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FOREWORD

Collaboration initiatives to build research capacity: FCHS (UWC)

The University of the Western Cape has an explicit commitment to the development of historically disadvantaged communities in South Africa from which it draws most of its students. It aims to play a particular role in this development by making its education accessible to students from these communities and from the rest of Africa. The Faculty of Community and Health Sciences, one of seven faculties, is a multi-disciplinary team committed to the promotion of a vision of Health and Welfare Services which aims to develop and play a role in global transformation. Both in the training and education it offers and in the professionals it produces it aims to advance the transformation of existing Health and Welfare Services in Southern Africa. The Faculty's commitment to excellence in education, research and community service positively contributes to the University's overall mission to become "a place of quality, a place to grow from hope to action through knowledge".

Over the last six years the UWC with the leadership of the rector developed a research programme called The Dynamics of Building a Better Society (DBBS) funded by Vlaamse Interuniversitaire Rood (VLIR) a part of the University Development Cooperation in Belgium. This involved partnership with the Flemmish Universities in Belgium. Six projects emerged lead by different deans. The faculty developed a project of research in Youth Wellness and Development, which is briefly described below.

Youth Wellness in Community Development: A Review of the first 5 years (2003 – 2007)
The aim of project was to develop research capacity within the Faculty of Community and Health Sciences. At the start of the project, the faculty had less academics with PhD's than any of the other faculties in the University (15 in 2002). The project identified youth wellness as an area of research and aimed to include all the departments in the faculty in the project. This broad research topic fitted our purpose and was truly interdisciplinary. In order to facilitate capacity building, scholarships were offered to seven masters' students and 6 PhD students. In addition staff relied was offered to 11 academics. The outcomes of the scholarships are reflected in Table 1 below.

Table 1:

Level	Outcomes
Masters	6 graduated 1 defaulted
PhD	2 graduated 1 submitted for examination 2 final draft 1 in progress
Staff Relief	5 graduated 1 submitted for examination 5 in progress

All the doctoral students were supervised by both the north and the south partners while all the masters' students were supervised by academics from UWC only, for we had the capacity. Staff relief was offered at two stages namely they either had to have reached a stage of both analyzing data and writing up or they were at the beginning and needed assistance with choosing a topic and to write a proposal. Each staff relief recipient was given six months. The spinoff was that another six staff sponsored differently also had the impetus to complete their PhDs following the success of the VLIR sponsored graduates.

This ultimately led to the number of academics with PhD's increasing from 15 in 2002 to bringing the number of PhDs in the faculty to 26 through the project and finally 48 in 2008. In addition the project was able to allow most of the successful candidates and their supervisors to attend and present papers at national and international conferences. Several publications in local and international journals have been realised and the faculty has dedicated this current journal to the work of some of these scholars.
It is thus evident that collaborative projects can effectively be used to develop research capacity within a faculty. Following a review of the work of the five years the following areas were identified as key areas of research within the faculty:

- Risk, resilience and health promotion
- HIV risk and reproductive health promotion

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YOUTH HEALTH RESEARCH AS AN AREA OF EXPERTISE AT THE UNIVERSITY OF THE WESTERN CAPE

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Abstract

Introduction:
There is mounting evidence of the health risk behaviours that adolescents are involved in on a daily basis. Local and national governments have advocated for intervention programmes to prevent an increase in the health risk behaviours among young people. In order to introduce effective prevention strategies, evaluation of the current situation is needed. The University of the Western Cape, identified Youth Wellness as one of the niche areas for research.

Aim:
This paper aims to synthesize the studies on youth wellness conducted at the University of the Western Cape.

Findings:
The studies conducted included epidemiological studies and intervention studies. Studies used both qualitative and quantitative designs. Most of the studies highlighted the need for intervention programmes at various levels such as personal (individual), community and policy.

Conclusion:
The findings of the research clearly highlights the need for researchers at UWC to identify appropriate criteria by which to measure the desired intervention outcomes

Key words:
Youth, wellness, interventions

INTRODUCTION

Recently adolescent health has been occupying the front pages of newspapers. There is mounting evidence of the health risk behaviours that adolescents are involved in on a daily basis. An increase in risk behaviours such as substance abuse, violent behaviour and poor physical activity patterns has become cause for concern. Local and national government have advocated for intervention programmes to prevent an increase in these health risk behaviours. These preventable risk behaviours contribute to adolescent morbidity and mortality. According to Zwieg, Lindberg and McGinley (2001), half of adolescents participate in one or more high risk behaviours. Omori and Ingersoll (2005) reported that although risk taking behaviours often are recognized as a normal part of adolescent's development, they should be of concern as they endanger adolescents' health and well-being. Various literature exists that indicate

that a variety of adolescent risky health behaviors have been linked to disability and disease in later life (Kulbok & Cox, 2002).

Adolescence is defined as the period between childhood and adulthood. Depending on the culture or context, youth are commonly referred to as adolescents, teenagers or young people. The age category for this varies in literature. WHO (2008) categorizes young people as people in the age group 10 - 24 years and youth between 15 and 24 years. In South Africa and much of sub Saharan Africa, youth is classified from 10-35 years (Blum, 2007). According to Kleinert (2007), "adolescence is a time in life that harbours many risks and dangers, but also one that presents great opportunities for sustained health and well-being through education. Seiffge-Krenke (2000) reported that adolescents are a group that are at risk of demonstrating extreme reactions to stressors, resulting from a period of great change, new demands and varying amounts of stress.

According to McGee and Williams (2000), adolescent actions are deemed to either enhance or jeopardize their health. Concepts such as coping, peer pressure, risk taking, self control and self esteem assume considerable importance in trying to explain the motivations behind a variety of health compromising behaviours such as cigarette smoking, early sexual activity, drug use, poor nutrition habits, lack of exercise and drinking and driving. During adolescence, physical appearance is an important predictor of popularity and self-esteem. In addition, adolescents also struggle with identity transition and self concept. Ireland et al (2005) suggested an association between emotional coping and poor health among adolescents. It is essential that adolescents develop effective strategies in order to cope with the stressors. According to Piko (2001), the type of coping strategy employed by an individual affects not only mental health but also physical well-being. During adolescence, physical appearance is an important predictor of popularity and self-esteem. In addition, adolescents also struggle with identity transition and self concept. McGee and Williams (2000) also stated that adolescents involved in health enhancing behaviours had a high level of self esteem.

In 1996, Blum surveyed adolescent health and highlighted areas that were of concern in the United States of America. These areas included violence related to adolescents, substance abuse amongst young people, teenage pregnancy and HIV/AIDS (Blum 1998). When looking for solutions, the author categorized strategies into four areas namely, integrating physical, mental and school based health services; strengthening community and school based services; strengthening health promotion strategies and strengthening school health. Blum and Nelson-Mmari (2004), concluded that studies on young people's assessments of their health needs focused on physical and psychosocial concerns. Thus to assess the situation in the Western Cape, South Africa, the research conducted at the University of the Western Cape was assessed to address the following questions:

1. What is the problem in the community and which epidemiological issues are being highlighted?
2. What are the local dimensions around the problem?
3. Have appropriate criteria for desired outcomes been identified?
4. Which environmental matters need to be considered when developing health risk behaviour prevention programmes.

The University of the Western Cape, identified Youth Wellness and risk behaviors among young people as one of their niche areas for research. Various studies conducted at the university have made considerable contribution to the area of youth wellness and risk behaviors. This paper aims to synthesize studies on youth wellness over the past 10 years in the Western Cape conducted at the University of the Western Cape in the Faculty of Community and Health Sciences. It also aims to highlight the central questions that health programmes at the University of the Western Cape need to address when advocating health risk behaviour prevention interventions.

METHODS

A computer search of all masters and doctoral studies conducted at the University of Western Cape since 1998 to 2008 was included in the review. Only masters and doctoral studies were considered as the university data base only recorded masters and doctoral theses. The

inclusion criteria for the review were: studies conducted at the faculty of community and health sciences; studies that focused on issues of youth wellness; populations between 10 and 35 years and the study had to be conducted in the Western Cape. Searches were conducted on the university website as well as a manual library search.

RESULTS

The search generated a total number of 45 theses. However, 30 Masters and Doctoral theses were excluded based on the fact that it did not meet the inclusion criteria relating to age and region. The final number of studies included was 15 of which three were doctoral studies and 12 were masters theses. The studies conducted included epidemiological and intervention studies. Of the studies included, eight used quantitative research designs, four used qualitative research designs and 3 used a mixed methods design. Table 1 below presents a summary of the studies included.The findings are presented according to the original questions asked.

What is the problem in the community of the Western Cape and which epidemiological issues are being highlighted?

The epidemiological studies highlighted various problems in the Western Cape community which included physical inactivity (Frantz, 2004), health risk behaviours (Phillips, 2006), teenage pregnancies (Cupido, 1998) and gang violence (Mingo, 1999). The prevalence of the risky behaviours that youth are involved in is immense, with continuing repercussions for the health and well being of the individual and society. It is also of such a level that it raises concern among health professionals. The studies identified utilized different approaches to conduct the research which included quantitative, qualitative as well as mixed methods. Thus the studies using a mixed methods approach (Frantz, 2004; Pillay, 2005; Phillips, 2006) was able to highlight the prevalence of the problem as well as provide an in-depth understanding of why the problems existed according to the views of the young people.

What are the local dimensions around the problem?

The studies among the youth were conducted in areas such as the Cape Flats, Cape Metropole, Tygerberg substructure, Helderberg, Paarl, Wellington and Caledon area. The areas in which the studies were conducted included urban, rural and semi-urban. Studies conducted among the youth included studies for able bodied youth (Cupido, 1998; Mingo, 1999; Phillips, 2000; Steyl, 2007) and youth with disabilities (Njoki, 2004; Wazakili, 2008). The local dimensions around the problem identified included physical, psychological as well as economic and social factors. In some of the studies environmental factors that influence health risk behaviours among the youth have also been identified. Studies were conducted in both community and school settings (Njoki, 2004; Pharaoh, 2005).

Have appropriate criteria for desired outcomes been identified?

Most of the studies highlighted the need for intervention programmes (Cupido, 1998; Phillips, 2000; Adams, 2002; Frantz, 2004; Njoki, 2004; Aitken, 2005; Davids, 2005; Phillips, 2006; Steyl, 2007). However, it was evident from the findings that criteria for the desired outcomes of these interventions have not been addressed. In order to implement successful intervention and prevention programmes, researchers at the University of the Western Cape focusing on youth wellness need to collaborate and identify appropriate criteria by which to measure the desired outcomes. It was highlighted by all the studies that it is vitally important for health professionals to address adolescent health issues with targeted health-related interventions and effective health-promoting programmes. The summary of studies presented emphasizes the need for programmes centered around:

- Health risk behavior prevention
- Sexuality education
- Combating violence
- Coping mechanisms

CONCLUSION

Various studies have been conducted among youth in the Western Cape and it is evident from the findings that there is still a need to address the physical, emotional and mental health of the young people. There is also a need to strengthen community and schools based services and thus strengthen health promotion strategies focusing on the youth.

Table 1: Summary of studies from 1998-2008

No	Year	Author	Type of thesis	Type of study	Population	Findings	Implications
1	1998	CupidoX. A study investigating the contraceptive knowledge, attitudes, beliefs and practices of coloured unmarried pregnant teenagers	Masters	Quantitative	45 pregnant teenagers registering at local clinics in the Western cape	40% of the sample had sex between the ages of 10 and 14 yrs and 85% had poor contraceptive knowledge	Intervention programmes for teenagers needs to be multi-levelled to provide participants with the information they need to make informed decisions to protect themselves and make them less vulnerable
2	1999	Mingo CD. Perceptions of gang violence in an Elsies River primary school in the Western Cape	Masters	Qualitative	17 children aged 11-15 years at local school.	Children expressed that gang violence is a result of parents' inability to meet their needs and lack of support.	Children's perception of gang violence differs from adults and it is important to start making a difference in marginalized communities at an early age.
3	2000	Phillips JS. Recreational physical activities among high school students in the Strand, Western Cape	Masters	Quantitative	4 schools in the Strand: Grade 8 -12 (n=1042)	64% of learners were considered irregularly active thus indicating that learners did not maximize the health benefits of participating in physical activity.	Intervention programmes at schools are needed to promote recreational physical activity
4	2002	Adams MO. The relationship between life stress, emotional adjustment and family relationships in early adolescents from low income areas	Masters	Quantitative	119 adolescents aged between 12 and 14 years from 3 low income communities on the Cape Flats in the Western Cape	A relationship between life stress and emotional maladjustment was found. Negative stressful life events led to increased symptoms of anxiety, depression and aggression	The findings confirm the role of stressful life events in the lives of adolescents from low-income areas and the resultant negative impact on their emotional adjustment.

No	Year	Author	Type of thesis	Type of study	Population	Findings	Implications
							Thus intervention strategies should address the psychological as well as socio-economic factors.
5	2004	Frantz JM. Physical inactivity among high school learners: a public health concern	PhD	Qualitative and Quantitative	3 schools in the Western Cape: Grade 8 – 11	Several risk factors for chronic diseases of lifestyle are present among the high school learners such as 33% smoked, 27% drank alcohol and 76% did not participate in any form of physical activity.	There is a need for the monitoring of physical activity levels and other risk factors for chronic diseases of lifestyle. Thus highlighting the need for the planning of community specific interventions.
6	2004	Rich EG. Alcohol use and unsafe sexual practices among students aged 17-25 yrs	Masters	Quantitative	777 university students aged between 17 and 25 yrs	It was found that unsafe sexual practices was engaged in by 42% and sex with multiple partners increased with the consumption of alcohol	This study confirms a relationship between alcohol use and unsafe sex practices such as non/inconsistent condom use, and multiple partners. Public health efforts should continue to be aimed at promoting consistent condom use and monogamy for young people in general.
7	2004	Njoki E. Health promotion needs of youth with spinal cord injuries in the Western Cape,	Masters	Qualitative	Youth in the Western Cape with spinal cord injuries discharged from Conradie	Participants were involved in risky health behaviours such as sedentary lifestyle, use of	Interventions targeting health risk behaviours among young people should not only aim at

No	Year	Author	Type of thesis	Type of study	Population	Findings	Implications
		South Africa			hospital	alcohol, drugs and smoking. Factors influencing behavior included struggles with identity, peer influence, intrapersonal and interpersonal barriers	able bodied individuals but should include disabled individuals
8	2005	Aitken L. The influence of HIV knowledge, beliefs, and religiosity on sexual risk behaviours of private school adolescents	Masters	Quantitative	123 Grade 11 and 12 learners from 2 private schools in Cape Town	37% of the respondents participated in sexual risk-taking behavior of which 58% had unprotected sex and they had a high level of HIV/AIDS knowledge.	It is vital that researchers continue to examine as many culturally, ethnically, and racially diverse populations as possible. This will not only provide a more comprehensive understanding of South African adolescents (as a whole), but will also allow for the development of more appropriate intervention programmes that are tailored for the specific population group in hand.
9	2005	Davids A. An explorative study of the influence of gang violence on the cognition and behaviour of adolescents in a community in the Western Cape	Masters	Qualitative	12 participants between the age of 13 and 17 years at a local school.	The culture of violence by gangs is a crisis which affects all youth involved as well as the entire community in which it has taken claim. Participants voiced that schools, teachers and	There is a need for interventions that will focus on the psychological effects that gang violence has on youth, the need for developing healthy coping

No	Year	Author	Type of thesis	Type of study	Population	Findings	Implications
						community members can play an integral part in the development of eradicating gang violence that occurs in their community	strategies and recreational projects to provide positive activities in order to keep the youth off the street.
10	2005	Pharaoh H. Knowledge, attitude and beliefs of learners in the Paarl district, Western Cape	Masters	Quantitative	The population consisted of 2197 learners aged between 13-18 years.	This study confirms that the learners have basic knowledge regarding HIV/AIDS. The learners make use of this knowledge during some stages of their decision-making but a lack of more in-depth knowledge in certain areas may put them at risk of becoming HIV infected.	Further research is needed to assist in providing means of improving ongoing and in-depth knowledge which can assist learners in selecting safer sexual practices, which could make the prevention of HIV/AIDS not a choice, but a way of life.
11	2005	Pillay T. Determining the effects of a physical activity programme on BMI, PR, BP and % body fat among high school learners	Masters	Quantitative and Qualitative	100 high school learners from grade 8 – 11.	The findings indicated that a short-term physical activity programme was successful in maintaining the learners' initial measurements of BMI, BP and %body fat within normal ranges in comparison to the non-intervention group where there was a substantial increase in measurements amongst variables over a 3 month period	One can conclude that, a short term physical activity intervention programme conducted at schools by students can be implemented to affect the BMI and blood pressure levels of adolescents. Such interventions should be encouraged on a regular basis in schools.

No	Year	Author	Type of thesis	Type of study	Population	Findings	Implications
12	2005	Wildschutt PJ. The effect of accumulative physical activity on the fitness and health status of rural school children	Masters	Quantitative	162 14-16 yr old school children in the Western Cape	The results indicate that only 55% of rural school children in the Caledon/Overberg region of the Western Cape engaged in sufficient health enhancing physical activity. With regard to body composition 11% and 3% of the girls were overweight and obese, respectively. Using the FITNESSGRAM standards only 30% of the girls and 52% of the boys had acceptable levels of cardiovascular fitness.	Sport participation and physical education at schools should be encouraged, since the school provides a protective environment for children to engage in physical activity. The education department and schools should find creative ways to engage children in the daily recommended levels of physical activity.
13	2006	Phillips JS. Health risk behaviours among black adolescent females in the Strand. A mixed methods investigation	PhD	Quantitative and Qualitative	801 13-18 yr old females at 3 schools in the Western Cape	The findings indicate that 45% smoked, 58% used alcohol, 11% used drugs, 28% were sexually active and 51% was physically inactive	There is a need for intervention programs relating to health risk behaviours at primary school level.
14	2007	Steyl T. An analysis of health promoting and risky behaviours among health science university students	Masters	Quantitative	201 full-time undergraduate university students	The findings indicated that risky behavior amongst the students included smoking (58%), drinking alcohol (77%), using drugs (33%) and physical inactivity (20%)	There is need for interventions relating to risk behaviours other than those related to HIV/AIDS

No	Year	Author	Type of thesis	Type of study	Population	Findings	Implications
15	2008	Wazakili M. Paradox of risk: sexuality and HIV/AIDS among young people with physical disabilities in Nyanga, South Africa	PhD	Qualitative	15 disabled young people aged between 15 and 24 years	Young people reported that they had limited access to education and other social amenities. Thus disabled young people indicated that they were sexually active and not taking the necessary precautions	There is a need among disabled young people to participate in mainstream education systems, sexuality education and HIV/AIDS prevention programmes

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TRIPLE DISADVANTAGE: DISABILITY AND GENDER SENSITIVE PREVENTION OF HIV AND AIDS THROUGH THE EYES OF YOUNG PEOPLE WITH PHYSICAL DISABILITIES

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ABSTRACT

Introduction:
This paper explores the different ways in which disabled girls and young women are disadvantaged and marginalised in expressing sexuality and accessing HIV and AIDS prevention and care services. Disabled young men tend to have greater access to basic information on the subject because their families allow them to freely socialise with peers and learn from them. Yet for cultural and other reasons, disabled young women are prevented from doing the same. Consequently, this group lacks vital information on how to express sexuality and to protect themselves from acquiring HIV infection.

Methods:
A qualitative case study design was chosen as the appropriate means for achieving the aim of this study. Sixteen young people with varying types of physical disabilities, aged 15-24 years participated in individual semi-structured interviews and three focus group discussions of 5-8 participants each. Consent procedures were followed. Demographic data of each participant, in-depth interviews and focus group discussions were audio-taped and transcribed verbatim. A thematic content analysis was conducted using the Atlas.ti computer package for analysing qualitative data. Textual features of Atlas.ti were used to sort the data through coding for common meaning. Contextual features were used to group the codes into broad content categories, through which the main themes were generated.

Results:
This study has shown that gender plays a crucial role in the way disabled young people experience sexuality and HIV and AIDS. While all disabled young people have limited access to sexuality education and HIV and AIDS prevention services, disabled young females are more disadvantaged, as they are confined to their parents' homes, are not allowed to express their sexuality freely and are forced to take contraceptives. Although disabled young men are allowed some freedom, they too remain misinformed about basic facts on sexuality and HIV and AIDS.

Discussion:
It is clear that all disabled young people are at risk of contracting HIV infection and have limited access to treatment and care, yet gender related factors increase the risk for disabled females. This group is acutely aware of the ever present risk of rape and yet their mothers' response to such a threat is provision of contraceptives to prevent pregnancy, rather than steps to prevent rape. In the interest of cultural norms, disabled young females in this study were overprotected and prevented from socializing and obtaining sexuality information from peers. Meanwhile, it was shown that some disabled young men feel that the answer to any erection is to have sex, while female participants express the frustration and difficulty of negotiating safe sex. Obviously, it would be difficult to negotiate safe sex with men who believe there is no other way of dealing with an erection, but sex. It is conceivable then that men who uphold such beliefs would also be inclined to force or rape partners who resist or attempt to negotiate safe sex. Similarly, it was revealed that some disabled young men are allowed to have sex outside marriage, but not to father a child as culture prohibits sex and child bearing out of wedlock. Yet disabled females are not only told to abstain from sex until they get married, they are also started on contraceptives without their consent or proper education on the subject. This prohibition is not accompanied by appropriate education about responsible sexual behaviour and prevention of pregnancy. Consequently, disabled girls remain silent about their sexual encounters for fear of disapproval by parents. Parents also anticipate that their disabled children would be having sex anyway, hence their concern to prevent pregnancy with no matching concern for prevention of sexually transmitted infections, including HIV.

Conclusion:
This study has revealed that disabled young men and women have different challenges in their experience of sexuality and HIV and AIDS. Disabled young women are disadvantaged by being confined to their parent's homes, not allowed to express their sexuality freely, having forced contraceptives and would probably be shunned if they were to become HIV positive. It is clear that some parents expect their disabled daughters to be raped in spite of the prevailing belief that these young people are asexual. Parents feel helpless as they appear unable to protect disabled females from being raped or to report such rape, which increases the risk of contracting HIV infection. Although disabled young men are allowed some freedom to express their sexuality and to access information on the subject, they remain misinformed about basic facts on the same. Participants in this study were not aware of any formal or informal sexuality and HIV and AIDS programmes specifically targeting disabled young people in Nyanga. There is a need for government and other AIDS service organizations to target all members of society, but specifically disabled young women and their parents.

Key words:
Gender, disabled young people, prevention, HIV and AIDS, triple disadvantage, Nyanga

INTRODUCTION

People with disabilities generally have limited opportunities for expressing their sexuality and/or accessing HIV and AIDS preventions services. However, disabled girls and women appear more disadvantaged and marginalized on three accounts. Firstly, they are discriminated against by virtue of being girls and women; secondly, they suffer discriminatory cultural and societal norms and prejudices because of their impairment, and thirdly, when they acquire HIV infection or AIDS, the discrimination is worsened, hence the triple disadvantage (Wazakili, 2007). By contrast, disabled young men tend to have greater access to basic information on sexuality and HIV and AIDS because their families allow them to freely socialise with peers and learn from them. Yet for cultural and other reasons, disabled young women are prevented from doing the same as their male counterparts (Wazakili, Mpofu, Devlieger, 2006). Consequently, disabled young women lack vital information on how to express sexuality and to protect themselves from acquiring HIV infection. They also have limited opportunities to learn from their families and peers.

Disabled women are often viewed by men and often by fellow women as sexually undesirable

(Smith, 2008). The way in which family, friends and society respond to disability in general determines the patterns of daily behaviour, including sexual behaviour of women with disabilities (Howland and Rintala, 2001). Traditionally, social expectations for women with physical disabilities are that they should not engage in dating behaviour. In addition, girls with disabilities have fewer opportunities to interact with their peers and learn from them (Nosek et al, 2001a). The process of socialising and interacting with peers is essential in enabling young people to learn from each other and assert themselves as sexual beings. Conversely, overprotection and internalised social expectations make disabled women and girls more vulnerable to psychological pressure for sex and intimacy, yet they have limited access to opportunities that would teach them how to set boundaries for physical contact (Nosek et al, 2001b). This means that there is a need to create awareness of the specificities of disability while shaping opportunities at the same time for young people to develop as sexual beings within a framework of being disabled.

Gender discrimination exacerbates the problem of sexuality for disabled girls and women (Singh, Sansar and Sharma, 2005). This problem persists because the subject has been poorly researched. Women have been scarcely involved or purposely excluded from such studies (Singh et al, 2005). The issue persists because of enduring assumptions that the sexuality of women with disabilities deserves little attention. Existing sexual attitudes and values from parents and others that "sex is dirty" and double standards of sexual behaviour for men and women, perpetuate the avoidance of women's sexuality. Religious and cultural beliefs that sex is only for reproduction and not for pleasure are additional socio-cultural factors that contribute to the negative impact on the sexuality of women with disabilities (Rao, 2002). For this reason, gender sensitivity in decision-making regarding sexuality education and HIV and AIDS prevention is essential for effective mitigation of the pandemic. Furthermore, participative and inclusive processes are needed to identify appropriate intervention strategies that meet the needs of disabled young men and women. It is against this background that the following questions are asked: a) What are disabled young people's perceptions of sexuality and HIV and AIDS? b) What are gender related risk factors for this group? C) What are gender specific factors that influence access to HIV prevention and treatment for disabled young people?

CONTEXT

Nyanga is one of the oldest and biggest 'informal settlements' in the Western Cape metropolitan area in South Africa. It was created under the apartheid era to accommodate displaced African people. Nyanga has a fluctuating population of some 60,000 people, 1600 of whom are disabled (Statistics South Africa, 2001). The informal settlement is characterised by poverty and makeshift housing, commonly known as shacks, and unemployment is estimated at 56% (Statistics South Africa, 2001). The majority of Nyanga residents are employed mainly in informal businesses or low-paid menial jobs, such as house maids and cleaners. Most disabled young people of higher functional ability attend special schools, away from their non-disabled peers. They have limited opportunities for tertiary education, skills training or gainful employment. Shacks do not provide privacy or adequate security for disabled young people.

METHODS

A qualitative case study design was chosen as the appropriate means for achieving the aim of this study, which was to explore perceptions of disabled young people regarding their experiences of sexuality and access to HIV and AIDS prevention services; focusing on gender sensitive issues. Thus, the objectives of the study were: a) to explore disabled young people's experiences of sexuality and HIV and AIDS; b) to identify gender related risk factors for HIV and AIDS and; c) to identify gender specific factors that influence access to HIV prevention and treatment services for the population under study.

A purposive sample of sixteen young people with varying types of physical disabilities, aged 15-24 years was selected (see table 1). These disabled young people were asked to express their views and perceptions about sexuality and HIV/AIDS. They participated in individual semi-structured interviews and three focus group discussions of 5-8 participants each.

Table 1: Profile of young people with physical disabilities

Name	Age	Sex	Disability	Appliance
Sibongile	19	F	Cerebral palsy	none
Nomthandazo	22	F	Left Hemiparesis	None
Xolani	24	M	Cerebral palsy	Wheelchair
Thandiwe	18	F	Cerebral palsy	none
Bongiwe	15	F	Right Hemiparesis	Walking stick
Mcumisa	17	F	Cerebral palsy	Crutches
Andiswa	20	F	Cerebral palsy	crutches
Bonginkosi	18	M	Post polio paralysis	Wheelchair
Ntokozo	19	F	Left Hemiparesis	None
Lindiwe	21	F	Contractures hips	none
Zandile	18	F	Right Hemiparesis	None
Vuyisela	17	F	Post polio paralysis	Crutches
Nontsikelelo	24	F	Contractures fingers	none
Nceba	24	M	Post polio paralysis	Crutches
Philisiwe	23	F	Post polio paralysis	none
Thembalethu	24	M	Post polio paralysis	Crutches

In-depth interviews were conducted with each participant. One advantage of interviewing is that it provides access to the context of people's behaviour and thereby provides a way for researchers to understand the meaning of that behaviour. Yet one of the limitations of interviewing lies in the fact that it often involves personal interaction for which co-operation is essential, without which it would be difficult to conduct successful interviews (Seidman, 1998).

The main issues arising from individual interviews were further explored through focus group discussions. Care was taken to ensure that each focus group had male and female participants depending, but not necessarily in equal numbers. One strength of a focus group technique is that it allows for group interaction so that participants are able to "build on each other's ideas and comments to provide an in-depth view not attainable from individual questioning" (Marshall and Rossman, 1994: 84). However, more outspoken individuals can dominate the discussions, so that viewpoints of less assertive people would be difficult to assess (Academy for Educational Development, 2004).
Consent procedures were followed. Demographic data of each participant, in-depth interviews and focus group discussions were audio-taped and transcribed verbatim. Field notes were made during and after interviews, focusing on group dynamics and particular reactions to key issues on the subject. These were added to the transcripts to strengthen the evidence. Participants had the opportunity to read or have the transcripts read back to them depending on their level of English reading competency. This created an occasion for them to verify, expand or develop new ideas. Since the majority of the participants only spoke isiXhosa fluently, the interview sessions were translated from English to isiXhosa and isiXhosa to English with the help of an intermediary.

ANALYSIS

A thematic content analysis was conducted for this study. The first stage of the data analysis involved reading the transcripts several times to gain understanding of the meaning of sexuality and HIV/AIDS as experienced and perceived by young people with physical disabilities. The second stage involved entering data into the Atlas.ti computer package for analysing qualitative data. Textual features of Atlas.ti were used to sort the data through coding for common meaning that met the aim of the study. Contextual features of Atlas.ti were then used to group the codes into broad content categories, through which main themes were generated. The process of summarising and coding responses by pattern coding is described by

Miles and Huberman (1991) as the main feature for analysing qualitative data. The emerging themes point to the intricate relationship between disability, sexuality and HIV and AIDS in the context of gender sensitive lenses and living in Nyanga. Five major themes were generated and are used as sub-headings in reporting the findings in the next section. These are: Sexuality information and education, HIV knowledge and awareness, Gender issues of concern, HIV risk factors and Intervention strategies.

RESULTS

The results of this study are presented and discussed together under five main headings listed above. These results indicate disabled young people's experiences and views regarding their sources of sexuality information, gender specific differences in their experiences, the level of knowledge about the subject and the availability of intervention strategies.

Sexuality Information and Education

This study reveals that all disabled young people have similar experiences, but for cultural reasons, young men and women experience sexuality and HIV and AIDS differently. The difference can be explained by the way disability is understood and also in the way families and society at large perceive females (Wazakili et al, 2006). The discrimination attached to disability and to HIV and AIDS, and the sexuality of females are not only similar, but exacerbate each other. In the absence of formal and informal ways of providing sexuality information and education, participants who can, look elsewhere for information. Male participants indicated that they rely on TV, friends and older siblings for information on sex and sexuality, while female participants did not have similar experiences as indicated below:

> [1]*FGD 3*[2] *(M): Yes, sex and sexuality is a taboo emaXhoseni (among Xhosa speaking people).*
>
> *Nkosinathi (M): I had seen a lot on TV (sex) and I was going to try, (laughs)… then my brothers taught me some other things like … use a condom.*
>
> *Mkuseli (M): My brothers told me about sex…in my culture, parents do not speak to their children about sexual issues.*

While acknowledging cultural reasons for lack of parental teaching on the subject, disabled young men have the opportunity, even when they have no TV, to go out and watch TV in public places. Parents have different expectations for their disabled daughters as indicated by Thamsanqa below:

> [3]*(F): No one (talked to me about sexuality)…my mother told me to clean the house and to wash myself when I have my periods… I must not sleep with boys otherwise I will become pregnant…but I do not have a boyfriend. My mother is just being careful (by starting her on contraceptives) because I move around alone, so I can be raped.*

Aware of the contradictions and mixed messaged from her mother, Thamsanqa attempts to justify the use of forced contraceptives in place of proper sexuality education. Undoubtedly, participants are acutely aware of the ever present risk of rape and yet in this case, the mother's response to such a threat is provision of contraceptives to prevent pregnancy, rather than steps to prevent rape. This sense of helplessness around sexual abuse of disabled young women does not only perpetuate the crime, it also places this group at increased risk for HIV infection. Disabled young females in this study were overprotected and prevented from obtaining sexuality information from others. Adherence to culture is generally viewed as a positive thing and seldom questioned, in situations where culture prevents efforts to prevent sexual abuse and the spread of HIV infection, then it should be questioned.

Although all disabled young people have limited information about their right to express sexuality freely and responsibly, disabled young females are more affected because they get less or no input at all on the subject as illustrated below:

1 In this study, FGD stands for Focus Group Disacussion,

2 (M) stands for male and pseudonyms are used to refer to individual participants

3 F stands for female.

> Bongiwe (F): *Nobody talks about that (sex and sexuality), even my family, my friends or at school.*
>
> Ncumisa (F): *I do not have friends …I have only one friend, we do not talk about such things (sex and sexuality) …*
>
> Siphokazi (F): *My parents do not want me to be involved … they tease me about getting married in the future, so I should stay in the house …but I know they don't want me to get married because I am disabled.*

Siphokazi's experience is evidence that some families do not take the need for sexual expression, let alone the intimacy needs of disabled young women seriously. Obviously, Siphokazi is aware that her parents are just teasing her about the prospect of her getting married when in actual fact they do not expect her to do so. Some participants in focus group discussions had comparable experiences as shared below:

> FGD 3 (F): *We talk these things with our families, they understand us. They say we should stay in the house, it is safe; they also say we should not marry; the disability grant is enough for us.*

Some parents expect their disabled children to stay in the house and not to marry, as they have the state grant to support them financially. Obviously, such parents deny their disabled children the opportunity to express their sexuality freely and to get married. Other parents equate their disabled children's need for love and marriage to their need for money, hence the declaration that a 'disability or social grant' is all that a disabled young person needs instead of marriage.

Evidently, parents of young people with disability in poor environments such as Nyanga, avoid the subject of sexuality and HIV/AIDS and concentrate on mundane issues such as hygiene and abstention to avoid pregnancy. This is done without matching focus on prevention of sexually transmitted disease including HIV and AIDS. It has been suggested that some parents are sometimes reluctant to acknowledge disabled young people's potential as sexual beings (DiGiulio (2003), and instead they shelter their disabled children from typical adolescent sexually-related experiences. Such proscriptions contribute to disabled young people's social inhibition, which leads to limited opportunity to learn about various aspects of growing up.

Gender issues of Concern

This study has shown that it is taboo among the Xhosa speaking people for parents to discuss sexuality, and consequently HIV and AIDS matters with their children, a finding that is similar among the Zulu speaking people (Hanass-Hancock, 2009). Yet in spite of this cultural proscription, disabled young men have some opportunities for acquiring such information in ways that females do not have. As pointed out earlier, disabled young men are allowed more freedom to go out of the house to socialise and interact with the wider community, in the process of which they acquire some skills and information on pertinent issues. If they are not in school, the female counterparts are mostly confined to their parents' homes, depriving them the opportunity to socialise and learn from their peers. Although in comparison, disabled young men appear to have more knowledge about sex and sexuality matters than their female counterparts, some disabled young men remain uninformed or misinformed about matters of appropriate sexual expression as illustrated below:

> Mkuseli (M): *You have to accept that us disabled people also have sexual feelings to relieve. We are not trained to offset the erections … teach us how to do that, then we will try. You don't know how it feels, when it comes (erection), you can't do anything … if you have a girlfriend, you must have sex now; that is the only way to offset the erection.*

While some disabled young men feel that the answer to any erection is to have sex, female participants express the frustration and difficulty of negotiating safe sex. Obviously, it would be difficult to negotiate safe sex with men who believe there is no other way of dealing with an erection, but sex. It is conceivable then that men who uphold such beliefs would also be inclined to force or rape partners who resist or attempt to negotiate safe sex:

> Nonhle (F): *It is very difficult to fight here (negotiate safe sex) … women are being beaten by their partners so it's very difficult for them to say that (initiate condom use). It is very difficult because the women also want sex.*

Women's desire for sex is often overlooked in most discussions about gender and sexuality. Such a desire could be among the factors that compromise females' ability to successfully negotiate safe sex; as they either stand the risk of losing an opportunity for a sexual experience or getting sex violently through rape.

This study has further revealed that cultural scripts about sexual expression and sexual and reproductive health are not only contradictory, but they also discriminate against disabled young women more than their male counterparts as shown below:

> Nkosinathi (M): *I was told … you can have sex before you get married, but do not have a child. If you get a child before marriage, you will be forced to marry her (mother of your child). As it turned out, Nkosinathi has a child with a woman he is not married to and refuses to support the child.*

The above quotation shows that Nkosinathi (M) is allowed to have sex outside marriage, but not to father a child as culture prohibits sex and child bearing out of wedlock. Yet this prohibition is not accompanied by appropriate education about responsible sexual behaviour and prevention of pregnancy. In the same vein, disabled females are not only told to abstain from sex until they get married, they are also commenced on contraceptives without their consent or proper education on the subject as illustrated by Nomaqhawe (F) below:

> *At Mpumelelo School…they will take you to a place for needles (contraceptives). For me, I had stomach ache and back ache…they took me to that room where they do needles…first they called my mother and told her that your daughter has done this and this (started menses)…it is time now that she gets family planning.*

Untoward consequences of silence on sexuality matters are that some disabled girls remain silent about their sexual encounters or involvement for fear of disapproval by parents. Parents also anticipate that their disabled children would be having sex anyway, hence their concern to prevent pregnancy with no matching concern for prevention of sexually transmitted infections. Silence also encourages disabled girls to engage in secret sexual relationships as illustrated below:

> Nonhle (F): *No, she (mother) did not know (that I had slept with two men before)…she only did not want me to fall pregnant if I meet a stranger and he sleeps with me (she was also commenced on contraceptives without her consent).*

It is evident that cultural scripts that promote abstention from sex before marriage do not only discriminate against females, but they also deny them the ability to fulfill their own desire for sex and to express their sexuality freely. Young women with disabilities mentioned that often parents collaborate with teachers and health workers and force disabled young women to use contraceptives to prevent pregnancy. Yet no similar collaboration is taken to prevent coercion or rape and the risk of contracting sexually transmitted diseases, including HIV/AIDS.

HIV/AIDS knowledge and awareness

The relationship between sex and HIV/AIDS prevents parents from discussing the pandemic with their disabled children, whom they assume are asexual. Some participants receive HIV information from institutions such as schools and clinics, but the majority who do not go to school for one reason or the other are left out. Most participants in focus group discussions and individual interviews indicated that they know nothing about HIV and AIDS as shown below:

> *FGD 3 (F): Nobody talked about AIDS at home, but when we go to the clinic, we hear something about AIDS.*

> *Andiswa (F): I do not know anything and I don't want to talk about that (HIV/AIDS).*

> *Mcumisa (M): I didn't learn at school*

The above assertions provide further evidence why disabled young people have limited information about sexuality and HIV and AIDS matters. While the quotations below show that the group is misinformed about the subject:

> Buhle (F): *On TV they say that HIV is transmitted by a man who you do not know and also when you do not use a condom when doing sex...*
>
> Mkuseli (M): *They told us at the clinic that you get AIDS when you sleep with someone who has a discharge…they also said we must get gloves when we want to help someone who has had an accident.*

Although the above quotations show that some participants are aware of HIV/AIDS, the information they have is not accurate enough to help them make informed decisions about self-protection from HIV infection, let alone protecting their partners from the same. Buhle needs to know that HIV can be transmitted by any man who tests positive for the HI virus regardless of whether he is known or not. While Mkuseli needs to know that having a genital discharge can only be a risk factor for HIV infection if the person is HIV positive as well, and that other sexually transmitted infections can equally be transmitted by someone with a genital discharge, which increases the risk for contracting HIV anyway. It is therefore not surprising that participants are afraid to have an HIV test as indicated below:

> Siphokazi (F): *No, I have not been tested (For HIV), I am afraid.*
>
> Luleka (M): *No, I have not been tested (for HIV), I am afraid.*

Male and female participants cited fear as the most common reason for failure to get tested for the HI virus. It is worth noting that disabled young men blamed disabled young women for spreading the virus as stated below:

> Mkuseli (M): *Yes, I am at risk of contracting AIDS…because the girls I have slept with were unfaithful to me.*
>
> Nonzwakazi (M): *Yes, they (disabled young people) are more at risk because disabled girls like men…they sleep with many men…They go to the shebeens (drinking places) and when they are drunk the men take them to their house and sleep there the whole night…parents do not know until morning because they are also busy drinking at night.*

Meanwhile, disabled young women felt particularly vulnerable to sexual abuse, including rape that places them at increased risk of contracting HIV infection. This finding in consistent with findings of a study done in KwaZulu Natal among disabled people (Hanass-Hancock, 2009). Thus, disabled females feel more threatened by HIV infection as indicated below:

> Zizipho (F): *Every disabled person is at risk of being raped; even when you are walking with crutches, you must be with someone always, don't walk alone.*
>
> FGD 3 (F): *We feel threatened by HIV/AIDS because people say we like men … we are just like them (non-disabled), no difference, they also like women.*
>
> FGD 1: *We are also at risk because we have sexual desires … we are also victims of rape … we are being raped all the time by disabled and non-disabled men … no difference at all … I know some people with disabilities who are in prison because of rape.*

Risk factors for HIV infection

The socio-cultural characteristics that place young people at risk of HIV/AIDS are equally applicable to disabled people (Groce, 2004). The particular circumstances that place disabled young people at more risk range from greater danger of sexual abuse because of their difficulty in escaping abusive situations, to a need for assistance with personal tasks from perpetrators of sexual abuse, to the stereotype that disabled young people are dependent and easy prey (Nosek et al, 2001). Participants in this study mentioned unfaithfulness, promiscuity, alcohol, sexual abuse and ignorance as some of the factors that place them at risk of contracting HIV infection.

Usizwe (F): *Yes, there were many guys who came to me…they were just using me…they wanted my money (disability grant) and to sleep with me. Then I realised that they did not love me…they were just using me.*

FGD 3 (M): *We have known women who pretend to love a disabled man just to get his money. When the money is finished, they go back to their able-bodied men.*

The above quotations show that both men and women offer sexual favours to disabled young men and women in exchange for cash. Owing to the disability grant provided by the South African government to its disabled citizens, unemployed disabled young men and women tend to have more cash than their non-disabled counterparts, hence the tendency for disabled young people to be exploited over the same.

Intervention strategies

Although Government and the private sector in South Africa have acknowledged the problem of HIV/AIDS among young people, intervention strategies have been designed on the assumption that all young people have the same needs (Kelly et al, 2002; Wazakili et al, 2006). Many AIDS service organizations do not target disabled young people with HIV intervention. Consequently, disabled young people remain at risk of being misinformed by their peers and older siblings, and even misunderstanding media messages about prevention of HIV infection.

Participants indicated that they do not know about any sexuality education and HIV/AIDS prevention programmes in Nyanga. Only one participant had ever attended an HIV/AIDS awareness campaign that was organised for the general population. Participants were then asked to indicate how intervention strategies should be organised to meet their special circumstances:

Some suggested *"Disabled people should teach disabled people if they know about AIDS. "I feel comfortable to be taught by a disabled person".*

Others: *This information (HIV/AIDS) should be given together; there should be no discrimination because the disease affects us all the same way.*

Thandisiwe: *We should have jobs, education, gospel music. People who are disabled have time to go to activities like football and netball … but there is no place for them to go and play.*

A common problematic feature discovered in this study was that, after completing or discontinuing at special schools, most disabled young people in Nyanga virtually face a lifetime of idleness. This group has limited opportunities for tertiary education, skills training or vocational training and employment. Idleness in turn leads to engagement is risk taking behaviours such as drug and alcohol abuse, which in turn increase the risk of contracting HIV infection. Idleness also may lead to chronic poverty.

Furthermore, it is clear that discrimination against disabled young people causes a vicious cycle of social isolation, illiteracy, low education levels, reduced opportunities for training, acquisition of vocational skills and employment. The cumulative consequences of such a cycle are abject poverty among disabled young people. The relationship between poverty and disability has been well documented (DFID, 2006); there is a tendency, among other things, for poor people to exchange sex for cash. In the case of the current study, there are two sides to obtaining sex for cash. Firstly, some mothers allow their disabled daughters to go out and have sex in order to supplement household income. Secondly, and as stated earlier, access to a government social grant places disabled young people at risk of financial exploitation by those who have no cash.

CONCLUSION

This study has shown that gender plays a crucial role in the way disabled young people experience sexuality and HIV and AIDS. While all disabled young people have limited access to sexuality education and HIV and AIDS prevention services, disabled young females are more disadvantaged, as cultural scripts do not favour girls. Disabled young men are allowed to socialize and learn from each other and disabled girls are not. Parents are prevented by their culture to discuss sex and sexuality, and HIV and AIDS matters with their

disabled children, but young men are allowed to express their sexuality, except to have children out of wedlock and females are expected to abstain.

This study has also revealed that disabled young men and women have different challenges in their experience of sexuality and HIV and AIDS. Although disabled young men are allowed some freedom to express their sexuality and to access information on the subject, they remain misinformed about basic facts on the same. Disabled young women are disadvantaged by being confined to their parent's homes, not allowed to express their sexuality freely, having forced contraceptives and would probably be shunned if they were to become HIV positive. It has also been revealed that parents expect their disabled daughters to be raped in spite of the prevailing belief that these young people are asexual. There is no urgency to protect disabled females from being raped or to report rape, as parents feel helpless about the rape situation, which increases the risk of contracting HIV infection. Participants in this study were not aware of any formal or informal sexuality and HIV and AIDS programmes specifically targeting disabled young people in Nyanga. There is a need for government and other AIDS service organizations to target all members of society, but specifically disabled young women and their parents.

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ALCOHOL USE AMONG BLACK FEMALE ADOLESCENTS IN A SOUTH AFRICAN COMMUNITY: A MIXED METHODS INVESTIGATION

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Abstract

Background:
According to the World Health Organization global alcohol consumption has increased in recent decades, with most of this increase occurring in developing countries. Added to this is the concern of the increased social acceptability of alcohol use and the widespread experimentation with alcohol during adolescence.

Objectives:
The purpose of this study was to better understand health risk behaviors, specifically alcohol use, among black female high school learners in a designated research locale of a local community in the Western Cape, South Africa.

Study design:
The method of inquiry in the study was a mixed method sequential explanatory strategy.

Results:
A lifetime prevalence of alcohol use was reported by 57.8% of the study sample. All the participants agreed that drinking has a negative influence on adolescent health.

Conclusion:
Alcohol use in South Africa is an ever-increasing health problem and the current study provides evidence that the prevalence of this behaviour remain a public health concern.

Keywords:
Alcohol use, adolescent health; female high school learners

INTRODUCTION

Unlike the very young child and the elderly, adolescents suffer from few life- threatening conditions. Adolescence appears to be one of the healthiest periods of the life course with lower rates of morbidity and mortality due to disease than any of the other life periods(Call, Riedel, Hein, McLoyd, Petersen and Kipka, 2002; Burt, 2002). However, adolescence is also a critical development period with a greater degree of exploration and experimentation than those of other age groups. The potential for risk taking during adolescence is thus greater with long-term implications for the health and well being of the individual and for the society as a whole. According to Geckova, Tuinstra, Pudelsky, Kovarova, Van Dijk, Grotthoff and Post

(2001) adolescence is also the period when young people establish concepts, attitudes and beliefs that may have long-term influences on their health. According to Holmberg and Berg-Kelly (2002), Irwin (2003), and Rail, Stanton, Wu, Li, Galbraith, Cottrell, Pack, Harris, D'Alessandri and Burns (2003), the adolescent period is thus extremely important from a public health point of view. Michaud (2003) alerted us to the fact that although somehow different in scale and scope, the main public health problems adolescents' faces around the world are quite similar in nature.

Alcohol has been consumed in human populations for centuries, but the considerable and varied adverse health effects have only been characterized recently (Rehm, Gutjahr and Gmel, 2001). According to the World Health Report 2002 (WHO, 2002), global alcohol consumption has increased in recent decades, with most of this increase occurring in developing countries. The increased social acceptability of alcohol use and the widespread experimentation with alcohol during adolescence are also great areas of concern (Ellickson, Tucker, Klein and McGuigan, 2001). Eaton et al. (2004) also emphasized that alcohol use continues to be one of the most significant risk behaviours engaged in by adolescents and it continues to grow in popularity in the youth culture. Of great concern are the results of analysis of the National Longitudinal Alcohol Epidemiology Survey in the United States of America (USA) that indicated that early age of drinking onset is associated with frequent heavy drinking in life (Hingson, Heeren, Jamarka and Howland, 2000). Furthermore Epstein, Griffin and Botvin (2004) expressed concern that the allure of alcohol for adolescents' remains strong and widespread alcohol use among adolescents remain common.

Roche and Deehan (2002) stated that there has been growing evidence in recent years that the levels and patterns of women's alcohol use have undergone substantial change. Female alcohol consumption has been noted to be steadily on the rise, particularly among women in younger age groups. These changes in women's levels and patterns of drinking are an international phenomenon (Bobak, McKee, Rose and Marmot, 1999; Neve, Diederick, Knibbe and Drop, 1993). Epstein et al. (2004) stated that it must be noted that over the course of adolescence, girls and boys may initiate or increase alcohol consumption for different reasons. Research has indicated that girls tend to have lower overall self-esteem than boys. There is also evidence that self-esteem is an important factor in the epidemiology of girls' alcohol use (Bolognini, Plancerel, Bettschart and Halfon, 1996; Epstein et al., 2004; Chub, Fertman and Ross, 1997). Kumpulainen and Roine (2002) also found in their study on Finnish adolescents, that for girls the probability of being a heavy drinking more than doubled due to feelings of ineffectiveness or low-esteem.

There is a substantial burden of illness associated with alcohol use among women. According to various researchers (Roman, 1988; Frezza, diPadova, Pozzate, Terpin, Baraona and Liebner, 1990) physical problems are experienced earlier in female drinking careers than males. They ascribed this in part to the fact that women have a lower body weight than men, less body water and a higher percentage of body fat. Furthermore women metabolize alcohol at a slower rate than men, so alcohol may remain in the tissue longer. In addition, Saunders, Davis and Williams (1981) stated that there is evidence that for equivalent doses of alcohol, women are more vulnerable than men to tissue damage and the onset of certain diseases such as cirrhosis of the liver and physical alcohol dependence. Alcohol use by women is also thought to be associated with an increased risk of osteoporosis and bone fractures (Baron, Bachman and Weiderpass, 2001). Women can also be more vulnerable to physical risks through violence or abuse when intoxicated (Jacobs, 1998).

For the purpose of this study, the former government's classification system of racial categories has been used: "African Black", "Colored", "White" and "Indian". The "Colored" population group is a population of mixed ancestry i.e. Afro-Euro-Malay-Khoisan ancestry (Temple, Steyn, Hoffman, Levitt and Lombard, 2001). Ellision, De Wet, Ijsselmuiden and Richter (1996) stated, that there are differences among the groups for many indicators of health, mediated by political and economic factors. Prior to 1994, fewer resources and funding had been allocated to the black population in South Africa. The inadequacies and inequalities in the system of "apartheid"

reflected and reproduced the socio-economic disadvantagement that was experienced by the disenfranchised racial groupings. Therefore in this study the use of the race/ethnicity refers explicitly to the social conception of race.

The purpose of this study was to better understand health risk behaviors, specifically alcohol use, among black female high school learners in a designated research locale of a local community in the Western Cape, South Africa. The method of inquiry in the study was a mixed method sequential explanatory strategy.

METHOD

This study is not a multi-site epidemiological study and locates itself in the specific community in the Western Cape, South Africa for various reasons. Firstly, the community is demographically typical of the Western Cape in its proportion of "Black African" and "Colored" youth. Another reason for this particular setting is that good access to all the schools in the specific community could be negotiated. All the learners from the schools come from the community, in which the schools are situated, thus enabling the researcher to investigate the contextual factors implicating health risk behaviors. Another compelling reason for choosing this particular research setting is that it has a good distribution of different ethnic groupings but living and schooling in the same environment.

Permission was obtained from the Education Department in the Western Cape, South Africa to invite the female learners enrolled at the schools to participate in the study. Subsequently, permission was then obtained from the principles and the parent-teacher association at the respective high schools to conduct the study at their schools. The principals of the schools took the ethical responsibility of informing the parents of the learners beforehand through the parent-teacher-association. Parent-consent forms and learner-consent forms were distributed at the parent-teacher-association meetings at the school. Learners returned signed parent-consent and learner consent forms to their teachers who in turn submitted it to the researcher. The final sampling frame thus consisted of those black female learners who returned the signed parent and learner consent forms.

This study utilized a mixed method approach, specifically the sequential explanatory strategy. Creswell, Plano Clark, Gutmann and Hanson (2003) identified six major strategies of mixed methods. The sequential explanatory strategy has been deemed to be the most straightforward of the six major mixed methods designs and identified this as one of its main strengths. The strategy is characterized by the collection and analysis of quantitative data followed by collection and analysis of qualitative data (Creswell, 2003). The purpose of this strategy is typically to use qualitative data to assist in explaining and interpreting the findings of a primarily quantitative study (Creswell et al., 2003). Borkan (2004) also stated that "mixed methods give the researcher additional perspectives and insights that are beyond the scope of any single technique".

In this study the priority is given to the quantitative data and the two methods are integrated during the interpretation phase of the study. The quantitative phase of the study incorporated a probability sample because every learner who was eligible for inclusion in the study had an equal chance of being selected for the study. This type of sample also enables the researcher to generalize the findings to the designated population. The study specifically employed a stratified sample using Grade level as the individual stratum. This means that a learner had to be enrolled for one grade only and inclusion in one stratum would necessarily mean exclusion from any other stratum. In other words, the sample was stratified into four strata corresponding to grades eight, nine, ten, and eleven respectively. In an attempt to minimize disruption in the academic program, it was decided to randomly select two classes from every school in every stratum or grade.

Twenty four classes in which 952 female learners were enrolled were randomly selected from grade 8-11 in the three participating schools for the quantitative phase of the study. Of the learners selected only 857 had signed parent-consent forms, the remaining 95 learners were thus excluded from the study. A self-administered questionnaire was administered to the learners to determine the prevalence of alcohol use and the relationship between alcohol use and socio-demographic variables. The questionnaire used was adapted from the Youth Risk Behavior

Surveillance Survey (YRBSS) developed by the Center for Disease Control and Prevention (CDC) in the USA. The questionnaire has demonstrated good reliability with kappas for the risk-behavior items ranging from .51 to .88. Approximately 72% of the items have "substantial" or higher reliability (Kann et al., 1999). The instrument has also been found to have both face and content validity.

A total of 801 learners submitted completed questionnaires. The overall response rate was thus 84.1%. The final sample thus consisted of 801 female high school learners ranging from age 13-19 years with a mean age of 15.75 years and a standard deviation of 1.57. The socio-demographic characteristics of the sample are illustrated in Table 1.

Table 1: Distribution of selected socio-demographic characteristics of the study sample (n=801)

Variable	n	%
Race/Ethnicity		
"African Black"	306	38.2
"Coloured"	449	56.1
Other[a]	26	3.2
Missing	20	2.5
Age (years)[b]		
13	53	6.6
14	161	20.0
15	156	19.5
16	135	16.9
17	145	18.1
18 and older	148	18.5
Missing	3	0.4
School grade		
8	211	26.3
9	195	24.3
10	218	27.2
11	166	20.8
Missing	11	1.4
Education of head of household		
Never attended school	37	4.6
Some primary school	168	21.0
Some secondary school	470	58.7
Tertiary qualification	80	10.0
Missing	46	5.7
Employment status (head of household)		
Employed	527	65.8
Unemployed	196	24.5
Missing	78	9.7
Religious affiliation		
Yes	679	84.8
No	106	13.2
Missing	16	2.0

[a] Other included Asian/Indian

[b] Mean age = 15.75 years, (SD= 1.571), median age = 16 years.

In the second phase of the study, focus group discussions were conducted to further explore and examine the socially constructed views of adolescent learners on alcohol use. The purpose for choosing this method and strategy was primarily to use the qualitative data to assist in explaining and interpreting the findings of the quantitative data.

The researcher considered using group differences obtained from analysis of phase 1 to inform the composition of focus groups. The major advantage of this would be increased homogeneity of focus groups. However (Bergin, Tally and Hamer, 2003) states that knowledge is socially constructed and that the credibility of focus groups is enhanced when the group composition is reflective of the social context within which female learners are spending the majority of the time. In view of this, female learners spend 8 hours per day at school in classes that are mixed. That is, classrooms are not homogenous nor are they formed along predetermined socio- and or demographic grouping variables. Thus the present study incorporated focus groups that were heterogeneous (in terms of race, age, school grades and socio-demographic characteristics). To this end participants were allocated randomly to focus groups within their grade level. It became evident that phase 2 was not dependant on the results or findings of phase 1. Thus it was decided to conduct all analyses at the conclusion of phase 2. This served a further purpose of reducing researcher bias in the facilitation of the focus groups in phase 2. In addition, the integration of data, as urged by Creswell (2003), was deferred to the discussion.

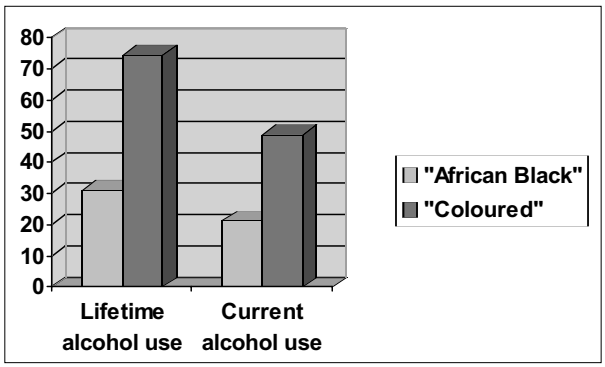
RESULTS

Phase 1: Quantitative data

A lifetime prevalence of alcohol use was reported by 57.8% of the sample [95%CI: 54.4 - 61.2]. More than one third of the sample (37.7%) reported current alcohol use [95% CI: 34.3 - 41.1]. Overall, 14% of the sample had drunk their first drink of alcohol before the age of 12 years [95% CI: 11.6 - 16.4].

Significantly more "Coloured" learners (74.6%) than "African Black" learners (31.1%) had reported lifetime alcohol use (X^2 =128.7866, p< 0.05). There was also a significant difference between "Coloured" learners (48.9%) and "African Black" learners (21.2%) in terms of current alcohol use (X^2 =53.0017, p<0.05). Significantly more "Coloured" ers (19.2%) than "African Black" learners (5.3%) had drunk their first drink of alcohol before the age of 12 years as illustrated in Figure 1.

Figure 1: Percentage of black female high school learners who used alcohol by race/ethnicity



Significantly more learners in Grade 9 (74.4%) compared to Grade 10 learners (40.5%) had ever used alcohol (X^2 =48.8850, p<0.05). The highest prevalence of learners classified as current alcohol users were in Grade 9 (50.0%) followed by those in Grade 8 (43.5%) (X^2 =22.3306, p<0.05). There was also a significant difference in the frequency of learners who had their first drink of alcohol before the age of 12 years grade. Significantly more Grade 8 learners (26.1%) compared to Grade 10 learners (4.6%) had their first drink of alcohol before the age of 12 years (p<0.05) as illustrated in Table 2.

Table 2 further illustrates that the older learners, i.e. 17 year olds (46.9%) and 18 year olds (46.6%) were significantly less likely than the younger learners, i.e. 13 year olds (60.4%) and 14 year olds (66.3%) to report lifetime alcohol use (X^2 =15.666, p<0.05). There was also a significant difference in the frequency of current alcohol use by age (X^2 =11.0006, p<0.005). The highest prevalence of learners using alcohol in the 30 days preceding the study was the 15 year olds (46.0%) followed by the 16 year olds (42.2%). There was a significant difference in the frequency of learners who had their first drink of alcohol before the age of 12 years (X^2 =11.0006, p<0.005). A significantly higher prevalence of younger learners, e.g. 13year olds (32.1%) had their first drink of alcohol before the age of 12 years when compared to older learners such as 17 year olds (3.4%) and 18 year olds (11%).

Table 2: Percentage (with 95%CIs) of black female high school learners who use alcohol by selected demographic variables

Variable	Lifetime alcohol use[a]	Current alcohol use[b]	Initiation <12 years[c]
Grade			
8	61.4 (54.8 - 68.0)	43.5 (36.7 - 50.3)	26.1 (20.2 - 32.0)
9	74.4 (68.3 - 80.5)	50.0 (42.9 - 57.1)	16.4 (11.2 - 21.6)
10	40.5 (33.7 - 47.3)	28.4 (22.4 - 34.4)	4.6 (1.8 - 7.4)
11	63.2 (55.0 - 71.4)	32.5 (25.4 - 39.6)	9.0 (4.6 - 13.4)
Age			
13	60.4 (47.3 - 73.6)	38.5 (25.3 - 51.7)	32.1 (19.5 - 44.7)
14	65.8 (58.5 - 73.1)	42.8 (35.1 - 50.5)	31.1 (23.9 - 38.3)
15	66.0 (58.6 - 73.4)	46.0 (38.1 - 53.9)	12.8 (7.6 - 18.0)
16	62.2 (54.0 - 70.4)	42.2 (33.9 - 50.5)	3.0 (0.1 - 5.9)
17	46.9 (38.8 - 55.0)	33.8 (26.1 - 41.5)	3.4 (0.5 - 6.3)
18	46.6 (38.6 - 54.6)	25.7 (18.7 - 32.7)	11.0 (5.9 - 16.1)

[a] Ever used alcohol in their lifetime
[b] Used alcohol on one or more days in the 30 days preceding the study
[c] Used alcohol for first time before the age of 12 years

Almost three-quarters (74.8%) of the learners knew what the effects of alcohol were on their health. There was a significant difference in the frequency of learners who reported lifetime alcohol use based on their knowledge of the consequences of alcohol use on their health (X^2 =10.599, p<0.05). 79.0% of the learners that reported lifetime alcohol use and 68.9% that reported no lifetime alcohol use were knowledgeable about the consequences of alcohol use on their health

Phase 2: Qualitative data

The groups were asked to generally discuss a broad question on alcohol use. The learners were relaxed, they laughed when they felt they wanted to and they used a fair amount of body language during talking. On further examination of factors that predispose and maintain the female high school learners' engagement in alcohol use, a variety of aspects were unearthed. The thematic analysis of the transcripts of the focus groups yielded five main themes namely: sources providing information about the consequences of alcohol use; behavioural regulations imposed by significant others; peer group factors; environmental and/or community factors; and personal attitudes and beliefs about alcohol use.

Sources providing information about the consequences of smoking

A general awareness of the negative consequences of alcohol exists among the learners. Learners agreed that alcohol use has a negative effect on your health. The quotations below elucidate this:

> *…It pollutes you. Alcohol is just as bad as smoking.*
> *Learner, 15 years*
> *…It affects your liver.*
> *Learner, 17 years*

Behavioral regulations imposed by significant others

Participants thought there was an equal amount of parents who were aware of their children's drinking and those who were not aware. The quotations below elucidate this.

…They get pocket money. Then they tell their mothers they're going to visit that one, then the parents are sleeping by the time they come back home…
Learner, 15 years

…I come home from the club, she (mother) can smell that I was drinking, then she tells me, you must behave yourself then I say, I am safely at home, I came home totally healthy, why wouldn't I behave myself…
Learner, 18 years

There was generally a disapproving response from the learners with regard to parents who knew about adolescents' drinking as illustrated below.

…Many of the people know their children drink, but they don't pay attention to it…
Learner, 16 years

…Sometimes the children drink with their parents…
Learner, 17 years

…Yes they drink together, like here [in this community], three out of ten drinks with their parents too…
Learner, 18 years

Environmental and/or community factors

There seemed to be confusion about the legal age for buying alcohol as some participants suggested that it is sixteen years. It became clear from the discussions that purchasing alcohol at informal establishments in the community when under the legal age was not regarded as a problem. It was highlighted however that formal business like liquor stores requires some sort of proof of age when youngsters buy alcohol. The discussions seemed to indicate that the environment creates easy access to alcohol with the establishment of shebeens (informal pubs in the community).

…At the yards. Some of the shebeens don't worry, as long as they can make a profit… (in response to question on where people under eighteen buy alcohol)…
Learner, 17 years

…At most shops they don't give children under the age of eighteen alcohol…
Learner, 16 years

Being under the legal age to purchase alcohol however does not seem to deter participants from obtaining alcohol. This is illustrated by the following statements.

…Send an older person…
Learner, 15 years

…There are adults who drink, who might not have money, then they think that a young child has money, then they drink with them, and so on…
Learner, 16 years

Peer group factors

There was mixed reactions to the acceptance of adolescent drinking at first glance. However all the participants agreed that drinking has a negative influence on the adolescent as highlighted by the following statement:

…It pollutes you. Alcohol is just as bad as smoking, the one is not better than the other…
Learner, 15 years

…I don't want to be there, I have better things to do…
Learner, 16 years

In general there seemed to be an acceptance of drinking but not of drunkenness and irresponsible behavior. There was an acceptance of drinking providing that "you know your limit" and stop drinking when they feel drunk. Drinking on special occasions was viewed as acceptable.

…I don't drink until I am drunk like other people in the street who fall, and such; I don't drink to make trouble…
Learner, 17 years

…And many people say, I can't understand it, many people say they drank the evening and the next day they can't remember what they did. It's impossible for me to believe, if I drink tonight then I will know everything that I did tomorrow…
Learner, 16 years

Personal attitudes and beliefs about health risk behaviors

Participants came to the conclusion that some learners drink because they have problems at home and see it as a solution.

…Some teenagers who drink have problems at home, so they run towards the wrong thing. It is the only solution they can think of…
Learner, 15 years

…They drink to forget their problems, but it doesn't help, the day after tomorrow you still sit with those very same problems…
Learner, 17 years

A lot of the participants were convinced that you have to use alcohol if you want to enjoy yourself at social functions as illustrated below.

…Now as I was saying, to enjoy myself, I just felt like drinking…
Learner, 16 years

… I don't drink daily, but if I go to special occasions, like the last time when the school had a dance, then I drank…
Learner, 16 years

DISCUSSION

Alcohol use in South Africa is an ever-increasing health problem and the current study provides evidence that the prevalence of this behaviour remain a public health concern. This study shows that the overall prevalence for lifetime and current alcohol use in the study were 57.8% and 37.7% respectively.

In this study a number of factors in the environment could also be seen as contributing to adolescent alcohol use. Some of these factors are the easy access to alcohol for under-aged learners at local shebeens (informal pubs in the community).

Numerous researchers have highlighted the fact that living in impoverished family and neighbourhood environments are associated with behaviours such as smoking, alcohol and drug use. These researchers argue that the effect of poverty and adolescents' risk taking is often indirect through its impact on their parents, who become anxious or hopeless and have little energy to focus on effective parenting and monitoring of their adolescent children (Jessor et al., 1995; McLoyd, 1990; Elder, Van Nguyen and Caspi, 1985). This notion is emphasized by the learners in the present study. Learners were in agreement that some parents and other adults are aware of their children's alcohol use.

"…They (adults) think that a young child has money, then they drink with them, and so on…"

Research has also indicated that adults play an important role in socialization of adolescents on the issue of alcohol use. Research has indicated that providing alcohol to an adolescent explicitly indicated approval of underage alcohol use, which may lead to future substance abuse (Foley, Atlman, DuRant and Wolfson, 2004; Baumrind, 1991).

The study clearly highlights that multiple strategies are needed to deal with the health and economic consequences of alcohol use among black female high school learners. The lack of legal regulation of the retail of alcohol at informal establishments such as "shebeens" should be addressed by government. This should include alcohol distribution and availability to minors.

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EXPLORING PSYCHOLOGICAL WELL-BEING AMONG SOUTH AFRICAN MOTHERS AND CHILDREN

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Abstract

Introduction
A review of the literature indicates a growing interest among researchers seeking to understand psychological well-being. However, relatively few studies on the subject have been conducted in South Africa.

Aim
The aim of the study was to ascertain self-esteem and life satisfaction as indicators of psychological well-being among a sample of South African mothers and their children.

Methods
Participants were a convenience sample of 245 mothers and their children residing in Cape Town, South Africa. Data was collected using the Coopersmith Self-Esteem Inventory and Satisfaction with Life Scale.

Results
The results showed that the majority of mothers and children attained medium scores on measures of self-esteem and satisfaction with life.

Conclusion
The data also showed a significant positive relationship [$r = .14$, $p < .05$] between mother and child self-esteem levels. For both mothers and children, satisfaction with life levels was significantly related to self-esteem levels. The implications of these findings are discussed.

Keywords:
Self-esteem, satisfaction with life, psychological well-being, socio-economic status, marital status.

INTRODUCTION

Psychological well-being is a fundamental characteristic which may be indicated by self-esteem and satisfaction with life. Self-esteem is considered to be an evaluative component of the self and important for individuals striving for achievement, success and independence (Cheng & Furnham, 2004). Because self-esteem is evaluative, researchers have extensively used it as an indicator of psychological and emotional well-being of and between children and adults (Cheng & Furnham, 2004; Deci & Ryan, 1985; Geca, 1971; Harter, 1999; Ryan, Stiller & Lynch, 1994).

High self-esteem has been linked to happiness and general psychological adjustment, which is synonymous with psychological well-being (Cheng & Furnham, 2004). In contrast, low self-esteem has been linked to a lack of self-respect, motivation, feelings of hopelessness and helplessness, the belief that one is not as good as others and the inability to reach personal potential which can cause pain, distress, breakdown, bad behaviour, relationship problems and even depression (Bulanda & Majumdar, 2009; De Witt & Booysen, 1995, 1999; Gecas, 1971; Gecas & Schwalbe, 1986; Hartley-Brewer, 1996; Van Der Ross, 1993;). Satisfaction with life is defined as a cognitive-judgemental process of one's life and is considered to reflect an individual's degree of happiness (Diener, Emmons, Larsen & Griffin, 1985; Pavot & Diener, 1993). Happiness in turn is defined as the degree to which an individual favourably judges one's quality of his or her life (Veenhoven, 1991). An individual's satisfaction with his or her life is associated with increased levels of self-esteem, global well-being and positive human functioning (Diener, et al., 1992; Gilman & Huebner, 2003). Satisfaction with life is dependent on the self and is therefore strongly and significantly correlated with self-esteem (Diener & Diener, 1995).

The relationship between mother psychological well-being and parent behavioural patterns and child well-being, adjustment and healthy appropriate behavioural outcomes have been well documented (Bulanda & Majumdar, 2009; Baumrind, 1997; Bosacki, 2003; Gecas, 1971; Gecas & Schwalbe, 1986; Grolnick, 2003; Milevsky, Schlechter, Netter, & Keehn, 2007; Robila and Krishnakumar, 2006; Shek, 2006; Soenens, 2006). Findings of previous research studies suggest that the mother's psychological well-being is related to the child's psychological adjustment and development (Brody, et. al., 2002; Rosenberg 1984; Shelton, 1990; Skuy, Koeberg & Fridjhon, 1997); that a child's positive sense of self was better predicted by the quality of the child-mother attachment than by the quality of the child-father attachment (Verschueren & Marcoen, 1999; 2002).

The aim of this study was to ascertain self-esteem and life satisfaction as indicators of psychological well-being among a sample of South African mothers and their children. Participants were drawn from low and high socio-economic groups and single parent and dual parent households. The hypotheses of the study were:

a) There is a significant difference in the psychological well-being of single and married mother-child dyads
b) There is a significant difference in the psychological well-being between mother-child dyads living in low and high socio-economic environments
c) There is a significant association between mother and child psychological well-being

METHOD

Participants

Participants were a convenience sample of children attending eight schools in the northern suburbs of the Cape Town. The schools in the area were classified as advantaged or disadvantaged based on school fees paid by parents. Children between the ages of 10 and 12 years were randomly selected using the school register as the sampling frame. The final sample consisted of 245 mother-child dyads as follows: The mean age of the children was 11 years, while the mean grade level was 5. There were more female (65%) than male (35%) participants. For mothers 73% mothers were married and 68% were high socio-economic status with ages ranging from 25 to 49 years. The criterion used to establish socio-economic status was household income, the official indicator established by Statistics South Africa.

Measures

The research tools consisted of the Self-Esteem Inventory (SEI) and the Satisfaction with Life Scale (SLS):

SEI

The SEI was developed to assess a person's ability to evaluate his or her self. The scale is a self-administered questionnaire which can be used with participants aged eight to adults. The School Short Form and the Adult Form were chosen for the current study to measure the levels of self-esteem of mothers and children. SEI requests participants to complete 25 items to which participants have to respond with either "Like Me" or "Unlike Me". Items included were "Things usually don't bother me"; "I give in easily"; "I have a low opinion of myself" and "Most people are better liked than me". A scoring key for each Form was used to attain a total raw score of each participant. The total raw score was multiplied by four (4) to attain a Total Self Score out of 100. The results for both mothers and children were easily comparable. High scores achieved on the SEI corresponded to high self-esteem and low scores indicate low self-esteem. In order to explain the position of an individual's self-esteem levels as compared with others in a group, the scores are interpreted as the upper quartile being considered as high self-esteem, the lower quartile as low self-esteem and the interquartile is considered as medium self-esteem.

The Satisfaction with Life Scale

The Satisfaction with Life Scale is a self-reported assessment developed to measure satisfaction with the respondent's life as a whole. The SWLS is a short, 5-item instrument designed to measure global cognitive judgments of one's life. The scale takes about one minute to complete and is in the public domain. The SWLS is scored on a 7-point Likert scale ranging from 1 (extremely dissatisfied) to 7 (extremely satisfied). Examples of some of the items are "I am satisfied with life" and "The conditions of my life are excellent". Scores on the SWLS correlate moderately to highly with other measures of subjective well-being, and correlate predictably with specific personality characteristics. The SWLS has been found to be suitable for use with different age groups (Diener, Emmons, Larsen & Griffin, 1985) and has been previously used in a South African context (Wissing, et al., 1999).

RESULTS

Psychological well-being of mothers

The results of the study indicated that there was no significant difference between married and single mothers nor between mothers living in high and low socio-economic environments with regard to psychological well-being (See Table 1). However, when the indicators of well-being were analysed separately, the data showed that high SES mothers scored significantly higher than low SES mothers for life satisfaction ($F(1, 192) = 6.46$, $p = .01$, partial eta squared = .03) and for self-esteem ($F(1, 192) = 15.87$, $p = .001$, partial eta squared = .08). In addition, married mothers scored significantly higher for life satisfaction than single mothers ($F(1, 192) = 12.23$, $p = .01$, partial eta squared = .06).

Psychological well-being of preadolescents

Preadolescents of mothers living in low socio-economic environments reported significantly lower self-esteem levels ($M=56.39$, $SD=15.39$) than preadolescents of mothers living in high socio-economic environments ($M=63.04$, $SD=15.08$): $F(1, 172) = 4.14$, $p = 0.04$). Table 2 shows that a difference between reported self-esteem levels by children of married mothers in low socio-economic environments ($M=54.74$, $SD=16.51$) than reported self-esteem levels of children of married mothers living in high socio-economic environments ($M=63.63$, $SD=15.07$). However, this difference was not significant.

Preadolescents' self-esteem scores were significant and positively related to how satisfied they were with their lives. There was a significant correlation ($r = .53$, $p < .01$) among preadolescents living in low socio-economic environments as compared to the other groups. There were significant positive relationships found between mothers' life satisfaction and mothers' self-esteem. Mothers who were single ($r = .56$, $p < .01$) and mothers living in higher socio-economic environments ($r = .58$, $p < .01$) had stronger correlations between their self-esteem scores and how satisfied they were with their lives. Table 3 shows the data.

A significant positive relationship was found between self-esteem of mothers ($r = .14$, $p < .05$) and preadolescents ($r = .20$, $p < .05$) in the total group and in the group of high SES mothers. The results showed a significant positive relationship between mothers' life satisfaction and mothers' self-esteem ($r = .48$, $p < .01$). Preadolescents' self-esteem scores were significantly and positively

related to life satisfaction scores ($r = .44$, $p < .01$). Further analyses indicated that neither mothers' satisfaction with life scores nor mothers' self-esteem scores were significantly related to preadolescents' satisfaction with life. A significant positive relationship was found between married mothers' self-esteem and preadolescents' satisfaction with life ($r = .15$, $p < .05$). The data are shown in Table 4.

Table 1: Mean scores and SD for life satisfaction and self-esteem for the total group of mothers and for the subgroups of mothers

	Low SES		High SES		Total	
	M	***SD***	***M***	***SD***	***M***	***SD***
Life Satisfaction						
Married Mothers	23.24	6.56	25.81	6.55	25.14	6.63
Single Mothers	18.96	7.18	22.15	6.83	20.62	7.12
Total Group	21.58	7.07	25.10	6.74	23.98	7.02
Self-esteem						
Married Mothers	62.42	20.85	72.30	17.18	69.73	18.64
Single Mothers	56.83	21.30	72.00	17.31	64.72	20.60
Total Group	60.26	21.03	72.24	17.14	68.45	19.23

Results of Analysis of Variance

	Dependent Variable	df	F	Sig.	Partial Eta Squared
SES	Life Satisfaction	1	6.46	0.01	0.03
	Self-esteem	1	15.87	0.00	0.08
Marital Status	Life Satisfaction	1	12.23	0.00	0.06
	Self-esteem f	1	0.88	0.35	0.00
SES * Marital Status (interaction)	Life Satisfaction	1	0.08	0.78	0.00
	Self-esteem	1	0.71	0.40	0.00

Table 2: Preadolescents' Mean scores and SD for life satisfaction and self-esteem as a function of mothers' marital status and SES level

	Low SES Mothers		High SES Mothers		Total	
	M	*SD*	*M*	*SD*	*M*	*SD*
Children's Life Satisfaction						
Married Mothers	25.66	4.48	26.43	5.63	26.23	5.35
Single Mothers	27.00	6.98	24.58	6.65	25.74	6.85
Total Group	26.18	5.56	26.07	5.86	26.10	5.75
Children's Self-esteem						
Married Mothers	54.74	16.51	63.63	15.07	61.32	15.89
Single Mothers	59.00	13.36	60.62	15.17	59.84	14.20
Total Group	56.39	15.39	63.04	15.08	60.94	15.46

Results of Analysis of Variance

	Dependent Variable	df	F	Sig.	Partial Eta Squared
SES	Life Satisfaction	1	0.71	0.40	0.00
	Self-esteem	1	4.14	0.04	0.02
Marital Status	Life Satisfaction	1	0.07	0.80	0.00
	Self-esteem f	1	0.06	0.81	0.00
SES * Marital Status (interaction)	Life Satisfaction	1	2.66	0.10	0.01
	Self-esteem	1	1.99	0.16	0.01

Table 3: Correlations between life satisfaction and self-esteem

	Total Group N=245	Married Mothers N=178	Single Mothers N=67	High SES Mothers N=135	Low SES Mothers N=64
Preadols	.44**	.46**	.42**	.41**	.53**
Mothers	.48*	.44**	.56**	.58**	.41**

**p<0.01

*p<0.05

Table 4: Intercorrelations between mothers' and preadolescents' scores for self-esteem (S.E.) and satisfaction with life (SWL)

Preadols	Mothers	Total Group	Married Mothers	Single Mothers	High SES Mothers	Low SES Mothers
SWL	**SWL**	.10	.13	-.15	.05	.18
SWL	**S.E.**	.10	.15*	-.04	.16	-.06
S.E.	**S.E.**	.14*	.13	.16	.20*	-.02
S.E.	**SWL**	.10	.10	.00	.06	-.00

DISCUSSION

This study explored the psychological well-being of mothers and their preadolescents by using self-esteem and satisfaction with life as indicators of psychological well-being. The data of the study supported the hypothesis of an association between mother and preadolescent psychological well-being. In other words, the results suggest that when mothers are psychologically well their preadolescents would also be psychologically well. This finding is supported by previous research, which highlight that there is a relationship between mother-child psychological well-being and that a child's positive sense of self was better predicted by the quality of the child-mother attachment than by the quality of the child-father attachment (Brody, et. al., 2002; Roman, 2003; Rosenberg 1984; Shelton, 1990; Skuy, Koeberg & Fridjhon, 1997; Verschueren & Marcoen, 1999; 2002).

However, the results also suggested that mother psychological well-being was only partly associated with the child's psychological well-being. In other words, only mother self-esteem was associated with preadolescent self-esteem, but not how satisfied mothers and preadolescents were with their lives. This could be because an individual's satisfaction with life is dependent on the self and not another individual's self-esteem or satisfaction with life (Diener, et al., 1992; Diener & Diener, 1995).

An examination of mother-preadolescent groups suggested significant differences for socio-economic groups rather than married and single mother-preadolescent groups. Thus even though single mothers may be considered to be at a greater disadvantage than their married counterparts (Ceballo & Mcloyd, 2002; Franz, Lensche & Schmitz, 2003; Olson, Ceballo & Park, 2002; Whitehead & Holland, 2003), there may be no significant differences in their psychologically well-being. This is in contrast with other studies (Crosier, Butterworth & Rodgers, 2007; Davies, Avison & McAlpine, 1997; Targosz, et al., 2003; Wade & Cairney, 2000) which indicate that single mothers are more likely to be susceptible to depression. However, the suggestion that marital status is possibly not a factor in the levels of psychological being of mothers is supported by previous studies, which indicated that there are possibly other factors associated with mother psychological well-being (Bank, Forgatch, Patterson & Fetrow, 1993; Feldman et al., 1990; Florsheim, Tolan & Gorman-Smith, 1998; Segal-Engelchin & Wozner, 2005). One of these factors could be socio-economic status.

The results showed socio-economic status may have an effect on self-esteem of mothers and preadolescents, particularly for the low socio-economic group. Single mothers living in lower socio-economic environments reported lower levels of self-esteem and satisfaction with life. The reality in South Africa is that many people, women especially, have lower education levels, low paying employment opportunities, sometimes lack of spousal financial support and inadequate and insufficient social support (Statistics South Africa, 2007). Being a single mother in a low socio-economic environment presents a great challenge to mothers and children as there is the added burden of being the sole provider in the family. The suggestion that socio-economic status is associated with mother-preadolescent psychological well-being is supported by previous research (Chua, 2003; Frisby & Crawford, 1995; Le Bruyns & Pauw, 2004; Trowbridge, 1972; Twenge & Campbell, 2002: 61).

While many South African mothers are confronted with socio and economic hardships on a daily basis the results of this study suggest that mothers and preadolescents are psychologically well. The results suggest that being a married or single mother does not significantly contribute to the mother-preadolescent relationship, but that socio-economic status is the main contributing factor to psychological wellbeing. Thus being single living in a low socio-economic environment poses more challenges than being married living in a low socio-economic environment and being married or single living in a high socio-economic environment. Future studies may clarify this relationship.

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INTRODUCING PHYSICAL EDUCATION INTO SCHOOLS: THE VIEW OF TEACHERS AND LEARNERS

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Abstract

Introduction
A number of initiatives were launched in various countries worldwide to provide quality physical education in schools. However, the promotion of participation in sport and specifically elite sport is still regarded to be economically more feasible, than the introduction of physical education in schools and "sport for all" programmes at community level. In order to improve the current situation, the conventional ideas of the school physical education programme needs to be reconsidered and more serious consideration should be given to the preferences and needs of the key stakeholders.

Methodology
The aim of the study was to determine the views of teachers and learners with regards to physical education and the promotion of physical activity in a local community school. Participants included learners and teachers involved in life orientation and coaching of sport in a high school in a local community in the Western Cape, South Africa. The school was purposively selected as it caters for the previously disadvantaged learners in the area. Data was collected by means of focus group discussions.

Results
The results indicated that both the learners and teachers appreciated the benefits associated with participation in physical education but also highlighted significant barriers that prevented the effective implementation of physical education programmes in the school.

Conclusion
South Africa needs a structured, cost effective approach to physical and health education in schools that stipulates national objectives and detailed strategies to realize the objectives.

Key words
Physical education, teachers, learners, views

INTRODUCTION

Since 1994, the South African government has undertaken several international and country level policy initiatives to promote the health and well-being of young people. At international level they participated in the signing of the World Summit Declaration and the ratification of the Convention on the Rights of the Child (UNICEF, 2003). At national level, the National Action Plan for Children was a further illustration of existing commitments to improving the health of the youth in South Africa (National Programme of Action Steering

Committee, 1996). The Ministry of Education, launched a five-year plan, the Trisano programme, to transform the education and training system from one of segregation to one of equal opportunity for all young South Africans (Department of Education 2001-2002) focusing on both the health and education of the learner. This leads to a focus on physical education in schools as a tool to address the health of the learner. The importance of physical education cannot be ignored if the health and well-being of young people are to be considered.

An audit on the state and status of physical education in 1999 provided a clear picture that physical education as a school subject was under threat worldwide (Hardman and Marshall, 2001). A number of initiatives were launched in various countries to provide quality physical education in schools. However, it was still regarded as economically more feasible to promote participation in sport and elite sport rather than physical education and "sport for all" at community level (Burnett and Hollander, 1999). Darlison (2001) indicated that despite the proven benefits of quality school physical education programmes, a need still exists for education policies that prioritizes the subject in schools. Within the South African context history reveals that the low institutional priority of physical education can be attributed to three problems namely: the availability of qualified physical education teachers in former black schools; lack of basic educational facilities and the non examination status of physical education which made it much less of a priority when it came to the provision of resources (Walter, 1994; George, 1995; Van Deventer, 1999). The Department of Education attempted include physical education programmes in schools by reinstating physical education as a school subject with full status as part of the Revised National Curriculum in the Life Orientation Learning area (DOE, 2002). According to the Department of Education in South Africa (2002), the development of learning programmes such as life orientation is the responsibility of the school and teachers. The fact that physical education specialists are no longer appointed at schools means that generalist teachers, who may have no knowledge about the subject, are required to teach life orientation (Hardman and Marshall, 2001). This could lead to physical education as a focus area in life orientation being ignored or alternatively widespread variations in the actual delivery of physical education programmes could occur.

The challenges facing physical education include the need to embrace strategic initiatives at school, community and policy level. In order to improve the current situation, the conventional ideas of the school physical education programme needs to be reconsidered and more serious consideration should be given to the preferences and needs of the key stakeholders namely the learners and teachers. The question that arises is: Are the needs of the key stakeholders being heard when we focus on the re-introduction of physical education in schools? According to Strand and Scantling (1994), gaining insight into student's beliefs assists in understanding their attitude towards and their interest and involvement in physical education curriculums.

Methods

The aim of the study was to determine the views of teachers and learners with regards to physical education and the promotion of physical activity in schools in a local community school. Participants included learners and teachers from a high school in a local community in the Western Cape, South Africa. The school was purposively selected as it caters for the previously disadvantaged learners in the area. Permission to conduct the research was obtained from the Western Cape Department of Education and the principal of the selected school. Written informed consent was obtained from participants and guardians of participants. Data collection methods included focus group discussions held separately with learners and teachers. The aims of the focus group discussions were to determine their views on the inclusion of physical education into the school curriculum as well as possible barriers to implementation and recommendations for the future. The sample of learners consisted of 2 learners from grades 8 - 11, randomly selected from a list of all learners in the various grades. This constituted a focus group of 8 learners of which 4 were male and 4 were female. The teachers involved in the teaching of life orientation and coaching of sport at the school constituted the second focus group. The focus group discussions were tape-recorded with

permission from the participants. The tape recorded information was then transcribed verbatim into a manuscript and the information was analysed into emergent clusters. The clusters were then coded and categorized into themes. Quotes are given that best support the theme identified.

RESULTS

The statement and question that was posed to both learners and teachers was: The Minister of Education had made the following statement "Physical education must be re-introduced into schools" and "How do you feel about this?" The learners and teachers that participated in the focus group discussions expressed that they recognized the values and benefits of including physical education in the school curriculum, however, they had reservations.

"Physical education assists in a child's holistic development and this is important, but…." (Teacher)

"Physical education is important for me as an outlet to let go of frustrations caused by studying as well as my personal circumstances" (Learner)

Teachers acknowledged that participation in sport and physical activity encourages discipline, improves fine motor control and stimulates the brain.

"Sport is needed within the school because it instills discipline within the children and they know that if they misbehaved they would not be allowed to do something they loved" (Teacher)

"I can control my anger better during the day if I can get rid of it through something like sport. Running around the field helps get rid of the feeling of wanting to hit someone." (Learner)

The main themes relating to barriers for implementation included lack of time within the school timetable; a paradigm shift on the part of learners and teachers regarding physical education; inadequate facilities and a lack of foresight of the Department of Education.

Teachers reported that a vacuum had been created for many years and that children were not used to the idea of sport and physical education being compulsory in schools. This idea was in part supported by the learners:

"This vacuum exists for many years, it is difficult to get the learners to accept that there is compulsory sport so you are sitting with a situation where you must almost threaten learners to something so you can evaluate them" (Teacher)

"I have been at this for four years and now all of a sudden they (teacher) want to make participation in sport compulsory. No way!!" (Learner)

Facilities within schools in previously disadvantaged communities are limited and cannot accommodate a wide variety of physical activities and sporting codes:

"It's difficult in a school set-up like this because although we have a hall it is not big enough to do any sport in it as it's not conducive for ball games or anything requiring space" (Teacher)

"We need more sports in our school. At the moment it's not possible cause we don't have the space or proper grounds" (Learner)

The Department of Education creates barriers to physical education by not assisting in creating facilities that are conducive to sport. The requirements of the Education department places more emphasis on academic performance with little or limited emphasis on promotion of physical activity :

"You have got the full academic programme … the minister also said he wants maths literacy and all those other little things included into the curriculum. I think there is no emphasis on sport in the curriculum and no real time for physical education in the school timetable" (Teacher)

"We must do all this research now as part of our subjects… where must we find time to do sport if we must go to the library to complete our assignments that has increased with this outcomes based education" (Learner)

"the role of physical education in the life orientation curriculum is not very clear and therefore no time and space is really made for it.." (Learner)

The new curriculum format called outcome based education at schools has placed an increased workload on teachers. Teachers have to fulfill multiple roles within the school that does not make it viable for physical education to be re-instated at present unless there is an increase in both human and financial resources.

"…The rich schools that can afford it, and can charge learners' large amounts of school fees, to employ physical education teachers. We don't have the money or the resources to employ physical education teachers" (Teacher)

"Teachers are so busy marking that they don't have time to properly supervise us for sport. Maybe they should have other teachers to do the sport."(Learner)

The teachers also made recommendations that could facilitate the re-introduction of physical education into this school. Teachers felt that physical education should become an examination-based subject with a theoretical component and a practical component. In order to assist schools to implement and sustain physical education programmes, appropriately trained physical education teachers should be appointed. In addition, opportunities should be created to train life orientation teachers to effectively provide physical education opportunities to learners.

DISCUSSION

A review conducted by Cale and Harris (2006) concluded that promotion of school-based physical activity interventions through physical education is a worthwhile effort. This statement is supported by both the learners and the teachers in the current study as they clearly identify the benefits associated with participation in physical activities. However, if a change is to be brought about in the approach to physical activity promotion and the inclusion of physical education in schools, all stakeholders need to work together. To achieve desired objectives of health promotion or social development, efforts must be co-ordinated and combined (Darlison, 2001; Spain 2000).

Richard and Banville (2006) highlighted the need for teachers to consider and listen to the voices of students when designing and modifying physical education curriculums. It is evident from the current study that learners and teachers as key stakeholders in physical education at schools have a definite opinion. A similar study conducted by Amusa and Toriola (2008) concluded that "as consumers of education, the perceptions and expressions of students on the value of physical education and school sport should inform the revamping of quality physical education in South Africa". Van Deventer (2008) highlighted the need for co-ordinated efforts or partnerships to assist in training life orientation teachers to effectively implement physical education programmes. The department of education in South Africa thus needs a structured, cost effective approach to physical education and health education in schools that stipulates national objectives and detailed strategies to obtain the objectives of health promotion and social efficiency amongst others.

CONCLUSION

The benefits of physical education and physical activity at schools are well known. However, it is evident that the Department of Education should assist schools to build capacity relating to successful implementation of physical education programmes. A collaborative approach to implementation of physical education and physical activity at schools, that equitably involves all partners in the process and recognizes the unique strengths that each brings, will facilitate a positive introduction of physical education into schools facing challenges.

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SPORT FOR DEVELOPMENT. AFRICAN INTERNATIONAL UNIVERSITY INITIATIVE (S.F.D-A.I.U.I.)
JUSTIFICATION AND BASIC ASSUMPTIONS OF A SPORT AND DEVELOPMENT STUDY PROGRAMME IN SOUTHERN AFRICA

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This paper gives the vision of the initiators of the programme on the two basic elements of the title: 'Sport for Development' and 'African International Interuniversity Initiative'. This vision is already partly put in concrete actions, however partly still under discussion between the interested partner universities. The explicit formulation and justification of the basic assumptions may help to find in an open discussion a creative solution for all challenges that may slow down or impoverish the realisation of the initiative.

POTENTIALS OF SPORT IN A DEVELOPMENTAL CONTEXT

Both recreative and competitive sport participation constitute a value in itself because on a personal level sport is commonly recognized and appreciated as a generator and or facilitator of positive values such as the development of motor and social skills, as well as high valued physical and psychological qualities, i.e. a sense of competence, health, fitness, self-esteem, pleasure, well being. On a community level sport is said to have the potential to facilitate in a direct and indirect way community development, social integration, peace building, dealing with trauma, provide safe spaces for children to play, and serve as containing contexts to restore a sense of normalcy in the lives of children affected by conflict or disaster, improving health, poverty alleviation etc.. Sport is indeed an arena where people meet, either in active participation or as leaders, officials or spectators. Either way, sport offers an easy accessible arena where awareness can be raised, positive activities introduced, education offered and healthy habits developed. In countries where HIV/AIDS prevalence rates are high and mainly affect the young poor, sport provides also a valuable means for including stigmatized youth and developing HIV/AIDS information and education activities. As a most dynamic cultural phenomenon, sport is ascribed considerable potential as contributing to education, socialization and social integration. Practices and policies worldwide have adopted sport programmes as a flexible, accessible and cheap field tool in relation to these outcomes of sport.

However less then ten years ago sport was seen as a luxury in developmental co-operation circles and funding sport projects was an extremely low developmental agenda priority. This may be due to the ethical consideration in the donor countries that basic conditions (peace) and needs (e.g. food, water, and medical care) should have priority on leisure and pleasure. However, this latter consideration ignores the 'potential' of sport as a tool in the pursuit of the development goals as mentioned above and also ignores the reasoning in the recipient countries.

This ethical consideration in the donor countries is now strongly challenged by the recognition of the potential of sport by international and national organisations (see references to reports, memoranda and statements in box 1), by the reality of the hundreds of successful projects (see reports of the Next Step Conferences, see regularly updated NCDO toolkit Sport for Development in Box 2) and by the growing involvement of the academic community (see e.g. Coalter, 2007; Vanden Auweele; 2006; Van Eekeren, 2006).

BOX 1:
World leaders recognized the power of sport and its values at the 2000 UN Millennium Summit and at the 2002 Special Session on Children. The 2002 outcome document 'A World Fit for Children' and the 'Millennium Development Goals (MDGs)' serve as the primary guideposts for all of UNICEF's programming.

BOX 2:
CDO TOOLKIT: - Address of the toolkit: www.toolkitsportdevelopment.org (includes information on the themes: gender, HIV/aids and sports, disability and sports, sports and reconciliation)- link to publication mega sports events:
www.toolkitsportdevelopment.org/mega-events - link to publications on gender and sports:
http://www.toolkitsportdevelopment.org/casablanca2008/

Moreover, the recipient countries expressed several times that sport (including all forms of games, sports education and physical education up to elite sports) helps them to take their minds off the hardships all around them. They even consider the organisation of championships (e.g. the FIFA World Cup in South Africa) being a good idea because they may have a tremendous impact on the mood and image of the country, boosting not just the reputation of those in power but also the morale of the population at large. The whole country celebrates at the time of the championships and there is worldwide focus and interest for a country which is normally disregarded or seen in a negative light (Dutch Ministry of Health, Welfare and Sport, 1998; NCDO, 2008; Vanden Auweele , 2006). We will explain below that the concerns that were expressed on the 2010 World Cup at the DBBS conference in Stellenbosch, April 2008 were targeting FIFA rather then the South African Government (see Box 3). See also Foster & Pope (2004), Jennings (1996), Giulianotti, 2006; Lenskyj (2006), Maguire (2006) for excellent analysis of the way global sporting organisations and the so called sports industrial complex enrich themselves at the expense of the organizing countries. They are said to operate in a non transparent way, to suffer from a democratic deficit and hardly can be held accountable for their decisions and actions.

Potentials of sport in a developmental context for Northern countries.

More than in other development projects, Sport and Development can be viewed from both a North-South as well as a South-North perspective. This form of development cooperation may have social returns for Western countries in terms of producing new insights of potential importance to their own multicultural challenges that became a hot issue due to the enormous influx of African and East European people and refugees from conflict areas from all over the world. Community work in Europe is learning a lot from models tried out in the South. Sport, is considered to be the second most accessible and cost-effective tool to reach (social integration) emigrants who in a first reaction of uncertainty and defence (but also because of poverty) withdraw themselves physically into certain sectors of the cities and mentally into the way of living of their former countries and cultures which is in many aspects contrasting with their new country (Dutch Ministry of Health, Welfare and Sport, 1998; Theeboom & De Knop, 1992; Theeboom, 2008).

OPPORTUNITIES FOR MODERN SPORT AS SUCH: A STIMULUS FOR A CRITICAL SELF ANALYSIS

Sport for Development may also initiate International Sport Organisations to question itself: 'which values are both explicitly and implicitly propagated in and by current (competitive) sport? What kind of human behaviour and type of sport is promoted? Which views are given a chance and which are not? What are the criteria for good sport

delivery?'(Vanden Auweele, 2004). Indeed, notwithstanding that we know sports' inherent value and its 'potential' to address the well-being of people, it would be naive to think that sport automatically elicits and promotes these positive effects. Sport participants are, especially in competitive sport, confronted with the massive entrance of commercialization via sponsors and media which influence moral and social values of managers, parents, trainers, etc. Differences in scales of values produce differences in thinking and acting.

Our position is that sport mustn't be allowed to be a facilitator or catalyst for increased egocentrism, abuse, violence and corruption on and around the competitions. The last thing that promoters of sport in a developmental context want is to increase the dominance of these negative values via sport in countries that, due to many structural factors (e.g. poverty…), are especially susceptible for corruption, violence and abuse.

Therefore, in order to unlock the positive potentials of sport and to avoid negative impacts we need to identify the active ingredients of positive and negative sport delivery, to develop evidence-based intervention strategies and educate all those using sport programmes in developing and upcoming countries. Policy driven enthusiasm on the positive 'potentials' of sport both on a personal and community level is too fragile a basis for the quality, efficiency and sustainability of sport in general and development oriented sport programmes specifically. As explained above, sport isn't 'always' and 'automatically' a useful instrument or goal. Moreover, how much do we really know (empirical evidence) about the effects of sporting activities on risk behaviour prevention, social inclusion, conflict prevention and peace-building? Do the organizations involved have sufficient know-how and do they make adequate use of the information available. (Burnett, 2006; Coalter, 2007; Maguire, 2006)?

A conference in Cape Town (University of the Western Cape, March 2008) in the context of our DBBS sport and development project resulted in the formulation of the following reflections on the organization of mega sport events. These reflections have been sent to FIFA.

BOX 3
Letter to FIFA

FACULTY OF COMMUNITY AND HEALTH SCIENCES

Dear Mr …(Member of the FIFA Executive Committee)

In March 2008 an international congress was organised on "the impact of mega sport events on developmental goals". It was hosted in Cape Town South Africa. Please find attached the results of the conference and the key ideas and recommendations emerging from it. The conference organising committee aspires to contribute to maximising the positive impacts of the 2010 FIFA world cup for SA Citizens, teams, fans, and supporters from abroad.

We greatly appreciate your entertaining the attached recommendations and request you to defend those that you concur with both in the FIFA medical committee and the FIFA executive board.

On behalf of the organizing committee,

Yours sincerely:

Representatives of the universities of the Western Cape, Stellenbosch, Johannesburg, Pretoria, Leuven and Utrecht have signed this letter

FIFA's reaction was negative and defensive. This wasn't surprising because the sports world hasn't in the past been renowned for its self-criticism, nor for accepting criticism rightly directed at it. Anyway it illustrates that sport for development may challenge the sport sector to reflect on its basics.

BOX 4:
The document we sent to FIFA

AN AFRICAN FOOTBALL WORLD CUP AT LAST: Maximizing the positive effects of the 2010 FIFA World Cup TM

We are conscious of the fact that FIFA has implemented various developmental initiatives such as the Football for Hope Project which is designed to have lasting legacy effects in the host nation. Notwithstanding this and other highly commendable initiatives and commitments, the March 2008 conference (Impacts of Mega Sports Events on Developmental Goals, 5-7 March, Stellenbosch, South Africa) highlighted additional developmental concerns that we wish to bring to your attention (see the accompanying brochure). The following are a set of developmental recommendations emanating from the conference proceedings:

Legacy effects

1. One of the conclusions is that the FIFA plan and vision of the legacy effects is somewhat unclear. It is recognized that the Legacy Plan might be very well developed by FIFA. The communication of that plan, however, is not evident and thus the Legacy Plan can be perceived to be unclear and not sufficiently articulated. It is recommended that the communication of the Legacy plans and effects be widely disseminated and publicised so that the South African population can have clarity on the benefits to be accrued from the hosting of the World Cup event.
2. The role of the commercial sponsors in the Legacy Plans is not evident or visible. It is recommended that FIFA consider generating greater visibility and/or involvement of the commercial sponsors in legacy projects through their corporate social responsibility commitments that will encourage and support longer-term developmental goals in South Africa.

Economic effects

3. The conference registered concern that the commercial activity benefits around the event will be restricted due to the tight regulation of revenue streams which, it appears, will exclude the informal sector that characterizes a large chunk of economic activity in South African urban settings. It is noted that there is widespread local expectation that the World Cup event will generate many opportunities for small businesses, entrepreneurs and vendors in and around the match venues and the supporting base camps and fan parks. We are concerned that there is a disjunction between these very high expectations and FIFA's plans to regulate commercial activity in and around the event. Our concern is that this constitutes a source of potential disappointment, disgruntlement and anger in local communities where expectations of direct commercial gain from the event are extremely high. We wish to bring this disjunction to the notice of FIFA. We recommend FIFA to create additional opportunities for small businesses and entrepreneurs and vendors around match venues and to think creatively about other opportunities to increase the benefits for the informal sector (20% of S.A.'s economy).
4. It is noted that the Volunteer Plan is not well understood at a local community level. It is recommended that this be more precisely articulated and communicated because there are expectations that the Volunteers will both be financially rewarded and accrue skills as a result of their voluntarism. In the African context the concept of voluntarism may have different connotations and may raise financial expectations.

Health effects

5. The conference noted concern with the seeming lack of a sexual health and safety plan given the World Cup is to be hosted in South Africa with its high HIV prevalence rate. It is noted that the sex worker industry is illegal in South Africa and, as a result, unregulated. This increases the risk of sexual hygiene problems and ultimately the risk of transmission of sexually transmitted disease (including HIV). The conference delegates noted it is very unclear where the responsibility lies for implementing an integrated sexual health awareness and prevention plan around the FIFA World Cup TM event.

Impact Study

6. The conference resolved that there is a need for rigorous studies of the impact of the World Cup on developmental indicators pertaining to social, health and economic issues. While it is realised that such studies are being planned and may already be under way, it is recommended that FIFA publicly supports such impact research that will inform future event planning in developing and developed contexts.

Social involvement and contact

7. The World Cup event is greatly anticipated at the local community level. There is a concomitant expectation that community members (youth in particular) will have first hand exposure to the visiting teams and players by having access to, for example, training sessions and autograph sessions. FIFA is requested to openly declare that this will, indeed, be the case. This kind of first-hand exposure is a critical source of motivation for sports development in local communities. It is recommended that FIFA encourage an articulated plan for teams to add value to local communities through such controlled engagement with local NGO's, sporting bodies and associations and youth initiatives.

AN INTERUNIVERSITY COLLABORATION: An African International University Initiative

Basis assumptions

1. The 3 basic objectives/tasks of each university are research, education and service to the public. Sport can be approached via two ways or with two interests, i.e. via competitive (elite) sport as a value in itself and sport as a means to reach developmental goals.

Two interests **Three objectives/tasks**	Competitive sport, Elite sport	Sport and development (Sport Plus and Plus Sport)
Research		
Education		
Service to the public		

2. The North- South- South developmental initiatives are carried out with the best intentions but fragmented and with a total unawareness of each other. This is true for both Northern (donor) and I in the Southern (recipient) countries (Develtere, 2009). As far as sport is concerned, universities, sport organisations and NGO's's within the same country, implement sport and development programmes in an uncoordinated and non-integrated manner. This is true for both sport plus or plus sport programmes (Box 4).

BOX 5:
Definition of Sport Plus and Plus Sport Programmes

'Sport plus' activities focus on sport and physical education itself and are designed to maximise the social benefits of such activities.
Integrating sport and physical exercise into other activities, such as rural development projects, programmes for street children and projects aimed at women, or into the management of refugee camps are termed **'plus sport'** activities.

3. South Africa has a history of both dealing with trauma (i.e. Apartheid) and working on the development towards a multicultural and multiracial society (post Apartheid) in a way (with high moral standards) that is still an example not only for Africa but for the whole world. South Africa can and must once again be an example and for Africa and for the whole world in giving impetus to an initiative which exemplifies big-heartedness, a lot of creativity, optimism, realism, voluntarism and flexibility. The University of the Western Cape (UWC) could be a pioneer here considering her mission statement and her position in South-Africa. Developing and implementing a joint educational programme on sport for development will realise a sustainable element in the South African educational and sport system and will be a sportive contribution to the African Renaissance.

Strategic choices based on these basic assumptions

Gearing competitive sport up with developmental interests, gearing the three university tasks (research, education, service to the public) and the interests of the different stakeholders up with each other (universities, sport organisations and NGO's), will constitute an academic, financial and most of all a political challenge. To consider this an easy task should be an underestimation of the impediments. Each university, each NGO, each sport organisation has his own history, his own challenges, difficulties and possibilities.

However the aim should definitely be a 'win-win' situation for all partners. This means we will have to overcome the challenges of unhealthy competition (to be the first, the best, and the biggest) and to reach an optimal cost-benefit investment for all actors and stakeholders, i.e. avoiding unnecessary costs and overlap and therefore targeting a combination of forces and expertise.

From a pragmatic viewpoint one may argue that not any single university (South or North) does have at this moment either the research or the educational capacity to organise such a multidisciplinary task alone. Other (Southern) African and (in our view, to a certain point) Northern universities should join whether with experts, researchers, lecturers, or students etc. Scientists and practitioners (sport organisations, Ngo's) could work together to produce a balanced curriculum with several modules while all could keep their identity and focus on their crucial issues and topics. This collaborative approach could lead not only to a joint curriculum but also to joined research and practical projects. In short, the educational programme could facilitate other forms of contracts with both African and Northern universities.

The major gain would anyway be the professionalization (theoretically and practically) of NGO's collaborators who are amateurs in sport on the one hand, and on the other hand the widening of the horizon of trainers, sport managers and administrators who are experts in one domain of sport (techniques, tactics, physiology, psychology, sociology, management, administration, etc.). Both target groups rely mostly upon (some) experience and a lot of intuition, goodwill and dedication. However this is not enough to generate the positive values attributed to sport participation. Pedagogical skills, knowledge of the broader sport goals (social skills to function optimally in a team, developing self-esteem, developing a healthy competitive life style) are necessary in addition to the skills needed

to select and organise those exercises and contexts that serve developmental goals (community development, peace building/keeping, risk behaviour prevention). To day we dispose at best of technical and tactical manuals in most sports but we don't have a well thought-out sport policy concept which aims explicitly to unlock both sport intrinsic values and values that facilitate developmental goals and which include pedagogical, psycho-social, medical and nutritional etc. aspects

In order to tackle these challenges we therefore suggest ' in concreto':

1. to start with a sustainable inter-university educational programme. For strategic reasons we think and have the personal experience in Europe that this is the most efficient entrance in the university's tasks including research, practise and education (Vanden Auweele, 2003).
2. A structure with good defined and shared functional and financial responsibilities of all partners involved (bilateral contracts?). The structure must have a clear coordinating board including educational, administrative and financial elements. Flexibility and respect for each others identity are the key word here: universities, Ngo's, sport organisations should be allowed to enter/contribute with all or only with some elements such as lecturers, students, administrative help, logistic support etc.
3. Although the starting point is 'sport for development', there may be not a contradiction between competitive sport and sport for development. Anyway we need a clear vision and a realistic decision (in terms of expertise and finances) on how far we want or can go in the linking between elite sport and sport for developmental purposes. (Allison, 2005).
4. A clear vision and decision on the level of the programme, in terms of entry requirements, diploma or certificate, validation of the programme;
5. Keeping in mind that the title mentions 'African ….Initiative' we need a provisory decision on the number and origin (only South or South and North to some extend, or…) of partners to start with and a policy (procedure) of expansion.

CONCLUSION

In order to tackle the academic and political challenges we need a clear and explicit vision on what we want to achieve with whom and with what means. No hidden expectations or agenda's. We need to target the active ingredients of sport in an optimal manner linking between recreation sport, competitive sport and sport for developmental purposes.

We need an operable education programme for managers, technical directors, supervisors and NGO collaborators to act as multipliers to put this vision into practice.

Notwithstanding traces of impatience, frustration, resentment and a reflex to defend our own organisations' interests, we need flexibility, creativity and above all the will to succeed among all partners. We mustn't agree on all points but must have gusto to come to a consensus.

Finally this initiative has to be monitored and evaluated with the same measures and criteria as any other 'sport and development' initiative.

At this moment one may evaluate the initiative as largely 'outside-in' (VLIR-DBBS/Belgium cooperation programme) with strategies, structures and contents that are borrowed from the European Erasmus/Socrates programme and from Northern and Southern experts in Education and Sport and Development.

However, it is the plan of the authors to strive as far as the implementation of the programme is concerned for a change from a cooperation status to an interuniversity network built up through bilateral contracts and equal power relations. This should be realised through a mobilizing of dynamics in all participating universities and strategic partners (Education departments of the participating universities' governments) for uptake and ownership.

Linking and bridging, collaboration, mutual reflection, association and identification will be the key words of the elaboration and implementation of the SPORT for DEVELOPMENT. African International University Initiative (S.f.D-A.I.U.I.)

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