workers to provide services to clients and their families, including those who contracted the virus. However, social workers received minimal attention in terms of debriefing sessions and emotional support. Therefore, the current study aims to explore social workers' experiences in service delivery during COVID-19 around Waterberg District (Limpopo).

RESEARCH METHOD

This study employed a qualitative research approach to develop an in-depth understanding of social workers' lived experiences of delivering social services during the COVID-19 pandemic. Qualitative research is appropriate for exploring people's lives, behaviours, experiences, emotions, feelings, and organisational functioning through rich, non-statistical accounts (Rahman, 2017), while allowing deeper exploration of meanings and experiences rather than generalised statistical explanations (Richard et al., 2011). An exploratory case study design was adopted to examine experiences, events, contexts, and lessons associated with particular circumstances (Taherdoost, 2022), particularly from the perspectives of social workers themselves.

The study population comprised male and female social workers aged 25–50 years employed by the Department of Social Development and providing services during COVID-19 in

the Waterberg District, Limpopo Province, South Africa, covering the Bavaria, Rebone, Tauyatswala, Shongwane, Bakernberg, Mokopane, Mahwelereng, and Mookgophong offices. A research population refers to the individuals, groups, or organisations about whom a researcher intends to develop knowledge (Casteel & Bridier, 2021). The inclusion of both male and female social workers enabled the study to capture diverse experiences and avoid privileging one gender. Social workers were selected because they were essential service providers who continued working during the pandemic and were significantly affected by its implications for professional practice.

A non-probability sampling approach was employed, whereby participants were selected according to predefined study criteria rather than through random selection (Terre Blanche et al., 2014; Allibang, 2020). The final sample consisted of 15 social workers, comprising six males and nine females. Within this framework, purposive sampling was used to identify participants who had direct experience of providing social services during COVID-19. Purposive sampling, also referred to as judgemental sampling, involves deliberately selecting participants based on characteristics relevant to the research objectives (Etikan et al., 2016). Recruitment was facilitated through supervisors at the identified offices, after which eligible social workers were informed about the study and invited to participate according to their availability.

Data were collected through individual semi-structured interviews using a predetermined interview guide. Research instruments are systematic tools designed to facilitate data collection and analysis (Oben, 2021), while semi-structured interviews combine predetermined questions with flexibility for probing and follow-up questions (De Vos et al., 2011; Kallio et al., 2016). The interview guide was pre-tested with two social workers who met the inclusion criteria but were not included in the main sample. Pre-testing enables researchers to assess whether questions are understandable and function as intended (Hilton, 2015) and is recommended before formal data collection to identify potential ambiguities or barriers (Murphy et al., 2015; Pana & Sana, 2020). The pre-test confirmed that the questions were clear and suitable for the main study. Individual interviews were conducted between December 2023 and February 2024 according to participants' availability. Open-ended questions and probing were used to elicit detailed accounts of participants' experiences. With participants' consent, all interviews were audio-recorded to support accurate transcription and analysis. Interviews are particularly suitable for obtaining in-depth information about participants' perceptions and experiences (De Vos et al., 2011; Taherdoost, 2022).

The data were analysed using thematic analysis, which involves systematically identifying, analysing, and reporting patterns within qualitative data (Alem, 2020; Braun & Clarke, 2006). The analysis followed Braun and Clarke's (2006) six phases: familiarisation with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. The researcher repeatedly listened to the recordings during and after transcription to ensure accuracy and become familiar with the dataset. The transcripts were then systematically coded, with meaningful segments grouped according to recurring experiences,

perceptions, challenges, and responses. Related codes were subsequently organised into broader themes and sub-themes, which were reviewed and refined to ensure coherence and alignment with the research questions. The final themes were defined and named before being integrated into a structured research report supported by participants' quotations.

Trustworthiness was addressed through credibility, transferability, and dependability (Stahl & King, 2020). Credibility was strengthened through the use of an appropriate qualitative design, purposive selection of informed participants, systematic data collection and analysis, and the inclusion of direct quotations linking findings to participants' accounts (Stenfors et al., 2020). Transferability was supported by providing sufficient contextual information about the participants, institutional setting, and experiences, enabling readers to assess the relevance of the findings to other contexts (Connelly, 2016; Cope, 2014; Stenfors et al., 2020). Dependability was enhanced through pre-testing the interview guide and examining consistency in participants' responses across the dataset (Kennedy-Clark, 2012; Shenton, 2004).

Ethical considerations were maintained throughout the research process to protect participants' dignity, safety, wellbeing, autonomy, and rights (Parveen & Showkat, 2017). The study addressed informed consent, confidentiality, anonymity, voluntary participation, avoidance of deception, and avoidance of harm. Participants received clear information about the study's purpose, procedures, potential risks and benefits, confidentiality, anonymity, audio recording, use of quotations, and their right to withdraw. Written informed consent was obtained after participants had been given sufficient opportunity to ask questions and make an autonomous decision about participation (Akaranga & Makau, 2016; Terre-Blanche et al., 2014). Confidentiality was maintained through secure, password-protected data storage and by ensuring that participants' identities were not disclosed (Rana et al., 2021; Wiles et al., 2008). Numerical identifiers were used instead of participants' names to preserve anonymity (Vainio, 2012). Participation was voluntary, with participants free to decline or withdraw without penalty (Rana et al., 2021). No deception was used, as participants were accurately informed about the research purpose and procedures (Akaranga & Makau, 2016; De Vos et al., 2011). Measures were also taken to minimise potential physical or psychological harm, including avoiding pressure to disclose uncomfortable information and arranging access to counselling support through the Department of Social Development if required (Akaranga & Makau, 2016; De Vos et al., 2011). Research data were stored securely and were scheduled for destruction after five years.

The principal limitation of the study was its relatively small sample of 15 social workers from the Waterberg District, which limits the extent to which the findings can be considered representative of all social workers in Limpopo or South Africa. Nevertheless, the sample was appropriate for the exploratory qualitative design, which sought depth of understanding rather than statistical generalisation (Theofanidis & Fountouki, 2018). The study was deliberately delimited to social workers employed by the Department of Social Development in the Waterberg District and excluded social workers employed by non-governmental organisations (NGOs). This delimitation was intended to maintain a coherent and manageable study population

and facilitate detailed analysis within the available time and resources (Theofanidis & Fountouki, 2018). Pre-testing the interview guide further supported the practical delimitation and quality of the data collection process.

RESULTS AND DISCUSSION

Theme 1: Case management during COVID-19

Participants described service delivery during the COVID-19 pandemic as a highly constrained and adaptive process. The implementation of lockdown restrictions substantially altered the ways in which social workers interacted with clients, assessed cases, provided psychosocial support, and coordinated access to essential resources. Participants reported that direct contact with clients was significantly restricted, particularly during the early stages of lockdown, because of concerns about infection and the need to comply with public health regulations. Consequently, telephone-based intervention became the dominant mode of service delivery, while face-to-face engagement was gradually reintroduced under strict health and safety measures. In addition to individual interventions, social workers were heavily involved in the assessment and distribution of food parcels, which became a major component of their service provision during the pandemic. The introduction of rotational work arrangements further transformed their working routines, with some participants working on a one-week-on, one-week-off basis. These changes required social workers to adapt rapidly to unfamiliar modes of practice while continuing to respond to clients' immediate and often urgent needs.

Telephonic intervention

Telephone-based intervention emerged as one of the principal mechanisms through which social workers maintained contact with clients during the pandemic. Direct interaction was restricted to minimise the transmission of COVID-19, requiring social workers to rely increasingly on telephone communication for case assessment, referrals, follow-up, and the provision of information. Pascoe (2021) similarly notes that changes in service delivery during the pandemic affected social workers across different sectors and fields of practice, with many practitioners adopting technological approaches, including telephone and video calls, to maintain services to clients.

Participants explained that office contact numbers were made available to community members seeking assistance, particularly those requiring food parcels. In many cases, social workers received lists of potential beneficiaries and were required to conduct assessments telephonically before determining their eligibility for assistance. Participant 4 explained:

> "We were using cell phones most of the time because our main concern was to provide the food parcels since most people were not working alright! So we would give out our own contacts then clients who need food parcels would call us, then we compile a list then after we would arrange for home visits to go and provide for those food parcels…so there was no one on one, clients were not coming in, there was no face to face

interaction, so we were only using cell phones." (P4)

Similarly, Participant 12 described how telephone-based assessments were conducted using limited communication resources:

> "I write their names and their IDs and the contacts only then afterwards those who are at home when they come back they will call them and do assessment through phone… sometimes you might find that you were given a list of 20 and there is only one phone we must exchange it amongst each other and then you can see that the days are gone and you might end up using your own airtime to call and do those assessment." (P12)

These accounts indicate that the shift towards telephonic intervention was not simply a technological adjustment but also a reorganisation of the practical conditions under which social workers performed their professional responsibilities. Although government telephones were available, participants reported that these resources were often insufficient. When official phones ran out of airtime, social workers relied on their personal mobile phones and resources to continue assisting clients.

Participant 6 explained:

> "The unfortunate part of the telephonic part is that, eer, the phone would run out so that means you would have to make a plan because you feel bad, people are not working, they can't go out and find jobs or any kind of help, and you realize that they need to be assessed for food parcels." (P6)

Participant 7 similarly reported:

> "And sometimes you might find that the airtime is finished or the other one is busy that side…and you are having many assessments that you must compile for that day. So sometimes you end up using your personal resources so that you can be able to finish your assessments in time." (P7)

The reliance on personal resources extended beyond the use of personal airtime. Participants indicated that clients sometimes sent callback requests, requiring social workers to respond using their own phones even when they were not officially on duty. Supervisors occasionally provided their personal phones when official communication resources became unavailable. Participant 6 stated:

> "The telephone was being shared because there was a landline here in the office, but the unfortunate part was that the landline was that it received a specific amount of airtime. So, when the airtime was done, you are done. The supervisor will borrow you her phone or you buy airtime and call clients." (P6)

The findings further reveal a tension between institutional expectations and the resources available to social workers. Participants reported that they had been informed that the Department would provide airtime and data or reimburse communication-related expenses. However, experiences varied, with some participants receiving support while others reported that promised resources were not provided. Participant 2 described the difficulty of conducting telephone-based interventions with inadequate institutional resources: "Em, I was attending them through phone, eer, but it was not easy, mm, because sometimes, that time because we didn't have our own phones…here in the office." (P2)

Participant 5 expressed a stronger sense of institutional disappointment:

"And the government, on the other hand I felt like, eer it betrayed us, it betrayed us too, to some level. Eer! Remember, you are using the telephone, what happened when the airtime runs out? Then you use your own…and…and it was like, use your own and you will be compensated. Keep receipts of whatever you buy, and we did that, we assessed some cases with our own phones." (P5)

The participant further explained: "They even promised us that, 'we will buy you airtime, give us your cell phone numbers, we will transfer airtime, directly to your phone numbers', but… nothing like that happened." (P5)

Beyond resource constraints, participants identified substantial limitations associated with the accuracy and reliability of telephonic assessments. Clients were generally prohibited from entering the offices, meaning that social workers had to rely heavily on information provided verbally by clients. This was particularly problematic when assessing needs for food parcels or responding to cases involving child neglect. Participant 7 recalled: "That time there was a circular that was available that says they cannot come and enter the office, so we were communicating with them telephonically." (P7)

The absence of direct observation limited the social workers' ability to verify the information provided by clients. Participants emphasised that telephone-based assessment created uncertainty because they could not physically observe clients' living conditions or independently corroborate the circumstances described during telephone conversations.

Participant 5 explained:

"We did a lot of case, eem a lot of things telephonically, telephonically, soo, you can't be sure of anything. Somebody, somebody comes in, and request food parcels and you are unable to go out and to assess. You just talk on the phone, whether the information is real or not, you cannot be sure." (P5)

Participant 6 similarly stated:

"Another challenge is that you can't confirm or verify accuracy over the phone, because someone can just say there is nothing or I'm unemployed, you can't verify. So, now you can just go to their house and check." (P6)

These accounts suggest that telephonic intervention altered not only the mode of communication but also the epistemic basis of professional assessment. Face-to-face practice enables social workers to observe contextual and behavioural cues and, where necessary, verify information through direct engagement. In contrast, telephone-based assessment placed greater reliance on clients' self-reported accounts, thereby limiting opportunities for independent verification.

Confidentiality and privacy also emerged as important concerns. Some participants reported that the telephones available for service delivery were shared and located in reception areas, meaning that sensitive conversations could take place within the hearing of other staff members. Participant 8 described this as a significant professional challenge:

"Even the intervention, you do it through the phone. So, it was a bit difficult because it is not how the intervention is supposed to be like. It is that thing of like, you have to compromise the issue of confidentiality because even the phone was a landline that was stationed at the reception you just have to talk to the client in the presence of people who are working at the reception, the auxiliaries, and the admin clerk you see." (P8)

This finding is particularly significant because confidentiality constitutes a fundamental component of ethical social work practice. Farkas and Romaniuk (2020) observed that social workers encountered considerable challenges in maintaining professional ethical values and principles during the COVID-19 pandemic. In the present study, the physical location and limited availability of communication equipment created circumstances in which maintaining confidentiality was difficult, despite practitioners' awareness of its importance.

Time constraints further compounded these difficulties. Because several social workers were required to share a single telephone, participants had to limit the duration of individual conversations and quickly make the telephone available to colleagues. Participant 8 explained:

> "And also time was limited, because that time it was that thing of… all of us have to use that phone and we are about 12 here I think, eer yes, somewhere there, 12 social workers so we must have that thing of, when you talk to the client you must immediately shift and give another one a chance just like that." (P8)

The limitations of telephone intervention became particularly evident in cases involving family conflict, where effective intervention often requires interaction among multiple parties. Participants explained that mediation and joint sessions were difficult to conduct when family members were not physically present in the same setting. Participant 9 illustrated the complexity of attempting to mediate remotely:

> "That was the challenge to say how were you going to mediate, because you call this one and hang up and then call that one and hang up. After that you must go back to that other one and say 'oh! That person said so so so so' oh! It was something else." (P9)

This experience illustrates how the transition to remote intervention potentially disrupted established forms of social work practice, particularly those dependent on simultaneous interaction, relational engagement, and mediation. Pascoe (2022) similarly highlights ethical implications associated with telephone-based practice, particularly in relation to confidentiality, privacy, and professional boundaries. Participants in the present study also reported difficulties in maintaining continuity in family-related cases because some interventions and sessions could not be conducted effectively through telephone communication.

Nevertheless, telephone intervention remained necessary for clients who were infected with or affected by COVID-19. Following initial case management, social workers continued to conduct telephone follow-ups to assess how clients were coping with the effects of the pandemic. Thus, while telephonic intervention was perceived as inadequate for some forms of social work practice, it nevertheless provided an important mechanism for maintaining continuity of services when face-to-face engagement was restricted.

Face-to-face intervention

Participants indicated that face-to-face interaction was largely suspended during the initial stage of lockdown. As restrictions were gradually eased, particularly during Level 3, limited face-to-face consultations resumed under strict health and safety protocols. These included the use of masks, hand sanitiser, physical distancing, and restrictions on the number of people permitted in an office. Participant 3 explained: “I think the second one during the level three, yes we started having face to face…interactions with clients with the masks on, and the sanitizers, and everything.” (P3)

Although face-to-face interaction resumed to some extent, it remained highly regulated. Some participants reported conducting home visits to clients who were infected with or affected by COVID-19, particularly when counselling or direct psychosocial support was required. However, these visits were conducted under conditions designed to minimise physical contact. Participants described providing counselling from a distance, including communicating with clients through windows.

Participant 10 explained:

> “In their homes, we used to do home visits then we do home visit then, because COVID-19 you never know whether they have it or…so we were able to stand at the windows then they stand at that side then we communicate and then after we give them counselling and tell them how to survive during COVID-19 so that they cannot spread the…the virus.” (P10)

Participant 11 similarly stated: “Even when we go, they were saying we must talk when we are outside maybe over the window.” (P11)

These accounts demonstrate that face-to-face intervention did not necessarily return to the pre-pandemic model of professional engagement. Rather, social workers developed modified

forms of physical interaction that attempted to balance the need for direct contact with the imperative to minimise infection risks. Following counselling, participants reported conducting follow-up contacts to monitor clients' well-being, although in some offices these follow-ups were conducted telephonically.

The physical limitations of office spaces also affected the nature of face-to-face intervention. Participants reported that only one client was permitted to enter an office at a time, while family conferences and group meetings were generally prohibited. Participant 12 explained: "They allow only one person in an office; we are not doing a family conference." (P12)

The participant further noted: "Because we were, because of the space. Our office is too small you cannot accommodate three or four people on that time." (P12)

Consequently, pandemic restrictions affected not only the frequency of face-to-face encounters but also the types of interventions that could be undertaken. Practices requiring collective participation, such as family conferences and mediation, became particularly difficult to implement.

Food distribution

The distribution of food parcels constituted a substantial component of social work practice during the pandemic. Participants reported that food assistance increased considerably because many community members experienced loss of employment and reduced household income during lockdown. In some offices, government vehicles were used to facilitate the delivery of food parcels. Participant 11 stated: "We had a car available to deliver the food parcels." (P11)

In other instances, external donors contributed vehicles and food supplies. Participant 5 described the involvement of community and private donors:

> "There were some men from Asians, yea, that's Asians, Indian, Pakistans. So, they came with their own cars and, yes and…we were taking them to those villages to provide food parcels, yes…yes! They were donations because they were also the donors, they came with the food parcels themselves, the government did not provide." (P5)

Other offices adopted voucher-based approaches. Following an assessment, clients' details were submitted to the district office, after which eligible beneficiaries received SMS notifications containing information about vouchers and the designated shops where the vouchers could be redeemed. Participant 8 explained:

> "Eer, with food they said… they were talking of, they will use the SMSes and send SMS to the potential clients, eeeer then then they will then come and take, what are they called … [thinking], to take some voucher of some sort." (P8)

However, participants indicated that the intense focus on food assistance sometimes displaced attention from other forms of social work intervention. Some participants perceived

that urgent material needs became the dominant priority, while cases involving child abuse and other complex social problems received less attention because of restrictions on direct consultation. Social workers were often expected to conduct telephone assessments and then participate in food distribution activities, despite the risks associated with physical contact.

Participant 6 explained:

> "When you go deliver food parcel, when the food parcels are, are being delivered, you must be there, yes. So, you get into houses, even though you don't touch people and what not, but, you need to pick up and put them inside. Who is going to pick up the food for you? You don't have manpower." (P6)

In some communities, food parcels were distributed from designated central locations rather than through door-to-door delivery. Social workers travelled to the community, called beneficiaries from predetermined lists, and distributed parcels while attempting to comply with social distancing, mask-wearing, and limits on the number of people gathering at one location. Participant 7 described the process:

> "After that when the food parcels arrive, so then it was that thing of like, they must assign two people or three if it's social workers, yes who were supposed go to the community. When they get there in the community, they must stay in one place, we don't go house to house and we delivered food parcels individually. That thing of like, the community would come, and you come with your list and you call them those you expect to meet and how many are they and also, they, they look at the issue of COVID, the rules and regulation…to check how many they are supposed to be that is expected to gather, like in the chief yard…what do they call them, the headmasters, something like that yes, so that's how they were giving food parcels." (P7)

In contrast, some social workers reported having no direct contact with beneficiaries during the distribution process. Instead, SASSA officials and supervisors assumed responsibility for physical distribution, while social workers remained focused on administrative and assessment-related tasks. Participant 14 explained:

> "But us we were never in contact with the beneficiaries we never go outside, we were just doing office work yea, the very people I'm talking about are those from SASSA and the supervisor, they are the ones who were delivering those food parcels." (P14)

Collaboration with other institutions was also evident. Participants described working alongside SASSA and representatives from the mining sector, particularly Anglo, to identify and support households requiring food assistance. Participant 15 stated:

> "And there was a project that we were, we were working with SASSA but it was lockdown and people were not working and we were providing food parcels to people. We were working with SASSA and we were also working with mine." (P15)

The process involved coordination between donors and the Department of Social Development. When a mining company indicated its intention to provide food assistance to a specified number of people, social workers were responsible for screening and assessing potential beneficiaries. Participant 12 explained:

> "When the mine says it wants to give people food, a certain list, it means you must make sure that you assess all people so that by that date when they want to give them food they are covered." (P12)

Participant 15 similarly described the collaboration:

> "We were working with SASSA after that we worked with Anglo, Anglo was saying that no…during the…what is it? …at the time like this we have the food parcels but they link them with the Department of Social Development to say we can screen people." (P15)

Taken together, these accounts demonstrate that food distribution became an important dimension of social work during the pandemic, requiring practitioners to move between assessment, administrative coordination, community engagement, and emergency relief provision. The findings also indicate that the pandemic blurred the boundaries between conventional social work intervention and emergency humanitarian assistance.

Rotational work arrangements

The introduction of rotational work arrangements constituted another major disruption to established patterns of service delivery. Participants reported that social workers were no longer working according to their normal daily schedules but were instead allocated alternating periods of office-based and off-site work, commonly described as one week on and one week off. Although this arrangement was intended to reduce the risk of infection, participants reported that it created challenges for continuity of care and case management.

Participant 10 explained:

> "Then the problem was that, you can see the client this week and then from there we were off…you will see them that other week—yes that rotation plan the way it was set…it made it very hard for us to work because when you came back next week you no longer remember where you left off." (P10)

The rotation system therefore created difficulties in maintaining continuity, particularly when cases required ongoing follow-up. A social worker might initiate an intervention during one working period and then be unavailable when the client required subsequent assistance. This was particularly problematic because clients' needs did not necessarily correspond to the organisation's rotational schedule.

Importantly, being officially off duty did not necessarily mean that participants were completely disconnected from service provision. Some continued to receive calls and callback requests from clients while working from home. This reflected a broader transformation of work arrangements during the pandemic. Al-Habaibeh et al. (2021) note that, as governments introduced lockdown measures to reduce the spread of COVID-19, millions of employees were required to work from home. In the present study, this transition created an ambiguous boundary between being formally off duty and remaining accessible to clients.

Participant 6 explained:

> "Some were a bit challenging because when clients are hungry, they do not, ee! Necessary understand that is the weekend or it's your or eer off, if… because we were rotating, you are not there or you understand, and they would then send call backs or they would call and say we need help, we don't have food, or this is what happened." (P6)

Participants also described difficulties associated with adapting to working from home. The transition represented a significant departure from their established practice, particularly because many of their clients traditionally required direct, face-to-face engagement. Participant 13 reflected:

> "It was very difficult to change from a day to day office going to work at home as it was difficult because we were not used to it in the first place but we did our best because the situation was around us and we have to cope with whatever is happening but it was not easy to attend the clients when we were at home because most of our clients we are supposed to face them face to face." (P13)

The findings indicate that COVID-19 fundamentally reshaped the organisation and delivery of social work services. Telephonic intervention provided an essential means of maintaining contact with clients but was constrained by inadequate resources, difficulties in verifying information, compromised confidentiality, limited time, and challenges in conducting relational and family-based interventions. Face-to-face intervention gradually resumed but remained subject to stringent health protocols and spatial restrictions. At the same time, food distribution became a major component of social workers' responsibilities, requiring extensive coordination with government agencies and external organisations. Finally, rotational work arrangements altered continuity of care and blurred the boundaries between professional and personal time. Rather than representing a straightforward transition from face-to-face to remote service delivery, the pandemic produced a complex hybrid and highly adaptive practice environment in which social workers continuously negotiated professional responsibilities, institutional constraints, client needs, and public health requirements.

Theme 2: Emotional Response During Service Delivery

Unhappy

Some participants expressed dissatisfaction with delivering services during the COVID-19 pandemic because of the nature and perceived risks associated with the virus. Other participants felt that they were failing their clients, which contributed to feelings of dissatisfaction while delivering services during this period.

Participant 1 stated: "Eeem! I was attending them with low mood because of the way they used to talk about it, this COVID-19. It was scary on its own." (P1)

Participant 6 explained:

"I, like even under normal circumstances you get cases where your heart just breaks, you see that this person really needs food parcels, for example, but when you check, you don't have eer a budget for them. You write a memo; you don't get them. It's like… when you are alone, after knocking off, you think about the cases to say but… so because it's under normal circumstances, if I were to call them under normal circumstances, there are plans we made, but under COVID there were no plans to be made. Either food was there, or food was not there." (P6)

Participants reported that they did not feel comfortable during service delivery because of the way COVID-19 spread. Participant 1 stated: "I was not feeling comfortable, it was that thing of, I don't know whether I can say it was sad or… but I wasn't happy when I was attending them." (P1)

For participants, delivering services was difficult while most people remained at home, whereas they continued working without receiving compensation. This contributed to feelings of frustration.

Participant 11 explained:

"It wasn't easy because most of the people were at home and us, we were working and we were not being compensated. That was the other thing that was giving us frustration. You see, if we were given something to appreciate, maybe things would be different." (P11)

Some participants asserted that they were demoralised during service delivery because of the lack of resources available within the province compared with other provinces.

Participant 6 explained:

"I personally felt thrown into the deep end like…. There you go, here is what we can eer provide to you and nothing more. And when you speak to your colleagues from…, I have colleagues from other provinces. I have one colleague who works in Pretoria in Town, and when you speak to her she will tell you 'No! We have one, we have two, we have three, they said we shouldn't share phones, we shouldn't…, everybody was er subsidized and

given one, two, three,' and you wonder, how? Are we not providing the same kind of service? You are., so it demoralizes you as well because you realize that no… but we are under one department." (P6)

Fearful

A few participants reported fearing that they might contract the virus and subsequently infect their family members.

Participant 4 stated:

"For me I felt like… with me it was like very emotional because I had, I just recently came back from maternity so I had a small baby. It was a challenge for me because I felt like what if I felt infected, then the child is also in danger." (P4)

Some participants feared what might happen if they contracted the virus. They described being placed in a risky situation while still being expected to continue rendering services.

Participant 13 explained:

"As I've indicated that it was not good, it was risky because when you were delivering services you used to hear that so and so is sick then… some they quarantine and succeed, some they quarantine and ended up dying. It was very much difficult for someone to cope with that situation." (P13)

Participant 15 stated:

"To be, to be honest we were scared. We were scared because we were the first people to start, but we told ourselves that let's go, there is no one who can, because they used to tell us that okay, within our office, they need people who can volunteer and we couldn't say refuse." (P15)

Privileged

A few participants expressed feeling privileged during service delivery because permit letters were provided to those delivering essential services or working as essential workers. A permit was a document that enabled or granted essential workers permission to travel from one location to another while COVID-19 movement restrictions were in place.

Participant 9 stated:

"I can just say is a benefit or is what? It was that thing like, they gave us the…, what were they? What were they called? Those letters of allowing you to go to Gauteng even though people are restricted…eer! Permit! What are they…something like—yea [phone ringing], it's how they call it, yes. Like even when I go to Shoprite, I never stand at the queue, I would show them that letter that I'm at work." (P9)

Important

Some participants felt important because being classified as essential workers during

COVID-19 made them realise that they were making a difference in their communities.

Participant 10 explained:

"Mm, first of all, maybe before you think about there is COVID-19 you started to see that maybe we are very much important, you see, to render services. So they saw that it means that it is important for us to be here during service delivery, so even you start to see and understand that it means to be me, like I give difference in the community." (P10)

Participants also expressed happiness and satisfaction from being able to make their clients feel valued.

Participant 11 stated:

"The fact that we were working and servicing our clients it was somehow giving us hope and like at least you were feeling happy because you made someone special. You see, by giving them services at this time of… where everyone is at home, not allowed to go to the shops, you see." (P11)

Participant 15 similarly explained:

"The most important thing was that we, we were just happy that we are working and we are helping other people. Just to say okay, I am also a social worker and…I made an oath. I must know that I have made an oath to say I'm going to help someone…regardless of money, as long as it is part of our job, that's what matters, yes." (P15)

Feeling Great

Some participants reported feeling great while delivering services during the pandemic and further indicated that social work was a profession they were passionate about.

Participant 12 stated:

"We deliver, and we like our job. Most of the time, even myself, I love the social work so much, that's why I just do it. Even when we are delivering the food parcels, I just go there to deliver. On a Saturday or Sunday, I just go there because I just have that feeling that these people need a social worker." (P12)

Participant 15 similarly stated:

"And I'm not, is not like I'm boosting, you see, you see during…during you know, during COVID-19 I'm proud. I'm proud of myself. We helped a lot of people and without considering the issue of money or, because we are social workers, yes." (P15)

Theme 3: Fear, Perceived Risk, and Concerns for Family Safety During COVID-19

Fear and perceived risk emerged as prominent experiences among participants during the delivery of social services throughout the COVID-19 pandemic. Most participants expressed concerns about contracting the virus, particularly because they were required to maintain direct or indirect contact with clients while the nature and transmission of the virus remained uncertain.

These concerns extended beyond their own health, as participants also feared transmitting the virus to their family members and questioned whether their immune systems would be sufficiently strong to withstand the infection (McFadden et al., 2021).

Participant 2: "And that time remember I was pregnant [smiling]. Mmm [laughter] then it was not easy, I was always scared…to say what if I become, I become positive, what's gonna happen to me and at the same time I'm pregnant"

Participant 8:

"Fit people were badly affected by that thing. People that we thought they were fit they were negatively affected, so it was the survival of the luckiest" (Participant no 3). "You are not even sure if you are contracted by a flu, you are not sure if it is flu or not, because you are always scared that it is COVID"

The fear of infection was particularly evident in participants' interactions with clients who visited their offices and during the distribution of food parcels. Participants recognised that their occupational responsibilities placed them at potential risk of infection and of subsequently transmitting the virus to people close to them. Despite these concerns, they continued to provide services to clients and communities, reflecting the position of social workers as essential service providers during the pandemic (Abrams and Dettlaff, 2020).

Participant 9:

"Fear that was there amongst us, it was like, when we deliver food parcels at people's homes, you find that, maybe the funder or the donor, comes, maybe sometimes they are Indians, you as a social worker you have to go with them to deliver those foods at the respective households, and you don't know whether these people have COVID or not. Mm, that's what made us to become fear, and me I was those who remained. Me I never rested, that thing of saying people is not coming to work"

Participant 12: "It was so horrible because we were always fearing that maybe this person can come with a disease and go back but we were just saying God is there"

Participants also questioned the adequacy of their workplaces in protecting them from potential exposure. Some participants felt that their offices were not sufficiently equipped to provide a safe environment for service delivery, particularly when compared with other departments and service settings where physical adjustments had been introduced following the declaration of COVID-19. One example was the installation of glass barriers between clients and officials, which participants perceived as an important protective measure.

Participant 12:

"We don't have any safety, like at the shops they have er this thing of…I think maybe department can make, they call it what? This thing of er… glass yes, a glass, just cover to say the client must be there and must be there and then you are covered"

The uncertainty surrounding the virus also extended to participants' willingness to seek healthcare. Some participants reported being afraid to visit clinics or hospitals because of concerns that they might become infected or experience worse health outcomes. This illustrates how the perceived risk of COVID-19 extended beyond the workplace and influenced participants' broader engagement with health services.

Participant 8:

"You are not sure, and you are also afraid to go to eee the doctor or to the clinic or to the hospital, just for fear of because of it's a restriction you can go there and find that you get sick even worse, you see"

Another source of fear was the uncertainty surrounding the duration and trajectory of the pandemic. Participants did not know when the pandemic would end or when effective treatment would become available. The rapid spread of the virus, combined with limited knowledge about its progression, contributed to a persistent sense of uncertainty.

Participant 10:

"And then another fear that I have was that you don't know whether it will pass or pass. We didn't know about it, we just hold on and see what's gonna happen. And again, mmm yea, even the issue of when are we going to get medicine for it or how"

The fear of infection was closely connected to the fear of death. Participants described how reports of increasing infections and deaths, including the deaths of healthcare professionals, intensified their concerns about their own survival. The increasing number of infections and fatalities represented an additional threat to social workers who continued to exercise their professional responsibilities during the pandemic (Martinez-Lopez et al., 2021).

Participant 3: "Will I will I be able to survive? Is my immune system being strong enough? But if I die from this thing how are they going to…to make it"

Participant 10:

"Yes fear yoo, obvious death [smiling]. And like the way COVID-19 was spreading fast, we were having that fear that one of the good days or one of the bad days you might find that I have contacted it you see"

Participant 10:

"And it was uncontrollable because just imagine when they say doctor so and so is gone and you are a social worker, you are social worker sitting there, you don't know about medical issues you see, but you end up hearing them saying doctor so and so is gone because of COVID-19. So, if you started to see those people passing on you start to be afraid to say yoo even with yourself there is a possibility of being infected and not able to be treated"

Participants' fear was further reinforced by their daily exposure to information about COVID-19 infections and deaths. Monitoring daily statistics and following news reports made the scale and severity of the pandemic more visible to them, thereby contributing to their anxiety about contracting the virus. As Okafor (2021) notes, the COVID-19 pandemic resulted in substantial loss of life, while social workers, as professionals involved in disaster response and the protection of clients' wellbeing, were nevertheless expected to continue providing essential services. This created a difficult situation in which participants had to negotiate their own fears while maintaining their professional responsibilities.

Participant 5: "We looked at the stats every day. Yes! We looked at the news, we watch the news, we watch the stats, so, yea it was, it was terrible"

Participant 6:

"People are dying left right and centre, you are also afraid of dying ("I use to say what's going to happen to me?, Am I going to die or what's going to happen [Laughter], because that thing of COVID like, when it's started to come, it's like everyone was afraid and not knowing how to protect themselves"

Participant 7:

"You are afraid of something that you don't know and you don't know what's going to happen with you. Even though you hear from the news, everywhere, social media, but you feel that this thing is very dangerous. And I'm an essential worker I must go to work"

Beyond concerns about their own health and survival, participants were particularly worried about the potential consequences of infection for their families. The possibility of bringing the virus home created an additional emotional burden, as participants feared infecting their children and other family members. Some also expressed concerns about being separated from their families and being unable to provide support if a family member became infected.

Participant 3: "And then what about my family, will I also infect them?" Participant 9: "Eer that one we were living inside a big fear, that one of 'what if I get virus and take the virus home, my kids won't be safe'"

Participant 10:

"Even the fear of losing family members, because if you can see we work far from people… just imagine when you are at work and you find out that your mother has COVID-19, you will start to get worried and not able to focus on work. Basically we had fear of what if one of the family member because we do not spend time at home, and you heard that they have COVID-19 or like passed away due to COVID-19, you are here yourself, the kids you are far from them, you don't even know like how safe they are"

Participant 11:

"To some of us it was for the first time when we know about COVID-19, and when we started to research and Google to check what is it you see. It was then that it told us what

it is, what it does to you, how it transfers from one person to the other, so it was a little bit scary, we were also afraid that we will infect our kids at home. Every time when you come back from work you ask yourself that 'didn't I come back with it?'"

Although fear was a dominant experience, it was not experienced uniformly by all participants. A few participants described their fear of contracting the virus as relatively minimal. Their perception was influenced by the precautionary measures implemented during the pandemic, particularly the widespread use of face masks and hand sanitiser. These measures appeared to provide participants with a sense of protection and contributed to reducing their perceived risk of infection.

Participant no 5:

"The fears were eer quiet minimum, the fear, fear was minimum. Because remember, by then, everybody was careful. People wore their mask. We also eer, so…, the sanitizers were available"

Theme 4: Managing Work Pressure and Personal Life

Participants' experiences revealed a tension between professional responsibilities and personal life during the COVID-19 pandemic. For many, lockdown restrictions, travel limitations, and changing work arrangements disrupted established routines and reduced opportunities to maintain family and social relationships. Participants who lived away from their families were particularly affected, as restrictions prevented them from returning home and created emotional strain associated with separation from partners, children, and other family members. One participant explained that the restrictions meant being unable to return home, while another described the emotional difficulty of no longer being able to determine when they could visit their family. These accounts suggest that the pandemic extended work-related pressure beyond the workplace, creating a blurred boundary between professional obligations and personal well-being.

The difficulties were particularly pronounced among participants with family and caregiving responsibilities. The expectation to continue working despite responsibilities at home created competing demands, especially for those caring for children. This finding is consistent with De Tiroina et al. (2021), who observed that working arrangements during the pandemic could make it difficult for employees, particularly those with substantial family responsibilities, to maintain a balance between work and personal life. Thus, the pandemic did not merely alter where social workers performed their duties; it also reshaped how they negotiated competing professional and familial expectations.

At the same time, the introduction of rotational work arrangements provided an important counterpoint to these challenges. Several participants reported that rotations created greater opportunities to spend time with family, attend to personal responsibilities, and recover physically and emotionally from work. One participant described the arrangement as particularly

beneficial because it allowed her to separate periods of work from periods devoted to family and personal activities. This finding is consistent with Ispen et al. (2021), who found that flexible working arrangements could contribute positively to work–life balance by providing employees with greater control over their time. Similarly, De Tiroina et al. (2021) noted that working remotely could provide opportunities for employees to manage their time more flexibly and accommodate personal responsibilities.

However, the benefits of rotation were not experienced uniformly. Some participants continued to experience work–life conflict because they could be recalled to work during their scheduled time off or because rotation schedules changed in response to changing pandemic restrictions. Consequently, the flexibility created by rotation was conditional rather than absolute. Working from home also did not necessarily eliminate work pressure, particularly because social workers were still expected to respond to clients despite the limitations of remote intervention. This indicates that flexibility can support work–life balance only when accompanied by predictable schedules, clear boundaries, and appropriate organisational support.

The introduction of travel permits further reduced some of the difficulties associated with geographical separation. Before permits were introduced, participants working away from their families experienced considerable difficulty travelling home. Once permits enabled movement across restricted areas, participants were better able to maintain contact with their families. Nevertheless, this benefit emerged only after an initial period of severe mobility restriction, during which participants experienced significant separation from their families.

Theme 5: Cases Handled During COVID-19

The cases handled by social workers during COVID-19 reflected a substantial shift in service priorities, with emergency socioeconomic needs becoming more prominent while interventions for complex social and family problems were constrained by lockdown restrictions. Participants reported that food parcel assessments constituted the majority of their caseload, reflecting the widespread economic consequences of the pandemic. Social workers consequently became important frontline providers of assistance to individuals and families experiencing unemployment, poverty, and food insecurity. This finding is consistent with Martinez-Lopez et al. (2021), who noted that social workers and other professionals prioritised services aimed at protecting the well-being of people living in poverty, homelessness, and other vulnerable circumstances. In the South African context, food parcels formed part of Social Relief of Distress (SRD) services, while the high demand for such assistance further increased social workers' caseloads (Abrams & Dettlaff, 2020).

Food parcels

Food parcel-related cases dominated the services delivered during the pandemic. Participants explained that many individuals had lost their sources of income and consequently sought assistance to meet basic needs. However, being assessed did not necessarily guarantee that assistance would be received, as the availability of food parcels was limited. As one

participant noted, most cases involved food parcel assessments, although only a small proportion of applicants ultimately received assistance. This indicates that social workers were positioned at the intersection of increasing community needs and constrained resources.

The delivery of food assistance also illustrates how COVID-19 transformed the nature of client–social worker interaction. Assessments were largely conducted telephonically, while some beneficiaries received vouchers through text messages and redeemed them at designated shops. In other instances, food was delivered directly or distributed at designated community locations. Consequently, the provision of material assistance continued despite restrictions, but with substantially reduced direct interaction between social workers and beneficiaries. The reliance on remote assessment and alternative distribution mechanisms enabled essential services to continue, while simultaneously limiting opportunities for comprehensive assessment and relationship-based intervention.

Domestic violence and family matters

Domestic violence and family-related cases remained part of social workers' caseloads, although participants indicated that these cases were more difficult to identify and address under pandemic restrictions. Some participants reported that domestic violence cases were numerous, whereas others perceived them as underreported or inadequately attended to. This apparent contradiction is important because it suggests that the observed caseload may not have reflected the actual prevalence of domestic violence during the pandemic. Abrams and Dettlaff (2020) similarly reported that restrictions and fear of infection affected clients' ability and willingness to access social services, contributing to reduced reporting of cases such as rape and domestic violence.

Family-related interventions were also complicated by the economic consequences of the pandemic. Participants described financial difficulties as an important source of family conflict and reported attempting to provide family preservation and conflict-resolution services remotely. However, telephone-based interventions, including conference calls, were perceived as inadequate for complex family disputes because participants could not observe interactions directly or ensure that all parties communicated openly. The absence of face-to-face interaction therefore limited the social workers' ability to mediate effectively and reach consensus among family members.

Foster care and child abuse

Foster care cases continued to emerge during the pandemic, particularly in relation to renewals, children's behavioural difficulties, and requests for assistance. However, the scope of intervention was restricted. Participants indicated that some foster care cases could only proceed to the intake stage, while clients experienced difficulties attending offices to complete necessary processes. This illustrates how restrictions affected not only the volume of cases that could be addressed but also the continuity of statutory social services.

Child abuse and neglect cases presented an even greater challenge. Although participants continued to receive reports, assessments and interventions were frequently conducted telephonically. Participants expressed concerns about the reliability of information obtained remotely because they were unable to physically observe the child's circumstances or verify competing accounts. The limitations were particularly serious in cases requiring child removal, as restrictions also affected court operations. Consequently, social workers perceived themselves as unable to provide interventions that were sufficiently comprehensive or satisfactory. These findings highlight a critical tension between the continuation of statutory responsibilities and the practical limitations imposed by pandemic conditions.

Gender-based violence

Gender-based violence (GBV) constituted another important category of cases, but restrictions significantly constrained social workers' ability to respond. Participants reported that although GBV cases were brought to their attention, their capacity to provide interventions beyond the office environment was limited. One participant specifically described being unable to go into the community and consequently restricting service provision to the office. This finding is particularly significant given evidence that GBV increased globally during the COVID-19 pandemic, with Kenya, Uganda, Nigeria, and South Africa among the countries substantially affected (Roy et al., 2022). At the same time, Roy et al. (2022) noted that government priorities during the pandemic were heavily oriented towards controlling COVID-19 transmission, which affected the provision of services perceived as non-essential. Leburu-Masigo and Kgadima (2020) similarly highlighted the use of technology and online services by South African social workers as an alternative means of responding to GBV and other client needs during the pandemic.

Theme 6: Availability of Resources for Service Delivery

The availability of resources emerged as an important determinant of social workers' capacity to maintain service delivery during COVID-19. Although the government provided essential resources, including telephones, state vehicles, personal protective equipment (PPE), masks, and sanitizers, participants consistently described these resources as limited, delayed, or insufficient. Importantly, some participants viewed resource scarcity as a longstanding institutional problem rather than a challenge created exclusively by the pandemic. Thus, COVID-19 did not necessarily create resource constraints within the Department of Social Development but exposed and intensified existing weaknesses in organisational capacity.

Communication and transport resources

The telephone became one of the most important resources during the pandemic because many cases were handled remotely. Participants indicated that office telephones, airtime, and data were used to maintain communication with clients. However, access to these resources was inconsistent. While some participants received airtime or data from the department, others had to rely on their personal phones and financial resources to contact

clients. This created an uneven service-delivery environment in which the ability to provide services depended partly on workers' access to personal resources.

The same pattern was evident in relation to transportation. Although state vehicles were available, participants described them as insufficient for the demands of service delivery. The scarcity of vehicles was reportedly not new and had existed before the pandemic. During COVID-19, however, limited transport became more consequential because social workers still needed to deliver food parcels and, in some circumstances, visit clients. Some participants therefore used their personal vehicles to maintain service delivery. These findings suggest that organisational resource shortages shifted part of the operational burden from the institution to individual social workers.

Protective equipment and occupational safety

The availability of protective equipment was similarly uneven. Participants identified PPE as one of the most limited resources, with some reporting that protective equipment was provided only after the pandemic had already begun. Gunhidzirai et al. (2022) similarly found that inadequate resources, including PPE, challenged social workers' ability to provide effective services during the pandemic. Although some participants reported receiving protective equipment such as aprons and gloves, these resources were not consistently available across participants or at all stages of the pandemic.

Masks and sanitizers were more commonly available than PPE, but their adequacy and continuity remained problematic. Several participants reported that masks supplied by the department were inadequate or unsuitable, leading them to purchase their own. Similarly, when sanitizers ran out, some participants had to purchase replacements using personal funds. This indicates that the formal provision of protective resources did not always translate into sustained occupational protection.

At the same time, interdepartmental cooperation partially addressed these shortages. Some participants reported receiving masks, sanitizers, and other protective materials from the health department where their offices were located. However, participants also described delays in the delivery and restocking of these resources. Even after employees returned to work following lockdown, shortages could re-emerge when supplies were depleted.

Theme 7: Reaching Out to Clients

COVID-19 substantially altered how social workers reached and interacted with clients. Restrictions on movement and efforts to minimise viral transmission reduced face-to-face encounters and encouraged the use of alternative modes of service delivery. Participants described three main approaches: telephonic communication, home visits, and office consultations. These approaches demonstrate how social workers adapted established practices to maintain service continuity under restrictive conditions.

Telephonic communication

Telephonic communication became the primary mechanism for reaching clients during the pandemic. Movement restrictions and concerns about infection limited face-to-face interactions, requiring social workers to conduct assessments and provide services remotely. Participants indicated that telephones were used throughout different stages of the service process, including client consultations and assessments.

Participant 8: "Even the assessment it was done through the phone then even the whole entire process." Participant 10: "We used to call clients and then we ended up addressing them through the phone…" Participant 15: "What happened was that there was landline. We were using landline phone."

These accounts indicate that telephonic communication functioned as an important adaptive mechanism for maintaining access to social services during mobility restrictions. However, the reliance on telephone-based communication also represented a shift from conventional face-to-face social work practice and potentially constrained direct assessment and interaction with clients.

Home visits

Despite the predominance of telephonic communication, some cases required physical engagement through home visits. Participants indicated that home visits were particularly necessary when cases could not be adequately addressed remotely, while food parcels also required direct delivery to clients. At the same time, restrictions and fear of infection substantially reduced routine physical interaction.

Participant 1: "Yes, there were some cases wherein we follow them." Participant 6: "There wasn't a lot of interaction with clients physically, majority of the interactions was telephonic."

Participants further explained that many clients avoided visiting social development offices because of both restrictions and fear of COVID-19. Nevertheless, some clients continued to arrive at offices despite restrictions, requiring social workers to respond to their immediate needs.

Participant 6:

> "Majority of the time, most clients didn't necessarily come to the office. I think it is also because of the fear as well, so when you saw someone at the…when someone was at the gate requesting to come in…"

The findings suggest that home visits remained an important component of service delivery when remote communication was insufficient. However, their use was constrained by the competing demands of infection prevention and the need to provide direct assistance.

Office consultations

Although face-to-face consultations were substantially reduced, office-based interactions did not disappear completely. A small number of clients continued to seek assistance directly,

particularly in cases considered urgent or requiring immediate intervention, such as child abuse.

Participant 9:

"But then… there were those who used to come in the office like let's say maybe a child got raped… yes, child abuse cases. They used to come at the offices then so that we can be able to intervene."

This finding indicates that the pandemic did not eliminate the need for direct social work intervention. Rather, the nature of the case influenced whether remote or face-to-face engagement was considered appropriate. Thus, service delivery during COVID-19 involved a pragmatic combination of telephonic communication, selective home visits, and limited office consultations, reflecting social workers' efforts to balance continuity of care with infection-control requirements.

CONCLUSION

It was difficult for participants to render telephonic services compared to face-to-face consultations. Telephonic methods were often not effective. Social workers had to adjust to the changes that were introduced by COVID-19. As a result, they introduced rotations. Cases which were handled were provision of food parcels, domestic violence, gender-based violence, child abuse, foster care, COVID-19 infected and affected, and other family matters. The main challenge faced by social workers was limited resources to render services which include telephone, state vehicles, and protective equipment (PPE, masks and sanitizers, and gloves). Lack of resources put participants at risk, instilling fear in them and others used their own expenses to render services. Furthermore, during service delivery participants experienced increased fear of contracting the virus and infect their family members. Although other participants did not feel happy during service delivery, others felt valuable and useful to their communities. Some participants faced difficulties to balance between work and life, whereas others relied on work shifts to balance this.

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