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The Journal of Community and Health Sciences

CONCEPTUALISATIONS OF CHILDHOOD IN NAMIBIA: NEW LEGISLATION VERSUS PUBLIC PERCEPTION

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Background
Namibia is in the process of developing new children's legislation. The aim of this research paper is to explore how the public conceptualisation of childhood in Namibia compares to provisions in the Child Care and Protection Bill (April 2010 draft).

Method
A qualitative methodological approach was used to explore participants' conceptualisations of childhood in Namibia. Detailed interviews were conducted with four community members aged 23-75 years. Interviewee one was a 23-year old Oshiwambo male; interviewee two was a 38-year old Damara/Nama female; interviewee three was a 42-year old white female age and interviewee four was a 75-year old white male. Using the data collected, thematic analysis was used to formulate themes within the data.

Results
The main themes identified were the role of the state versus the role of parents in childhood, the participation of children in decision-making and the protection of children. The results show that whilst public opinion and the proposals in the bill overlap in some areas such as the need to protect children, in many areas public opinion and the proposals in the bill differ to a great extent. Differences are particularly noticeable for issues such as parental authority versus parental responsibility and child participation.

Conclusion
At present the conceptualisation of childhood envisaged by the new legislation goes beyond public understanding of childhood. Government and stakeholders should do more to prepare the public for the bill to ensure that the Act is well-received in Namibia.

Keywords: childhood, conceptualisation, perception, legislation.

Introduction

The conceptualisation of childhood varies from person to person, family to family and country to country. James and James (2004) state 'childhood' is the structural site that is occupied by 'children', as a collectivity and it is within this collective and institutional space of 'childhood', as a member of the category 'children' that any individual 'child' comes to exercise his or her unique agency. However, despite the breadth of understanding of what childhood means to different people, researchers are increasingly using the term 'global childhood' to describe the phenomenon that conceptualisations of childhood across the world are becoming ever closer (Nieuwenhuys, 2010). Many people attribute this change to the ever-strengthening international human rights framework and the impact of human rights agreements for children such as the United Nations Convention on the Rights of the Child (CRC, 1989) or the African Charter of the Rights and Welfare of the Child (ACRWC).

However, whilst there is a trend, and often legal obligation, for signatories of international conventions to align with the principles within the agreements, some of the provisions can be more progressive than public opinion allows for. For example, the concept of child participation, which is described as one of the 4 "P's" in the Convention on

the Rights of the Child (CRC, Mahery, 2009), is often not fully understood in many countries and there is a long way to go before the principles of child participation envisaged in the CRC are realised across the globe. Strong public opinion can also conflict with the provisions in international agreements. For example, a common construction of childhood is the idea that children are blank slates that should be moulded and developed (Aries, 1962; Montgomery, 2008). In the past, this concept has often been realised in legislation through concepts such as parental authority and marital power. Indeed, it is not all that long ago that a husband had power over both his wife and his children. However, current thinking about parental care has shifted from parental authority to parental responsibilities and duties (Skelton, 2009). The disparity between principle and practice across the world can lead to challenges in promoting the best interest of the child.

Countries, such as Namibia, are experiencing the challenges of aligning international obligations with public belief and understanding. Namibia is a country strongly affected by poverty and HIV/AIDs. With an unemployment rate of over 50% and approximately 18% of the population HIV positive, childhood is far from easy for many children (MHSS 2008a, Ministry of Labour and Social Welfare, 2009). Namibia has an estimated 250 000 orphans and vulnerable children and becoming independent at an early age is a necessity for many (MHSS 2008). Even when both parents are alive, luxuries in life may be few and far between as Namibia has been cited by at least one source as having the highest level of inequality in the world, with nearly 30% people being classified as poor, and 13% as severely poor, in Namibia (Central Bureau of Statistics, 2008, UNDP, 2009). However Namibia is also a country with strong religious and moral values (MHSS 2008). Children are part of a patriarchal system of man first, then woman, then children. The concept of parental authority is strong and it is not uncommon for parents to beat their children for the slightest misdemeanour (Menges, 2008). Thus whilst on the one hand children are expected to be the caretakers of their own lives, they are also expected to be obedient and to fit within a set social order.

The independence, and yet restriction of children at a young age in Namibia, is reflected in the law. For example whilst from the age of 16 children can consent to sexual activity and at 18 can work in any type of job, drive, buy alcohol and gamble, it is not until 21 that a child gains majority. The definition of youth is from 16-35 (Government of Namibia, 2009; not yet in force) and the concept that children must adhere to parental decisions is strong. Indeed, despite data that shows that girls between the ages of 15 and 19 are becoming pregnant (MHSS, 2008), public opinion is still mixed over whether or not children should have independent access to contraceptives (MGECW, 2009). This, as well as other issues means that the often idealised construction of childhood in Namibia does not always fit with the reality of children's lives.

A further challenge for the conceptualisation of childhood in Namibia has been the fact that the country still uses an old South African law, the Children' Act of 1960, as its main source of legislation. As legislation is often used to define how we understand concepts (James & James, 2004), the Children's Act has influenced the construction of childhood in Namibia through its reflection of concepts such as parental authority and lack of recognition of issues such as HIV/AIDs and child trafficking. However in 2009 the Namibian government circulated the Child Care and Protection Bill, which is intended to replace the Children's Act, for public comment. This Bill brings Namibian legislation in line with internationally accepted principles of children's rights and will make a number of changes to the legislative framework in Namibia. It will also influence the construction of childhood in Namibia, where previously children are perceived to be 'in the background' – seen but not heard. How children are perceived, or the concept of childhood constructed, is important, since the protection, care and the acknowledgement of the voice of the child may be in conflict with people's understanding, acceptance and application of the law. This study explored the constructions of childhood in Namibia in comparison to provisions in the Child Care and Protection Bill (April 2010 draft). Furthermore, this study considered the possible areas of understanding that will need sensitisation prior to the enactment of the new law.

Methodology

This study used a qualitative methodological approach. Qualitative interview design was used to explore participants' constructions of childhood and

children in relation to the provisions in the Child Care and Protection Bill (April 2010 draft). The interviews were designed to be open and explorative. This allows the participants of the study to speak for themselves instead of predetermined hypothesis-based questions. The participants were purposefully selected to fit the age groups of 18 – 25, 25 – 40, 40 – 60 and over 60 years as one of the research criteria. Selection of the final four participants was based on their willingness to participate, availability for limited interview times and an attempt from the researcher to create gender diversity within the sample. The participants were asked a series of pre-formed questions that were written by the course directors for the Child and Family Studies Masters course. All participants live in Windhoek, the capital of Namibia. Interviewee one was a 23-year old Oshiwambo male; interviewee two was a 38-year old Damara/Nama female; interviewee three was a 42-year old white female age and interviewee four was a 75-year old white male. Whilst it cannot be argued that four interviews provide a representative understanding of the Namibian conceptualisation of childhood, they do provide an in-depth understanding of what childhood means to them.

Prior to the interviews the participants were informed of the nature and intension of the study and the benefits and limitations of completing the interview. Participants were informed about their rights not to participate in the study, that they could withdraw from the study at any point during the research process and that they could refuse to answer any of the interview questions they were uncomfortable with. Participants were also assured of their confidentiality and anonymity. Once the participants were willing to continue with the study, the informed consent forms were carefully explained and signed. The interviewees were given the opportunity to discuss the interview schedule or the issues discussed with the researcher and had the opportunity for debriefing afterwards if they wished. The participants understood that their participation was confidential and anonymous and that no harm was associated with the study. The four participants are referred to as interviewee one, two, three and four in this report to protect confidentiality.

Face-to-face interviews were conducted with four community members between the ages of 23 and 75 years. A convenient time and venue were arranged to conduct the interviews. Each interview lasted at least an hour. The interviews were recorded with a digital voice recorder and were transcribed for the purpose of data analysis. The data were analysed by means of thematic analysis. *Step 1* is the familiarisation and immersion (getting to know the data and engaging in it). In *Step 2* is the inducing [of] themes (working with themes that easily stand out) with themes arising from the data relating to the research question. *Step 3* entails coding (breaking up the data in understandable ways). *Step 4* is elaboration (exploring themes more closely) and *Step 5* is interpretation and checking the data (to give the researcher's understanding and inspection of the data) (Terre Blanche & Kelly, 2001:140-144).

Results and Discussion

The role of the state in the conceptualisation of childhood

Although Namibia has been independent for 20 years, the apartheid era and violent history of the country is not far from people's minds. Namibia has a strong Constitution, has signed many international human rights agreements and has implemented national legislation that protects the rights of all citizens. However this acceleration from discrimination to rights can be challenging for some people. As interviewee two says *"nowadays children have too many rights."* Suddenly, children have rights, children cannot be beaten, some parents even feel that children cannot be disciplined. Interviewee two explains this problem; *"you can't beat a child without them complaining about their rights"*.

Part of the problem appears to be that whilst the government rhetoric on children's rights has been effective, less has been said on children's responsibilities. The four interviewees note this with concern because they feel that children no longer recognise their responsibilities – as interviewee two says, the problem is that *"nowadays parents come home and have to ask why the house is not clean."* Interviewees one and four present similar concerns: *"Today the children are over-entertaining themselves. [They are] no longer under the control of their parent....There is no discipline nowadays"*

and *"there is also a breakdown of authority. Children don't know what they are supposed to do."* To put the problem into perspective, interviewees one, two and three described the responsibilities they had as children:

> *We had to do chores...if my parents were out of the house I had to make sure that it was cleaned, dishes washed, floor mopped. I had to feed the pets (like dogs and cats). I had to make sure the kids went to school.* (Interviewee one)

> *As part of the older group, I was taking up more responsibility for the young ones and in charge of household tasks... We knew our responsibilities, such as needing to keep the house clean or do to our homework.* (Interviewee two)

> *We all had our chores...as I got older, I had more responsibilities. I was given chores to do and my room to tidy.* (Interviewee three)

In contrast, modern day children *"have many rights and less responsibility nowadays"* (Interviewee 2). The strength of their responses on this issue suggest that according to the understanding of the participants, one important construction of childhood in Namibia is to fulfil responsibilities designated to them by adults. Indeed, one of the most interesting aspects of the interviews was how interviewees two and three stated that *"children must be children"*, but explained this concept as the need to respect their elders and to fulfil family duties and chores; *"we were taught children should act like children and always listen to the elderly. If a grown up came into the room, we would stop what we were doing and go out. The respect was there"* and *"kids should be kids. They need to be guided by their parents. Nowadays if a parent tries to discipline them, the kid runs off to someone saying that I have rights. Some things are just not negotiable"*. As the global use of the phrase *"children should be children"* is more commonly associated with the concept of the idealised child, this alternative definition is striking.

In keeping with the public opinion that children should have responsibilities, the government has chosen to provide clarity on this issue through the provision of children's responsibilities in the bill. Such a shift is supported by Himonga (2008), who states that "the incorporation of the communal ethic into the children's rights legislation ensures that the child sees the family and community of which he or she is a member as significant part of his or her life" (Himonga, 2008: 81-82.)

Therefore the inclusion of a provision for children's responsibilities in the bill is likely to be well received by the public. The African concept that *'a child belongs to everyone'* is strong in Namibia, and the inclusion of responsibilities in the Child Care and Protection Bill is likely to help promote this communal view of solidarity. However more than putting provisions of responsibility in the bill is needed. As interviewee one says *"[the government] do not go into detail about how to raise up a child....The government needs to do more to explain more."*

The role of parents in the conceptualisation of childhood

All four interviewees had strong opinions about the parental control of children:

> *I think that it [childhood] was good. [You are] under your parents' control, they had to take care of you.* (Interviewee one)

> *We obeyed our parents and other elderly [people].* (Interviewee two)

> *We knew the boundaries. Not like kids today. Kids need boundaries.* (Interviewee three)

> *Children can only be independent within a framework of dependency. Children can be individuals, but they are not independent. Children do not have rights. They are products of society, of their parents.* (Interviewee four)

Their statements show that the interviewees see children as individuals who should be moulded and developed. This opinion is in keeping with the "blank slate" philosophy of childhood and the fact that childhood is a time of innocence and play, as suggested by Aries (1962). The interviewees suggest that the participants see parental control as allowing children to develop in a safe environment but in a strict framework that ensures the children develop according to the values of the family and society.

However although the Child Care and Protection Bill reflects the Namibian social value that children

have responsibilities, the bill differs from public opinion in the area of parental control as it moves away from the concept of parental authority and instead provides for parental responsibility. As explained by Freeman (1997: 318) in a discussion about the British Children's Act which provided for the transition from parental authority to parental responsibilities more than twenty years ago, the change is a move "away from the notion of children as consumer durables, completing the family after the CD player and video recorder". Whilst children in Namibia may not be perceived as goods akin to a CD player or video recorder, the concept of parental authority is extremely strong.

With the incorporation of the new Act, education will be needed to assist parents to understand the difference between control and responsibility. The opportunity for education on this area may be best achieved through education about roles and responsibilities in the family. Article 5 of the CRC requires State Parties to *"respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child...."* but in the context of *"evolving capacities of the child..."*. This teaching point may assist the public to understand the role of parental authority in the context of the developing child. The challenge will, however, be to ensure that this message is correctly disseminated.

The role of children as participatory citizens

A short section of the Child Care and Protection Bill is devoted to the concept of child participation, as per the requirements of Article 12 of the CRC. As explained by Ehlers and Frank (2008), *"the observations of children not only breathe life into the tenets of international instruments such as the CRC, but also expose the real discrepancies between the good intentions articulated in these instruments and the realities of children's lives"* (111-112). However, based on the responses of the four interviewees, it may be some time before the concept of child participation is fully understood in Namibia. For example, when asked about participation as a child, interviewee one responded *"there might be sport at school, or a concert somewhere. The child had to be involved."* His answer demonstrates positive community cohesion but not active child participation, as he says *"the child had to be involved"*. The ultimate goal of child participation is child-guided participation, not adult-driven participation (Steinitz, 2009). Interviewees three and four make similar comments about controlling child participation *"I am not convinced that children should have so much of a say in society"* (Interviewee three); *"Adults know better. Children need to be educated and disciplined....There is no way in which a child can be independent"* (Interviewee four). This is not to say that the concept of child participation will not be accepted in Namibia. For example, in interviewee two's response to a question about whether she participated in decision-making as a child, she says *"no not really, but I didn't mind as I didn't think then it was wrong."* Her response indicates that she is aware that there is a global move towards increasing child involvement in decision making.

The concept of evolving capacities may be another challenge for Namibia. Whilst interviewees one and two recognise developmental stages in childhood; *"I think that starting from age 14, [a person] must go on like a grown up person, not like a child"* (Interviewee one) and *"For me, childhood stopped at around age 14. This was when I went to high school, so it was a change from being at primary school. We finished school at 17 so these were the final years. It was a change in environment, I became a teenager not a child, I stopped playing in the streets"* (Interviewee two). This concept was less clearly defined in the interviewees with participants three and four: *"I was a child until about 16/17. I still played with dolls until then, I sat on my father's lap."* (Interviewee three) and *"Childhood ended when I left school at 17"* (Interviewee 4). The fact that interviewees one and two see that childhood ends at age 14 despite the age of majority being 21 shows that they see the intervening period as a stage before adulthood. In contrast, interviewees two and three see childhood continuing up to age 17 and linked to the end of school and entry into the working world. This suggests that opinion is mixed regarding whether children develop capacity as they mature or whether childhood and adulthood are two separate stages. This may prove challenging for the acceptance of demonstrable capacity provisions that have been included in the Child Care and Protection Bill. Indeed, even though interviewees

one and two see childhood as an evolving process of competence, in light of their strong opinions about parental authority:

> *The problem with children of today is that they are "no longer under the control of their parent.* (Interviewee one)
>
> *We obeyed our parents and other elderly [people]."* (Interviewee two)

It is likely that many people in Namibia, even those who recognise childhood as consisting of development stages, will face some challenges in accepting some of the more progressive proposals in the bill.

As commented in the previous sections, more public education is needed. As with the understanding about parental authority versus parental responsibility, the entry point for education may be on roles in the family. As explained by Petrén and Hammarberg, the Committee which monitors the CRC *"has consistently encouraged children's participation in decision-making within the family."* 'The family becomes the ideal framework for the first stage of the democratic experience for each and all of its individual members, including children' it [the committee] has stated (2000: 61). Therefore it may be helpful in Namibia to first focus on the role of children as participatory citizens in the family.

The protection and empowerment of children in Namibia

All four interviewees felt that children of today face greater challenges than they did:

> *[Children of today face] HIV/AIDs, alcohol and drug abuse, criminals, fighting, kill one another. Peer pressure is kind of high and they [children] expose themselves to sexual intercourse when they are drunk.* (Interviewee one)
>
> *There was no rape. I can't remember a violent incident.... If my children want to go to the shops I would rather take them in the car than let them walk on their own.* (Interviewee two)
>
> *Children are more vulnerable. Divorce rates are higher, the high rate of HIV means that children lose their parents, there are work pressures on parents, economic pressures, safety issues. Children are not quite so free as we were.* (Interviewee three)
>
> *The breakdown of intimate relationships is a big problem. Adults do not have staying power anymore. The fragility of relationships is the problem. It gives children of today a very hard time. There is enormous confusion. There is also a breakdown of authority. Children don't know what they are supposed to do.* (Interviewee four)

These responses show that all four interviewees felt that children should be protected. For example interviewees three and four say *"children need a well-balanced environment, they need love, to be well-cared for, cherished. They need to feel secure"* and *"children need tactile love. They need to hear "I love you". The maternal and paternal influence cannot be reproduced. Society cannot provide this-instead children feel lonely, unaccepted"*. Indeed, it is perhaps due to the problems of modern day society and the need to protect her children that interviewee two wants to extend the duration of childhood for her children. Even though she felt that her childhood ended around age 14, her children are aged 15 and 16 but she says that *"I see them as children – although they probably don't see themselves as children."* Furthermore, even though she thinks *"they are exposed to more violence and other bad things"*, she does not see a linkage between this and faster growing up. Instead she sees it as a reason to prolong the innocence of childhood:

> *I think they see it* [society] *as much safer than I do. They don't see the problems. They think that it is fine to tell me they are going to visit a friend. As a mother I am freaking out – I need to know who this friend is, who the parents are. My father didn't ask those types of questions. They trusted what we were doing because we were in a safe environment. They even sent my sister to school in Keetmanshoop [a town about 500km away] because it was safe. Now, even if my children go to Mareua Mall I am in contact with them through sms.*

However, whilst children do need protection, the problem with this conceptualisation is that the image of the child can become one of a victim and the role of the child as an autonomous being is lost.

Smith (2007: 153) supports this statement, arguing that *"children's opportunities for expressing their ideas and for active participation outside the home, school or community have diminished as children are protected and excluded. Rethinking childhood to include their voice is essential to redress the balance, and is likely to enhance children's capability of contributing to society as active citizens."*

The passing and enactment of the Child Care and Protection Bill will be a major step forward for children's rights, because before children can reach the stage of asserting their view, they must first have interests that they can protect (Freeman, 1997). One area that will be particularly useful to the empowerment of children is the guiding principle that all decisions must be made "in the best interests of the child". This principle helps to overcome stereotypical conceptualisations of childhood and instead requires all decisions to be taken from the perspective of what is best for that particular child in a specific situation (the principle also applies to more general decisions about the best interests of children as a group). However, whilst this principle is good in theory, James and James (2004) point out that when the best interests of a child differ from the opinions of the adult, it can be that the best interests of the child are deferred to the interests of the adult. As Hillary Rodham Clinton states "[n]o other group is so totally dependent for its well-being on choices made by others" (cited in Jenkins, 1998: 11). Furthermore, if the interpretation of best interests is dependent on adult views, and adult views are dependent on the socio-economic, cultural and political climate, the definition of a child becomes dependent on the prevailing construction of childhood. Yet again this area becomes another issue that will require more education to ensure that the principles and provisions as envisioned in the Act are understood as they are intended.

Conclusion

This study has briefly compared and contrasted constructions of childhood based on the opinions of four individuals in Namibia with the respective provisions in the Child Care and Protection Bill. In some areas, public opinion and the proposals in the bill overlap, such as the conceptualisation that children have responsibilities. However in other areas public opinion and the proposals in the bill differ. For example, public opinion favours parental authority whereas the bill provides for parental responsibility. Furthermore, the concept of child participation is underdeveloped in Namibia as is an understanding about the promotion of child empowerment. In 2000 Petrén and Hart stated that "no nation has yet seriously engaged parents in a dialogue about their views of children's rights in relation to the Convention [of the Rights of the Child]" (2000: 43). Their comment is still relevant ten years later in Namibia. Much more dialogue is needed in Namibia to align the national and global conceptualisations of childhood. Although James and James (2004; 13) are correct in their statement that "'childhood' is, at one and the same time, common to all children but also fragmented by the diversity of children's everyday lives", legislation can have a significant impact on understanding and when legislation and public opinion strongly differ, this can present problems in achieving what the laws intend. Therefore, whilst the Child Care and Protection Bill has done much to further Namibia's need international requirements of children's rights, the Act will only be effective if there is more dialogue in Namibia about the conceptualisation of childhood. At present the legislation goes beyond public opinion. To ensure that the Act is well-received in Namibia the government and stakeholders should do more to prepare the public for the bill, including promoting a generalised debate about many of the fundamental concepts of childhood that seem currently to be in conflict with the Act.

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AN ANALYSIS OF THE TRANSITION OF NEWLY QUALIFIED REGISTERED NURSES DURING THE FIRST YEAR OF REGISTRATION WITH THE SOUTH AFRICAN NURSING COUNCIL: A SHORT REPORT

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ABSTRACT

Introduction:
Literature shows that the process of transition from student nurse to qualified registered nurse has long been recognized as a stressful experience. The South African Nursing Council requires newly qualified nurse practitioners to have the necessary knowledge, skills, attitudes and values which will enable them to render an efficient service. The purpose of this research was to analyse the views of newly qualified registered nurses on their clinical experiences during their first year of registration.

Methods:
A quantitative descriptive design was used. The population included 40 newly qualified nurses who were still in their first year of being registered nurses. Convenience sampling was done.

Results:
This study revealed that the transition period remains stressful for some newly qualified practitioners because of the minimal support they receive.

Conclusion:
It is recommended that there should be careful planning of student experiences in their final year of study and that the inconsistencies in clinical settings be addressed.

Keywords: newly qualified registered nurses; clinical placement; clinical roles; role transition.

INTRODUCTION

Workplace realities require nurses to be competent in performing nursing activities. According to Chung, Wong and Chueng (2008) nursing activities usually include direct and indirect patient care, shift reports, rounds and case conferences, routine maintenance of the environment and general management. The operation of these activities is affected by care delivery models and the clinical environment. These variables pose challenges to the development of competent graduates. While the experiences of newly qualified registered nurses (RNs) is a subject that has not been well researched, available literature on this topic clearly demonstrates that being a newly qualified RN is particularly stressful and that many newly qualified RNs feel unprepared for this role (Moeti, van Niekerk & van Veiden, 2004; O'Shea & Kelly, 2007).

The experiences of newly qualified RNs cannot be viewed solely in terms of education policy and reform. The 1990's have seen extensive changes in the organization and delivery of health care (Gerrish, 2000) which have impacted upon the experiences of student nurses and the employment and practice of newly qualified RNs. Gerrish, in undertaking a study in 1999, found that the experiences of nurses interviewed were similar to those identified by other researchers (Lathlean, Smith & Bradley, 1986). These researchers state

that graduate nurses felt they lacked relevant communication skills and lacked confidence in talking to bereaved relatives and making decisions. According to Halfer and Graf (2006), "'Fumbling along graphically illustrates how graduate nurses learned to perform their new role, in the light of what they perceived to be inadequate preparation" (p. 152).

In their study on the perceptions of graduate nurses regarding their work experience, Halfer and Graf (2006) found many categories where graduate nurses had experienced the same difficulties despite changes that had taken place in nurse training. Some new problems had emerged, however, including that of role conflict. The nurses complained of feeling a 'jack of all trades' and experienced conflict when coping with clinical and management responsibilities (p. 152). Halfer and Graf also identified that newly qualified nurses felt an increased responsibility and experienced difficulty in coping with their teaching role. These researchers concluded that although most satisfaction was gained from direct patient care, many nurses felt unprepared for the sudden increase in management responsibility, finding it difficult and stressful (Halfer & Graf, 2006). The work environment and norms of registered nursing practice are not what many RNs expected when they entered the workforce (Halfer & Graf, 2006). Because there is a divergence between the nursing practice experienced in an academic clinical rotation and institutional expectations experienced in the acute care setting, new RNs are faced with having to learn how to be nurses and function within an unfamiliar, sometimes unsupportive organizational culture, while being asked to assume increasing levels of responsibility (Valdez, 2008).

In South Africa, according to Morolong and Chabeli (2005), the South African Nursing Council (SANC) requires registered nurse practitioners and midwives to have the necessary knowledge, skills, attitudes and values which will enable them to render an efficient service. The health care system also demands competent nurse practitioners to ensure quality in health care. In the light of competency being a national priority and statutory demand, the question that emerges is, how prepared are the newly qualified RNs that are in clinical settings (Morolong & Chabeli, 2005).

Various research articles (Valdez, 2008; Halfer & Graf, 2006; Casey, Fink, Krugman & Propst, 2004) highlight the stress that new RNs experience when in clinical settings for the first time. While the new work environment and feelings of inadequacy are elements of the high level of stress experienced by novice and advanced beginner nurses, other stressors have also been identified in the literature. These include: (a) fear of independent practice (worried about knowing what to do and how to respond to patient needs); (b) dealing with new situations; (c) work schedule challenges, dissatisfaction, or both; (d) unclear expectations and (e) finances and student loans (Halfer & Graf, 2006; Valdez, 2008). According to Casey et al. (2004), new RNs become dissatisfied with their work schedules, salaries and believed that they lack opportunities for career development. This is in line with Valdez (2008) views that newly qualified RNs need support and guidance in their first few months in practice however, the extent to which such support to be provided is variable. The perceived reasons for this support to be multifaceted are dependent on the amount of pressure of the work load and the availability of staff to do the work. (Maben & Clark, 1998; Casey et al., 2004; Morolong & Chabeli, 2005).

According to Bryant and Williams (2002), one of the main issues in preparing the student nurse for a better transition to being a RN revolve around the issues of the work environment and students' preparedness. Various factors such as the nature and extent of the workload, knowledge of ward routine, performance expectations, management of patients with complex health problems and uncertainty about social integration into nursing have been common areas of incompetence and require support, as highlighted by Berry (2005). Similarly, Chung et al. (2008) point out the factors that influence role transition, including feelings of 'reality shock' and unpreparedness, the availability and typology of preceptorship programmes in the clinical learning environment (Midgley, 2005, p. 342), and interpersonal relationships. These, according to Duchsher (2005), are challenging times for registered nursing practice for there is minimal qualitative evidence to inform what constitutes an optimal work environment for the acute care, hospital-based practicing nurse and even less evidence to detail the factors that

exhaust, alienate and discourage those professionally competent and caring nurses we most need to attract and retain (Duchscher, 2005).

The aim of this research was to determine the views of the newly qualified RNs on their roles and to determine how their roles as newly qualified RNs had changed in their first year after registration with the SANC at a selected hospital in KwaZulu-Natal (KZN).

RESEARCH METHODOLOGY

A quantitative descriptive research design was used in this study which was conducted at one of the hospitals in Northern KZN. The target population for this study were the newly qualified RNs who were in clinical placement during the first year following registration with the SANC. Convenience sampling was used to select all the newly qualified RNs to participate in the study. All newly qualified RNs in each unit in a clinical area of the selected hospital, on both day and night duty, were requested to participate. There were 14 units in the selected institution and the newly qualified RNs were working in various units including medical, surgical, paediatrics and orthopaedics. The total population for the study was 40.

A self-developed, structured questionnaire that was guided by the Rungapadiachy and Madill (2006) model for transition from being a student nurse to a RN was used for data collection. The items for the questionnaire were selected based on an extensive literature research with regard to RN transition and development in clinical settings. The instrument consisted of two sections: Section A requested the participant to provide demographic data and Section B attempted to elicit the experiences of the newly qualified RN on his/her experiences or transition in the first year of clinical exposure in the clinical settings. Content and face validity of the instrument was assessed.

Permission to conduct the study was obtained from the University of KwaZulu-Natal Research Ethics Committee, the Hospital Research Ethics Committee, the nursing service manager at the participating hospital and the operational managers of each unit where newly qualified RNs were allocated. After obtaining permission, data was collected by requesting each newly qualified RN to respond to the hand distributed questionnaire, once informed consent was obtained.

Each questionnaire was assigned a number for coding. Data analysis was done using Statistical Package for Social Science (SPSS) for Windows. There were 40 questionnaires distributed, with a total of 31 returned; which was 77.5% return rate.

RESULTS

The mean age of the participants was 26 years with a range of 18 to above 35 years. The majority of the participants were female (84%) and from the African race (94%). The results indicated that the majority (n=23, 74%) of the newly qualified RNs had been working as an RN for seven to twelve months and 23% had been registered with the SANC for less than six months. A total of 23 (74%) newly qualified RNs had been allocated to one unit since their registration as RN's, 19% (n=6) had rotated between two units and only 6% (n=3) had been allocated to a maximum of three units in the first twelve months following their registration as RNs with the SANC. The majority of the newly qualified RN's were allocated to day duty (n=28, 90%) as compared to 6% (n=3) of whom were allocated to night duty. The profiles of the participants are presented in the table 1 below.

Table 1: Participants Profile

Variable	Category	Number	Percentage
Gender	Male	5	16%
	Female	26	84%
Age	18 – 25 years	17	55%
	26 – 35 years	9	29%
	> 35 years	5	16%

Views of the RNs on their Preparedness for Clinical Placement during First Year

In terms of the views drawn by the participants on their experiences on clinical placement during the first year following registration with SANC, the participants reported differing experiences. Table 2 depicts that most of the participants felt prepared enough to work independently as RNs. In addition, 71% (n=22) of the responses indicated that they felt confident in their clinical nursing skills and abilities to do their jobs as RNs. The findings further indicated that 55% (n=17) of the participants felt

that the knowledge and skills they possessed was not adequate for the allocated work (role ambiguity) in the clinical settings, whereas 45% (n=14) reported that the knowledge and skills possessed was adequate for work allocated to them as RNs.

Table 2: Preparedness of Newly Qualified RN's at the End of One Year

ITEMS	Frequency	
	Yes	No
Feel able to cope with clinical expectations and work allocation.	50%	50%
Feel confident in my clinical nursing skills and abilities.	71%	29%
Feel able to carry out nursing procedures like those that will be expected of me as a registered nurse.	77%	23%
Able to record clinical data systematically.	94%	6%
Able to identify my own educational needs.	90%	10%
Able to understand and observe patients under my care for actions, interactions and adverse reactions.	68%	32%
Able to cope and the allocation of work is up to my knowledge and skills.	45%	55%
Able to discuss health issues with patients.	74%	26%
Able to approach others in the ward regarding my learning needs.	97%	3%
Able to confidently approach more senior staff for help.	81%	19%
Support from seniors at any time when needed.	19%	81%
Feel the lack of resources hinders my effective functioning.	87%	13%
Lack of support in the clinical area frustrates me and hinders my functioning in the unit.	65%	35%

DISCUSSION

There was a predominance of females (83.9%) to males (16.1%) in the study. It seems to be a common trend that most men view nursing as a female profession with the result that few males enrol for the nursing profession (Duchscher, 2005). Some of the reasons why males do not join the nursing profession could be that they receive little or no career guidance concerning nursing in high schools (O'Shea & Kelly, 2007) and also that they might fear that they will be perceived as not being manly by their peers and clients.

The majority of the participants had been working for more than six months as qualified RNs and many of them had been allocated to only one unit during their time at the hospital. As many new graduates experience reality shock as they make the transition from the culture of being a student nurse with a given set of values and ideals to another culture of being a RN often with different, and even conflicting, values and ideals (Chung et al., 2008), keeping newly qualified nurses in the same or similar unit for longer allows for professional grounding, development and growth needed in the field. This reduces the level of stress as graduates adapt to the professionalisation and role of a RN. Gerrish (2000) and AACN (2009) pointed out that it is well known that the first six to twelve months of employment as a graduate RN are among the most stressful in a nurse's career and the most critical in terms of their decision about whether or not to commit to a career in nursing (Moeti et al., 2004).

Views of the RN's on their Preparedness for Clinical Placement during their First Year

Role ambiguity: The findings of this study revealed that 55% of the RNs felt unable to cope with the allocation of work because of role ambiguity. The code of conduct for nurses in South Africa makes advocacy a requisite of the nursing role, stating that nurses should always act in such a manner as to promote and safeguard the interests and well-being of their patients. Several authors (O'Shea & Kelly, 2007; Halter & Graf, 2006) report ambiguity as whether RNs clinical procedures are conducted in accordance with the legislation and are supervised by a more senior nurse.

Theory–practice gap: Half the number of RNs (50%) felt they were able to cope with clinical expectations and work allocation and the other half felt they were unable to cope with the clinical expectations of being a RN. Most participants recognized the significance of the theoretical knowledge acquired in their training, but found it difficult to apply it in practice. This was in line with Berry (2005) who suggests that teachers often generate knowledge in the classroom that is not immediately related to practice. Similarly, O'Shea and Kelly (2007) argued that it is not always possible to apply theory to practice because the environment is not always conducive. The contexts that students are taught and trained are not always the same as the clinical settings for practice. Therefore, part of the theory-practice gap may be due to ideological differences between clinical placements and the nursing education institutional teaching methodology (Valdez, 2008).

Support from others: The findings revealed that 83% of the RNs felt they did not get support from seniors when they needed it. Several researchers, (Gerry, 2000; AACN, 2009; Halfer & Graf, 2006), report that the lack of support could lead to low morale, as could the lack of influence the newly qualified RN had over the type of patients admitted to their unit. Research has found that a positive clinical learning environment is crucial for the transitional period. A supportive clinical environment provides some of the most important learning opportunities for newly qualified RNs in terms of skills, knowledge, practice, reflection and cultural socialisation (Lathlean et al., 1996; Meyer, 2007). A supportive milieu also allows the newly qualified RN to improve and consolidate clinical skills and improve patient management and time management in a context of provision, maintenance, and positive reinforcement and nurture (AACN, 2009). In line with AACN, Meyer (2007) asserts that a positive, stimulating and supportive environment results in higher staff satisfaction and also that nurses who were more proactive and satisfied were better at achieving a more effective clinical placement experience.

RECOMMENDATIONS

It needs to be acknowledged that transition role of a RN is often difficult as the individual adapts to new responsibilities and expectations. Nevertheless, the findings from this study have suggested that although the transition remains stressful, newly qualified RNs felt they had developed more active learning strategies to enable them to adjust to the responsibilities of their new role and believed that they had been more or less appropriately supported through the transition process. In order to ease the transition process, consideration needs to be given as to how undergraduate nursing programmes can provide more appropriate opportunities for student nurses to develop the clinical organizational and managerial skills necessary for their future role. Additionally, further attention needs to be paid to the bridging period over the latter part of the four year programme and the first twelve months post-qualification in order to enable the neophyte nurse to acclimatize gradually in becoming an accountable practitioner. It is suggested that supernumerary status and preceptorship programmes for newly qualified RN's be implemented to help ease the stress associated with the transition process.

CONCLUSION

Newly qualified RNs were asked about their views on the transition from being students to RNs and on their first year's experiences as RNs in the clinical field. Although the transition from student to qualified RN remains stressful and newly qualified RNs still felt inadequately prepared, this study has suggested that the transition process does not seem that difficult. Many newly qualified RNs reported that nothing had hindered their practice as RNs. They did, however, mention a few challenges such as lack of support from senior staff members and role ambiguity.

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STAFF DEVELOPMENT STRATEGIES FOR PUBLICATION IN THE FACULTY OF COMMUNITY AND HEALTH SCIENCE AT UWC: A SHORT REPORT

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Abstract

Introduction:
Strategies for improving the publication output of academics are an essential component of research directives at tertiary institutions. The aim of this report was to highlight the effects of a writing retreat as an intervention strategy used by a university faculty to improve academic publication output. The strategy used included a structured programme over a period of three days guided by a facilitator.

Methods:
The report uses a qualitative design to report the effects of the writing retreat on the participants.

Results:
The major themes that emerged were reviewing and critical reading, writing for publication, personal growth and confidence, dedicated time, peer mentoring, programme structure and facilitation, and future directives.

Conclusion:
From the feedback obtained, it is evident that strategies such as a writing retreat, provide academics with an opportunity to produce articles that are a benefit to the authors' career trajectories as well as the institutional publication profile of their university.

Key words: scholarly publication, writing strategies, writing retreats, UWC, tertiary institutions, Community and Health Sciences

BACKGROUND

Developing a research 'track record' is imperative in the academic world. One of the key indicators of a research track record is an extensive publications list. "This can influence job satisfaction, promotion opportunities, rating as a researcher and success in obtaining grants and consultancies" (Harrison & Herbohn, 2010). Research productivity which includes publications is one of the most important means by which researchers in universities and research institutions are evaluated (Frantz, Rhoda, Struthers and Phillips, 2010). Writing papers is a critical task for researchers. According to Harrison and Herbohn (2010), "some researchers are 'writerholics' who write through compulsion; others are strongly disinclined to 'put pen to paper' and will always find something else pressing to do rather than write up their research". Academics at university level need to shift from primarily teaching to finding a balance between teaching and research. Currently the proportion of the publications published by authors in the allied health sciences is assumed to be insignificant (Ncayiyana, 2006). While success in research is to a large extent an individual experience, a number of strategies may be employed to increase effectiveness (Rhoda et al, 2006).

The research output of academic departments has been under scrutiny at the University of the Western Cape. The number of articles published in peer-reviewed journals has been low relative to academic rung, years of experience, the number of papers presented at conferences, as well as the number of postgraduate theses supervised to completion (Frantz et al, 2010). This discrepancy suggests that many of the academics have experienced difficulty publishing articles in peer-reviewed journals. Often research presented as conference presentations at conferences is never subsequently converted to a publication (Scherer,Dickersin, & Langenberg, 1994; Weber et al., 1998). Numerous barriers to publishing have been cited in research, and these commonly include lack of time (Dyson & Sparling, 2006; Oermann, 2003; Sprague et al., 2003), training (Grzybowski et al, 2003), and mentoring/ peer support (Grzybowski et al., 2003; Stepanski, 2002).

The Faculty of Community and Health Sciences at the University of the Western Cape has established a policy of providing support for staff in all aspects of research productivity including providing opportunities for writing for publication. These opportunities were based on the demonstrated value of peer support (Grzybowski et al., 2003; Tudiver et al., 2008), and dedicated time. A writing retreat was conceptualized as an intervention providing dedicated time and support for staff in the faculty. In addition mentoring relationships were established for novice authors Each participant was required to act as a reviewer or critical reader for other participants. In this way, participants had the experiential exercise of giving and receiving feedback which simulated the review process editors follow at journals. Thus this study aims to highlight the effects of a writing retreat as an intervention strategy used by a university faculty to improve academic publication output.

METHODS

Research setting

The Faculty of Community and Health Sciences at the University of the Western Cape is one of six faculties. It currently hosts the departments of Physiotherapy, Occupational Therapy, Social Work, Human Ecology, Dietetics and Sport recreation and exercise science. In addition, the schools of Public health, Nursing, and Natural medicine are also located within the faculty.

Participants:

A general invitation to participate in the writing for publication intervention was extended to staff members from the Faculty of Community and Health Sciences. The only eligibility requirement was that interested staff needed to have completed the following pre-workshop tasks: a) have collected research data b) identified a journal , c) collected related articles. Interested staff submitted a 500 word abstract evidencing that they have met the above criteria. A total of 20 places were reserved for the retreat. However, only 14 responded voluntarily with the common goal of needing time out to write an article. All 14 applicants were selected for inclusion in the intervention.

Intervention:

A 3-day structured writing retreat was facilitated during the June 2009 vacation. As stated before, participants were requested to report for the intervention with analysed data, related articles and the authors' guidelines of the journal they wish to submit their article to.Table 1 below illustrates the basic format that the workshop took. Each day of the retreat is reflected in a column whilst sessions are reflected in rows. Each cell summarizes the content of a session with its corresponding action plan.

RESULTS

Participant profile

Table 2 below summarizes the demographic data of the participants including the departments represented (n=14). These participants were a highly self-selected group in that they shared common goals around writing for publication. The large majority of the participants were novice authors.

Table 1: Format for writing retreat

Day 1	Day 2:	Day 3
Session 1: Introduction Participants received information regarding guidelines for writing an introduction **Action plan** Wrote an introduction	**Session 1: Reviewing** Participants submitted introduction and methods section to another critical reader in there group **Action plan:** Read and write feedback Consultation with others	**Session 1:Reviewing** Participants submitted corrections and discussion section to a critical reader in the group **Action plan:** Read and write feedback Peer discussion
Session 2: Editing Participants submitted an introduction to a critical reader in their group and received an introduction from another participant **Action plan:** Edit introduction as a critical reader. Start thinking about the methods section	**Session 2: Feedback** Participants gave feedback to the person whose article they read and discussed possible recommendations and received feedback on their own article **Action plan:** Evaluate feedback	**Session 2: Feedback** Participants gave feedback to the person whose article they read and discussed possible recommendations Participants received guidelines for writing the conclusion and reviewing this section **Action plan:** Write conclusion and add references. Submit full draft of article to your original critical reader
Session 3: Feedback Participants gave feedback to the person whose article they read. Identified and received feedback on their introduction **Action plan**: Evaluate feedback	**Session 3:methods & editing** Participants corrected the introduction and methods section. Participants received guidelines for writing results and reviewing these sections. **Action plan:** Write the results section and make corrections	**Session 3: Reflection and outcome** Participants had: - Reviewed an article - Gone through the process of writing an article
Session 4 Integration Participants corrected their introductions. Received the methods section guidelines **Action plan:** Write the methods section	**Session 4: Discussion** Participants submitted the corrected sections and the results section to critical reader. Participants received guidelines for writing the discussion and reviewing these sections. **Action plan:** Receive and give feedback on the sections submitted Write the discussion	

Table 2: Demographics of participants

Departments represented	Nursing Physiotherapy Social Work Sport, Recreation and Exercise Science Core Courses
Gender	2 Males 12 Females
Academic Status	2 Associate Professors 2 Senior Lecturers 10 Lecturers
Qualifications	2 PhD's 12 Masters
Author status	11 novice authors (< 3 publications) 2 developing authors (3-10 publications) 1 established author > 10 publications

Workshop Evaluation

The writing retreat was formally evaluated by the participants. Overall, the feedback was resoundingly positive and participants reported that the writing retreat facilitated personal growth of the participants as well as skills relating to writing. The feedback has been subjected to a rudimentary thematic analysis and 7 themes were identified namely reviewing and critical reading, writing for publication, personal growth & confidence, dedicated time, peer mentoring, programme structure & facilitation, and future directives (Table 4).

One year follow up information

At the end of the writing retreat each participant had completed a draft article from the introduction to the references. The status of the articles following the writing retreat (12 months later) is illustrated in Table 3 below. Of the articles completed at the writing retreat, 75% were submitted to a journal for review and consideration for publication. Of those submitted, 42% (n=5/12) were submitted to accredited journals of which three were published, one accepted for publication and the other was asked to revise.

Table 3: Status of articles 9 months after the writing retreat (n=14)

Status of article	No	%
In progress	2	14.3%
Asked to revise by journal Peer reviewed Accredited journal	2 1 1	14.3%
Accepted for publication Peer reviewed journal Accredited journal	1 0 1	7.2%
Published Peer reviewed journal Accredited Journal	9 6 3	64.2%

Discussion and Conclusion:

The findings reported above is consistent with the literature where dedicated time for academic writing is extremely useful and necessary for consistent publication output (Grzybowski et al. 2003; Steiner et al 2008). The resounding positive feedback from participants suggests that at a summative level the writing retreat was successful in fostering greater confidence in academic writing, building capacity in academic writing & publication, as well as assisting staff to overcome internal barriers as is evident by the 12 articles that have been submitted for consideration in a journal. These findings are

Table 4: Themes and comments of participant evaluations

Theme	Category	Comment
Reviewing & critical reading: This theme summarized participants' thoughts and experiences about participating in a review process that aimed to develop their skills in critical reading, as well as giving constructive feedback and receiving feedback in a non-defensive manner.	Acquire critical reading or reviewing skills	" learnt to read my work more critically" "The sharing and reviewing of different peoples work helped to broaden my perspectives"
	Learnt to give constructive feedback	"Gained confidence in giving feedback as a critical reader" "Reviewing others work was good and the group support was great"
	Receive feedback non-defensively	"I am now more open to the writing process and less afraid of showing others my work" "I have learnt to take criticism positively from the other readers"
Writing for publication. This theme summarized the reflections of participants about their ability to engage in academic writing for publication.	Augment their knowledge about the writing process	"I gained valuable insight re: writing process" "Able to grow in understanding of the writing process"
	Produce a draft article	"I came with nothing and had to start from scratch and now I have a draft article." "My article is ready for final editing"
Personal growth, professional development and confidence. This theme summarized participants' feedback about how the retreat contributed to their development.	Personal development.	"This was a major contribution to my personal development" "I have been able to pay attention to my own personal development"
	Increase mastery and goal achievement	"I have been able to pay attention to my own goals and I've achieved what I intended during the 3 days"
	Increased confidence	"I have gained confidence from this retreat – the group was supportive and I felt accepted within the group"
	Overcoming internal barriers	"So many internal barriers were overcome by being exposed to this process"

Dedicated time. Participants unanimously stated that the dedicated time was beneficial.	Time and space	“The luxury of having all the time to focus on writing only is definitely conducive to the process” “Creating the space for writing is appreciated” “The dedicated time out was what was needed to accomplish the task of writing an article” “Dedicated time and the resources of established authors guiding novice authors was good”
Peer mentoring & supportive relationships. The theme summarized the feedback from the participants that the peer mentoring relationships at the retreat were	Conducive to learning Supportive.	“The experienced authors assisted in building the confidence of the novice authors” “Allowed people at different phases of their writing career to compare notes and to give tips” “The spirit within the group was supportive “ “I appreciated the non-judgemental approach of all involved” “I felt like a member of the group and the dynamics was good”
Programme structure & Facilitation: This theme summarized participants’ evaluation of the programme structure and facilitation style.	Programme structure	“Although this retreat involves intensive writing it allows one to meaningfully contribute to others work and also add value to your own” “Discussions during and after sessions were informative” “Excellent – able to use time effectively to produce draft article”

	Facilitation style	"The approach of the workshop was very effective" "The informal pace and flexibility yet focussed design is excellent and should be maintained" "Very relaxed facilitation approach thus making me comfortable to work at my own pace but still be productive"
Future directives. This theme captured the participants' sentiments about future interventions.	Should intervention be repeated? Benefits to the university	"An endeavour that needs to be repeated" "Follow up sessions needed" "Need ongoing support for editing, critiquing etc" "Endeavours such as this should happen more often as output will be beneficial to the university "

similar to those of Steiner et al (2008) who reported that writing workshops can help junior academics in developing in the process of scholarly writing. The value of a supportive environment has previous been noted by several authors (Bryan 1996; Grzybowski et al. 2003). It is thus evident that peer writing groups and the motivation to working with others can play an important role in helping academics acquire the skills needed for publication.

Of the articles submitted for publication, 6 articles were published in a peer reviewed journal, the opportunity provided for novice authors by local peer reviewed journals cannot be mistaken. The peer review process offers authors the opportunity to be evaluated by their peers and to be subjected the scrutiny of ensuring that the published work is relevant and acceptable. According to Ware (2008), academics are committed to the peer review process, with the vast majority believing that it helps scientific communication and in particular that it improves the quality of published papers. In addition, three of these articles have been published in accredited journals which translated into funds for the university and the respective authors.

Thus it would appear that it would be beneficial to consider how the principle of dedicated time can be adopted at various levels of the university in formal and informal ways. At a formative level, the structure of the writing retreat proved effective and useful in familiarizing staff with the writing process, building capacity and strengthening peer relational or mentoring ties or expanding their knowledge of and insight into the aforementioned processes. However, these initiatives do not necessarily have to have major cost implications but can be designed for small groups in a department or in the faculty (Frantz et al 2010).

Implications for future staff development endeavours

It is suggested that the Faculty of Community and Health Sciences consider the following recommendations to improve publication output:

– Strategies for staff should focus on strategically dedicating time for academic writing
– Providing infrastructural support for writing retreats as a strategic staff development initiative
– Target submissions to accredited journals to

increase the potential income from publications and to offset costs associated with the facilitation of such interventions.

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NURSING EDUCATION THROUGH INFORMATION, COMMUNICATION AND TECHNOLOGY

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Abstract
Nurses are front-line health care workers in a district based primary health care system. The shortage of nurses with its impact on health care is well documented. The challenge is how to train sufficient competent nurses. Stellenbosch University is addressing this educational need and has invested in e-Learning products to enhance the training it offers postgraduate nurses.

A blended “brick and click” approach was designed to obtain the optimal blend of e-Learning activities to achieve the outcomes of a range of postgraduate programmes for nurses. This blend includes face-to-face activities, text based materials and activities on web-based learning management systems, activities on the Interactive Telematic Education (iTE) satellite-based platform and Skype. Many prospective postgraduate students living in remote areas often experience barriers which deters access. For these students iTE serves as a convenient technology vehicle to participate in post-graduate programmes. The iTE platform is based on satellite, cell phone and smart card technology and consists of an on-campus studio and twenty five remote learning centres situated across South Africa to create a virtual learning environment to support synchronous teaching and learning opportunities for post-graduate students. iTE allows direct two-way communication between the lecturer and students while a lecture is in progress. Real-time interaction between the lecturer and students which is one of the distinctive attributes of iTE, allows for the collaborative co-construction of knowledge rather than a passive one-way transfer of knowledge which makes it appropriate for postgraduate adult learning. iTE forms a vital component of the postgraduate delivery strategy of the nursing division in its attempts to address the increasing demands for nurse training.

Keywords
Innovation, technology, nursing education, ICT, eNursing.

Introduction and background

In common with other developing countries, South Africa’s public health system is characterised by human resource shortfalls, especially in rural areas (van Rensburg, Steyn, Schneider & Loffstadt, 2008). Nurses play a pivotal role in ensuring the delivery of effective and efficient healthcare in South Africa. The primary health care sector includes clinics, satellites and mobile clinics which are nurse based (Daviaud & Chopra, 2008). Since South African healthcare depends on nurses for healthcare in the public sector it is of utmost importance to train nurses appropriately and adequately to address the shortage and maldistribution of nurses. Nurse training is centralized in towns forcing nursing students to move to these areas. The migration of the nurses to the urban areas inevitably results in resources lost to the rural area since the nurses often do not return to the rural area following their training.

Innovative use of technology in a nurse training project

The Division of Nursing has demonstrated the capability to recruit postgraduate students with an average annual growth rate of 20 -25 % over the past 8 years from a diverse social, educational, generational, class and geographic base. iTE forms

a vital component of the post-graduate delivery strategy of the nursing division in its attempts to address the increasing demands for nurse training.

Yu, Chen, Yang, Wang and Yen (2007) state that e-learning, as a diverse learning style, has been widely recognized in several countries. The learning environment extends beyond the classroom and establishing a technology driven culture is seen as essential to the future of nurse education and the facilitation of life long learning (McVeigh, 2009). Information, communication and technology (ICT) allows for the design and implementation of an eHealth Nursing Strategy to overcome some of the challenges faced with conventional nurse training. These challenges include, heavy family duties, conflict with personal preference, lack of flexibility, staffing shortages created and lack of ensuring teaching consistency nor accommodation of diverse learning needs of students, (Yu et al 2007; Jeffries, 2001). Since the early 1990s, together with the rapid growth of Internet, a number of various applications for e-training or e-learning have been developed around the world (Abramczyk, Lewoc & Izworski, 2005).

Tele-education and telemedicine have been cited as ways of overcoming professional isolation, and the South African National Telemedicine Strategy included tele-education as an important component (Mars, 2009). The use of ICTS's in this project not only encompasses nursing training but also include service delivery. It demonstrates the innovative use of technology in the decentralization of nurse training, *thereby taking nurse education to the nurses*. Yu, Chen, Yang, Wang and Yen (2007) describe the benefits of e-learning in nursing education as achievement of life-long learning, fulfillment of personal interests, time-saving, consideration of job needs, information diversity, flexibility in time and space, self-regulatory learning, cost-effectiveness and less impact on family duties and life. ICT has been viewed as a resource at least as effective as conventional face-to-face teaching methods (Reime, Harris, Aksnes & Mikkelsen 2008; Bloomfield, Roberts & While, 2010). Nevertheless the authors suggest that, If interactive multimedia is to be used, the learning process and tools must be designed to support in-depth learning and not only superficial learning.

Strengthening Nursing Education & Practice in South Africa using ICT's

Information and communication technology (ICT) has a leading role in the distribution of information in South Africa, Africa and around the world. Africa has experienced an large increase in ICT usage the last decade. According to a World Bank report (2007), Africa was rated as the fastest growing mobile network with subscriptions rising from 54 million to almost 350 million between 2003 and 2008. In the decade between 1995-2005 (Smith, 2009) US$25 billion was invested in the information and communication technologies (ICT) sector in Sub-Saharan Africa, mainly by private operators and investors – resulting in the phenomenal expansion of usage.

The demand for alternatives to traditional educational approaches has expanded more rapidly than anyone could have predicted a decade ago (Seibert, Guthrie, & Adamo, 2004). McVeigh (2009) states that recent trends and current policies guiding the direction of higher education worldwide indicate that effectively embedding an e-learning culture is an essential element to future educational development. According to Tsuda, Scott, Doyle & Jones (2009), traditional textbooks are being augmented and replaced by interactive Web-based and digital media platforms. In surgical skills training for example, video education has become mainstream in the learning of new procedures (Tsuda et al., 2009). Technology can be utilized in new ways to expand faculty and educational resources through strategies such as teleconferencing, enabling additional cohorts of students to benefit from a single lecture (Allan & Aldebron, 2008).The study by McVeigh (2009) suggested that we may still be a long way from the ideal. Potential barriers identified in the study included the functional capability of students, perceived levels of computer literacy, perceptions of e-learning as time consuming, competing home life elements and the lack of work based support.

In 1995, the South Africa government formed the National Health Information Systems Committee, tasked with designing a comprehensive national health information system for South Africa. The Medical Research Council (MRC) of South Africa has a Telemedicine Lead Programme tasked with evaluating existing and planned telemedicine

systems, coordinating national telemedicine activities and establishing tele-education for health care professionals. In collaboration with the University of Stellenbosch, the MRC has developed a primary health care workstation for use in primary health care facilities run by nurses and part-time doctors and dentists (Mars, 2009).

Working in a demanding environment in addition to caring for their families often result in difficulties for nurses to engage and sustain their required learning experiences (Presho, 2006). ICT's could potentially address this shortcoming as a result of its flexibility and availability. This is already evident in various Telemedicine projects that have been implemented abroad and throughout South Africa. A study compared multiple-choice test results of a group of nursing students who used an e-learning program versus another which had a 3 hour long lecture on infection control (Reime et al, 2008). The study found that E-learning has to be viewed as a resource in the same way as a lecture.

Yu et al (2007) investigated the feasibility of developing e-learning examined reasons for adopting or rejecting e-learning as an alternative way to conduct continuing education (CE) for 233 public health nurses (PHNs). The majority of PHNs (88.84%) showed an affirmative intention towards adopting e-learning as their one way of CE. Those who rejected e-learning as their way of CE indicated main reasons as poor computer competence, lack of personal computer and without internet access, heavy work load, heavy family duties, conflict with personal preference, heavy economic burden, lack of motivation, and low self-control. Another study reported on the use of a low-tech telemedicine videoconferencing solution (Skype) as a tool in medical education (Gosman, Fischer, Agha, Sigler, Chao, & Dobke, 2009). The results showed potential in several areas of telemedicine as an alternative solution for introducing students to international health. The study also found that telemedicine facilitated the active participation of more students than would normally have been possible in the operating room.

A Primary Health Care (PHC) telemedicine workstation was implemented at Grabouw Community Health Centre in the Western Cape, South Africa predominantly for teledermatology and paediatric consultations where nurses were the main users (Mars, 2009). The nurses not only used the PHC workstation for telemedicine consultation but also for skills development. After every telemedicine case is loaded, nurses discuss the response received from the specialist. Nurses have now requested that the telemedicine initiative be expanded to other more specialized areas like mental health, where there is lack of capacity and skills available to attend to this specialty. The main goal of telemedicine is to give health professionals the opportunity of improving their knowledge and clinical skills. Besides medical diagnosis and patient care, telemedicine is used for treatment, health education and Research (Stanberry, 2001).

At the University of Stellenbosch the nursing department has recently embarked on a project looking at various ICT initiatives to strengthen nursing education. These include telematic education, DVD's, online library, e-resources and Skype. The aim of the project is to use ICT's to decentralize nursing education and also capacitate existing nurses in their current settings.

Main components of the existing technology platform at Stellenbosch University

Interactive Telematic Education

Stellenbosch University is addressing the educational need for ICTs and has invested in e-Learning products such as the Learning Management System (LMS) and satellite based Interactive Telematic Education (iTE) systems to enhance the training it offers postgraduate nurses. A blended learning approach is designed to obtain the optimal blend of e-Learning activities to achieve the outcomes of a range of postgraduate programmes for nurses. This blend includes face-to-face activities, text based materials and activities on web-based learning management systems and the activities on the Interactive Telematic Education satellite-based platform. Students who are based overseas and distant places nationally, also have an opportunity to participate through the use of Skype. Skype allows users to communicate by voice, messaging and video conferencing. Voice chat allows both calling a single user and conference calling. A single user call allows for a one on one consultation whilst a conference call includes more tan two users.

The enabling properties of iTE are that one can learn without having to travel a long distance to attend clases or seek consultation (Lehoux, Sicotte, Denis, Berg & Lacroix, 2002). Mercuur (2010) state that the revolutionary power of eLearning is the combination of a world-wide web connecting the presenters and learners with the immediacy of text, audio and video, as well as interactivity and collaborative sharing. Many prospective post-graduate students living in remote areas often experience that a residential university has barriers which deters access. These include financial constraints, isolation of rural nurses lack of on-campus student accommodation, work environment related problems such as the unavailability of study leave, time, and family circumstances (Penz, D'Arcy, Stewart, Kosteniuk, Morgan and Smith, 2007). For these students iTE enables them to participate in post-graduate programmes and continue with lifelong learning, as the profession requires (Meyer, 2003). The iTE platform is based on satellite with General Packet Radio Service (GPRS) and smart card technology and consists of an on-campus studio and twenty five remote learning centres situated across South Africa to create a virtual learning environment to support synchronous teaching, learning opportunities and quality tutorial for many post-graduate students. Cellphones with GPRS are used to transmit communication from students at remote learning centres to the educator. A smart card stores and transacts data and is stored in a reader (cell phone). Electronic recordings of the iTE lectures (broadcasts) are also made available. iTE students are asked to login with their student cards or by means of their cell phones to register their presence at the different learning centres. By doing so an attendance register is electronically compiled. A complete record of student participation is captured on the iTE database. iTE allows direct two-way communication between the lecturer and students while a lecture is in progress. Real-time interaction between the lecturer and students, which is one of the distinctive attributes of iTE, allows for the collaborative co-construction of knowledge rather than a passive one-way transfer of knowledge which makes it appropriate for postgraduate adult learning (Van der Merwe & Park, 2008).

Web-based learning management system

Blackboard (previously WebCT), a web-based learning management system, is the other institutional e-learning technology that lecturers can use. Stellenbosch University has a long track record of using this type of web-based technology in teaching and learning. The University was one of the first universities in Africa to adopt WebCT in 1999 and the first University in Africa to adopt the Enterprise version of WebCT, WebCT Vista, in 2005. This type of enterprise technology combined with the considerable expertise not only with regards to the technology, but also the educational use thereof over the past nine years, has enabled the University to remain at the cutting edge of web-based teaching and learning.

Turnitin, a software application that checks the academic integrity of students' assignments, is seamlessly integrated into WebCT. Students submit their assignments via the WebCT interface and Turnitin then generates an originality report by comparing the student's assignment with an extensive database of Internet and journal sources. The software reviews the submission for plagiarism and provides a detailed report. The Portal Project at Stellenbosch University (SU) is one of the key projects in the University's broader e-Campus Initiative, a six-year initiative (2002-2007), which is an organised and co-ordinated effort to not only further the integration of ICT into all the University's activities, but to create a "networked" university.

Future project scope

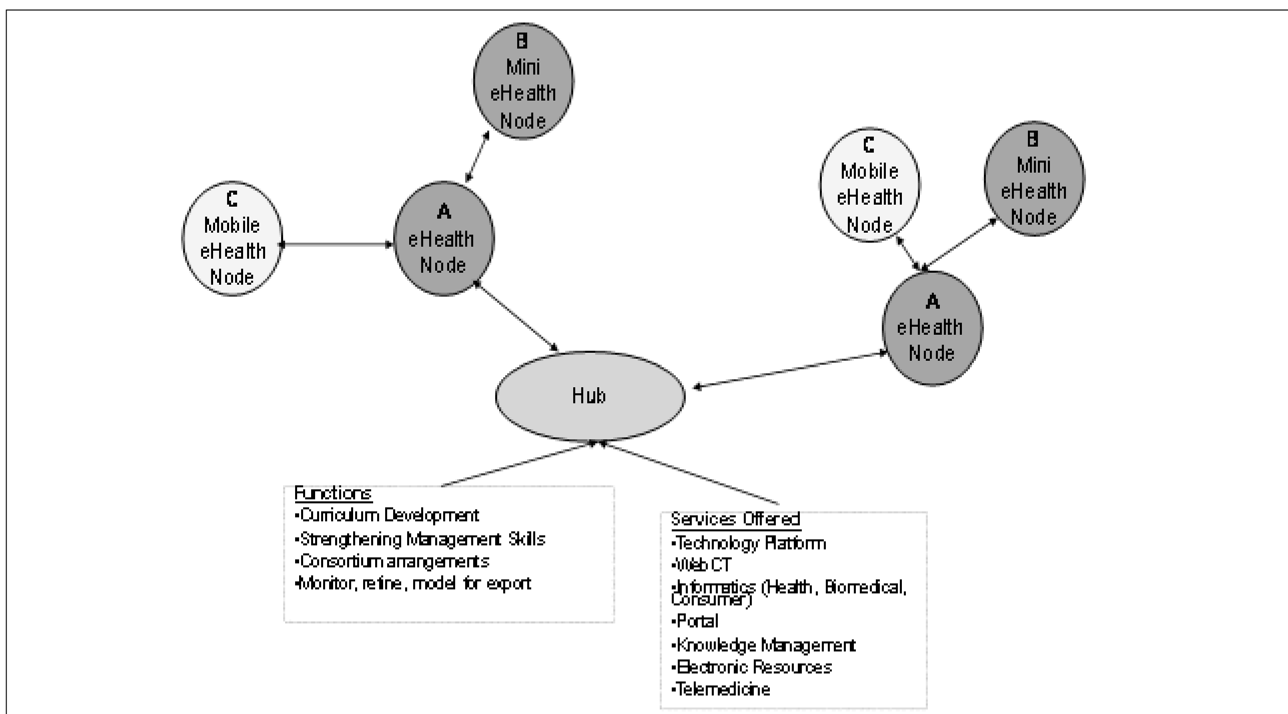
The challenge of increasing the limited capacity of the existing eHealth application is an abiding endeavour. The focus of the project would be to create an eHealth platform to strengthen nursing education especially in areas where no formal nursing education exists in partnership with governmental structures. In so doing it will also create an opportunity to recruit nurses from disadvantaged areas and have better retention of nurses as they will not be taken out their existing environment. It is the vision of the Department of Health in the Western Cape not only to strengthen nursing education but also to create nurses training centres in the largely rural sites of Boland; Overberg; Central Karoo and Eden by 2010. The eHealth platform promises to address the challenge of lack of trainers and training in nursing without

putting major additional strain on the human and financial resources. It is envisaged that this may be achieved by utilization of ICT's such as eHealth nodes, satellite transmission, internet, WebCT and Videoconferencing at several different sites (Table 1).

Hubs and Nodes

A hub is a centre that facilitaes and support ICT activities. Nodes are centres that are linked to a hub. An eHealth Hub will be developed at Tygerberg Campus of the university. In addition an eHealth Node will be developed in Worcester and George. Two Mini eHealth Nodes and 2 Mobile Skills Labs will also be developed and they will be linked to Worcester and George respectively. The project life cycle will be over a 4 year period. Within year 1 & 2 there will be a substantial amount of design; development and implementation. Whereas in years 3 & 4 the focus will be to develop a business model which will ensure the sustainability of such an initiative. Evaluation will occur at the end of each year.The project will focus on using existing physical infrastructure to commence the eHealth nodes. The existing infrastructure includes: telecommunications, buildings (e.g. classrooms), computer hardware and software. This project will use cutting edge technology appropriate to South Africa.

Figure 1: Services to be provided at nodes



Activities at the hub will include curriculum development, staff development, consortium arrangements, monitoring, evaluation, and refining the Project. **The eHealth Hub** support personnel and services will include: nurse trainers and managers; curriculum development; continuous professional development; eLibrary; satellite broadcasts; audio & video development; WebCT; internet access and videoconference facilities.

eHealth Node it is envisaged that this would be hosted at regional health facilities distributed within all districts of the Western Cape. The eHealth node will offer an eLibrary; satellite broadcasts; audio & video recordings; WebCT; internet access and videoconference facilities. The purpose of the eHealth node would be to recruit and train volumes of nurses. In addition it will also provide continous professional development to nurses and postgraduate training. The eHealth node will link directly with the hub.

Mini eHealth Node should focus on primary healthcare and community health facilities. The eHealth node should provide access to eLibrary; audio & video recordings; WebCT; internet access; videoconferencing. The purpose of the mini eHealth node is to provide support and training to primary

healthcare nurses, postgraduate students and nursing assistants. The mini eHealth node will link to the e-Health node.

Table 1. Current Status of eHealth Nodes for Nurses Training

There are currently six satellite facilities available in the Western Cape.

Table 1. Current Status of eHealth Nodes for Nurses Training

District	Node	Satellite	Internet	WebCT	Videocon	Cur Dev
Central Karoo						
Boland	Worcester	X			X	
Eden District	George	X				
Overberg District	Caledon	X				
West Coast	Vredenburg	X				
Metropole	Tygerberg	X	X	X	X	X
	Stellenbosch	X				
	Bellville	X				

Mobile eHealth Skills Lab

This initiative will focus on providing a mobile eHealth skills lab to allow home based caregivers, possible nursing students and community workers to access information and training where currently there are no fixed facilities. The mobile eHealth skills lab may include an eLibrary; audio & video recordings; webCT; internet access and videoconferencing. The eHealth Hub will be situated and managed by tertiary and academic hospitals. eHealth Nodes will be situated and managed by regional hospitals and the Mini eHealth Nodes will be situated and managed by district hospitals; community health centre and primary healthcare clinics. It is intended that the Mobile eHealth Skills Lab reaches out to district hospitals, community health centres and primary healthcare clinics.

Conclusion

The increase in the demand of nursing education calls for drastic measures in training and a shift from the traditional classroom method of training. Studies have shown that ICT can be used to deliver training in nursing with similar outcomes to traditional methods. Access to training of learners in rural ares may be increased through the use of ICT. The major challenge of using ICT is the skills of learners to use the services. The project is likely to increase postgraduate education and training of nurses in the region. Advancement in technology should be used as a tool to enhance teaching and learning and development of skills for nurses especially those in remote and disadvantaged areas.

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THE EFFECT OF OCCUPATIONAL-RELATED LOW BACK PAIN ON THE FUNCTIONAL ACTIVITIES AMONG MANUAL WORKERS IN CONSTRUCTION COMPANIES.

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Abstract

Introduction:
Low back pain is the most prevalent musculoskeletal condition and one of the most common causes of disability in the world. The disability resulting from low back pain continues to plague the construction industry leading to absenteeism and early retirement among construction manual workers.

Purpose:
The aim of the review was to explore global literature concerning the effect of occupational-related low back pain on the functional activities among manual workers in construction companies.

Method:
A retrospective search of articles published from January 2000 to April 2010. The following electronic data bases, Google Scholar, Academic search premier, CINAHL, ERIC, Health source-consumer Edition, Health source: Nursing/Academic Edition, Master FILE Premier, MEDLINE, MLA Directory of Periodicals, Science direct, MLA International Bibliography, Pre-CiNAHL and PubMed were individually searched using specifically developed search strategies. Methodological quality was evaluated using the Critical Appraisal Skills Programme (CASP) tool and was done by two independent reviewers.

Results:
The search yielded eleven articles of sound quality. There is evidence that a high percentage of construction workers suffer permanent disability and fail to return to work forcing them to go into early retirement due to occupational related low back pain. The cohort studies have shown that poor performance, reduction in productivity, restrictions on usual activity and participation and incurring high medical costs all pose a challenge to construction manual workers and their employers as a result of occupational related low back.

Conclusion:
The findings support that occupational related low back pain is a challenge among construction manual workers causing serious disability. Further well designed research in Africa into the most effective strategies to prevent and manage occupational related low back pain among construction manual workers is needed.

Key words:
Occupational related low back pain, Construction manual workers, Function, Disability, Impairment, Activity limitation, Participation restriction.

INTRODUCTION

Low back pain is a highly prevalent and costly somatic complaint accounting for a large percentage of all sickness absence in the world (Latza, Pfahlberg & Gefeller, 2002; Gheldof, Vinck, Vlaeyen, Hidding & Crombez, 2007). It has been found to be more common amongst construction manual workers compared to all occupational

groups (Deacon, Smallwood, & Haupt, 2005). The consequences of low back pain among workers mainly lead to sick leave and disability pension often resulting in limitations in activity and restriction in participation (Bautz-Holter, Sveen, Cieza, Geyth, & Roy, 2008).

Low back pain is highest in construction manual workers compared to all occupational groups (Deacon, Smallwood & Haupt, 2005). Due to the high mechanical nature and hard physical labour, construction work has a reputation of being an unhealthy industry. Heavy manual handling twisting and trunk rotation and maintenance of static and awkward body postures for long hours are typical positions adopted by construction manual workers. These activities exert a lot of strain on spinal structures and consequently lead to low back pain. (Latza, Pfahlberg & Gefeller, 2002). According to Gallagher (2008), construction manual workers may suffer from low back pain but do not report it as an injury. Nonetheless, such “non-reported” pain may result in decreased productivity and quality of life (Gallagher, 2008). Childs, Fritz, Flynn, Irgang, Johnson, Majkowski and Delitto (2004) highlighted that billions of dollars in societal and medical expenditures are lost each year because of low back pain in construction.

In addition to economic loss, Katz (2006) indicates that low back pain may result in significant levels of disability, producing restrictions on usual activity and participation, such as inability to work normally (especially in construction work). According to Punnett, Pruss-Ustun, Nelson, Fingerhut, Leigh, Tak and Phillips (2005), occupational related low back pain has enormous effects on an individual’s functional ability leading to absenteeism from work and loss of one’s quality of life. It has been noted that individuals with low back pain (in construction companies) tend to have negative attitudes towards strenuous activities and leisure pursuits based on fear avoidance beliefs (Woolf & Pfleger, 2003). Anxiety, stress, depression, somatisation symptoms, stressful responsibility, job dissatisfaction, mental stress at work, negative body image, weakness in ego functioning, poor drive satisfaction and substance abuse were among the highlighted psychosocial factors associated with occupational related low back pain (Andersson, 1999). Though low back pain is a big problem among construction manual workers, very little has been published about its effect on the functional activities of the manual workers in construction companies especially on the African continent. This was identified by the researcher as a gap that needs to be explored and thus the aim of this review is to determine the effect of occupational-related low back pain on the functional activities of the manual workers in construction companies.

METHODS

A comprehensive search for literature related to the topic was done from January 2000 to April 2010 in all the University of the Western Cape (UWC) library accessible databases.

The search considered any full text peer reviewed research studies around the world relevant to the topic. The PICO (Population, Intervention, Comparison and Outcomes) was used as the searchable format for the clinical question and to review the articles and the abstracts. All identified literature was screened using the Sackett’s level of evidence hierarchy system and to determine the eligibility of the paper for inclusion in the study (Sackett, 1989). Only literature published in the English language from 2000 to 2010 was considered. The final screening of all the identified literature was done by two independent reviewers.

The databases searched included: Google Scholar, Academic search premier, CINAHL, ERIC, Health source-consumer Edition, Health source: Nursing/ Academic Edition, Master FILE Premier, MEDLINE, MLA Directory of Periodicals, Science direct, MLA International Bibliography, Pre-CiNAHL and PubMed. The main key terms used for searching for the literature were: Construction manual workers, Low back pain and Functional limitations.
In Medline and Science direct, “and” was used as a Boolean operator. Other databases did not produce any results except the ones given in Table 1.

Search results

The search generated a total of 6 185 articles of which twelve were found relevant to this topic. A total of 6 173 articles were excluded because they did not conform to the objectives and inclusion criteria of this review. Details of the search results are illustrated in table 1.

Table 1: Search results

Database	Hits	Retained	Excluded	Included
Science direct	5	4	1	4
Google scholar	6176	4	6173	3
Medline	3	3	3	0
Pubmed	1	1	1	0

Assessment of methodological quality

After selection of the twelve studies presumed to be of acceptable designs, the Critical Appraisal Skills Programme (CASP) tool for cohort studies (CASP, 2006) was used to assess methodological quality of the cohort, cross-sectional and longitudinal studies. CASP for cohort studies uses an instrument to appraise reviews based on 12 questions (Milne & Chambers, 1995). These questions address key domains (e.g. comprehensive search, validity assessment, results combination) of methodological quality (CASP, 2006). Therefore, all articles included in this study were evaluated for quality and each study was classified as good if it scored between (8-12/12), moderate (5-7/12) and poor (1-4/12). The only systematic review included was evaluated for quality using the (CASP) tool for systematic reviews (Oxman, Cook & Guyatt, 1994). This tool comprises of 10 questions thus having scores ranging from 1-10. The scores are classified as good if an article scores between (8-10/10), moderate (5-7/10) and poor (1-4/10). Of the twelve retained articles, seven had a good methodological quality and were therefore included for review (Table 2). Five articles scored between 1- 4 and were excluded because they were considered to be of poor quality.

Table 2: Methodological quality scores of included studies

Title	Authors	CASP Score of Methodological quality
Good management practice as means of preventing back disorders in the construction sector.	Gervais, M. (2003).	8/10
The health and well-being of older construction workers.	Deacon, C. T., Smallwood, J. & Haupt, T. (2005).	10/12
Health problems lead to considerable productivity loss at work among workers with high load jobs.	Meerding, W. J., Ijzelenberg, W., Koopmanschap, M. A., Severens, J. L. & Burdurf, A. (2005).	10/12
Demonstration of the healthy worker survivor effect in a cohort of workers in the construction industry.	Siebert, U., Rothenbacher, D., Daniel, U. & Brenner, H. (2001).	9/12
Cohort study of occupational risk factors of low back pain in construction workers.	Latza, U., Karmaus, W., Sturmer, T., Steiner, M., Neth, A. & Rehder, U. (2000).	10/12
Development of and recovery from short- and long- term low back pain in occupational settings: A prospective cohort study.	Gheldof, L. M, Vinck, J., Vlaeyen, J. W. S., Hidding, A. & Crombez, G. (2007).	10/12
Impact of repetitive manual materials handling & psychological work factors on the future prevalence of chronic low- back pain among construction workers.	Latza, U., Pfahlberg, A. & Gefeller, O. (2002).	9/12

RESULTS

The seven studies included in the review comprised of one systematic review, one longitudinal study, two cross-sectional and three cohort studies. Of the included articles, most of the studies were conducted in developed countries with only one study conducted in South Africa. Various methods were used for data collection. Among the methods used for data collection were questionnaires (Meerding, Ijzelenberg, Koopmanschap, Severens & Burdurf, 2005; Gheldof, Vinck, Vlaeyen, Hidding & Crombez 2007) medical examinations only (Siebert et al., 2001; Latza, Pfahlberg, & Gefeller, 2002), medical examinations and an interview (Deacon, Smallwood, & Haupt, 2005; Latza et al., 2000) and a systematic review used screening as the criteria of including literature (Gervais, 2003). The sample participants of the studies ranged from 142 to 1 809 participants with the age group ranging from 15 years to 65 years and the sample mean age of 40 years. A summary of the studies included in this review is illustrated in Table 3.

DISCUSSION

The aim of the review was to determine the effect of occupational-related low back pain on the functional activities of the manual workers in construction companies. Firstly, the prevalence of occupational related low back pain was high as is shown by literature (MacIntoshi & Hall, 2008). Two cohort studies by Latza et al. (2000) and Latza et al. (2002) have shown that among all occupational groups, construction manual workers are the worst affected by low back pain due to the nature of the activities they perform while on duty. Gheldof et al. (2007) highlighted in their prospective cohort study that construction manual workers are more exposed to back disorders due to manipulation of heavy loads, heavy lifting that exceeds the lifting tolerance, forceful exertions and maintenance of awkward postures for long hours such as bent or twisted back. As a result of these risk factor exposures, low back pain has consistently been the leading cause of occupational disability and absenteeism in the construction industry (Gheldof et al., 2007).

In the included systematic review, Gervais (2003) uncovered that there was a high percentage of construction workers suffering permanent disability and failure of returning to work due to occupational related low back pain. Furthermore, the two cross-sectional studies uncovered that construction activities exacerbate low back pain in construction workers and these activities lead to restrictions in daily activities such as standing, walking, bending, lifting, travelling to work, socialising and interference with personal care (Meerding et al., 2005; Deacon et al., 2005). Construction activities are highly associated with absenteeism, poor performance and consequently reduced production (Meerding et al., 2005), with the effects being worse among older construction manual workers (Deacon et al., 2005). The number of day's lost due to sick leave and the costs incurred on the rehabilitation of low back pain have imposed socio-economic challenges among construction workers and the employers (Pinto, Cleland, Palmer & Eberhar, 2007). Germany recorded a total of 11 138 (15%) construction workers claiming compensation from insurance funds in 1999, out of 42 million employees in the industrial sector due to occupational disorders with low back pain being the most prevalent disorder (Latza et al., 2002). In the United Kingdom, lost productivity and resulting economic costs, due to low back pain were estimated to be in the region of 12 billion pounds in 1998 (Van Vuuren, Van Heerden, Zinzen, Becker & Meeusen, 2006). One cohort study established that back and spine disorders among construction manual workers lead to about 63% of the workers retiring early and about 43% suffering permanent disability (Siebert et al., 2001).

CONCLUSION

The results of this review indicate that there is reason for concern regarding occupational related low back pain among construction manual workers worldwide. High quality interventions should be undertaken by health professionals and employers to ensure better support for workers suffering from low back pain and therefore enhance primary prevention of back disorders in the construction companies. The findings of this review also indicate that primary prevention should be considered a priority in the management of occupational related low back pain among construction manual workers to prevent psychosocial disorders, absenteeism, early retirement, reduced production, and permanent disability and constraining of economic resources for the worker and the company due to the ever increasing health care expenses. In Africa,

Table 3 Summary of description of reviewed studies

Reference	Design	Country	Population	Tool	Objective	Outcome
Gervais (2003).	Systematic review	Canada	Review of 40 studies	Independent screening (tool not mentioned)	To develop a basis for new intervention strategies for back disorders in the construction sector.	Primary prevention of back disorders can be done by administrative and engineering controls.
Deacon, Smallwood, & Haupt (2005).	Cross sectional	South Africa	142	Interview & medical exam	To investigate the health status of older construction workers.	Construction activities exacerbated low back pain in older construction workers & were highly associated with absenteeism & poor performance.
Meerding, Ijzelenberg, Koopmanschap, Severens, Burdurf (2005).	Cross sectional	Netherlands	182	Questionnaire (self administered)	To assess the feasibility of two instruments for the measurement of health-related productivity loss at work.	High physical load jobs in construction have considerable reduced work productivity & sickness absenteeism.
Siebert, Rothenbacher, Daniel, & Brenner, (2001).	Cohort	Germany	10 809	Medical exam	To assess the potential of a healthy worker survivor effect due to differential occupational mobility in a cohort of construction workers.	Back & spine disorders led to permanent disability hence early retirement & mortality when associated with other health conditions e.g. diabetes.
Latza, Karmaus, Sturmer, Steiner, Neth, & Rehder (2000).	Cohort	Germany	571	Structured interview & medical exam	To identify work related risk factors of future low back in a cohort of construction workers free of low back pain at the start of follow up.	Differences in work characteristics, average working hours per shift & psychosocial factors (job satisfaction) can predict the future prevalence of low back pain.
Gheldof, L. M., Vinck, J., Vlaeyen, J. W. S., Hidding, A. & Crombez, G. (2007).	Prospective Cohort	Netherlands	1 294	Questionnaire (Self administered)	To investigate the role of work-related physical factors and psychological variables in predicting the development of and recovery from short term to long term low back pain.	High fear –avoidance beliefs (re)injury regarding construction work increased the failure from recovery from acute to chronic low back pain.
Latza, U., Pfahlberg, A. & Gefeller, O. (2002).	Longitudinal study	Germany	488	Medical exam	To investigate the influence of manual stone & brick handling & psychosocial work factors on the risk of chronic low-back pain & to describe the impact in terms of risk advancement period.	Repetitive work in bent positions & manual manipulation of heavy stones increases the risk of low back pain in construction.

there is still a dearth in research and information on back disorders among construction workers suffered on duty. Therefore, more studies of sound methodological quality exploring this area need to be done.

IMPLICATIONS FOR PRACTICE

Occupational related low back pain is a challenge among construction manual workers causing serious disability. It is therefore imperative that primary preventive measures are put in place at epidemiological level and require implementation by the employer, health professionals and construction manual workers. This will improve on the socio-economic challenges of the manual workers and reduce on their impairments, limitations in activity and restrictions in participation they suffer due to occupational related low back pain.

The Physiotherapist's physiological understanding, the assessment, and the treatment skills results in a professional with the knowledge to direct an efficient preventative program (Jones & Kumar, 2001). Physiotherapists must embark on work place disability management programs in their clinics when treating construction manual workers suffering from occupational related low back pain. The physiotherapist's role must include prevention, early assessment, proactive treatment, timely rehabilitation and early return to work in the hope to prevent psychosocial disorders, absenteeism, early retirement, permanent disability, reduced production and minimizing the cost of the low back problem.

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THE MANAGEMENT OF MINOR HEALTH AILMENTS BY DOCTORS, CLINICAL NURSE PRACTITIONERS AND CLIENTS AT THE PRIMARY LEVEL OF CARE IN CAPE TOWN

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Abstract

Introduction:
Community Health Centres (CHCs) are overcrowded. The overcrowding poses a problem to health professionals as they are in charge of screening clients and the management of minor health ailments (MHA) in the primary health care setting.

Methodology:
The aim of this study was to describe and compare the perceptions and attitudes of clients presenting with MHA to those of doctors and clinical nurse practitioners (CNPs) (health professionals) at the CHCs regarding the management of MHA. The study was conducted at the four selected CHC in Khayelitsha and Phillipi, Cape Town. Information was collected from 100 clients and 15 health professionals. Data was analysed both qualitatively and quantitatively and the descriptive method was used.

Results:
All three groups had similar perceptions of what MHAs are and how MHA should be managed. There were different perceptions regarding where these ailments should be managed. The doctors and CNPs were frustrated and felt overburdened by clients presenting with MHA. Doctors were of the opinion that educating clients about the management of these ailments would alleviate their load.

Conclusion: Health education was identified as a tool that could assist in the situation of managing MHA and as the key underpinning principle for the delivery of comprehensive primary health care (PHC).

Key words: management, minor health ailments, primary level of care

Introduction

Khayelitsha and Phillipi, the residential areas in which the study was conducted, are two black townships near Cape Town in South Africa. Khayelitsha was established when the apartheid government planned to move all Africans living near the city centre to areas further away from the city and suburbs (in other words, away from white people). Phillipi started at Brown's Farm, where people working on the farm built shack dwellings for housing. Khayelitsha and Philippi are located approximately 26 and 20 kilometres respectively from Cape Town city centre, and both areas emerged out of informal settlements.

One characteristic of the informal settlement is rapid population growth. It is estimated that the population increase in Khayelitsha is 8.5% per year. The community profile of Khayelitsha that was done in 2001 estimates that Khayelitsha alone houses approximately 300 000 to 400 000 people. However, because of the rate of people settling in

Khayelitsha, the numbers could be much higher. It is estimated that approximately 110 316 people live in Phillipi. The population of these areas comprises mainly young Xhosa-speaking people, the majority of whom are between ages 19-39 years and 91,1% is unemployed (Anderson, Azari and van Wyk, 2009). Poor conditions, such as overcrowding and poor infrastructure, leave these young people prone to an array of illnesses.

In 1996, the Department of Health of the Provincial Administration of the Western Cape (Department of Health, 1996), in line with the government's national initiatives, developed a district health plan to provide access to health care for all citizens of South Africa. The district health system would be supported by the development of CHCs and clinics to enhance the services provided. Khayelitsha and Phillipi fall under Districts 7 and 3, with three and four CHCs respectively. The doctor:patient ratio is meant to be 1:60 and the clinical nurse practitioner:patient ratio is meant to be 1:25. In reality, both the doctors and the clinical nurse practitioners see far more patients than these, especially when there is a shortage of staff.

While the new post-apartheid health agenda was geared towards shifting both human and financial resources from the large incumbent tertiary institutions to the envisaged district health system. There was no clear plan regarding the percentage of shifts or an operational plan for the different layers of the health delivery system, that is, primary, secondary and tertiary health care (Louw and Edwards, 1997). A psychiatric patient died on the doorstep of a tertiary hospital after having taken an overdose of his psychiatric medication. He was refused access to the tertiary hospital in question because he was not carrying a referral letter from the primary level of health care (Bond, 1997).

A clinical nurse practitioner (Personal communication, Sr. Sigwela, 2001) stated that due to the large numbers of clients attending CHCs, health professionals have no time to educate clients on the prevention and management of minor health ailments. The easiest way to manage the situation is to listen to the patients' problems and prescribe medication for the clients without doing any proper assessment and education. The clients are aware of alternative methods for the management of minor health ailments but they do not utilise alternative methods and medicines, such as the indigenous health knowledge of elderly persons, traditional healers, community health workers, pharmacists and other resources available within their communities.

The problem of overcrowding of CHCs (Michael Mapongwana and Khayelitsha) was discussed in the community health forum with the facility managers of these CHCs, health professionals, clinical facilitators from the University of Cape Town (UCT), students from UCT and elderly persons from Khayelitsha and Phillipi. There was a group of elderly persons residing in Khayelitsha and Phillipi who had the perception that minor health ailments could be managed at home using home remedies.

The new health care agenda never discussed how communities would work together with government to develop PHC (Louw and Edwards, 1997). The researcher further proposes that if this had been addressed, issues such as client accountability and responsibility, as well as the relationship between clients and staff members at the facilities, including measures to address staff fatigue and issues relating to the sustainability of the services would have been discussed with all parties concerned in community health forums. According to the Alma-Ata Declaration of 1978, PHC should address the main health problems in the community by providing promotive, preventive, curative and rehabilitative services. Education concerning prevailing health problems and the methods of preventing and controlling illnesses underpins the comprehensive delivery of primary health care (Fry and Hasler, 1986).

The implementation of PHC in South Africa was aimed at improving access to health care services. This attempt to shift resources resulted in the proliferation of CHCs in areas such as Khayelitsha and Phillipi, where health services were previously either inadequate or absent. These CHCs in Khayelitsha and Phillipi became overcrowded with clients. The overcrowding undermines access to the CHCs, as people wait for hours before seeing the health professionals. It is not clear whether the clients in this study first tried using any other medication before visiting CHCs. This brings us to the question of how primary health care is

implemented in these communities: Were existing resources within the communities considered, and what is the relationship between the CHCs and the communities that they serve?

In 2003, Minister Manto Tshabalala-Msimang hosted a conference to celebrate the completion of 40 years post Alma Ata. This is what she had to say in her opening address:

> *As a result of the implementation of PHC in South Africa, the payment barrier to access to PHC services has been removed. People with disabilities, for example, now have free access to health services, and more than 700 clinics have been built or upgraded to mainly serve the most vulnerable and needy communities. Most surveys indicated that 80% of the public are satisfied with the health care they receive whilst the remaining 20% are unhappy largely with the attitude of health workers and the lack of drugs* (Tshabalala-Msimang, 2003; Rasool, 1997).

Although there are assumptions that the clients do not pay for primary health care services and that they do not utilise available health resources within their communities, no study has been done on clients attending CHCs and presenting with minor health ailments in Khayelitsha and Phillipi in order to investigate the perceptions and attitudes of the clients, doctors and clinical nurse practitioners towards the management of minor health ailments at CHCs.

According to Hjortdahl and Laerum (1992, in Atkinson and Haran, 2004), providing the health care measures of accessibility, availability and convenience are consistently associated with higher satisfaction in health care. The continuity of care providers has also been positively associated with satisfaction. Williams and Calnan (1991, in Atkinson and Haran, 2004) noted the importance of the interpersonal aspects of the patient-professional relationship, such as the amount and clarity of information regarding the condition of the patient, bedside/chairside manner during the consultation, similarity of socio-demographic backgrounds and the extent to which the patient could express opinions. They indicated that these are positively associated with satisfaction about health (Williams and Calnan, 1991, in Atkinson and Haran, 2004).

Overcrowding had been identified as a problem in the Michael Mapongwana and Khayelitsha CHCs. There is a perception that a reasonable number of clients present with minor health ailments. It is believed that clients and health care professionals have different perceptions regarding where these minor health ailments should be managed. Hence the aim of this study was to describe and compare the perceptions and attitudes of clients presenting with minor health ailments, doctors and CNPs at CHCs in Khayelitsha and Phillipi.

Methodology

Study design

A descriptive study was conducted using self-compiled and self-administered structured questionnaires. Both quantitative and qualitative methods were used to collect data from participants.

Sample and sampling methods

A purposefully selected sample of 100 clients was used. Twenty-five clients presenting with minor health ailments were selected from each CHC (Michael Mapongwana, Khayelitsha, Inzame Zabantu and Mzamomhle). Ten doctors and five clinical nurse practitioners who voluntarily agreed to participate in the study were recruited from the purposefully selected CHCs in Khayelitsha and Phillipi except for those working at Mzamomhle CHC because they did not want to participate in the study. The doctors and clinical nurse practitioners identified the 100 clients presenting with minor health ailments after consultation. Pink stickers were put on their folders to distinguish them from clients who presented with serious ailments.

Patient selection procedure

Doctors and CNPs assisted in identifying clients with minor health ailments. The compilation of the list and the selection of clients with minor health ailments were done with the understanding that minor health ailments are difficult to define, as what is regarded as minor today can later become a serious ailment. A list of minor health ailments that was agreed upon by experts on primary health care, doctors and CNPs from the CHCs was used to identify the clients with minor health ailments. These ailments were **Respiratory:** colds, upper respiratory tract infection, hay fever; **Abdominal and urinary tract infection (UTI):** diarrhoea,

stomach ache, gastro-intestinal complaints, acute urinary tract infection; **Skin disorders:** insect bite, rash; **Body pains:** back pain, acute back syndrome, migraine, emotional problems; **Ears:** cerumen, acute otitis media; **Accidents:** minor cuts, nose bleeds, accidents or burns.

All clients who presented with these minor health ailments had pink stickers attached to their folders after consultation so that the doctors and CNPs could identify them.

Instrumentation and methods of data collection

Instruments used: A self-compiled structured questionnaire with closed-ended and open-ended questions was used to collect data that answered the aim and objectives of this study from the clients and health professionals (doctors and clinical nurse practitioners). The instrument was piloted at another CHC for reliability and validity to both clients and health care professionals. This questionnaire consisted of two sections. Section A was used to obtain demographic information and Section B collected information from the participants regarding their own perceptions and attitudes pertaining to the management of minor health ailments.

Ethical considerations

Permission to conduct the study was obtained from the Research Ethics Committee of the University of Cape Town and from the facility managers of the CHCs where the study was conducted. Participants were requested to sign a consent form that also informed them of the procedure of the study.

Data analysis

Data were collected in 2003 at the different sites in Khayelitsha and Phillipi. All the responses of the clients, doctors and CNPs were gathered separately and the information was summarised according to the responses to the questions. The responses requiring ‘yes’ and ‘no’ answers were counted and presented as percentages. Common themes from qualitative data were identified by coding them for both clients and health professionals. The responses from the questionnaire were captured on an Excel spreadsheet and the results were presented in tables and themes.

Results

Demographic details of participants

There were 100 clients (63 female and 37 male), 10 doctors (9 male and 1 female), 5 CNPs (all female) who participated in this study. Of the clients, doctors and CNPs who participated in this study the majority (n=108) of the participants fell within the age group of 18 to 49 years, followed by 6 clients who fell within the 50-59 years and only 1 was in the age group 60 to 65 years. Of the clients who participated in the study 55% (n=55) visited the CHC for the first time and 45% (n=45) had visited the CHC more than once for the same minor health ailment on the day of the interview.

List of minor health ailments mentioned by clients, doctors and CNPs: Although a list of minor health ailments to be used for the identification of clients with minor health ailments had been compiled by the researcher in consultation with PHC experts, doctors and CNPs, the clients, doctors and CNPs in this study also mentioned ailments that they knew and regarded as minor. While the participants mentioned many illnesses, the list was shortened by taking the top ten illnesses that were mentioned more frequently than others. Table 1 shows the most common minor health ailments mentioned by the clients, doctors and CNPs.

Table 1. List of most common minor health ailments mentioned by clients, doctors and CNPs

Clients	Doctors	CNPs
Fever	Headache	Colds
Stomach ache	**Diarrhea**	Respiratory tract infection
Cough	**Back pain**	Otitis media
Chest pain	Common colds	Minor burns
Rash	**Rash**	**Rash**
Back ache	Abdominal pain	**Back pain**
Discharge	**Cough**	Sore throat
Sores /Wounds	Arthritis	Impetigo
Pimples	Impetigo	**Diarrhoea**
Diarrhoea	**Penis discharge**	**Cough**

The minor health ailments in bold were mentioned by all three groups or by the client and one of the doctors or CNPs. The results shown in Table 1 demonstrate that clients, doctors and CNPs viewed

a number of common ailments as minor health ailments, for example, cough, rash, back pain and diarrhoea. Discharge was also a common ailment mentioned by both the clients and the doctors as being a minor health ailment.

Knowledge of clients regarding minor health ailments that can be treated at home

Regarding minor health ailments that can be treated at home, 59% (n=59) of the clients knew some of these, while 41% did not know. Table 2 shows the list of minor health ailments mentioned by the clients that can be treated at home. There were clients who identified more than one ailment that can be managed at home.

Table 2 List of minor health ailments that can be treated at home mentioned by the clients

Ailment	Number of clients (n=59)
Headache	39
Stomach ache	28
Fever	15
Coughing	10
Diarrhea	9
High temperature	5
Tuberculosis (TB)	4
Vomiting	3

The clients that responded to this question mentioned more than one ailment that can be treated at home. The top three ailments that the clients mentioned could be treated at home were headache, stomach ache and fever, mentioned by 39, 28 and 15 clients respectively. Of concern is the fact that some clients mentioned TB as an ailment that can be treated at home, even though it needs intense investigation and monitoring of the treatment (see Table 2).

Health facilities utilised by the clients when in need of medical assistance

Table 3 shows the type of health facilities that the clients would use when in need of medical assistance.

As can be seen from the results, the majority of clients (80%) visit CHCs when they are in need of medical assistance. Only 20% use other health facilities.

Table 3 Health facilities that clients would use when in need of medical assistance

Health facilities	Number of clients
CHC in study	69
Other CHCs (not those in study area)	11
Private doctor	11
Hospital	8
Other	1

Perceptions regarding assistance received by the clients from the four CHCs when presenting with minor health ailments

The clients were asked about the assistance that they received at the CHCs besides medication (pills) when they presented with minor health ailments. A total of 53% felt that they had been assisted at the CHC, while 47% felt that they had not been assisted.

The responses of those who were assisted were:

- They were referred to other departments for further assistance.
- They felt better after they had consulted the health professionals.
- They got advice for their ailments during the consultation.
- They were satisfied with the service received from the health professionals.

The responses of those who felt they were not assisted were:

- They had been waiting long hours to get the service.
- The problem lay with the CNPs, whom they regard as nurses without clinical examination skills.
- The other staff members did not treat them pleasantly when they were at the CHC.
- No medication was prescribed for them.
- They did not know what the problem was.
- The problem lay with them, as they did not follow the instructions given to them by the doctors and clinical nurse practitioners at the CHCs.

Knowledge of the clients, doctors and CNPs of community-based advisors for the management of minor health ailments

Only 21% (n=21) of the clients knew of people who could advise them of home remedies for the management of minor health ailments. The types of advisors mentioned are listed in Table 4.

Table 4: Advisors mentioned by clients, doctors and CNPs for managing MHAs using home remedies

Clients	Doctors	CNPs
Community health workers	**Community health workers**	**Community health workers**
Mother/parents	**Grandparents**	**Grandparents**
Faith healers	**Faith healers**	
Nurses	**Professional nurses**	
Traditional healers		
Social workers		
Sister		
Friends		
Other people		

The results of table 4 demonstrate that the range in advisors known by the clients, doctors and CNPs include family members, community health workers, health professionals, friends, faith healers and traditional healers. These are the people who are found in the community. There is some overlapping information between the clients, doctors and CNPs regarding people who can assist with the management of minor health ailments, namely, community health workers and parents/grandparents. This does not mean that they consult them even if they know that these people can be consulted within the community.

Education regarding minor health ailments for the clients and the educators

When the clients were asked if they received education at the CHC regarding the ailments they presented to the doctors and CNPs, only 38% (n=38) said they received education about their ailments at the CHC, while 62% (n=62) said they did not receive any education about their ailments. Table 5 shows the sources of education for clients regarding minor health ailments.

Table 5 Sources of education regarding minor health ailments received by clients at CHCs

Educators	n=38
CNP	25
Doctor	10
Doctor and CNP	1
CHC	1
God	1

As can be seen from these results, 25 clients received education about their minor health ailments from the clinical nurse practitioners, 10 received education from the doctors, 1 received education from both the doctor and the clinical nurse practitioner, 1 received education from the CHC (it is assumed that they received it from the CHC posters), and 1 claimed to have received education from God.

The impact of overcrowding at the CHCs on service delivery

Seven doctors said that they felt frustrated, one felt frustrated and burnt-out and two did not feel any different. The latter two doctors said that there was no difference in their feelings whether the CHC was overcrowded or not. The CNPs expressed feelings ranging from being frustrated and burnt-out to feeling energetic or having no change in feelings when the CHCs were overcrowded and when there was a shortage of staff. Of the five CNPs who participated in the study, two experienced no change in feelings, one felt frustrated, one felt frustrated and lazy, and one felt energetic.

Problems arising during consultation due to the impact of overcrowding

Problems that arose during consultation when the CHCs were overcrowded were as follows:

- Improper examination
- Poor doctor-patient relationship
- Limited time to listen to the patients' problems
- Limited time to educate patients about their conditions
- No time to review records of previous visit.

The main area of concern felt by most doctors and CNPs (n=4 for both) was the limited time available to listen to the patients' problems.

Discussion

Gessler et al. (1995) characterised CHCs as overcrowded environments with long queues, long waiting times, and a brief encounter (often less than five minutes) with the doctor or medical staff, no opportunity to express one's own concerns and being given medicine without any explanation of the effects of the drugs. This description is similar to the situation of overcrowding that prevails in the Khayelitsha and Phillipi CHCs. During the data collection period in 2003 CHCs were still overcrowded with clients who presented with different ailments. Khayelitsha CHCs implemented extending services to clients who are presenting MHA since January 2010. This helped the health professionals to spend more time with their clients presenting with MHA (Personal communication, Sr Sigwela, April 2010)

The health professionals were young newly qualified doctors in their mid-twenties. They had minimal experience of working in environments that are faced with the challenges of clients in this study, the majority of whom were also young, ranging from 18 to 39 years and presenting with MHA. These young doctors are introduced at community level to gain experience in working with clients from the community. The clinical nurse practitioners have experience of working with clients at community level and under stressful conditions. They see more clients than the standard ratio of 1:25. Roden (2006) suggests that health professionals use the health belief model as a tool to assist their clients with health problems since it will focus on health promotion especially for young families. Boneham and Sixsmith (2006) acknowledge the experiences of elderly women in the management of health problems and they strengthened this by having support networks to help each other.

It was clear when the doctors, CNPs and clients were asked to mention minor health ailments that they had a common understanding of what these could be. It is thus recommended that these three groups of participants need to explore further what minor health ailment are and come up with a list of minor health ailments that would be understood by the health professionals and community at large.

Although the researcher was encouraged by the clients' knowledge of minor health ailments that could be managed at home, there is concern about the fact that some of the clients (n=4) believed that illnesses such as TB could be managed at home. The perception of these clients could arise from the service provided by the community health workers who are trained by health professionals to administer TB medication to the clients in the community. Tuberculosis needs medical attention, including being monitored to ensure that the patients are taking medication regularly and correctly and observations to determine how they are responding to medication.

The impact of overcrowding at the CHCs made the doctors feel that they did not assist the clients to their satisfaction, as they miss out on important procedures such as health education, which is one of the most important aspects of primary health care. They also felt frustrated and burnt-out about doing what was required of them when consulting their clients. The clinical nurse practitioners were satisfied with the assistance that they provided to the clients, even though they were overloaded by clients presenting with minor health ailments. They expressed different reactions to overcrowding in the CHCs, ranging from frustration and burn-out to becoming energetic, the latter being quite surprising in the light of the fact that they were seeing more than the required 25 clients per day.

Conclusion

Minor health ailments in particular are seen as contributing to the overcrowding at CHCs. Different perceptions exist regarding how minor health ailments should be managed. The health professionals felt that the assistance that they were

providing to the clients was not up to standard due to overcrowding and very little time spent during consultation. On the other hand, a group of clients was happy with the type of assistance offered at the CHCs. However, some clients were concerned because they were not being educated about their minor health ailments, which disempowered them in terms of strategies that they could utilise to manage minor health ailments.

As identified by the clients and health care professionals, there are people in the community that could assist with the management of minor health ailments, such as family members, community health workers and faith healers. Elderly people in the home and community health workers in the community were identified by the clients, doctors and clinical nurse practitioners as resources that could assist with the management of MHA. The recommendations are: It is recommended in future, that the three groups of the study participants could come together and decide on which ailments should be regarded as minor ailments, and then formulate a strategy for managing these ailments at home. These discussions should be underpinned by education regarding the treatment of MHA, as the study brought to light that this aspect is grossly lacking. It is the researcher's opinion that we will be starting to practice primary health care at its fullest once this level is reached.

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CHALLENGING MODERN SPORTS' MORAL DEFICIT; TOWARDS FAIR TRADE, CORPORATE SOCIAL RESPONSIBILITY AND GOOD GOVERNANCE IN SPORT

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Abstract

Integrity management policy should be built on aberrant behaviour's common grounds rather than on separate aberrant behaviours. A major common ground is likely to be an unhealthy match between the economic globalization and commercialization and some sport intrinsic factors such as egocentrism and a striving for power and glory. We suggest therefore that an integrity management policy in sport should include three components: 1) A reconsideration of the sports structures **(Good Governance)** 2) The development of an ethically more justified relationship with commercialization, media, sponsors and fans **(Fair Trade)**; 3) The inclusion of the needs and objectives of the societal context in which sports organisations are operating **(Corporate Social Responsibility)**.

Introduction

Today's worldwide growing irritation and concern with current sports practice has been fuelled by a number of high-profile scandals. These include match fixing and illegal betting in soccer and cricket, child abuse, child trafficking, child labour and corruption of sport managers. Scandals like these have been extensively reported in the mass media (e.g. www.transparancyinsport.org), *analysed* in scientific literature (e.g. Brackenridge, 2006; Bredemeier and Shields, 1986; Coakley, 1998; David, 2004; Donnelly and Petherick, 2006; Forster and Pope, 2004; Giulianotti, 2006; Hong, 2006; Lenskyi, 2006; McNamee & Fleming, 2007; Morgan, 2006) and challenged in political documents (e.g. E.U. and U.N. documents: Oxford, 2010; Arnaut, 2006; UNICEF, 2010).

In addition to these abusive and criminal actions less extreme behaviours in sport have also been analysed and described as inappropriate, poor or malpractices. We are talking about athletes cheating, taking doping, being aggressive and intolerant and about trainers, coaches and parents putting exaggerated pressure on young athletes for their own egocentric reasons etc. (e.g. Roberts, 2004, pp. 77-78; Bredemeier & Shields, 1986, pp.15-28; Parry, 2004, pp. 107-115; Vanden Auweele, 2004, pp.179, 180).

Although it is clear that we are dealing here with an amalgam of behaviours that do not feel right in reference to a just as large amalgam of standards, rules, ethical precepts, human and civil rights, it is the authors' opinion that the continuum of aberrant behaviours, ranging from inappropriate to criminal, may be symptoms of the same common grounds. A more effective strategy may be therefore to build on this basic common grounds rather than targeting the major aberrant behaviours, the most vulnerable groups and the most likely groups of perpetrators separately (Oxford, 2010; UNICEF, 2010). Combating causes instead of symptoms may be a more difficult and a more long term strategy; however it may lead to a wider range of strategies and may eventually remove the ground for most aberrant behaviour. This angle also allows us to look at sport from a broad societal perspective and to use a multi-disciplinary discourse: 'Why do sports matter morally? What could and should be the role of sport in current society?'

We agree with Morgan (2006, p. 6) that debunking sports' moral deficit is a delicate exercise and requires a balanced approach excluding both being too hypercritical and cynical versus being too romantic towards the power of the positive potentials of sport. Without denying or embellishing the facts, an effective social criticism should provide

some credible belief that there is a good chance that things can be changed for the better. In line with this position our aims will be first to present our analysis of sports' moral deficit in a way that people can take it to heart, secondly to suggest at least a potential way out of the problems and hopefully to unlock within sports organisations a sense of urgency to do something about it.

To be specific, we will describe some common grounds for behaviours that do not feel right. To substantiate this we will refer to research in sport economy, sociology, psychology and ethics (Allison, 2005; Brackenridge, 2006; Giulianotti, 2006; Forster & Pope, 2004; McNamee, 2008; Morgan, 2006, Roberts, 2004; Tamburrini, 2005). We will then suggest elements to be included in a re-conceptualization of sports that target these aberrant behaviours' basic common grounds.

Common grounds in the reported aberrant behaviours

Gradually and implicitly, some developments in society and the values which they externalize have matched to some intrinsic characteristics of sport (Bredemeier & Shields, 1986; De Wachter, 1980). Described already since the eighties (Eitzen, 1988; Seifart, 1984) these societal developments have acquired a self-evident central place in sports practice and influence to a great extent the moral atmosphere and subsequently the moral behaviour of all stakeholders in sport (McNamee, 2008, p.75).

1. ***Sport relevant developments in society:***
    - The increasing importance of commercialization, sponsorship, marketing, merchandising and the related mediatising of society has resulted in an increasing commodification of sport.
    - The globalization of the world resulted in the development of Global Sports Organisations (GSOs) such as the IOC, FIFA and IAAF that have to manage a surplus of power and money.

2. ***Sport intrinsic factors as susceptible receptors of these societal developments***
    - The basic egocentrism in sport.
    - The possibility to acquire power and esteem via sport.
    - The passion to explore one's own limits according to the adage 'citius, altius, fortius', and the pressure to win, whether coming from inside or outside the athlete.

The marriage of these societal and sport intrinsic factors isn't in principle in contradiction with sports' potential to unlock positive values such as well-being, fair play, solidarity and health. We certainly don't argue that this going together automatically leads to aberrations. However it turns out that it easily causes to conflicts of interests and ethical dilemmas and because of maladjusted procedures, structures and attitudes, the positive values usually end up at the losing side (DeSensi & Rosenberg, 2003; Maesschalck & Vanden Auweele, 2010, p.2).

Commodification and globalisation of sport as a challenge/threat to its integrity .

Sport as an economic sector is massive. The total revenue in the five biggest European football leagues has more than tripled from €2.5 billion in 1996-1997 to €7.9 billion in 2007-2008 (www.deloitte.com). A business volume of 200 billion US$ a year seems to the Australian sport economists Forster & Pope (2004, p. 1) a reasonable figure although they add that this figure may give us only glimpses of the volume of all financial aspects related to sports. Anyway the impact of commerce in sport has never been more important than today. In a few decennia many sports organisations are said to have turned progressively from purely sport oriented into commerce oriented companies. Sport has become a commodity (Walsh, & Giulianotti, 2001).

According to an EU working group (Arnaut, 2006, p. 19) there is a danger that this overly commercial approach to sports will end up compromising important sporting values and undermining the social function of sport. It is true that much of sport remains at the 'village' and 'amateur' level and that there is much difference between leagues in terms of markets for spectacle and participation. It is also true that the greatest proportions of the revenues are to be attributed to only 'some' leagues (e.g. soccer, Formula 1, tennis, golf, etc…) and within these leagues only to 'a few' dominant professional clubs (e.g. in soccer Manchester United, AC and Inter Milan, F.C. Barcelona etc…). However, considering the power and impact of these Global Sports Organisations and elite clubs serving as a

model for the lower levels, one may assume that the same attitudes, orientations and atmosphere filter through to the grassroots.

Without being exhaustive, we will elaborate some 'threats' or (expressed in a positive way) 'challenges' to the integrity of sport linked to the globalisation and the increased importance of commerce: *'competitive imbalance, child exploitation, gambling and match fixing, questionable management, pressure of sponsors and media, conditioning of athletes behaviour'*.

Competitive imbalance.

The fact that sports organisations can have a far greater reach in a globalized world, has resulted in a growing 'asymmetrical' interdependence between sports organisations and between clubs within each sport organisation. Global Sports Organisations (IOC, FIFA, IAAF etc.) and elite clubs (AC Milan, Manchester United etc.) organise themselves in such a way that it becomes more and more difficult to be challenged by national sport bodies, by less professional clubs and clubs with a more restricted market. This creates competitive imbalance and tension between sport in Western and emerging and developing countries; between popular and less popular sports and between elite and less professional and recreational sport clubs' (Arnaut, p. 52, 82, 83). Investment in youth sport and talent development has become less important for them because they can buy the best players on the market.

While this may be acceptable (or even desirable) in a normal business or industry, this shouldn't be acceptable or desirable in sport (Arnaut, 2006, p. 52). The outcome of a sport contest shouldn't be dictated by whoever has the deepest pockets. Sports governing bodies should therefore implement models designed to equalize conditions of competition or at least reduce the scope for competitive imbalance. The introduction of some form of regulatory control (e.g. only a given percentage of club revenues may be spent on players' salaries) has been suggested as well as the redistribution of a greater proportion of centrally generated income (Arnaut, 2006, p. 83; Parrish & McArdle, 2006, p. 112; Forster & Pope, 2004, 38-39).

Abuse and exploitation of children, i.e. child trafficking and child labour.

Any conditions in professional or pre-professional sports that involve individual athletes under the age of 18 being treated as commodity, that involve them moving from their homes and that are unregulated, might be considered as trafficking of children. This is most revolting in soccer. Talent scouts and agents are recruiting young players in Africa and South America young players for the wealthy soccer clubs in Western Europe. Exclusive contracts are signed with poverty stricken parents and it is reported that many are exploited. Many of these children don't make it and the International Office of Migration' reports mentioned that many of these children are abandoned and live in the streets and some are sexually exploited (Donnelly & Petherick 2004, pp. 15-18). Strict laws for licensing both agents and underage athletes should be the answer here (Oxford, 2010, p. 16).

The relocation to developing countries of manufacturing jobs in the sporting goods industry (e.g. sport shoes and clothing) had as a side effect an increase of child labour in these countries due to the poverty of the parents (Donnelly and Petherick, 2006, p.11-15; Frenkel, 2001, pp.531-562). Since some of the adults (e.g. coaches and parents) may depend on the labour and income of young athletes for their livelihood, they may have more interest in the athletes' performance than in their healthy development. The sports sector must be able to ensure that children aren't exploited (Donnelly & Petherick, 2004, pp. 24-26).

Gambling and match-fixing

Where revenues once were the means to sporting ends, it is now sport that is the means not only to financial success for the sports organisations, the media and the sponsors but also to pocket easy money for (legal and illegal) gamblers and Mafiosi (Foster & Pope, 2004, pp. 21, 141; Oxford, 2010, pp. 11-12.). According to the EU working group (Arnaut, 2006, pp. 92-95) some regulatory controls can be introduced and monitored by the sport authorities themselves. Certain other measures will require a more active involvement of the state authorities, working in tandem with the sport governing bodies.

Questionable management of the accumulation of a surplus of power and money

As mentioned above, sports organisations have been caught as originally non-profit organisations in a commercial environment. Because they have to combine sport-regulatory and commercial functions, conflicts of interest in their actions and decisions have become all the more likely. They have found themselves increasingly involved in off-field issues such as commercial disputes, legal controversies and human rights' violations (Arnaut, 2006, p. 19; Morgan, 2006, p. 191).

The management of sports organisations and in particular the Global Sports Organisations (GSOs), often appears at odds with the behaviour that they impose upon countries, member organisations and individual athletes and with their self-prescribed positive role in global society as a means to preserve peace and human dignity in a globalized world. These GSOs secure substantial revenues from organising mega sport events and take advantage of the bidding countries' eagerness to organise, in putting nations off against each other in order to maximize their profit (Forster & Pope, 2004, pp. 59-62; Kesenne, 2005, pp. 133-142).

The EU working group suggests more financial solidarity and a greater proportion of the generated income to be re-distributed not only to the participant teams or nations but also to grassroots sports and to the specific developmental objectives of the organising city or country (Arnaut, 2006, p. 163).

A humiliating aspect of the questionable management has been revealed by Foster and Pope (2004, pp. 111-114) and Giulianotti (2006, p. 67). Despite the GSOs rhetoric of their interest in human rights and development, they unearthed an indecent imbalance between the amounts of money allocated for humanitarian and local organisers' support and those for inner circle excesses. Moreover,), the investigative journalist Andrew Jennings ads since 1996 accusation of criminal offense to unfairness and exaggerated self-enrichment (www.transparancyinsport.com; 2000).

To conclude: Because sports organisations have to combine sport-regulatory and commercial functions, conflicts of interest in their actions and decisions have become all the more likely. This is a breeding ground for questionable management and corruption.

The pressure of sponsors and media as a threat/challenge to sports' integrity

The fact that some sports (soccer, tennis, Formula 1, rugby, etc.) are a worldwide favourite consumer product for a lot of fans stimulates both sponsors and media to intensive bidding processes and to offer grandiose sums. Because sponsors want maximum exposure and because the media are dependent of their consumers they both know that ratings and viewing figures and thus financial success are related to their ability to produce what the public want to see by preference at prime time. The public highly estimates emotions related to winning or losing, to risk taking, danger, drama, to ambitious striving but also to identification. Sponsors and media put pressure (directly and indirectly) on nations, Global Sports Organisations, clubs, trainers, parents, medical staff etc. This may result in exaggerated nationalism and patriotism (e.g. Hong, 2006, pp. 53-54), in forcing too strict marketing and commercial favours at the disadvantage of local businesses, in interference with the preparation for competitions, in the shortening of the revalidation period after an injury, in the condoning or trivializing of manifest emotional and physical abuses (Brackenridge, 2006, pp. 41-42; Donnelly & Petherick, 2006; Foster & Pope, 2004, pp. 149-156; Morgan, 2006, p. 192; Vanden Auweele, 2008, pp.363-364). In conclusion, a more ethical justified and regulated relationship between sponsors, media and sports organisations is needed.

The conditioning of athletes' behaviour

Commerce influences the value which the athletes put on their sporting practice, their motivation, their objectives (e.g. to win at all costs) and the way they look at their body. Their body is considered to be an instrument which must be optimized physically and mentally by preference with legal means (nutritive supplements, mental training etc.) but if necessary with illegal means (doping etc.).

Breaking the rules deliberately, insulting the referee, aggressive behaviour may add an element of excitement, drama and challenge to the action and are therefore are considered attractive from a commercial and spectacle viewpoint. Athletes displaying this type of behaviour have been rewarded let alone by the attention which they receive. As a result the athletes' behaviour has been shaped (conditioned) progressively towards

the expectations of those who pay them, expectations regarding risk taking, pain tolerance and the expression of emotions. The moral dilemma here is the fact that if the outcome of certain behaviour and its related emotions are that important, then each behaviour leading to this outcome is more acceptable. Anyway, the threshold to manifest that behaviour lowers. (Bredemeier & Shields, 1986; McNamee, 2008, p. 73- 80; Roberts, 2004, 77-90).

A corrective comment to the above described sponsors' attitudes and reward practices, might be that today more and more sponsors realize that they have commercial interest in dealing with clean athletes with high moral standards. They no longer want to be associated with cheating, abuses and corruption and recently put pressure on both sports organisations and athletes to cling to the letter and the spirit of the rules, e.g. by including a clause in the athletes' contract of immediate discharge in case of proved drug abuse.

Athletes should be protected against the pressing context by strict codes of conduct regulating their behaviour and their relationship with commerce, sponsors and media.

Sport intrinsic factors as susceptible receptors of the commodification and globalization of sport

Many of the problems of modern sports can be traced to the economic level. However these economic factors couldn't have had such an impact if they haven't matched receptive sports intrinsic factors. Striving for excellence, for good results and to win are sport inherent drives that yield self-esteem, honour, prestige and power which are the most important motives to get involved in sport for all stakeholders in the sports sector. These motives are the driving forces behind all sports practice; the reasons why sports attracts people. They constitute the basic features of sport and are to be considered the workable elements that may produce the positive effects attributed to sport if not undermined by sports external motives.

Egocentrism in sport

It is inherent to sports to be centred on oneself, to devote oneself for the teams' interests in order to beat the opponent. A game or a competition loses its essence when one of the parties involved refuses to win or to defeat the opponent. Egocentrism is allowed in sports or evermore it is presupposed. However egocentrism in sport isn't freewheeling individualism. It is only legitimate as far as it is displayed within a framework and strict rules which are agreed upon. These include spatial and temporal borders and so provide an ethical dimension. During the game they guarantee the conditions for fairness; they protect against injuries and specify appropriate sanctions for breaking the rules. After the game all players, winners and losers return to normal life (De Wachter, 1980, pp. 5-20; McNamee, 2008, p.75).

Problems only arise when these limits are crossed. This is the case when specific game strategies and tactics are used without those restrictions or outside the context of play, i.e. outside the playground between fans or managers of competing clubs. This is also the case when sports become labour and sports organisations become profit oriented, when unreasonable high salaries and bonuses are paid to athletes, trainers and managers and substantial flows of money are related to winning, beating records, and thus to competition in se. To control or at least to reduce the uncertainty of competition and the related uncertainty of their income, athletes, trainers and managers are prepared to use game tactics outside the game context.

Both philosophers and psychologists reported logical and empirical evidence for a link between unrestrained egocentrism and unethical behaviour. Athletes perceive their opponents as plain obstacles that need to be surpassed to achieve their goal. This perception is likely to provide them with a justification for engaging in unethical behaviour. Referees, trainers, athletes can be bribed, athletes are put under pressure to play more aggressively (Bredemeier & Shields, 1986, pp.5-28; De Donder, 2006, 45; De Wachter, 1980, pp. 5-20; McNamee, 2008, P. 75; Vansteenkiste, Mouratidis, & Lens, 2010, pp. 237-238).

Ethical implications of the acquisition of power, honour, prestige and self-esteem through sport

Next to the sponsors and media who want, as mentioned above, a return in terms of product publicity or increasing viewing figures, also other actors have an interest in good sport results and in bidding for mega sport events, although partially for other reasons (power, prestige) than money.

Politicians know that despite an increasing awareness of aberrations, sports still attracts the masses. Politicians cannot afford to neglect people's basic needs and aspirations and they invest considerably in sport. They especially expect as return for their investments a feeling good for their citizens and an increased prestige for their country (Hong, 2006, p.53-56). The seamy side is that as far as the bidding for mega events is concerned, some nations are prepared to far-reaching sacrifices in order to both bring the mega events in and to organise them. They are prepared to engage in private agreements (concealed bribes?) with the GSOs (see recent reports of the investigating journalist Andrew Jennings, www.transparancyinsport.org). They are also willing to suffer financial sacrifices (e.g. compliance of South Africa, Brazil, Belgium and The Netherlands with the stringent FIFA regulations and expectations on stadium construction and commercial benefits) and sacrifices as far as human and children's rights are concerned (see recent reports on the relocation of people in China, e.g. Hutongs in Beijing's' city centre, and South Africa, e.g. township areas near Cape Town airport; street children in Durban (Mivelaz & Cahn, 2007). Another constraint or threat to the integrity of sport is that in some nations the striving for nation building, the striving to unite all parties in society turns into a passion of extreme patriotism to show via the number of medals its power to neighbour countries (Hong, 2006, pp. 53-54).

Fans and Supporters as sports consumers now have more influence than a few decades ago, they not only encourage, they cheer, condemn, call names, demand the removal of players, trainers, referees, managers etc. (Dixon, 2007; pp. 441-449). Sport can be described as a process of self-enlargement by which an 'I' becomes a 'We'. This means that the actions, the meanings and the values that sports excite are common, including mutual understanding and public acknowledgment of the shared character (Morgan, 2006, pp. 178-179). This is the case for the athletes themselves but also for the spectators, the fans and supporters who vocalize their emotions and passions and are more than willing to argue with one another about what they have witnessed on the field. They range side with their stars to share both in the glory and benefits of success but also in the frustration and disappointment of defeat.

The passion of the athlete to explore his physical (citius, altius, fortius) and mental limits (resilience, toughness) runs parallel with the scientists' passion to explore and test the technological and scientific frontiers (Allison, 2005; Tamburrini, 2005). The pursuit of progress, improvement and records has always been the driving force behind the search for legal as well as illegal advantages in sport. Technology and science try to improve the equipment, outfit, gear (bicycle, pole, swimming suit etc.) as well as the body of the athlete (nutrition, drugs, pressure cabins, genetic technology etc.). Although these innovations have undeniable resulted in a more sound and proper sports, there is a drawback too. To some scientists sport is an ideal testing ground and athletes are receptive subjects to test experimental devices and products (Tamburrini, 2005).

To conclude, the more influential external actors have (self) interest (not only money but also power and glory) in winning and in well performing athletes, the more positive values such as fairness, self control and respect are under pressure and the more patriotism, prestige, harshness and exaggerated rivalry come to the forefront.

As mentioned in the introduction the aim of our paper is to move beyond complaints about moral deficit of sports and to focus on the common grounds of the aberrations in sport and to suggest a direction of an answer that can add at least to the discussion as to find a way out of the problems. We see a similarity with what has been developed in the international trade and the environmental protection sector.

What should be the leading principles of an integrity policy in sport?

There is a growing body of opinions both within and outside the sports sector who identify as a common ground of many of the aberrations in sports, the unhealthy match between the commodification and globalization of sports and an exaggerated egocentrism, an unrestrained passion to excel and to win at all costs, and an obsessive striving for power and prestige of the various stakeholders. There are also a growing number of authorities and organisations within and outside the sports sector who want a re-conceptualization of sport to counterbalance these negative developments (Arnaut, *2006*).

Examining all suggestions mentioned to solve the aberrations e.g. redistribution, to level down athletes' salaries, the limitation of transfer sums, a better regulation of children's involvement in high level sports, a more ethically justified relationship with sponsors and media etc., I cannot escape the impression that a way out of the problems may be found in a striving for a new culture of rights and relationships similar to what is developing in the international trade and environmental protection sector. The key concepts which we found relevant in these sectors are: *'Fair Trade, Corporate Social Responsibility (CRS) and Good Governance'*. Being aware of the Western origin of these concepts and their related political discourses, movements and actions we must certainly adapt them to cultural differences and the specifics of the sport context (Giulianotti, 2004, pp. 69-72). In this regard McNamee & Fleming (2007) have already done some pioneering work including these key concepts in their theorized and conceptually informed method to undertake an ethics audit in sports organisations.

Fair Trade and Corporate Social Responsibility in sport

To answer the negative effects of *globalization and commodification* of sport a redefined and ethically justified relationship with commercialization, media and sponsors should be forged so that both private aspirations no longer take precedence over common public ones (Morgan, 2006, pp.1-2) and the asymmetrical interdependences in sports are corrected (Arnaut, 2006, 131).

Fair trade in sport should exclude exploitation of children and be conceived as a partnership based on dialogue, transparency and respect that seeks greater equity and re-distribution of revenues and preserves competitive balance, encourages player education and training, and fosters ties of sporting and financial solidarity.

Corporate Social responsibility (CSR) in sport should include public interest into the organisations 'decision making, i.e. by assuming responsibility for the impact of its activities not only on its stakeholders but also on the social context in which they operate; by promoting community growth and development and by the elimination of practices that harm the public sphere (e.g. offering better trading conditions and securing the rights of marginalized small businesses, workers and people of the cities and countries in which they organise sport events). (Youth) Olympic Games and all national and international competitions should expand beyond athletic events and provide an array of activities that address the well-being of all humanity in a competitive global economy.

Good Governance in sport

The legitimacy, autonomy and privileges of at least the GSOs (UEFA, FIFA and IOC as pre eminent examples) are undeniably under question. Good governance should be the answer here. According to the"Principles of Good Governance in Sport", adopted in Budapest 2004 by the European Ministers responsible for sport (cit. in Arnaut, 2006, pp.84-85) 'Good Governance' should include that the relevant sports governing bodies 'continuously' examine their own structures to ensure that they are sufficiently representative and democratic and that their powers are not exercised in an unreasonable, discriminatory or arbitrary manner. Good governance in sport should furthermore include that all stakeholders are properly involved and consulted to give legitimacy to the decisions that they take and that all stakeholders' (sometimes conflicting) interests are balanced to ensure not to favour a single interest group. Good governance in sports should finally include the development of an appropriate integrity management framework that not only prevents serious integrity violations in sports but also supports people in the sports sector in dealing with complicated ethical dilemmas where it is not immediately clear what the appropriate should be (Maesschalck & Vanden Auweele, 2010, pp. 2-4).

Conclusion

We acknowledge that, despite its low moral status, sports possess important features (i.e. striving for excellence, self-determination, shared commitment and identification with a reference group, a WE-feeling) that have the potential to encourage social moral and political values crucial to a democratic polity. It is this 'potential' that makes sports matter morally. There is no doubt whatsoever about the limits being overstepped when sexual abuse, illegal trafficking of children are concerned, when matches are fixed or when drugs are sold unrestrained and uncontrolled. However, we acknowledge that all actors in today's sport are challenged by difficult

dilemmas and choices; that the behaviours described as poor practices may be related to sport intrinsic values and that it isn't always clear where the lines have to be drawn or whether the limits are just strained or overstepped.

Our basic assumption is that the whole continuum of aberrant behaviour, ranging from inappropriate to criminal, are symptoms of the same common ground, which we have identified as an unhealthy match between the commodification and globalization of modern sport and an exaggerated egocentrism, an unrestrained passion to excel and to win at all costs, and an obsessive striving for power and prestige of the various stakeholders.

As a way out of the problems we have suggested an integrity policy built on the basic common grounds rather than targeting all aberrant behaviour separately. Specifically we have suggested developing a policy including Good Governance, Fair Trade, Corporate Social Responsibility (CSR) and more pro-active measures to defend sports' basic features against any attempt to weaken them, similar to the strategies that have been developed in the trade and the environmental protection sector. A policy including these themes, involves breaking with dominant tendencies and must eventually lead to a New Sports Model.

Sport managers, especially CEO's from Global Sports Organisations, should exhibit appropriate leadership instead of withdrawing in a defensive position and should show both courage and commitment to meet such an ambitious objective. By doing so, without being forced, they would not only remove the ground for most aberrant and abusive behaviour but would also be able to put things in perspective, prevent exaggerations and dramatization and suggest procedures that are in proportion to the size and the nature of the problems. The sports sector should regain credibility and guarantee that the social, political and moral potentials attributed to them be actualized.

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NEW RESOURCE ON CHILD HEALTH

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"The *South African Child Gauge 2009/2010* brings together a unique set of empirical data on the health status of children, law reform related to child health, and a set of clearly written essays describing what needs to happen to improve the care and health status of children in South Africa. It is an attractive publication which is accessible and readable. It beautifully weaves together the information on which much of nursing practice is based: the scientific data, the broader context of health care and the possibilities of good practice in the delivery of good safe care to children and their families."

Minette Coetzee, associate professor of Child Nurse Practice Development, School of Child and Adolescent Health, University of Cape Town

The *South African Child Gauge* is published annually by the Children's Institute, University of Cape Town, to monitor government and civil society's progress towards realising children's rights. Focusing on child health in the fifth issue, the *Child Gauge 2009/2010* presents a series of essays on critical issues that must be addressed to ensure the survival, health and optimal development of all children in South Africa. Contributors include leaders in child health from the University of Cape Town, the University of the Western Cape, the University of the Witwatersrand, the Medical Research Council, UNICEF and the Department of Health. The publication is introduced by Marian Jacobs, dean of the Faculty of Health Sciences, UCT, and is accompanied by a reflection on child health by UNICEF's chief of health, Mickey Chopra.

The first of the themed essays starts by defining **children's rights to health**. These include access to health care and other services such as water, sanitation, housing and social security, as well as the right to access information on health care, and to participate in their health care decision-making. While a number of laws, policies and programmes give effect to these rights, they have not yet led to improved health outcomes for South Africa's children.

The following essay on the **status of child health in South Africa** points to unacceptably high child mortality, particularly amongst children under five. In reflecting on the risk factors and determinants of the dominant childhood disease pattern, the authors illustrate how poverty, and resultant inequalities, are key drivers of child mortality. A description of Madagascar's and Malawi's successes in reducing under-five mortality points to the importance of initiatives at community and primary level. A summary of South Africa's progress toward the Millennium Development Goals illustrates insufficient advancement to meet the 2015 deadline, and even a reversal of progress towards certain targets.

HIV is the leading cause of death for children under five, and tuberculosis rates are alarmingly high, and rising. The essay on **HIV, TB and child health** outlines the impact of these two diseases on children's health, and describes the government's current response to the dual HIV/AIDS and TB pandemics. The need for integration of HIV/AIDS and TB services is discussed alongside several other recommendations for improving South Africa's response to the two pandemics.

An integrated approach to malnutrition in childhood reflects on how malnutrition impacts on child health and looks at the immediate, underlying and basic causes of malnutrition. An evaluation of the Integrated Nutrition Programme and its impact

on household food security, infant and child feeding practices and nutrition points to a series of recommendations that should improve the nutritional status of children in the country.

Unsafe sex, interpersonal violence and alcohol abuse are leading drivers of death and disability in South Africa. These risk behaviours have their roots in childhood and adolescence and can significantly impact on children's physical and mental health. In looking at recent data on sexual risk-taking, substance abuse and violence, the essay on **mental health and risk behaviour** illustrates the need for a greater emphasis on mental health promotion and prevention programmes delivered across a range of settings, including the family, school, community and mass media.

Children's right to basic health care services is not yet defined in law, and this essay stresses the need to define a package of essential services for children from conception to adolescence**.** In analysing whether South Africa is equipped to deliver good quality basic health care services, the authors also stress the need for vertical and horizontal integration of health services to enable universal access to, and continuity of, care.

The essay on **managing resources and building capacity in the context of child health** points to a number of systemic problems that hamper the delivery of health care services for children and outlines potential solutions that should improve leadership, accountability, efficiency and communication within the public health care system. This includes consistent investment in community health workers.

Two draft policy frameworks are presented in the essay on **strengthening community-based child health services in South Africa**. These aim to standardise the management, training, supervision and financing of community-based programmes; and to define a basic package of community-based maternal and child health services. The Mothers2mothers programme and a community-based care programme in the Eastern Cape are discussed as examples of best practice. These are accompanied by recommendations on how to strengthen community-based maternal and child health services.

The Children's Act, which came into force in April 2010, defines children's right to participate in health care decision-making in line with their evolving capacities. This means child- and family-friendly services are no longer an optional extra, but an imperative. Drawing on best practices in the southern African region, the **towards child- and family-friendly health services** essay shows how these services can improve the quality of care and prevent unnecessary suffering and trauma without requiring additional resources.

Children's health is shaped by the political, economic, physical and social environments in which they are born, live, grow and develop. **The social and environmental determinants of health** essay examines how child poverty and poor access to essential services continue to put children's health at risk. The authors call on the Department of Health to initiate partnerships at national and district level to address deep-rooted inequalities, reduce poverty and improve living conditions so that all South Africa's children have the opportunity to develop their full potential.

Minister of Health, Dr Aaron Motsoaledi, reflects on his **vision for child health in South Africa** in this essay. He identifies the need to strengthen key programmes such HIV/AIDS, immunisation and the Integrated Management of Childhood Illnesses. Health workers are called on to bridge the gap between policy and implementation, while he urges all South Africans to work together to ensure that mothers and children not only survive, but thrive.

A final summary of the key **recommendations** of the themed essays identifies four essential steps for government, civil society and caregivers of children towards realising children's right to health in South Africa: 1. address the deep-rooted poverty and inequality; 2. improve the quality and coverage of child health services; 3. strengthen community-based services; and 4. build partnerships to create a safe and healthy environment for children.

In addition to the themed essays, the regular feature on **recent legislative developments affecting child health** focuses on the Children's Act, the Prevention of and Treatment for Substance Abuse Act, provincial health legislation, the Tobacco Products Control Amendment Acts,

regulations to the Basic Conditions of Employment Act and new regulations to the Social Assistance Act.

The last section of the publication, called **Children Count – The numbers**, houses child-centred data that illustrate how children's living conditions and access to services impact on their survival and optimal development. Many of the indicators track trends over the 2002 – 2008 period and cover children's access to health, education, housing and basic services, as well as data on income poverty and social grants, and on care arrangement such as co-residence with biological parents, orphaning and child-only households.

The *South African Child Gauge 2009/2010* is accompanied by a **pull-out poster on child health** that presents essential data on the status of child health, social determinants and access to health services. Visit www.ci.org.za to download or order copies.

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Erratum:

Correction to article titled: **Sexual abuse victim empowerment programme: an archival study**.
Author: Dr M Smith
Reference: *Journal of Community and Health Sciences 5(1): 48-55*

***Sample & Data collection procedure** should read:*

The sampling frame was comprised of the register of cases with completed assessments seen in the SAVE programme at the time of data collection. Data was extracted from case files during 2005. From this sampling frame cases were selected following systematic random sampling during which every third case was selected until a sample of 250 cases have been reached. Verbatim responses on protocols were rescored by two independent researchers with considerable experience in assessing intellectual functioning in an attempt to reduce variability. In addition, ten percent of the cured data was checked for accuracy.

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