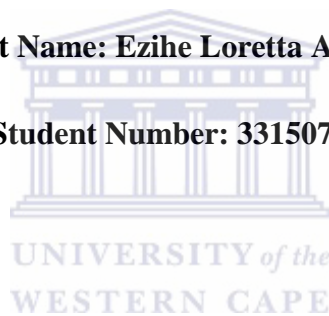**University of the Western Cape**

Faculty of Community and Health Sciences

Development of a framework for health care professionals to lead youth victims of violence towards wellness in the Genadendal community of the Western Cape

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UNIVERSITY *of the*
WESTERN CAPE

A thesis submitted in fulfilment of the requirements for the degree of Doctor Philosophiae in the School of Nursing, University of the Western Cape.

Supervisor: Prof Karien Jooste

Co-Supervisor: Dr Firdouza Waggie

May 2015

DECLARATION

I, Ezihe Loretta Ahanonu declare that this research study titled '*Development of a framework for health care professionals to lead youth victims of violence towards wellness in the Genadendal community of the Western Cape*' is my own original work. It has not been submitted before for any degree or examination at any other university and all the sources that I have used or quoted are indicated and acknowledged as complete references.

Ezihe Loretta Ahanonu

Student number: 3315076

Signature   …………………………………………

Date   …………………………………………

This thesis has been read and approved for submission by:

Prof Karien Jooste

Supervisor

Signature   …………………………………………

Date   …………………………………………

DEDICATION

This dissertation is dedicated to the memory of my beloved father, Engr. Lawrence De Ahanonu.

ACKNOWLEDGEMENTS

I am most grateful to God Almighty for good health, guidance, tender mercies and loving kindness that were essential to the completion of my Doctor of Philosophiae degree programme.

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I want to thank every person who assisted me during the period of data collection and with transcribing of the interviews.
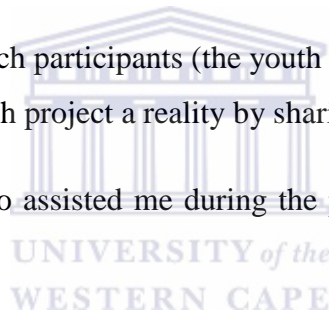
I am grateful to all those who assisted with analysing the collected data and editing of my dissertation.

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Last but not least, I want to express gratitude my family for their unceasing love, encouragement, prayers and support. From the very depth of my heart, I say thank you for the sacrifices you made that enabled me to be who I am.

To everyone, thank you again for all you have done.

ABSTRACT

The Wellness Leadership White Paper states that leadership is needed in a supportive environment with the purpose of guiding clients to lasting wellness. Wellness can be defined as an active process that enables an individual to become aware of all aspects of the self and to make choices in terms of a more healthy existence by means of balancing and integrating various life dimensions. Health care professionals are leaders who play an important role in creating an environment that contributes to wellness. Their leadership is, therefore, viewed as a wellness strategy.

Leadership has been identified as an essential role of health care professionals with a responsibility to attend to the needs of their clients, such as youth victims of violence, with the aim of leading them towards wellness. The Provincial Nursing Strategy of the Western Cape in South Africa emphasises the need for health care professionals to demonstrate their leadership capacity in practice. In the communities of the Western Cape Province of South Africa, many youth victims of violence report for treatment at the health care facilities; it places a high burden on the health care system. Even though health care professionals provide treatment to this group of youth, *it is not clear* how health care professionals lead them towards wellness after an incidence of violence. The purpose of this study was to develop a conceptual framework that can be implemented by health care professionals to gain a better understanding about the important role they play in leading youth victims of violence towards wellness in a rural community in the Western Cape Province of South Africa.

This research study applied a qualitative, exploratory, descriptive and contextual design. The study population who were selected by means of a purposive sampling technique consisted of youth attending a high school and who had been victims of violence and of health care professionals (professional nurses, medical doctors and social workers) working at the health care facilities in the community where the study was conducted. The study was conducted in *four phases*. *Phase 1* of the study focused on the exploration and description of the expectations of the youth victims of violence about how health care professionals should lead them towards wellness. Focus group discussions (FGDs) were conducted at a high school at the study site. *Phase 2* explored and described the experiences of health care professionals who were supporting youth victims of violence at the health care facilities in the community of study. The execution of this phase comprised of unstructured individual interviews.

The total number of the FGDs and unstructured individual interviews conducted in this study was determined by data saturation. Data analysis of the data collected involved transcription of the voice recordings of the all the interviews and writing up of field notes. The steps of Tesch's coding technique were used at the end of Phases 1 and 2. To ensure trustworthiness of the collected data, Guba and Lincoln's strategies of credibility, transferability, dependability, confirmability and authenticity were applied. *Phase 3* of this study entailed the development of a conceptual framework for health care professionals to lead youth victims of violence towards wellness. It was based on the findings from Phases 1 and 2 of the study; *Phase 4* of the study involved peer debriefing and validation of the developed conceptual framework.

In Phase 1 of the study, a total of nine (n = 9) FGDs were conducted among fifty eight (n = 58) youth participants between the ages of 15 and 19 years. Each group consisted of 6 to 8 participants and the interviews did not last more than an hour per session. The data analysis in this phase showed that the youth victims of violence did have expectations from the health care professionals in guiding them towards wellness. They shared their interpretation of the term wellness and were also quite aware of the challenges in their community. Four categories emerged from the data in Phase 1:

Category 1 - Dimensions of wellness as it related to healthy body, mind, spirit and positive interactions: The findings of this category revealed that youth participants described wellness as a holistic concept that comprised healthy living, self-care and a healthy personality and mind (emotional, psychological) as well as spiritual well-being. They did not necessarily consider wellness as the absence of sickness or illness,

Category 2 - Common problems among youth in the context of the community: They articulated that drug abuse, teenage pregnancy and violent behaviour were important issues of concern to them in their community.

Category 3 – Building a sound and trusting relationship: They expressed their need for health care professionals to have a positive attitude towards them, to be respectful and to provide them with accurate information, as well as confidential and supportive services.

Category 4 - Guidance of youth to wellness: The youth also proposed strategies that they believe could be used by the health care professionals while guiding them towards wellness.

These strategies were: Provision of information / health education, school and community outreach programmes, provision of counselling services and role modelling.

For the second phase, seven (n = 7) health care professionals were interviewed. Two (n = 2) were professional nurses, three (n = 3) medical doctors and two (n = 2) social workers. The findings of the individual interviews indicated that the health care professionals recognised the fact that wellness is very important. However, they felt that guiding youth victims of violence toward wellness was a challenging process. Three categories emerged from the data in Phase 2:

Category 1 - Different points of view about the concept of wellness: The health care professionals described wellness as the holistic wellbeing of a person, an absence of illness or disease and living a healthy lifestyle.

Category 2 - Barriers to leading youth victims of violence towards wellness: The health care professionals reported challenges while attempting to lead youth victims of violence towards wellness which included low socioeconomic status of families, unsupervised youth, violent behaviour, drug and substance abuse, a lack of resources in the community, negative staff attitudes, inadequate physical infrastructure and human resources as well as the absence of a process of guiding youth victims to wellness.

Category 3 - Guidance to leading youth victims to wellness: The health care workers proposed strategies for guiding youth victims towards wellness. Those strategies included the provision of support in the form of counselling services, use of support groups, family and community support; recreational activities, dedicated staff to work with youth victims of violence and a multidisciplinary team approach.

The findings from the first two phases were triangulated during the third phase of this study with the purpose of developing a conceptual framework. The survey list of Dickoff, James and Wiedenbach formed the foundation of the reasoning map for the development of the framework.

The unique contribution of this study is the development of an original, participative leadership framework that provides health care professionals with information for leading youth victims of violence towards wellness in a rural community in the Western Cape.

This study was conducted in a single rural community of the Western Cape Province of South Africa. Despite this limitation, the framework could be evaluated for use in similar settings.

Finally, guidelines to implement the framework and recommendations for improving community health care practice, nursing education and nursing research were suggested based on the findings from the study.

Keywords: framework, health care professionals, professional nurses, social workers, medical doctors, lead, youth, victims of violence, wellness.
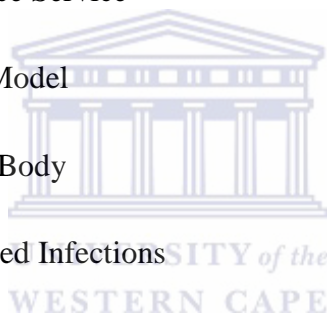
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LIST OF ABBREVIATIONS

ADL	Activity of daily living
ARD	Anti-Retroviral Drugs
ART	Anti-Retroviral Therapy
ASD	Acute stress disorders
ASR	Acute stress reactions
CBO	Community Based Organizations
CCM	Contextual Constructs Model
CCT	Contextual Constructs Theory
CDC	Centre for Disease Control and Prevention
CHA	Cambridge Health Alliance
CHS	Community and Health Sciences
CompHP	Core Competencies Framework for Health Promotion
CPS	Child Protection Service
CYCC	Child and Youth Care Centres
DALY	Disability-adjusted life years
DoE	Department of Education
DoH	Department of Health
DoJ	Department of Justice
DSD	Department of Social Development
ECD	Early Childhood Development

ECP	Emergency Contraceptive Pill
ED	Emergency Department
FG	Focus Group
FGD	Focus Group Discussion
HCP	Health Care Professional
HIV	Human Immunodeficiency Virus
HOD	Head of Department
IEC	Information education communication
ICN	International Council of Nurses
Intw	Interviewee
ISF	Interactive System Framework for Dissemination and Implementation
N	Total sample size
No	Number
NDoH	National Department of Health
NDP	National Development Plan
NGO	Non-governmental Organization
NIC	Nursing Interventions Classification
NIMSS	National Injury Mortality Surveillance System
NPO	Not for Profit Organization
NREPP	National Registry of Evidence-based Programmes and Practices
NYP	National Youth Policy

P   Participant

PEP   Post Exposure Prophylaxis

PHC   Primary Health Care

PTSD   Posttraumatic stress disorder

RCL   Representative Council of Learners

RSA   Republic of South Africa

SA   South Africa

SAMHSA   Substance Abuse and Mental Health Services Administration

SAPS   South African Police Service

SEM   Social-ecological Model

SGB   School Governing Body

STI   Sexually Transmitted Infections

TLC   Tender loving care

UN   United Nations

UNICEF   United Nations Children Funds

VEP   Victim Empowerment Framework

VOV   Victims of Violence

WCDH   Western Cape Department of Health

WCED   Western Cape Education Department

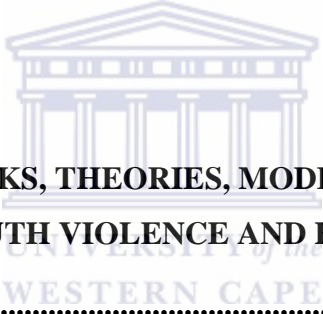WCP   Western Cape Province

WHO   World Health Organization

YVV   Youth Victim of Violence

YV   Youth Violence

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CHAPTER 1

RATIONALE AND OVERVIEW OF THE RESEARCH STUDY

1.1 INTRODUCTION AND RATIONALE

The Wellness Leadership White Paper (Human Resources Institute, 2011, p. 2) states that leadership is needed in a supportive environment to guide clients to lasting wellness. Wellness can be defined as an active process during which an individual becomes aware of all aspects of the "self" and makes choices towards a more healthy existence by balancing and integrating multiple life dimensions (Corbin, Lindsey, Welk & Corbin, 2002; Goss & Cuddihy, 2009; Hettler, 1980a; Lent, 2004; Witmer & Sweeney, 1992). Health care professionals are leaders who play an important role in creating an environment that contributes to wellness. Their leadership could, therefore, be an integral part of a wellness strategy (Human Resources Institute, 2011, p. 3). Youth victims of violence should be led towards wellness, since violence is seen as a social problem.

The aspect of youth violence is crucially important. The World Health Organization (WHO) considers youth violence as a global public health problem that contributes significantly to the burden of untimely deaths, injury and disability. An estimated 250 million deaths occur annually among the youth between the ages of 10 and 29 years globally as a result of violence. For every youth who is killed, about 20 to 40 more sustain injuries that require medical treatment (World Health Organization, 2011, para. 1-3). In the National Strategic Plan for Nursing Education, Training and Practice, it is pointed out that violence contributes to high levels of morbidity and mortality (National Department of Health, 2012, p. 2). However, it is recognised that there is no one-size-fits-all leadership framework to support youth victims of violence towards wellness (Human Resources Institute, 2011).

Violence among people is the intentional use of threatened or actual physical force and power against oneself, another person, or against a group / community that either result in or have a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002, p. 5). This point of view takes into cognisance the chances of violence having a more philosophical impact on individuals, communities and societies. Youth violence is also the involvement of young people, either as victims or perpetrators, in incidents that are involving the threat or use of physical force in the context of interpersonal, inter-communal or other conflict, or crime. This violence may be

inflicted with or without a weapon and may or may not result in physical injuries or death (Graham, Bruce & Perold, 2010, p. 38). While the involvement in and experience of violence among youth vary in terms of the type of violence, all youth who have been victims of violence experience trauma that inevitably interferes with their health and welfare.

There are different definitions of the term youth around the world. The United Nations defines youth as individuals between the ages of 15 and 19 years (United Nations, 2013, para.1), while the World Health Organization uses a much broader age range by classifying persons between the ages of 10 and 29 years as the youth (World Health Organization, 2011, para. 1). Furthermore, the African Youth Charter defines the youth as people between the ages of 15 and 35 years (African Union, 2006). In South Africa, the National Youth Policy (NYP) defines the youth as individuals between the ages of 14 and 35 years (Government of South Africa, 2009).

Furthermore, there is an increasing interest in youth violence among health care professionals due to the grim impact that violence has on the psychological wellbeing of its victims (Butchart, 2011; Ruffolo, Andresen, & Winn, 2013; Rutherford, Zwi, Grove, & Butchart, 2007; Zeldin, 2004). For instance, several studies demonstrate an association between exposure of the youth to an incidence of violence and their wellness in relation to problems; such as anxiety, depression, post-traumatic stress, aggression, alcoholism, drug and substance abuse, suicidal attempts and risky sexual behaviour (Cooley-Quille, Boyd, Frantz, & Walsh, 2001; Farrell & Bruce, 1997; Fowler, Tompsett, Braciszewski, Jacques-tiura, & Baltes, 2009; Gorman-Smith & Tolan, 2003; Lynch, 2003; McDonald & Richmond, 2010; Webster, 2004).

In the third instance, these prevailing problems place a high responsibility on health care professionals to take the lead in promoting wellness among youth victims of violence. Health care professionals; such as nurses, doctors and social workers are called upon to demonstrate their leadership capabilities by leading youth victims of violence towards wellness (Snider & Lee, 2007, pp. 167-168). However, the manner in which health care professionals implement the task of leading youth victims of violence towards wellness after an incidence of violence remains unknown.

1.2 AN OVERVIEW OF THE ISSUES OF VIOLENCE, WELLNESS AND LEADERSHIP

1.2.1 Violence

The WHO groups violence in the categories of self-directed violence, collective violence and interpersonal violence (Krug *et al*., 2002, p. 6-7). Self-directed violence describes the violence that an individual metes out at oneself; it includes suicidal thoughts, behaviour and self-abuse (for example, self-mutilation). Collective violence refers to violence that gets committed by larger groups; such as political and militia groups, terrorist Organizations and organised groups or states with the aim of advancing or supporting a particular agenda or course. It includes terrorist acts, mob violence, war and related violent forms of conflict. Interpersonal violence refers to violence that is occurring between individuals. It is divided into two sub-categories that are (i) family and intimate partner violence, as well as (ii) community violence. Family and intimate partner violence – violence that occurs between family members and intimate partners – further includes other forms of violence, such as child abuse and abuse of the elderly. Community violence is the type of violence that occurs among individuals who are not related and may not necessarily be known to each other. It generally includes random acts of violence, rape or sexual assault by strangers and violence at institutional settings; such as schools, the workplace, prisons and nursing homes (Krug *et al*., 2002, pp. 6-7).

Youth violence can also be defined as the involvement of young people, as victims, in incidents that involve the threat or use of physical force in the context of interpersonal, inter-communal and other conflict, or crime. This violence might be inflicted with or without a weapon and might result in physical injuries or death (Graham *et al*., 2010, p. 38). Violence has been reported to contribute to disability-adjusted life years, as well as placing a high burden on health care systems and contributing significantly to health care costs (Matzopoulos, Bowman, Butchart & Mercy, 2008, pp. 177-185).

In South Africa, youth violence is regarded as one of the major and most difficult challenges that are facing the country (Demombynes & Özler, 2005, p. 265). The South African Police Service (SAPS) has consistently reported high rates of murder, attempted murder, assault with the intent to inflict bodily harm, public violence and sexual offences for the period 2004 to 2012 (South African Police Service, 2012). Similarly, the 2008 annual report of the National

Injury Mortality Surveillance System (NIMSS) reveal that violence in the country is the leading cause of unnatural death among individuals between the ages of 15 and 34 years. The majority of these deaths result from sharp object injuries, firearm related injuries and blunt force injuries (Donson, 2009, pp. 5-8). Statistics of incarceration in South Africa further confirm the problem of youth violence. The Department of Correctional Services (2011) reported that by 31 March 2011, out of a total of 162 162 incarcerated persons in prison, a total of 54 717 were youth between the ages of 14 and 25 years. This implies that 34% of the entire prison population are youth under the age of 25 years. The majority of the youth aged 18 to 25 years were incarcerated for aggressive crimes, economical crimes and sexual crimes.

Factors reported to be associated with violence in the country include disruption in social structures (particularly in families) resulting in poor parenting skills that are required for raising healthy non-violent children, a post-apartheid violence legacy embedded in the belief of using violence as a legitimate means of achieving change, high levels of poverty and gender inequality, substance abuse and the availability of illegal drugs; such as cocaine and methamphetamine (*tik*), particularly in parts of the Western Cape (The Social Development Department and The World Bank, 2012).

A nationally representative survey conducted by Matzopoulos, Prinsloo, Butchart, Peden and Lombard (2006, p. 50) at secondary and tertiary level health care facilities in South Africa reveals an annual case load of approximately 1.5 million trauma cases (40 per 1 000 of the population) in South Africa. More than half of these injuries result from violence. This report most likely underestimates the actual trauma case load because it does not include cases that might have reported to the primary health care facility level, private clinics and hospitals for violence related injuries.

The prevention of violence is regarded as a national public health priority (Rutherford *et al*., 2007, p. 764; Seedat, Van Niekerk, Jewkes, Suffla & Ratele, 2009, p. 1011) and health care professionals who occupy an important position in safeguarding and improving the health status of all people have an important role to play in preventing violence among the youth in society. However, it is not clear how health care professionals lead youth victims of violence to wellness, hence the need for this study to be conducted.

1.2.2   Wellness

Wellness is a concept that emanated from the concept of holistic health and over the years, it has been conceptualised to mean different things to different authors. Primary sources, such as Dunn, provide a high-level definition of wellness: "An integrated method of functioning which is orientated toward maximizing the potential of which the individual is capable; it requires that the individual maintain a continuum of balance and purposeful direction within the environment in which he is functioning" (Dunn, 1961, p. 5). Additionally, the National Wellness Institute defines wellness as: 'an active process through which people become aware of and make choices toward, a more successful existence' (National Wellness Institute, n.d.). Sometimes, wellness is described as a person's advancement towards enhancing the quality of his or her life, health, as well as psychological and social wellbeing in practical and positive ways (Witmer & Sweeney, 1992). Wellness is characterised by optimal physical health, as well as psychological and social well-being and does not merely refer to the absence of illness, a state defined as "health" (World Health Organization, 1946).

Though there are likely many more definitions of the term wellness that exist, the definition offered by Myers *et al*. (2000) is adopted in this study. These authors define wellness to mean: *'a way of life oriented* [sic] *toward optimal health and well-being in which the body, mind and spirit are integrated by the individual to live life more fully within the human and natural community'* (Myers *et al*., 2000, p. 252).

While the terms *wellness* and *health* are sometimes synonymously used by some authors (LaFountaine, Neisen & Parsons, 2006; Roscoe, 2009), it is important to point out that wellness is a concept that is distinct from yet related to health. For instance, wellness is more of a 'lifestyle' geared towards optimum functioning and existence (Myers *et al*., 2000; Myers & Sweeney, 2008).

1.2.3 Leadership and wellness

The Human Resources Institute in 1999 has determined that leaders have a role in promoting wellness (Human Resources Institute, 2011, p. 3).

'To lead' in the context of this study, refers to leadership. Leadership can be defined as the process that allows a person to influence a group of people in order to achieve a common goal (Northouse, 2010, p. 3). Similarly, it can be described as a relationship between a leader and his or her followers in which the leader uses power, authority and influence for the creation of a shared vision and the attainment of goals (Jooste, 2009, p. 5). Leadership as a process

implies that it is a transactional event that takes place between the leader and the followers rather than it being a trait or characteristic that solely resides in the leader. It implies that a leader affects and is affected by the followers. It is further suggested that the leader directs the energy of the followers (Northouse, 2010, p. 3).

It is important to mention that there is a clear distinction between management and leadership. Management requires a person who coordinates resources (people, activities, materials and time) to achieve Organizational goals through the processes of planning, budgeting, directing, organising and controlling (Cherry & Jacob, 2014, p. 288; Daft & Marcic, 2013, p. 9). Leadership, on the other hand, is about inspiring and empowering people towards achieving a collective goal (Jooste, 2009, p. 5). Nonetheless, there exists an interdependent relationship between the two concepts, since managers are expected to demonstrate leadership skills just like leaders are required to possess management skills in order for them to be effective (Jooste, 2014, p. 284).

Some people view leadership as a position of authority where a senior team member is given full authority (Lloyd, Patterson, Robson & Philips, 2001; Thilo, 2005) while other people regard leadership as a shared activity by all members of a team (Flin, Fletcher, McGeorge, Sutherland & Patey, 2003; Klein, Ziegert, Knight & Xiao, 2006; Xiao, Seagull, Mackenzie & Klein, 2004). In health care settings, leadership could be both; it can refer to a position of authority (role or experience), as well as a function that can be delegated to or shared amongst different team members. This view is congruent with recent developments in leadership research that state that leadership is a shared social process that is concerned with human beings and their relationships to one another and that leadership functions are distributed among different team members (Yukl, 2006). Leadership is an essential role for health care professionals because they have an ethical responsibility in practice to attend to the needs and concerns of their clients (Northhouse, 2010, p. 4). As leaders, they have a key responsibility as role models *who lead* clients towards health or wellness.

Limited literature outlines how leadership promotes wellness. However, Myers *et al.* (2000) state that leadership (to lead) promotes wellness through inter alia four strategies:

- Sharing the wellness vision, including how wellness is defined, why it is important and how employees can participate in the wellness initiative.

- Serving as a role model by participating in the wellness programme and by adopting a healthy lifestyle.

- Aligning cultural similarities that are formal and informal policies and procedures; such as rewards, communication and wellness training.

- Monitoring and celebrating success with the purpose of setting individual and group level wellness goals and recognising progress.

In this study, it is assumed that health care professionals are leaders with a shared responsibility to their clients while the followers are the youth victims of violence. Therefore, there is a need to provide health care professionals with a framework that can be implemented to create new leadership support, evaluate their current contributions and improve or modify existing platforms to enhance wellness of youth victims of violence.

1.3 PROBLEM STATEMENT

Although limited research has been conducted about leading youth victims of violence towards wellness, a leadership initiative was already undertaken in 1999 by the California Wellness Foundation to promote wellness of youth victims of violence (California Wellness Foundation, 2010). It implies that this issue is not an unknown phenomenon.

Many youth victims of violence report for treatment at the health care facilities in the communities of the Western Cape Province of South Africa. It places a heavy burden on the health care system (Govender, Matzopoulos, Makanga & Corrigall, 2012, pp. 303-306; Western Cape Department of Health, n.d. p. 8). Genadendal is a rural community located in the Theewaterskloof municipality of the Western Cape Province. The community is situated more than a hundred kilometres east of Cape Town in the Riviersonderend Mountains. The racial composition of this community mainly comprises coloured people (Section 3.2.4.1 provides an in-depth description of the study site). Alcohol and drug abuse are major challenges amongst the youth residing in the community of study.

The Provincial Nursing Strategy of the Western Cape states that the leadership capacity of health care professionals, such as nurse managers, should be demonstrated in health care practice (National Department of Health, 2009, p. 16). Even though health care professionals provide treatment for this group of youth, *it was not clear* how they lead them towards wellness after an incidence of violence. Furthermore, very few research reports focus on the

manner in which health care professionals are leading youth victims who are caught up in violence towards wellness in their community.

From the research problem, the following research questions were asked:

- What are the expectations of the youth victims of violence with regard to health care professionals who are leading youth victims of violence towards wellness in the Genadendal community?
- What are the experiences of health care professionals in Genadendal while they are leading youth victims of violence towards wellness?
- What framework can enable health care professionals in Genadendal to lead the youth victims of violence towards wellness?

1.4   PURPOSE OF THE STUDY

The purpose of this qualitative study was to develop a framework for health care professionals to lead youth victims of violence towards wellness in the Genadendal community.

1.5   OBJECTIVES OF THE STUDY

In this study, the objectives were to:

1. explore and describe the expectations of the youth with regard to health care professionals leading youth victims of violence towards wellness in the Genadendal community.
2. explore and describe the experiences of health care professionals while they are leading youth victims of violence towards wellness in their Genadendal community.
3. develop a framework for health care professionals in Genadendal to lead youth victims of violence towards wellness.
4. validate the framework with the assistance of the youth and health care professionals in the context of the study.

1.6   PARADIGMATIC PERSPECTIVE

A paradigm can be described as a set of theories or principles that guides actions. It represents a world view that generally describes the orientation about the world that a researcher maintains (Denzin & Lincoln, 2005, p. 191; Creswell, 2009, p. 6). Denzin and Lincoln (2008,

p. 31) define a paradigm as 'a net that contains the researchers' epistemological, ontological and methodological premises'. In other words, paradigms are ways in which a researcher looks at reality, it is 'a model or frame of reference through which to observe and understand' (Babbie, 2010, p. 33). The paradigmatic perspective of this study refers to meta-theoretical, theoretical and the methodological assumptions.

1.6.1 Meta-theoretical assumptions

A meta-theory describes the philosophical foundations, nature and structure of scientific theories. Issues that are considered on the meta-theoretical level include the nature of scientific development and the meaning of truth (Henning, 2005, p. 14).

The Theory of Health Promotion in Nursing (University of Johannesburg, 2009, pp. 4-6) was the point of departure of the meta-theoretical assumptions in this study. There are four central concepts that are supporting this nursing theory. These concepts are person, environment, health and nursing. In this study, it was assumed that:

- **Person** comprises the youth and the health care professional (professional nurses, doctors and social workers). Each one of them is viewed as a holistic being who functions in an interactive and integrated manner with the internal and external environment. The youth and health care professional also exhibit knowledge, skills and values that should support the promotion of health.

- **Environment** consists of the internal and external environment with which a person constantly interacts. The internal environment of the youth and health care professional comprises the body, mind and spirit. The body refers to anatomical and biological (physiological) processes while the mind includes intellectual, emotional and volitional processes. The intellect refers to the competence and quality of psychological processes of thinking, association, analysis and understanding. Emotions include affection, desires and feelings while volition refers to the process of decision making and the implementation of choices. The spirit includes the relationship with God and conscience.

The external environment consists of the physical, social and spiritual dimensions. The physical dimension is the physical environment or the context in which a study is conducted. The social dimension refers to the available human resources in the external environment of the person and the spiritual dimension refers to the religious aspects of the community

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(principles and ethics). A person is always in constant interaction with both his or her internal and external environment.

The researcher assumed that the external environment encompassed the physical and social environment or community where the study was conducted by means of either one-on-one or group interactions. Also, it included the available resources at the provincial level (Western Cape Department of Health) and the national level (policy and legislative frameworks) to promote wellness in the context of the study.

- **Health:** In this study, health reflected the relative status of the interaction between a youth victim of violence and his or her environment that included health care professionals' interventions to lead the youth to attaining wellness. Health promotion was regarded as mobilising resources (for example, health care professionals) to attain wellness of youth victims of violence towards health on all levels of being.

- **Nursing:** It refers to the modelling of human behaviour during interaction with the environment. In this study, nursing referred to the interactive and partnership process that included the authority of a professional nurse (as part of the multidisciplinary health care team) to lead youth victims of violence towards wellness.

1.6.2   Theoretical assumptions

1.6.2.1   Wellness

The theoretical assumptions of this study were adapted from the Health Promotion Model (Pender, Murdaugh & Parsons, 2011). The Health Promotion Model was first proposed in 1982 and later reviewed in 2002 by Nola Pender, a nurse educator and psychologist. The model was developed as a means of enhancing the holistic wellness of individuals (Alligood & Tomey, 2010). Pender recognises the holistic nature of a person and how the person interacts with his or her environment to pursue wellness. The applicability of the model in promoting wellness among people has been noted by nursing scholars and researchers (Alligood, 2014; Pender *et al*., 2011). This model was adapted for this research study because it emphasised wellness promotion among persons that was consistent with the principles of a holistic approach in nursing and also underlined the invaluable role of health care professionals in leading persons towards wellness.

The fundamental assumptions of Pender's Health Promotion Model adapted for this study were:

- A person strives to build situations or circumstances where he or she can show distinct capabilities of maintaining health.

- All persons have the ability to reflect and become aware of themselves and their competencies.

- Persons appreciate positive growth and seek an individually satisfactory and balanced life.

- Individuals dynamically look for ways of controlling their own behaviour.

- The various parts of a person interact with both the internal and external environment and as time passes, the environment as well as the person change.

- For change to be effective, a self-initiated reOrganization of the interaction between person and environment has to take place.

- Health care professionals are an important part of the social environment and they have authority to lead persons to wellness.

Wellness is, therefore, viewed as the active process in which an individual makes choices toward a healthier existence and psychological and social well-being. This process comprises the balancing and integration of multiple life dimensions by adopting a holistic way of life (body, mind and spirit) orientated towards optimal health with the goal of living life more fully (Myers *et al.*, 2000, p. 252).

1.6.2.2 Practice Orientated Theory

This study departed from the theoretical assumptions of the Practice Orientated Theory of Dickoff, James and Wiedenbach (1968, p. 434) as outlined in Sections 1.6.1. The survey list of the Practice Orientated Theory of Dickoff *et al*. (1968, p. 434) served as a reasoning map in this study (Figure 1.1) in order to develop a conceptual framework for the findings of the study. The activities of the reasoning map in the Dickoff *et al*. (1968:438) survey list were consistently applied (Chapters 4 and 6).

```
            ┌─────────────────────────┐            ┌─────────────────────────┐
            │         Agent           │◄─────────► │       Recipient         │
            │  Professional nurse,    │            │  Youth victim of        │
            │  social worker, and     │            │  violence               │
            │  medical doctor         │            │                         │
            └─────────────────────────┘            └─────────────────────────┘
                              │
                              ▼
                    ┌─────────────────────┐
                    │       Context       │
                    │  A South African    │
                    │  community          │
                    └─────────────────────┘
                              │
                              ▼
                    ┌─────────────────────┐
                    │      Dynamics       │
                    │  Factors that       │
                    │  promote successful │
                    │  implementation of  │
                    │  the framework      │
                    └─────────────────────┘
                              │
                              ▼
                    ┌─────────────────────┐
                    │     Procedure       │
                    │  Processes in the   │
                    │  framework          │
                    └─────────────────────┘
                              │
                              ▼
                    ┌─────────────────────┐
                    │      Terminus       │
                    │  Framework to lead  │
                    │  youth victims of   │
                    │  violence towards   │
                    │  wellness           │
                    └─────────────────────┘
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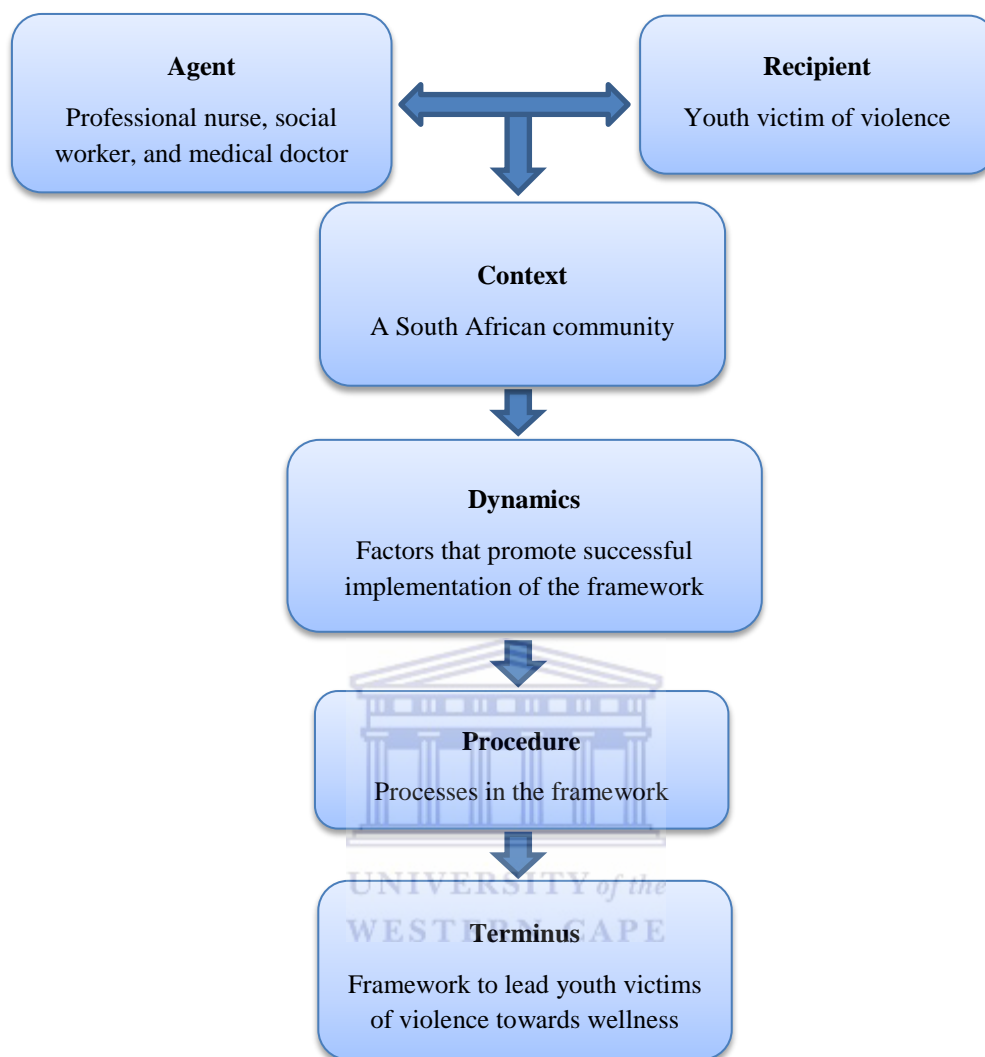
Figure 1.1:   The reasoning map

The Practice Orientated Theory survey list of Dickoff *et al*. (1968:434) in Figure 1.1 was utilised in this study to describe a conceptual framework for the study. The activities that Dickoff *et al*. (1968:438) identify in their situation producing theory are included in the reasoning map.

These activities assume that the following questions in relation to the components would be addressed:

1.   Who or what performs the activity (agent)?

The activity, in this study, referred to leading youth victims of violence towards wellness. In this study, the researcher conceptualised a framework for professional nurses, social workers and medical doctors (agents) to provide leadership to the youth victims of violence towards wellness in a community (rural health practice environment) of the Western Cape Province in South Africa.

2.   Who or what is the recipient of the activity (recipient)?

The conceptual framework of this study described the recipients as the youth victims of violence because the agents were expected to lead them to wellness.

3.   In what context is the activity performed (framework)?

The conceptual framework described the context of a rural community health practice environment in the Western Cape Province of South Africa.

4.   What is the energy source for the activity; whether physical, biological, or psychological (underlying dynamics)?

The conceptual framework included the dynamics that were sources the agent and recipient in the specific context needed to facilitate the successful implementation of the conceptual framework at a later stage.

5.   What is the guiding processes, techniques, or protocol (procedure)?

The procedure focused on the processes to be included in the implementation of the context-specific framework for leading the youth victims of violence towards wellness.

6.   What is the endpoint of the activity (terminus)?

The terminus was the outcome that confirmed whether the goal of the activity had been achieved. In this study, the terminus was the conceptual framework (Chapter 6) for leading the youth victims of violence towards wellness in the community of Genadendal in the Western Cape Province of South Africa.

1.6.2.3   Other theoretical concepts

- **Expectations** are rational anticipations grounded on reality that a person has or looks forward to (Kreuter, 2013, p. 155). In this study, expectations referred to what the youth victims of violence anticipated or looked forward to in relation to health care professionals who could lead them towards wellness.

- **Experience** is defined as the understanding or learning that a person derives from previous successes and disappointments (Guy, 2009, p. 183). In this study, experience referred to the health care professionals' learnings from their past achievements and frustrations while attempting to lead youth victims of violence towards wellness.

- **Framework** is an abstract logical structure of meaning that links findings to the body of knowledge in nursing (Grove, Burns & Gray, 2013, p. 116). A conceptual framework was developed in this study that referred to a network of interlinked concepts that collaboratively provided a comprehensive understanding of a phenomenon or phenomena (Jabareen, 2009, p. 54).

- **Health care professionals** are involved in providing therapeutic services to individuals and include medical professionals and professional nurses (Forrester & Griffiths, 2010, p. 174). In the context of this study, the term health care professionals referred to nurses (professional nurses), medical doctors and social workers.

- **Lead** refers to guide or direct in a course, in a front position (leading). Section 1.2.3 also describes leadership. 'To lead' in the context of this study referred to leadership. Leadership is the process that allows a person to influence a group of people in order to achieve a common goal (Northouse, 2010, p. 3). In this study, health care professionals led youth victims of violence towards attaining wellness (goal). It can be described as a relationship between a leader and his or her followers in which the leader uses power, authority and influence for the creation of a shared vision and the attainment of goals (Jooste, 2009, p. 5).

- **Medical doctor:** Section 17 of the Medical, Dental and Supplementary Health Service Professions Act of 1974 (Act No. 56 of 1974) defines a doctor as a person with an MB ChB degree who is registered with the Health Professions Council of South Africa. In this study, the term medical doctor referred to an individual practitioner at the community health care facilities in the Genadendal community with an MB ChB degree and licensed to practise as a professional medical practitioner under Section 17

of the Medical, Dental and Supplementary Health Service Professions Act of 1974 (Act No. 56 of 1974).

- **Nurse:** According to the Nursing Act No. 33 of 2005, a nurse is a person who is registered as a professional nurse under Section 31(1), in order to practice Nursing or Midwifery (Act 33 of 2005:5). Jooste (2010, p. 77) defines a nurse as a central role player to all activities in a unit and carries out certain fundamental functions; such as planning, organising, *leading* and controlling. In this study, the term nurse referred to a professional nurse working at the community health care facilities in the Genadendal community.

- **Social worker** is a professional who seeks to improve the quality of life of people and to promote peace, human rights, equality and social justice by using theories of human behaviour and social systems to intervene where people interact with their environments (SAQA, 2012). Social workers are registered under Section 17 of the Social Service Professions Act 110 of 1978 of the South Africa (Department of Social Development, 1978). In this study, it specifically referred to social workers at the community health care facilities in the Genadendal community.

- **Violence** is defined as the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation (Krug *et al*., 2002, p. 5).

- **Youth:** In this study, 'youth' referred to persons between the ages of 15 and 19 years of age in the community of Genadendal.

- **Youth violence** is defined as the involvement of young people, as victims, in incidents that are involving the threat or use of physical force in the context of interpersonal, inter-communal, other conflict, or crime. This violence might be inflicted with or without a weapon and could result in physical injuries or death (Graham *et al*., 2010, p. 38).

- **Youth victim of violence:** In the context of this study, a youth victim of violence referred to a youth who had been a prey of violence in the community of Genadendal that had involved one or more random acts of violent behaviour; such as physical combats, sexual abuse and rape caused by a person or persons who may be known or unknown to the youth.

1.6.3 Methodological assumptions

A constructivist approach was followed in this study. Constructivism is a worldview that posits that individuals actively create their own interpretations and representations of reality based on their personal understanding and experiences (Ultanir, 2012, p. 197).

1.6.3.1 Qualitative research design

A qualitative research design was used in conducting this study. The methodological assumptions of qualitative research according to Babbie (2010, p. 92) and Creswell (2009, p. 4) are:

- It is based on the assumption that human beings are influenced by their individual thought patterns, meanings and personal principles.
- Focuses on the meaning that individuals ascribe to their experiences.
- The physical interactive processes between the researcher and the research participants are carried out in a natural setting.
- The meanings gained are descriptive and are produced through the understanding of the dialogue with the participants and the observations of the researcher during the interactive processes.
- Inductive and deductive reasoning processes are used to create an understanding of and concepts from the experiences of the participants' and researcher's observations.

1.6.3.2 Framework development

In this study, the researcher assumed that framework development was a process.

- **Contextual Constructs Model approach**

Some principles from the phases of this research model – Contextual Constructs Model (CCM) of Knight and Cross (2012) (Figure 1.2) – were followed in this study. It is a research framework that provides an all-encompassing perspective of scientific inquiry, which allows a researcher to identify possible methods of study and analysis according to the identified research constructs and their contexts. It can be used to conceptualise inductive theory building with the aim of compelling the interpretivist researcher to consider the constructed validity of their theory building.

CCM determines the boundaries of research as a contextual process of phases and identifies the conceptual, philosophical, implementation and evaluation tasks that are associated with a research investigation.
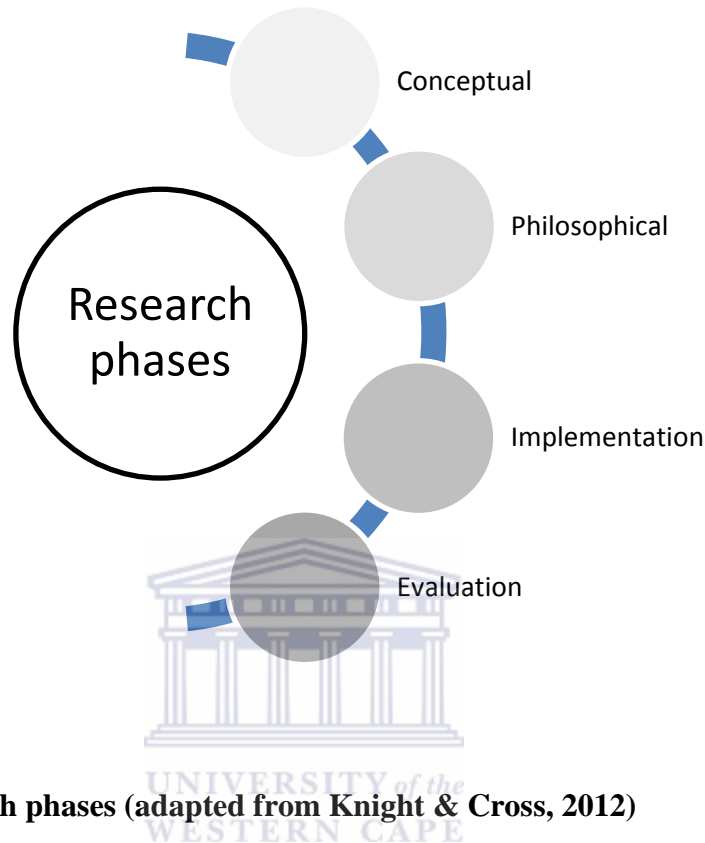
Figure 1.2:   Research phases (adapted from Knight & Cross, 2012)

The theory that underpins the CCM is described as 'Contextual Constructs Theory' (CCT). The CCT focuses on research that involves the fusion of two key component parts; namely (1) context and (2) constructs. The theory assumes that constructs are seen to never exist outside of a context. In turn, the theory has an inherent influence on the development of the research constructs.

A research context is the associated entities surrounding the research and researcher, such as the discipline of the research project; e.g. health sciences, the phenomenon (also called the research object) being investigated (leading youth victims to wellness), previous theory related to the research object, as well as the researcher and the conceptualisation of the manner in which the research object will be investigated.

The researcher must find ways to build abstract constructs that are used to represent or describe the phenomenon being investigated. The four adapted phases of this model are:

The conceptual phase involves the finding of the research focal point and the three elements that collectively establish the focal point of the research are (i) the research-phenomenon characteristics (including the nature of the data), research problem, research topic and questions; (ii) the research discipline and body of knowledge; and the research skills and lens (perspective) of the researcher.

The philosophical phase (paradigmatic perspective) presupposes the underlying idea of the way in which a researcher perceives the world. To a great extent, the philosophical phase determines his or her assumptions about that world and the constructs and phenomena they contain.

The implementation phase encompasses the research methodology and design that should ensure the retention of the research data validity in relation to the research project. Conceptual validity is achieved when both the constructs of investigation and any philosophical assumptions made about that are acknowledged and understood in the context of a study.

The evaluation phase addresses the analysing of the data and writing the findings.

The data to be examined does not pre-suppose the user results only; data could be conceptualised from previous theory, observations from other sources, analysis notes and the combination of data-sets. It requires critical reflection while describing the results and findings.
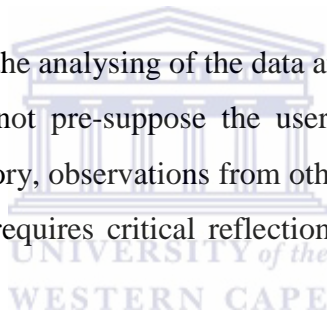
- **Building a conceptual framework**

The steps of Jabareen (2009, p. 54-62) were adapted for the development of the conceptual framework. The following steps were followed in this study (Table 1.1):

Step 1: *Identifying the data sources and conduct comprehensive data collection.* It requires conducting interviews with participants from various disciplines whose work focuses on the targeted phenomenon to ensure validity. Data was collected from the youth and health care professionals (professional nurses, social workers and medical doctors) in this study.

Step 2: *Identifying and naming themes and categories.* The aim of this step is to read and reread the selected data with the purpose of identifying themes and categories emerging from the data collected (interviews and field notes).

Step 3: *Deconstructing the findings and categorising concepts.* The aim during this step is to review the themes and categories with concluding statements; to identify its main attributes, characteristics and roles; and subsequently to identify essential concepts that would form part of the conceptual framework. Concepts derived at are organised according to the survey list of the Practice Orientated Theory of Dickoff *et al.* (1968) (Section 1.6.2.2, Table 4.4 and Table 5.3).

Step 4: *Integrating concepts.* This step aims at triangulating and integrating the key concepts from the findings. In this study, the key concepts in relation to the youth (Chapter 4) and health professionals (Chapter 5) had to be triangulated. This step used the survey list of the Practice Orientated Theory of Dickoff *et al.* (1968) to organise the concepts (Section 1.6.2.2 and Figure 6.1).

Step 5: *Synthesis, re-synthesis and allowing it all to make sense.* Synthesise concepts into a framework. This step involved describing the framework.

Step 6: *Validating the conceptual framework.* This step aims at validating the conceptual framework. In this instance, the question whether the proposed framework and its concepts make sense needs to be answered, not only by the researcher but also by participants.

1.7 RESEARCH DESIGN

Christensen, Johnson and Turner (2011, p. 507) define a research design as "the outline, plan, or strategy used to investigate the research problem". A qualitative, exploratory, descriptive and contextual design was followed. Using a qualitative design enables a researcher to carry out an in-depth investigation of the phenomenon by collecting rich narrative material while using a flexible approach in order to understand and give meaning to the experiences of the participants (Polit & Beck, 2006, p. 508). This design was selected for this study due to the nature of the topic and the research questions that needed to be explored.

An *exploratory* research design aims at establishing new facts and gathering new information or ideas (Babbie, 2010, p. 92). The concept of health care professionals who were leading youth victims of violence was unclear; using the exploratory design aided the researcher with understanding this phenomenon.

A *descriptive* research design allows situations and events to be described as they occur naturally (Johnson & Christensen, 2012, p. 584) and also provides a precise interpretation of

situations in order to explain what exists (Burns & Grove, 2011, p. 256). For the purpose of this study, a descriptive design was used to obtain data about the expectations of the youth and the leadership roles of health care professionals in addressing youth violence and the experiences of health care providers in relation to youth victims of violence.

Contextual research is used for describing and gaining insight into events in the context of a concrete and natural setting where they occur (Henning, Van Rensburg & Smit, 2007, p. 62). This study was contextual in nature because it was restricted to the experiences of the youth and health care professionals in a rural community of the Theewaterskloof Municipality in the Overberg District of the Western Cape Province, South Africa.

1.7.1   Population and sample

Christensen *et al*. (2011, p. 505) define a population as "the full group of interest to a researcher, to which one wants to generalise and from which the sample is selected". The target population for this study consisted of (i) youth who had been victims of violence in the community of study and (ii) health care professionals (professional nurses, medical doctors and social workers) who worked at the health care facilities in the community.

A purposive, non-probability sampling technique was used. Polit and Beck (2012, p. 517) describe purposive sampling as the selection of cases or type of cases that will best generate the data to assist with meeting the objective or requirement of the study. Burns and Grove (2011, p. 317) recommend that the number of participants in a qualitative research study should be adequate to ensure that data saturation occurs. Therefore, the researcher continued with the data collection until data saturation occurred among the fifty eight (n = 58) youth participants and seven (n = 7) health care professionals. Data saturation takes place when no new information is produced while redundant previously collected data starts to be repeated (Burns & Grove, 2011, p. 317).

- **Inclusion criteria**

The *youth* attending a high school who were purposively selected for this study were residents of the Genadendal community and between the ages of 15 and 19 years, and had been victims of community violence no longer than six months before participating in the study.

The *health care professionals* who were considered to be eligible for this study, had to have a minimum of two years of experience working in a health care environment in the Genadendal community at the time of the study.

1.8   RESEARCH METHODS

A research method refers to the ways or strategies for collecting, organising and analysing data (Polit & Beck, 2006, p. 504).

1.8.1   Preparation for the study field

After ethical approval to conduct this study was granted by the Higher Degrees Committee of the Faculty of Community and Health Sciences (CHS), University of the Western Cape (ethical clearance registration number 13/9/39). A multilateral agreement existed between the University of the Western Cape and the Western Cape Department of Health to conduct research at health service facilities in the Theewaterskloof area where the community health centre is situated. The School Governing Board provided permission for the study. They were presented with the research proposal and ethical clearance for this study, where after the objectives of the study were fully explained to them. Once their approval was obtained, the researcher proceeded with data collection at the study site.

1.8.2   Data collection

Four pilot interviews (two focus group discussions with the youth and two unstructured individual interviews with health care professionals) were conducted. This was done to assess whether the issues raised with the participants elicited the required information for the purposes of the study. The results formed part of the findings of the main study as the data of these interviews yield the required information.

1.8.2.1   Phase 1: Expectations of the youth

The first phase focused on the exploring and describing of the expectations of the youth. This phase utilised focus group discussions and field notes for data collection. Two pilot focus group discussions were conducted. Focus group discussions are very useful for obtaining rich data and for gaining an in-depth understanding of phenomena in the original words of the participants (Liamputtong, 2011, p. 6; Langer, 2006, p. 4). The FGDs in this study consisted of about six to eight participants per group and lasted not longer than 60 minutes. The

researcher articulated an open-ended question with the purpose of eliciting a discussion about the experiences of the participants. The opening question was followed by relevant probing questions. Focus group discussions continued until data saturation was reached. This was indicated when Repetitive themes that started to occur amongst participants determined the point of data saturation (Polit & Beck, 2012, p.62). Further description of Phase 1 is outlined in Section 3.3.2.1.

1.8.2.2   Phase 2: Experiences of health care professionals

The objective of the second phase was to explore and describe the experiences of the health care professionals while they were supporting youth victims of violence to wellness. During this phase, unstructured individual interviews were conducted and field notes were also recorded. As a guide for an interview, Johnson and Christensen (2012, p. 204) recommend that a researcher should have a general plan of enquiry and should take care not to ask questions in any predetermined order. They further suggest that a researcher should allow the participant to do most of the talking with the aim of stimulating the sharing of rich data. The researcher talked very little during the individual interviews. An open-ended question was verbalised and that was followed by probing questions to stimulate a wealth of data from the participants. Phase 2 is further described in Section 3.3.2.2.

1.8.3   Data analysis of Phases 1 and 2

In qualitative research, data analysis is an iterative process of gathering and evaluating the data simultaneously with the purpose of maximising the meaning of the data (Creswell, 2009, p. 183; Polit & Beck, 2012, p. 556). In this study, analysis of the data collected during Phases 1 and 2 was done separately and involved verbatim transcription of the voice recordings of all the focus group discussions and the subsequent unstructured individual interviews. Furthermore, the field notes taken during these phases were meticulously recorded. The researcher read through the transcripts several times to make general sense of the data while using the steps of Tesch's coding technique (Creswell, 2009, p. 186) for analysis of the data (Chapter 2). An inter-coder consensus was meeting held between the researcher and an independent coder to reach an agreement about the coding. The data analysis process is discussed in detail in Section 3.3.4.

1.8.4   Phase 3: Development of the conceptual framework for health care professionals to lead youth victims of violence towards wellness

The developed conceptual framework was based on the findings from the participants (Phases 1 and 2). The survey list of the Practice Orientated Theory by Dickoff *et al*. (1968) served as the reasoning map for the description of the identified concepts. The steps utilised in developing the conceptual framework are described in Section 1.6.3.2.

1.8.5   Phase 4: Validation of the conceptual framework

Validation is a crucial aspect of authenticating findings generated from qualitative research based according to the perspectives of the research participants in a specific field of study (Creswell, 2009, Lincoln & Guba, 2000). In Phase 4 of this study, respondent validation (Bryman, 2012, p. 391) was carried out. The criteria for validation were founded on the criteria for the evaluation of nursing models suggested by Pearson, Vaughan and FitzGerald (2005, p. 226). The validation process is thoroughly described in Section 3.3.6.

1.9   TRUSTWORTHINESS OF THE STUDY

To ensure valid and credible findings of a study, the strategies of credibility, transferability, dependability, confirmability and authenticity (Guba & Lincoln, 1994; Lincoln & Guba, 1985) need to be applied. Credibility refers to the ways in which a researcher establishes confidence in the findings of a study. To achieve credibility in this study, data triangulation (the use of multiple methods for data collection) and member checking (consulting with the participants to verify the information collected) were conducted. Transferability encompasses the degree to which findings from one study can be applied or transferred to another research setting or group with similar characteristics. The researcher endeavoured to achieve transferability in this study by presenting a thick description of the participants, the context and the setting of the research study. Dependability establishes whether the study can be replicated when the same or similar participants and setting are used. To achieve this, the researcher ensured that an external audit of the research process was conducted. Confirmability relies on whether a study is conducted in a manner that is free of either personal bias or prejudice. In this study, the researcher maintained neutrality by reflexivity and by reporting the exact words of the participants (Lincoln & Guba, 1985, p. 290-331). Authenticity is established when a researcher exhibits fairness in the research and truly displays different realities (Polit & Beck, 2012). The researcher ensured authenticity by

accurately conveying the tone of the expression of the paricipants' feelings in relation to their experiences.

1.10 ETHICS CONSIDERATIONS

The researcher observed the principles guiding the 1978 Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978) and the International Council of Nurses (ICN) Code of Ethics for Nurses (International Council of Nurses, 2012) by:

- ensuring that informed consent is obtained from each participant after adequate explanation of the study objectives and purpose has been provided. For participants below the age of 18 years, a letter seeking consent from a parent or guardian will be supplied and assent will be sought from these participants.

- treating participants with utmost respect and dignity and informing them of their right to withdraw from the study at any stage without suffering any consequence.

- not subjecting participants in any way to unnecessary risks, injury, stress, or discomfort.

- assuring participants that their identity will remain protected and all information provided will be strictly kept confidential and will not in any way be used to prejudice them. To further protect their identity, pseudonyms or codes will be used instead of their real names.

- entertaining questions from the participants and they will be informed that they can contact the researcher at any time when they have further questions.

- discontinuing the interview immediately when any participant experiences any psychological problem as a result of the study during the research interaction and prompt referral to a counsellor or psychologist will be facilitated.

- sharing the findings of the study with the participants prior to public dissemination or publication, e.g. in a peer reviewed journal.

- securely protecting the transcripts and voice recordings of the interviews by using password-protected files that cannot be accessed by other persons other than the researcher. These records will be destroyed after a period of five years.
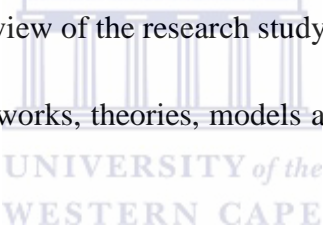
The ethical considerations are discussed in more detail in Chapter 3.

1.11 CONTRIBUTION OF THE STUDY

The study contributes to the knowledge base of health care professionals leading youth victims of violence towards wellness in a rural community. An original conceptual framework based on participative leadership emerged from the data analysis obtained from the youth and health care professionals. The framework can be utilised by health care professionals for a better understanding and actual implementation of leading (leadership) youth victims of violence to wellness in their community. This study is the first of its kind to be conducted about the leadership of health care professionals who moderate the wellness of youth victims of violence in a rural community.

1.12 LAYOUT OF THE REPORT

The layout of the chapters in this study is presented below:

Chapter 1:   Rationale and overview of the research study;

Chapter 2:   Overview of frameworks, theories, models and programmes on youth violence and health;

Chapter 3:   Research methodology;

Chapter 4:   Discussion of findings from Phase 1: Youth;

Chapter 5:   Discussion of findings from Phase 2: Health care professionals;

Chapter 6:   Conceptual framework for health care professionals to lead youth victims of violence towards wellness; and

Chapter 7:   Conclusions, guidelines for implementation of the framework, limitations and recommendations of the study

1.13 SUMMARY

Chapter 1 presents the rationale and overview of this research project. Articulation of the research questions and objectives assists with focusing the scope of the research. The

researcher reflected on the chapter including the methodological approach proposed to be used for the development of the conceptual framework using principles from Knight and Cross (2012). The conceptual phase started with the researcher identifying exactly what it was that she wanted to investigate and the context of such an investigation.
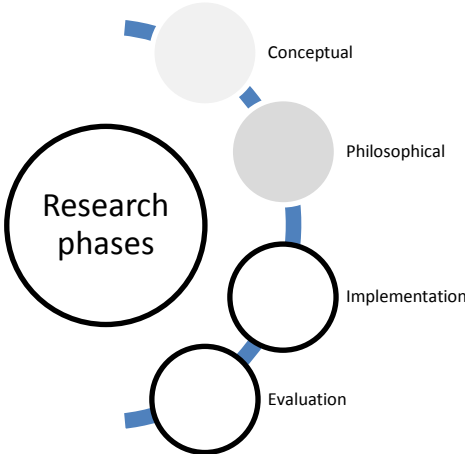
Figure 1.3:   Research phases

The *context* of the research study had been identified that guided the identification of the research method for the study. The context was discussed to explain the fundamental issue of youth violence in the community of study, the gap in literature with no existing framework for leading youth victims to wellness and the need for health care professionals to take up the responsibility of leading youth victims of violence towards wellness in their community. Hence, the literature presented in this chapter incorporated references to empirical studies, as well as theoretical and policy documents nationwide. The reason for using this approach was to illustrate the importance of the research problem and to provide a *transparent* motivation for the significance of the study. The research questions assisted with focusing on the scope of the research and developing a conceptual framework. The researcher was *committed* to conducting the research study owing to her understanding and training in nursing, public health and wellness promotion. The researcher was an integral part of developing the framework based on the phenomenon of the research project; therefore, she became more knowledgeable in the field of interest. As a result, it was possible for the researcher to continually adapt and refine her theoretical point-of-view (Knight & Cross, 2012). Also, the

act of researching, e.g. determining methodology had the accumulative effect of improving research skills.

The point of departure and suppositions for a conceptual framework of the study were based on meta-theoretical, theoretical and methodological assumptions. Those assumptions were described in relation to the Theory of Health Promotion in Nursing (University of Johannesburg, 2009), Health Promotion Model (Pender *et al*., 2011), Practice Orientated Theory of Dickoff *et al*. (1968) and the Contextual Constructs Model (Knight & Cross, 2012). From the researcher's point of view, it was important to outline those assumptions early because they resonated with the researcher's principles and would later be reflected in the description of the conceptual framework in subsequent chapters. These assumptions facilitated the research approach and purpose of the study (Knight & Cross, 2012). To align with the constructivist paradigm, the researcher subscribed to using a qualitative, exploratory, descriptive and contextual design. The research method was described and presented logically, starting with the manner in which the study would be conducted in four phases, the methods of data collection and analysis, and Organization and explanation of the elements of the conceptual framework by using the survey list of Dickoff *et al*. (1968). Also, the researcher described how the developed framework would be validated. It was important that the researcher stated beforehand the strategies that the study employed to ensure the trustworthiness of the findings and to observe the ethical considerations.

Furthermore, during the writing of this chapter, the researcher reflected on the *importance* and *impact* of the study. These reflections emphasised the unique contribution of this research project to the knowledge by strongly taking the background of the study into account.

Table 1.1:   **Summary of the phases of the study**

Adapted Contextual Constructs Model approach Knight and Cross (2012)	Adapted from Jabareen (2009) Framework development	Phases according to the objectives of the study	Objectives	Population and sampling	Data collection	Data analysis	Reasoning strategy
Conceptual and philosophical phase and departure	Paradigmatic perspective Overview of frameworks, theories, models and programmes about youth violence and health						Deductive
Implementation phase	Identify the data sources and conduct comprehensive data collection Identify and name themes and categories Deconstruct and categorise the concepts	Phase 1: Youth expectations	Explore and describe the expectations of the youth with regard to health care professionals leading youth victims of violence towards wellness in the Genadendal community.	**Population:** •Youth **Sampling method:** •Purposive	Focus group discussions Field notes	Tesch (1990) method Themes and categories Survey list of Dickhoff *et al.* (1968) Literature control	Inductive Deductive

Adapted Contextual Constructs Model approach Knight and Cross (2012)	Adapted from Jabareen (2009) Framework development	Phases according to the objectives of the study	Objectives	Population and sampling	Data collection	Data analysis	Reasoning strategy
		Phase 2: Experiences of health care professionals	Explore and describe the experiences of health care professionals while they are leading youth victims of violence towards wellness in their Genadendal community.	**Population:** Professional nurses Medical doctors Social workers **Sampling method:** •Purposive	In-depth individual interviews Field notes	Tesch's method Themes and categories Survey list of Dickhoff *et al*. (1968) Literature control	Inductive Deductive

CHAPTER 2

OVERVIEW OF FRAMEWORKS, THEORIES, MODELS AND PROGRAMMES ABOUT   YOUTH VIOLENCE AND HEALTH

2.1   INTRODUCTION

The primary purpose of a literature review is to identify and integrate both the known and unknown about a research area in order to give the reader an understanding of the body of available research in a specified area (Polit & Beck, 2014, p. 116). Nonetheless, for qualitative studies, there are different points of view among qualitative researchers with regard to the purpose of a literature review and under what circumstances should it be conducted (Burns & Grove, 2011, p. 192; Polit & Beck, 2012, p. 94). For instance, Holloway and Wheeler (2010, p. 37) posit that for qualitative studies, the review of literature should be carried out at the start of the study with the aim of providing a simple overview of the available knowledge-base in a specific area of study.

Oftentimes, these varying opinions are connected to the different qualitative research traditions. Phenomenologists believe that literature should be reviewed after data has been collected and analysed in order to prevent any possible researcher bias or prejudice about the phenomenon being studied. Ethnographers typically do a literature review before and after data collection, similar to quantitative studies in order to firstly provide a background for conducting the study and secondly a basis for interpreting findings. Furthermore, historical researchers often conduct an extensive preliminary and subsequent literature review in order to choose their research topic, develop their research questions and explain how the study phenomenon has changed over time. Grounded theory researchers include a minimal review of literature at the beginning of the study to enable the researcher to be conversant with prior studies that have been conducted instead of directing the study (Burns & Grove, 2011, p. 192). Some researchers hold the opinion that data should be collected before reviewing literature when the theory is adequately developed; the purpose is to examine how prior studies either fits or extends the emerging theory (Polit & Beck, 2012, p. 94).

The researcher decided that it was important to understand and appreciate the context of the phenomenon of the proposed study. The purpose of exploring the research context of a research project is the foundation and conceptual phase of any research during which previous

investigation of the phenomenon and phenomenon-specific methodologies can be considered (Knight & Cross, 2012).
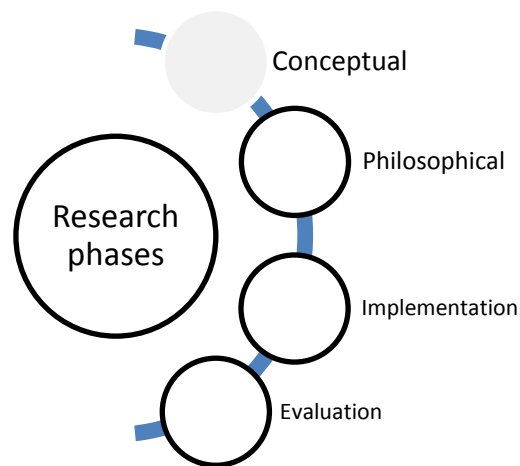
Figure 2.1: **Summary of research phases**

This chapter aims at providing an overview of the theories, models, frameworks and programmes related to youth violence and leading them to a healthy and fulfilling life.

2.2 FRAMEWORKS, THEORIES AND MODELS ON YOUTH VIOLENCE

2.2.1 The Core Competencies Framework for Health Promotion (CompHP)

The Core Competencies Framework for Health Promotion (CompHP) was developed on the initiative of the European CompHP project, a project sponsored by the European Union to address the need for innovative and changing health promotion competencies in response to health concerns; such as non-communicable diseases, promotion of healthy ageing, as well as positive mental health and wellbeing (Barry, Battel-Kirk, & Dempsey, 2012; Delobelle, 2014).

The framework has been developed by means of a consensus-building process and articulates the essential knowledge, skills, abilities and values that are required for effective health promotion practices in a variety of settings. At a round table discussion arranged by the School of Public Health at the University of the Western Cape Province in South Africa, academics and health promotion experts reflected on the CompHP and came to the conclusion that the framework could provide lessons for the development of health promotion programmes in South Africa, including but not primarily those programmes that targeted youth violence prevention in the country (Delobelle, 2014).

The core competencies that the framework for health promotion activities emphasises include the following areas:

- **Be a change agent**

This involves assisting persons, groups, Organizations and communities to develop their abilities in order to either augment the recovery process, or enhance their wellbeing, for example by developing particular personal skills, participation in health promotion activities and informational empowerment (Barry *et al*., 2012, p. 658).

- **Be an advocate for health**

Practitioners should seek advocacy avenues collaboratively or on behalf of individuals, communities and Organizations with the aim of improving their health. This can be achieved by awareness creation while appealing to key stakeholders in different sectors to develop policies, guidelines and procedures that support workable health promotion actions (Barry *et al*., 2012, p. 658).

- **Be a mediator in partnerships**

A mediator facilitates the development of multidisciplinary (e.g. professional nurses, medical doctors and social workers) and multi-sectoral e.g. health, education) partnerships and collaboration to improve the impact and sustainability of actions (Barry *et al*., 2012, p. 658).

- **Be a good communicator**

A good communicator uses correct techniques and explores ways of conveying health promotion actions successfully to the recipients. Conveying health promotion information successfully includes practising effective communication skills; such as observational and listening skills, as well as culturally appropriate methods and tools (Barry *et al*., 2012, p. 659).

- **Be a leader**

A leader inspires a shared vision among all stakeholders by initiating and implementing strategic actions for successful health promotion action which aims at improving the wellbeing of persons and communities. This can achieved in various ways, including by means of innovation, empowerment, development of leadership skills, motivation, effective

decision making and problem solving, and participatory teamwork (Barry *et al*., 2012, p. 659).

The CompHP framework, however, is a generic approach to core competencies that individuals in urban and rural areas need. It does not indicate the specific context in which it can be applied and the essential dynamics that may obviate health promotion processes. The focus is clearly on prevention and not on processes to lead victims of violence to wellness.

2.2.2   The Social-ecological Model: A framework for violence prevention

The Centre for Disease Control and Prevention (2014) describes a four-level Social-ecological Model (SEM) that requires an intricate interaction between *individual, relationship, community and societal factors*. The model intends to provide and enhance an understanding of violence and the impact that possible approaches might have on the prevention of violence and focuses on preventing violence before it occurs (Dahlberg & Krug, 2002). They recommend that the strategies selected for programming should be developmentally appropriate and need to cover several levels of the SEM in order to increase the effectiveness and sustainability of the prevention approach.

- **Individual**

The *individual* represents the core of the framework. On this level, programmes should address personal and natural factors; e.g. age, educational level, substance use and history of engaging in violent acts that increase the chances of a person ending up as either a victim or a perpetrator of violence (Dahlberg & Krug, 2002; World Health Organisation, 2014d). The goal of violence prevention programmes on an individual level should be to encourage healthy beliefs, attitudes and actions that would ultimately prevent violence. For instance, when planning a youth violence programme targeting youth in a community, strategies could include a school-based programme to assist the young people to develop social, emotional and behavioural skills they need for positive relationships; group activities to aid an understanding of healthy dating; as well as management strategies for stress, depression, frustration and loss (Centres for Disease Control and Prevention, 2014).

- **Relationship**

This is the second level of the framework. It focuses on close relationships that might possibly increase the possibility of individual suffering from violence either as a victim or perpetrator.

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Some examples of these kind of close relationships include those relationships with intimate partners, family members and peers. Poor parental relationships and supervision, unsupportive family and friendship with delinquent peers also increase the chances of the involvement in violence. The goal of violence prevention programmes on the relationship level should be to support healthy relationships (Dahlberg & Krug, 2002). Hence, youth violence programmes could include family education or support on ways to promote positive child development, mentoring programmes for the youth, training about respectful community relationships (Centres for Disease Control and Prevention, 2014).

- **Community**

This is the third level of the framework and it examines the context in which social interactions and relationships occur; for example at schools, offices and in local communities. This level of the framework focuses on identifying the factors of the context that increases the chances of becoming victims or perpetrators of violence; for example limited economic opportunities, a lack of recreational facilities and the per capita income level of the community. Youth violence programmes could include the establishment of recreational areas for youth in the community, the development of after-school programmes for in-school youth in the community, skills and capacity building programmes for out-of-school youth and the creation of more employment opportunities in the community (Centres for Disease Control and Prevention, 2014; World Health Organization, 2014d).

- **Societal**

This is the fourth level of the framework and it explores the all-embracing factors that assist with stimulating and producing an environment that is violence free; for example, health, educational, social and economic policies. On this level, youth violence programmes could include campaigns to sensitise individuals about wellness and legislation to improve the living circumstances of the people (Centres for Disease Control and Prevention, 2014).

The SEM model is one of the models that focus on preventing violence in a community rather than supporting victims of violence. It presupposes a strong infrastructure that is not always available in a rural community.

2.2.3   The Ecological Systems Theory

The Ecological Systems Theory developed by Urie Bronfenbrenner identifies environmental systems that influence an individual in his or her environment. This theory has been applied in many disciplines; including psychology, education and community health to analyse and organise information about the various interconnected factors that influence an individual (Bronfenbrenner, 1979, 1992, 1994). These systems are the microsystem, the mesosystem, the exosystem, the macrosystem and the chronosystem:

- **Microsystem**

The microsystem refers to the immediate environment where an individual has direct face-to-face interpersonal relations, for example peer group, family, school, neighbourhood and at the health clinic (Bronfenbrenner, 1994; Kail & Cavanaugh, 2013).

- **Mesosystem**

According to Bronfenbrenner (1994, p. 40), the mesosystem 'comprises the linkages and processes taking place between two or more settings' where a person interacts; for example person and school, school and home, as well as health care facility and family (Kail & Cavanaugh, 2013).

- **Exosystem**

The exosystem encompasses linkages and processes occurring in a context where an individual does not interact directly but these linkages and processes still influences that individual (Bronfenbrenner, 1994; Kail & Cavanaugh, 2013).

- **Macrosystem**

The macrosystem is the broadest system that contains all the other systems. It embraces customs, belief systems, as well as government policies and regulations that could carry on influencing an individual (Bronfenbrenner, 1994; Kail & Cavanaugh, 2013).

- **Chronosystem**

The chronosystem comprises transitions and changes related to ageing, for instance changes in a family structure (Bronfenbrenner, 1994).

Ecological Systems Theory is a systems theory that focuses on the influence of the environment on an individual. However, it is not context-specific. No clear processes are mentioned about how victims of violence could be supported.

2.2.4 The Interactive System Framework for Dissemination and Implementation

The Interactive System Framework for Dissemination and Implementation (ISF) was developed by Wandersman, Duffy, Flaspohler, Noonan, Lubell, Stillman, Blachman, Dunville and Saul (2008) to address the areas of child maltreatment and youth violence with the purpose of reducing the societal and health costs of violence and injuries. The framework assists to bridge the gap between research and practice by stipulating systems and processes to support the dissemination and implementation of evidence-based programmes, processes, practices and policies. The framework was designed to be used by researchers, practitioners and funders and offers an understanding of the requirements, obstacles and resources of the different systems; the structure for examining existing research; as well as the process that identifies areas of priority for actions and research. The three fundamental systems needed for this process are: (i) the prevention synthesis and translation system, (ii) the prevention support system and (iii) the prevention delivery system (Wandersman *et al*., 2008, p. 171).

2.2.4.1 Prevention synthesis and translation system

The function of the prevention synthesis and translation system, according to Wandersman (2008), involves filtering of information created through research about innovative programmes and making it available for use and implementation by practitioners working in the field.

2.2.4.2 Prevention support system

The prevention support system is a fundamental element of the ISF. It goes a step further than merely providing information about innovative programmes to practitioners, since such information usually is not adequate to change prevention practice. The role of the prevention support system, therefore, involves supporting the work of practitioners who are putting the innovative programme into practice through capacity building and technical assistance with the view of enabling them to function effectively and also providing other forms of general support; such as coaching, supervision, partnerships and developing leadership skills (Hall & Hord, 2006; Wandersman *et al*., 2008).

2.2.4.3   Prevention delivery system

The purpose of the prevention delivery system is the successful implementation of innovative programmes in practice settings; e.g. in the community, Organization, province or on a national level. A functioning prevention programme are highlighted emphasises the characteristics of individuals, Organizations and communities who maintain and deliver such a programme. The individual factors include education, positive attitudes towards the programme and similar experiences about the programme. The Organizational factors for successful implementation include a clear vision and goals, leadership and commitment, structure and a good work environment. The important community factors for successful execution of prevention programmes include community capacity and readiness for prevention, community competence and community empowerment (Livet & Wandersman, 2005; Mendel, Meredith, Schoenbaum, Sherbourne, & Wells, 2008; Wandersman et al., 2008).

The ISF is a generic management framework that provides guidance about dissemination and implementation of a project.

2.3   SELECTED VIOLENCE PREVENTION AND VICTIMS OF VIOLENCE PROGRAMMES

Many youth violence prevention and victims of violence management programmes exist. However, an overview is provided of selected international and local youth violence prevention and victims of violence management programmes that have been successfully implemented in different settings.

2.3.1   The Victims of Violence (VOV) Programme of Cambridge Health Alliance (United States of America)

The Victims of Violence (VOV) Programme of Cambridge Health Alliance (CHA) was established in 1984 as part of the Harvard Medical School training programme with the aim of providing a broad range of mental health services for crime victims and crime victimised communities (Cambridge Health Alliance: Havard Medical School Teaching Hospital, n.d.; Powell, 2014). The goal is to assist victims of violence with mobilising resources for developing resilience, gaining mastery and encouraging renewed hope and restoring self-esteem. The programme is directed by an understanding that resilience, recovery and healing

from psychological trauma occur in stages and are influenced by complex interactions involving the victim, relationships, social support, environmental factors and satisfaction with professional services (Cambridge Health Alliance: Havard Medical School Teaching Hospital, n.d.).

The VOV programme comprises six interconnected programmatic components: direct clinical services and consultation, research, public education, victim advocacy, community-based collaborations and a social justice / social action initiative to prevent violence. The direct clinical services component of the programme utilises approaches, such as short term and long term crisis intervention for acutely traumatised crime victims and their families (encompassing crisis assessment, treatment planning and psychotherapy) and group therapy services. In tandem with this process, victim resource centre provides access to consultations, information and support to victims and their family members, as well as to community groups and agencies. (Cambridge Health Alliance: Havard Medical School Teaching Hospital, n.d.).

The programme focuses strongly on addressing psychological trauma. Although this programme aims at assisting victims of violence to develop resilience and to restore self-esteem, it does not explicitly emphasise the role that the victims have to play in developing these attributes. Still, services are not targeted at specific groups of clients, such as the youth victims of violence who are very likely to have incomparable needs from their adult counterparts.

2.3.2   Yarrow Place: Rape and Sexual Assault Service (South Australia)

The Yarrow Place is a centre in South Australia, established in 1993, to respond to rape and sexual assault victims (male and female) who are 16 years or older (Yarrow Place, 2010). The services that the centre provides include provision of direct medical services; advocacy to influence public policies relating to sexual violence; and leadership training for professionals such as social workers, professional nurses, medical doctors and police involved in management of victims of sexual violence. *Direct* medical services are provided by a team of professionals, including medical doctors, who provide medical care including treatment of injuries, forensic examination, psychological assessment, counselling, risk and safety assessment, pregnancy and sexually transmitted infections (STIs) prevention and an around the clock crisis response service for victims inclusive of weekends and public holidays. The

centre also provides support for the families of victims and for court preparation and support for victims who decide to go to court (Yarrow Place, 2011).

This service only deals with victims of sexual violence and provides specialised services in an urban area with a 24-hour crisis response service. Such a service is not available in rural areas of the Western Cape Province.

2.3.3 The Cardiff Violence Prevention Programme (United Kingdom)

Some years ago in the Welsh city of Cardiff in the United Kingdom, large numbers of violent cases were reporting for treatment at the Emergency Departments (EDs) and the majority of these cases were not identified by the police (Shepherd, 2001). Therefore, Professor Jonathan Shepherd of the Cardiff University School of Dentistry proposed that health care professionals working in the EDs should become influential leaders for violence prevention and promoters of community wellbeing through partnerships with the police and other crime prevention authorities in their local community (Warburton & Shepherd, 2004, 2006). The Cardiff model for violence prevention programme is a multiagency partnership model that offers ways in which health care professionals working in the EDs can uniquely contribute to violence prevention in their community by information sharing between the ED and the police. The strategies for violence prevention include provision of prompt treatment for victims of violence, collection of anonymous information (if possible, electronically) from victims of violence reporting to the ED for treatment about the exact location of violence, day and time of violence, the assaulters and the weapons used, as well as initiating and taking part in local wellbeing movements (Cardiff University, 2007; Schweigh, 2014). This is a preventive model that provides efficient policy assistance in Wales. In South Africa, such assistance is not available in all in urban areas.

2.3.4 Aggressors, Victims and Bystanders: Thinking and Acting to Prevent Violence (United States of America)

This programme aims at preventing violence and aggressive behaviour among youth learners between the ages of 12 and 17 years at schools, particularly the ones residing in settings with high rates of violence in the United States of America. The objective of the programme is to improve the mental health of young people by training them to develop and practise problem-solving skills, conflict management and encouraging them to reconsider myths that support aggression and also to assess their roles as aggressors, victims and bystanders. The

programme is delivered by means of a school-based curriculum offered in twelve 45-minute classroom sessions, once to thrice a week over a 4 to 12 week period. Implementers of the programme include health educators, physical education instructors, police officers, language and arts teachers and school resource / safety officers (NRPP: SAMHSA's National Registry of Evidence Based Practice, 2014).

While this mental health promotion programme concentrates on violence prevention among school learners, it does not provide any strategies for any behavioural outcomes related to violence, as well as alcohol, tobacco and drug use.

The National Registry of Evidence-based Programme and Practices (SAMHSA, 2014) is an example of another preventive programme that focuses on school learners and fails to include practices for leading youth victims of violence to wellness in a specific rural setting.

2.3.5   Victim Crisis Response Programme (Canada)

Victim Crisis Response Programme provides 24-hour assistance services to individuals, including young people in Toronto, Canada. Services that are provided to the victims include immediate on-site crisis management, phone crisis intervention, trauma counselling, provision of safety and support services that include individual and family support to victims of crime and sudden tragedies. The goal is to help alleviate the detrimental effects on the victim and their family members caused by a traumatic experience and to assist with stabilising the victim sensitively. The victim is also provided with appropriate support services in their community, for instance referrals to agencies in the community to continue providing continual support to the client (Victim Services Toronto, 2013).

This Canadian programme specifically focuses on curative aspects during the first 24 hours after an incident.

2.3.6   Olweus Bullying Prevention Programme (Norway and the United States of America)

The Olweus Bullying Prevention Programme was developed by Dan Olweus (Ph.D.) of the University of Bergen, Norway to decrease and prevent bullying among learners younger than 18 years at schools and to develop their interpersonal relationship skills, reduce antisocial behaviours and improve the social climate in classrooms. The programme also engages teachers and parents in bullying prevention, creates community awareness and sensitisation

about bullying and provides support and care for victims (Olweus Bullying Prevention Program, 2014). This programme has been implemented in many elementary and middle schools across the world, including Norway and the United States of America. It offers a comprehensive approach that consists of individual, classroom, school, and community components. At school level, the programme focuses on assessing the occurrence and types of bullying in the school setting, establishing a system where students are supervised outside of the classroom by adults and setting up functional committees for the coordination of the programme while classroom interventions include discussions and activities that promote anti-bullying values and standards. At the individual level, efforts are made to assist young people who have a history of either bullying or victimisation (Blueprints for Healthy Youth Development, 2014; Olweus Bullying Prevention Program, 2014).

This programme addresses important domains of psychosocial and emotional aspects but does not provide a holistic view that includes physical aspects.

2.3.7   Youth Against Violence Project (South Africa)

The Youth Against Violence Project is one of the programmes organised by The Trauma Centre for Survivors of Violence and Torture, a non-governmental Organization located in Woodstock, Cape Town, South Africa. The project targets learners at schools to create awareness about violence and to provide them with support for violence-related matters. The support includes equipping the learners with the necessary information that enables them to make informed decisions about their wellbeing and safety. In addition, individual and group counselling sessions, as well as family support are provided. It supplies information about avoiding aggressive behaviour such as bullying and staying away from gang initiation. the interventions include strategies for rape prevention (The Trauma Centre for Survivors of Violence and Torture, 2013).

This project is important, however, it focuses on school learners while in many rural areas, victims of violence either left school already or are beyond school attending age.

2.3.8   Rape Crisis Programme (South Africa)

The Rape Crisis Programme provides support and empowerment services for female rape survivors in Cape Town, South Africa to encourage healing of the traumatic experience. Services provided to clients include professional face-to-face counselling for survivors,

partners, family members, or friends; 24-hour rape crisis management; as well as continual social support through support groups and court support. The programme offers training and awareness creation packages and workshops to other NGOs, officials of the criminal justice system, religious Organizations and schools. Training at schools emphasises the empowerment of high school learners by raising awareness about rape among their peers. The Organization conducts research on rape and maintains an extensive rape case database of survivors and a comprehensive service directory. It also partners with other Organizations and civil society that manage rape-related issues in the community (Rape Crisis, 2014a).

2.4 SUMMARY

Chapter two presents an overview of some relevant theories, models, frameworks and programmes that deal with youth violence in different parts of the world. Since a literature review does not always precede a qualitative study, only relevant background literature was reviewed in relation to the topic.

In writing this chapter, the researcher reflects on the most prominent theories, models, frameworks and programmes about youth violence in relation to literature that addresses the phenomenon of youth violence with regard to *scope* for and *relevance* to public health and health promotion. Literature indicates inter alia a generic approach to core competencies needed in urban and rural areas by individuals. A generic approach does not necessarily follow a holistic approach to health. Instead, it focuses on specific issues such as the prevention of violence in a community rather than interventions for victims of violence. Systems theories focus on the environment without mentioning clear processes that address victims of violence; without outlining management guidelines on dissemination and implementation of a project; without targeting specific groups of clients such as youth victims of violence; or without comprehensively focusing on more than victims of sexual violence and specialised services that are not universally available and accessible.

The researcher regards the discussion in Chapter 2 as important for the understanding and appreciation of youth violence prevention rather than addressing youth victims of violence who need to be led to wellness. Due to no specific literature on leading youth victims of violence to wellness in a rural community, it became clear that the need for the study could be justified. The researcher was confident she had some understanding of where the study was situated in the larger field of the phenomenon. The reader would notice that the

methodological considerations in some literature on the phenomenon (Chapter 2) include qualitative approaches. Chapter 3 addresses the research methodology of this study.

CHAPTER 3
METHODOLOGY

3.1   INTRODUCTION

The research methodology comprises the rational and systematic approaches to conducting a research study. It is an important part of the research process because it guides and gives direction to a research study (Jonker & Pennink, 2010, p. 33; Khan, 2008, p.70).

The main purpose of this chapter is to describe the research design and methods in the paradigmatic perspective of a study; in this instance, it refers to the development of the framework for health care professionals to lead youth victims of violence to wellness in a rural community of the Western Cape, South Africa. This chapter begins by describing the research design and its components to allow for an intrinsic understanding of the study. Furthermore, the data collection methods and procedures and the measures used in ascertaining trustworthiness are presented before the ethical standards employed in the study are discussed.
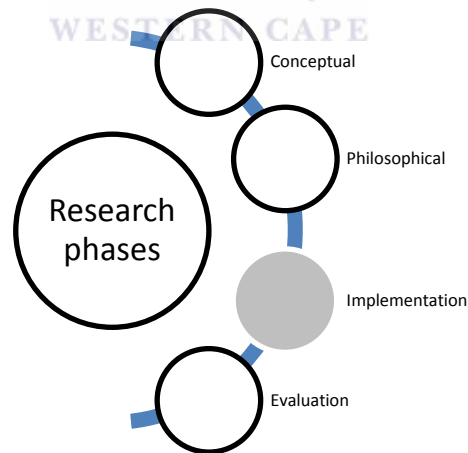
Figure 3.1:   Methodology

This chapter, therefore, focuses on the research methodology and design with the aim of ensuring that the research data retains its validity to the research project (Knight & Cross, 2012).

The researcher was the main instrument for gathering, analysing and interpreting data during qualitative research inquiry (Onwuegbuzie, Leech & Collins, 2008, p. 2). However, the

researcher avoided any personal bias that could have inhibited the research participants from sharing their views and experiences about the phenomenon under investigation.

3.2   RESEARCH DESIGN

A research design outlines the plan or strategy used in examining a research problem and can be regarded as the blueprint for conducting a research study (Christensen, Johnson & Turner, 2011, p. 507). It can be categorised as either a qualitative, quantitative, or mixed methods research approach. Qualitative research methods centre around exploring and describing the views, opinions and experiences of research participants in a real-life setting with the purpose of comprehending the meaning that the participants ascribe to reality (Harwell, 2011, p. 148). It also makes use of textual data (the words of the research participants) and typically, research participants are selected purposefully (Hennink, Hutter & Bailey, 2011, p. 16). On the other hand, quantitative research methods involve the creation of hypothesis and the testing of relationships and associations using mathematical or statistical tests. The focus in quantitative research includes predictions and confirmation that the results of the research are replicable, as well as generalizable. Thirdly, mixed methods combine both qualitative and quantitative research methods in a way that balances the differences between the two research method (Harwell, 2011, p. 148; Punch, 2014, p. 206).

Burns and Grove (2011) maintain that the research design selected for a research study must be suitable to adequately address the research question(s). This study used a qualitative, exploratory, descriptive and contextual design. It was decided to follow a qualitative design instead of a quantitative design because it was more suitable for addressing the research problem. Through a qualitative design, the research questions could be meaningfully explored, answered and understood.

3.2.1   Qualitative design

A qualitative design was used for collecting rich data about the phenomenon under study, since the participants provided in-depth information in their natural setting. It is a flexible method to gain an understanding and the significance of participants' experiences (Polit & Beck, 2006, p. 508). It also assisted the researcher with obtaining a detailed understanding of experiences about leading youth victims of violence towards wellness. According to Denzin and Lincoln (2005):

Qualitative research is a situated activity that locates the observer in the world. It consists of interpretative practices that make the world visible… Involves an interpretive, naturalistic approach to the world and this means that qualitative researchers study things in their natural setting, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. (p. 3).

Qualitative studies are interpretive (Creswell, 2009, p. 4). This study followed an interpretive paradigm that sought to understand the perspectives of individuals by getting their narratives directly from them, a process also referred to as the *emic* perspective (Hennink *et al.,* 2011, p. 14). The researcher considered a qualitative research design as appropriate owing to the purpose of the research and the nature of the research questions. It allowed the researcher to meaningfully explore and understand the experiences of the youth victims of violence and health care professionals leading those youth victims of violence towards their wellness in the community. A qualitative design is used for exploring and understanding the interpretation that individuals or groups ascribe to a social problem, such as violence (Creswell, 2009, p. 4).

3.2.2 Exploratory

An exploratory research design was used to search for answers to unclear research questions in a relatively unknown area of scientific enquiry (Streb, 2010, p. 372). Exploratory studies aim at establishing new facts through the collection of new information or ideas and determining the existence of new patterns. It is used to explore research questions that only little is known about (Babbie, 2013, p. 91; Babbie, 2010). Furthermore, in his explanation of an exploratory design in research, Streb (2010, p. 372) advances that an exploratory design 'investigates distinct phenomena characterized by a lack of detailed preliminary research'.

The researcher decided on following an exploratory design in this study because the concept of health care professionals leading youth victims of violence to wellness was unclear and there was no literature describing a framework that could be utilised by health care professionals to lead victims of violence towards wellness. The exploratory design aided the researcher with understanding this phenomenon and also with developing an original framework that described the phenomenon.

3.2.3 Descriptive

In qualitative research, a descriptive design involves the researcher observing, documenting and describing in detail the phenomenon under study to the point where the findings can be transferred to another social setting (Babbie, 2013, p. 91).

In human sciences, descriptive research is the most frequently used approach, since it permits researchers to examine situations that occur naturally. It is viewed as a form of naturalistic investigation because it describes situations and events as they occur naturally (Babbie, 2010, p. 93; Given, 2007, p. 251).

A descriptive design was used to gather data that gave a voice to the expectations of the youth victims in relation to the leadership roles of health care professionals in addressing youth violence in their community and also to the experiences of health care providers in leading the youth victims of violence towards wellness. In order to ensure that the study was truly descriptive in nature, focus group discussions and unstructured individual interviews were employed as data collection methods. The focus group discussions were conducted among the youth victims who attended a high school in the community of study. During those focus group meetings, participants were allowed to describe their individual experiences, their definition of wellness and their expectations of being led towards wellness by the health care professionals working in their community. During the unstructured individual interviews, the health care professionals were given an opportunity to freely describe their experiences of the youth who were victims of community violence.

3.2.4 Contextual

The understanding and interpretation of findings from this qualitative investigation took into consideration the context or setting where the research study was carried out. Henning, *et al.* (2007, p. 62) suggest that the interpretation of findings should take into account the context of a research study and the interaction between the research participants and the setting where they live or function. As methodological departure (Chapter 1), Knight and Cross (2012) confirm the importance of the context in the 'Contextual Constructs Theory'. It is assumed that constructs obtained from participants' experiences) are never seen to exist outside a context; in turn this means that it has an inherent influence on the development of the research constructs.

The research context focused on the phenomenon being investigated while keeping in mind the background of previous theory related to the research phenomenon (Chapter 2, the researcher and the conceptualisation of the way in which the research phenomenon would be investigated in the community of Genadendal.

This study was contextual in nature because it focused on the experiences of the youth victims of violence attending a high school in the community of study and the experiences of the health care professionals working in that same community. The researcher acknowledges that the reports of the participants' experiences were dependent on their unique context and also that the experiences of the participants were moulded by the prevailing factors in their environment.

3.2.4.1   Study setting

Location – this study was conducted in a rural community of the Theewaterskloof Municipality in the Overberg District of the Western Cape Province, South Africa. It is nestled in the Riviersonderend Mountains approximately 5 kilometres from Greyton, 40 kilometres from Caledon and approximately one hour's drive east of Cape Town.

History – The community was discovered by a German missionary from the Moravian Church named Georg Schmidt in 1738. Schmidt organised a lot of missionary activities amongst the *Khoi* people who were the aboriginal inhabitants of the place. Later on, Schmidt returned to Germany on 5 March 1744 after allegations from the Cape Dutch Reformed Church that he was baptising the natives. At the time, the Cape Dutch Reformed Church banned him from carrying out this religious service because they considered Schmidt not to be an ordained minister. In addition to their religious obligations, the Morovian missionaries carried out many significant pioneering activities in the community. Those included literacy, music, arts, printing and furniture making. Afterwards, missionary work resumed in the place in 1792 and by 1838, a seminary as well as the first Teachers' Training College in South Africa were opened. Initially, the place was called *'Baviaanskloof'* meaning *'Ravine of the Baboons'* in Afrikaans before it was renamed Genadendal after 1806; Genadendal means *'The Valley of Grace'*. Located in the town are many historic landmarks and monuments. The Teachers' Training College had been converted into a museum and its contents declared a cultural treasure of South Africa on 8 March 1991.

- **Social problems**

The majority of adults have only a Grade 12 / Standard 10 / Form 5/ Matric level as their highest level of education (Statistics South Africa, 2013). There is a high level of poverty, unemployment, as well as alcohol and drug abuse in the community. The community also has a large number of elderly people receiving grants for older persons from the government. Other types of social grants commonly received by the people living in this area include foster care, child support and disability grants (Theewaterskloof Municipality, 2013). Crime, teenage pregnancy and dropping out of high-school are also very common among the youth residing in the community.
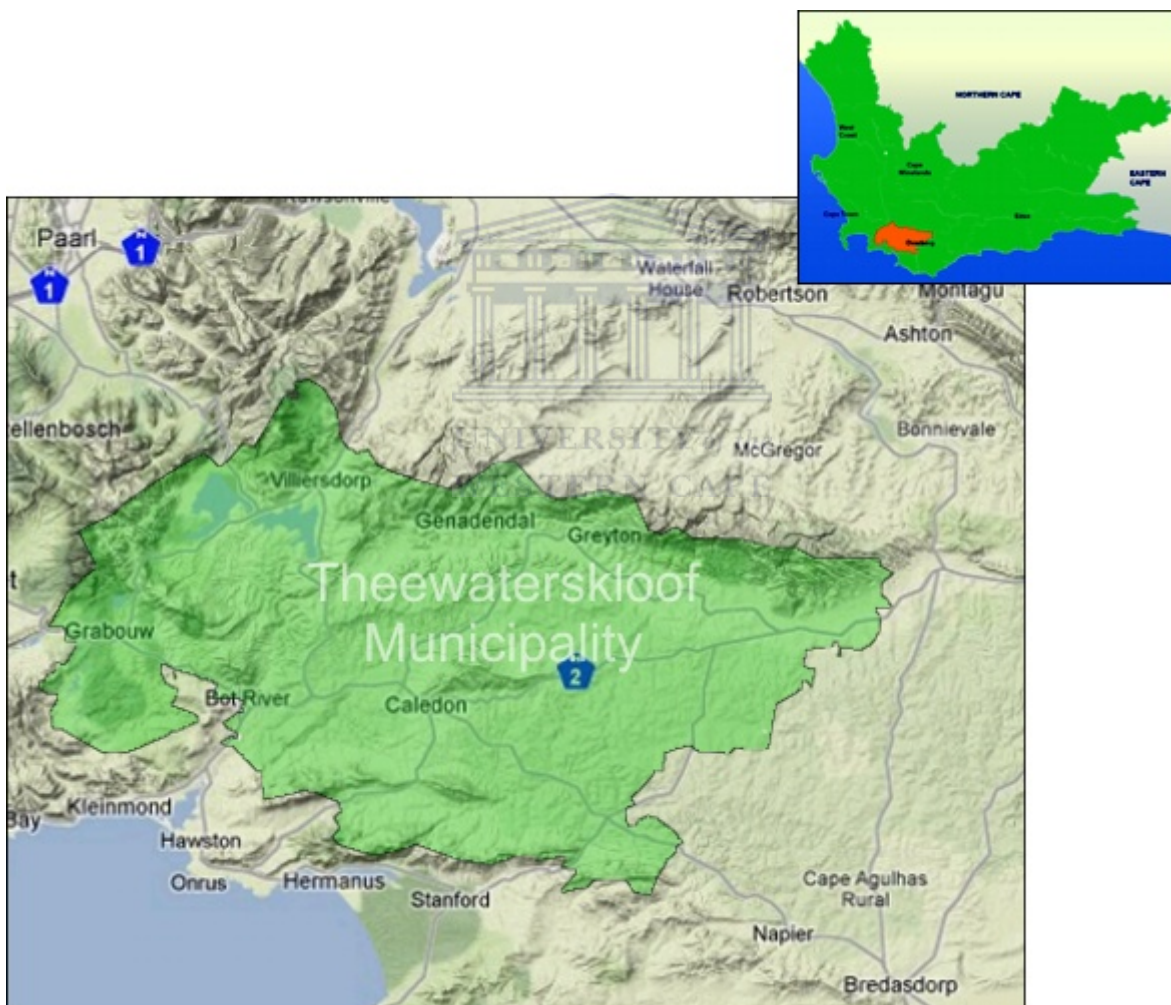
Figure 3.2: **Map of Theewaterskloof Municipality in the Overberg District of the Western Cape Province, South Africa**

(Source: http://www.westerncape.gov.za/your_gov/11)

- **Racial composition**

The dwellers are mainly of the 'Coloured' (mixed) racial group.

- **Social Services**

There is an office of the Department of Social Development located in the community. This office provides social welfare services to the community.

- **Health services**

Health service provision for community members is provided via a single primary health care clinic supervised by the District Hospital in Caledon. The clinic opens only on weekdays (Mondays to Fridays) and offers basic medical services between the hours of 8:00 to 16:00. The clinic is staffed daily by a professional nurse and two staff nurses. A medical doctor visits the clinic once a week, usually on Tuesdays.

- **Occupation of the people**

The residents of the community are mainly involved in either small-scale subsistence farming or gardening.

- **Schools**

There is only one public primary school and one high school for the learners in the community.

3.2.4.2   The high school in the community

The high school is a co-educational public school for boys and girls. The school serves learners from the community and many other neighbouring communities; such as the communities of Greyton, Berea, Voorstekraal, Caledon and the surrounding farms. The school also provides boarding facilities for learners from distant communities; such as Hawston, Kleinmond, Riviersonderend and Cape Town. The total number of learners enrolled at the school for the 2013 academic year were 565 learners (Table 3.1). The school is headed

by a principal, supported by a deputy principal and two heads of department (HODs). For the 2013 academic year, there were 21 teaching staff members (11 males and 10 females) at the school and the learning areas offered were English, Afrikaans, Mathematics, Business Studies, Accounting, Consumer Studies, Biology, Physics and Geography. The school governing body (SGB) comprised the principal, the deputy principal, the teachers, some parents, the non-teaching staff and two members from the Representative Council of Learners (RCL), which was the body of learners managing the affairs of the learners at school. Also, there were 7 non-teaching staff members (1 secretary, 1 financial clerk, 1 administrative clerk at the boarding school, 3 caretakers and 1 general worker) and 10 domestic staff members and volunteers responsible for cleaning, security and supervision of classes at school. At the time when data was collected, there were a total of three hundred and forty nine (349) grade nine, ten and eleven learners attending the community high school.

Table 3.1: **Number of learners by gender in grade nine, ten and eleven enrolled at the high school for the 2013 academic year**

Gender	Grade level			
	Nine	Ten	Eleven	Total
Male	62	48	36	146
Female	70	93	40	203
Total	132	141	76	349

3.2.5 Research population

A research population is a group of interest to a researcher from whom the sample is selected and to whom the findings and the conclusions of the research would be applied or generalised (Christensen *et al*., 2011, p. 505). The target population of this study included (i) all *youth* in grades nine, ten and eleven attending the high school in the community of study and (ii) all the *health care professionals* (professional nurses, medical doctors and social workers) working at the health care facilities in the community.

3.2.6 Sampling technique and sample

Sampling is the process of selecting cases that represents the total population to whom inferences are made (Polit & Beck, 2012, p. 275). The researcher used a purposive sampling

technique to solicit participation from the members of the community who met the inclusion criteria. Homogenous purposive sampling is a type of non-random sampling technique when a researcher specifies certain characteristics that research participants must have and then chooses only participants meeting such characteristics to participate in the research study (Johnson & Christensen, 2012, p. 231; Polit & Beck, 2012, p. 517). The researcher decided to use this sampling method because the goal was to include eligible participants who would make useful contributions to the discussions and interviews and whose participation would be of benefit to the study.

The *youth participants* selected to participate in the focus group discussions in Phase 1, were victims of community violence and in the same age group. On the other hand, the *health care professionals* interviewed in Phase 2 were qualified health care professionals in community health practice.

3.2.6.1   Sampling criteria

The inclusion criteria or eligibility criteria are the conditions that all potential participants must meet to be included in the study (Johnson & Christensen, 2012, p. 92; Polit & Beck, 2012, p. 274). The researcher considered the criteria that *a youth* participant had to meet to be part of the focus group discussions. The youth had to be:

- a victim of community violence during the six months preceding the group discussions;
- willing to participate in the research study;
- ages of 15 to 19;
- a permanent resident of the community of study (Genadendal);
- enrolled in either grade nine, ten, or eleven at the local high school; and
- in possession of a signed parent or guardian permission form and student assent form if the participant was a minor (below the age of 18 years).

The researcher chose the lower age limit of 15 years because literature indicates that young persons in this age category ought to be, or are close to being physically, spiritually, psychologically and socially developed (Hockenberry & Wilson, 2007). In other words, they should be sufficiently capable of sharing their wellness principles and experiences. The researcher chose to select learners in grade nine, ten and eleven at the local high school because the grade eight learners were mostly below 15 years old and, therefore, they were considered to be less matured or experienced. The grade twelve learners were not included in

the study because they were occupied with preparations for their matric examinations during the period of data collection.

For a *health care professional* to qualify for an interview with the researcher, he or she had to be:

- willing to participate in the research study; and
- working at a health care facility in the community of study for a minimum of two years at the time of data collection.

Exclusion criteria refers to the characteristics that disqualify a member of the population to participate (Polit & Beck, 2012, p. 274). Any potential participant who did not meet the inclusion criteria or did not give consent to participate in the study were excluded from the study.

3.2.6.2   Sample

- **Youth**

The researcher conducted nine focus group discussions among 58 (23 males and 35 females) youth learners studying at a high school in the community (Table 3.2). The total number of focus groups conducted was determined by data saturation.

The researcher grouped the learners according to their grade and age group. The researcher anticipated that learners would be more comfortable discussing issues with other learners who were in the same grade as they were or of the same age.

Table 3.2:   Focus group discussions conducted in Phase 1 according to the participants' grade levels

Grade level	Number of focus group discussions
Grade nine	3
Grade ten	3
Grade eleven	3
Total	9

- **Health care professionals**

The researcher conducted seven unstructured individual interviews that included interviews with two professional nurses, two social workers and three medical doctors working at health care facilities in the community (Table 3.3).

Table 3.3: **Unstructured individual interviews conducted among categories of health care professionals in Phase 2**

Category of health care professional	Number of unstructured individual interviews
Professional nurse	2
Social worker	2
Medical doctor	3
Total	7

The sample sizes of the two groups (youth and health care professionals) were determined by reaching data saturation. Data saturation was detected during the interviewing process at the point that no new information were provided by participants (Burns & Grove, 2011, p. 317). In Phase 1, no new information was generated by the ninth focus group discussion and in Phase 2, no new information was forthcoming by the seventh unstructured individual interview.

3.3   RESEARCH METHOD

3.3.1   Preparation for the study field

After ethical clearance for this study had been received from the Higher Degrees Committee of the Faculty of Community and Health Sciences (CHS) and the Senate Research Committee of a university in the Western Cape, South Africa; approval was also received from the Western Cape Department of Health and the management of the high school where the focus group discussions among the youth were conducted.

The researcher had gone to the Genadendal community to arrange the data collection activity a week prior to the time when data collection started. A key collaborator for this research study who also happened to be an aboriginal resident of the community assisted with the preparation of the study site. He introduced the researcher to the gatekeepers in the study site;

i.e. the managers of the community health care facilities, the community high school, the department of social development, community leaders, as well as the non-governmental Organizations in the community. An information sheet containing the objectives and purpose of the study was circulated. The information sheet notified the stakeholders about the research study and sought their support for the study.

For Phase 1, the researcher carried out the identification and acceptance process of the research participants for the focus group discussions. The researcher was assisted by one of the teachers working as a counsellor at the high school who assisted with identifying and contacting some youth who met the eligibility criteria for the study. Those young people were contacted and invited to participate in the focus group discussions. The researcher also asked them to refer other youth they knew at school who met the criteria. Subsequently, the referred youth were contacted and invited to participate in the discussions. All the potential youth participants were given an information sheet about the study. In addition, potential youth participants who were under the age of 18 years who were interested in participating in the study were given letters seeking consent from either their parent(s) or guardian(s). The researcher requested that they bring along a signed copy of the permission letter when attending a focus group discussion. In addition, they signed an assent form before they were allowed to participate in the study. The head of the school provided a venue for the focus group discussions on the school premises. The venue was regarded to be very conducive and free from distraction. It was a large private room with comfortable chairs arranged in a circle around a large table. The researcher and the principle of the school scheduled the time for all the focus group sessions. The made sure that the time scheduled for each of the focus group discussions did not interfere with the school activities of the participants.

For Phase 2, the researcher contacted the health care professionals to secure appointments for the unstructured individual interviews. The interviews were scheduled at a time and place convenient for them. Some of the interviews were conducted after hours in the health care professionals' private office while some were carried out after work hours at the home of the health care professional.

Before each focus group discussion and unstructured individual interview commenced, the researcher ensured that the voice recorder was in good working condition and that an extra voice recorder and related hardware were available. The researcher created a good rapport

with the participants and thanked them for taking the time to participate in the study. They were all informed that they could withdraw from the study at any time.

Pilot interviews are done to assess the adequacy of the questions that are to be asked during the interviewing or data collection process and to discover and correct any likely error (Hennink *et al*., 2011, p. 120). In this study, four pilot interviews (two focus group discussions and two unstructured individual interviews) were conducted to assess whether the questions that were put to the participants were clear and well understood and to ensure that the questions generated the information that was required. It was confirmed that the questions were clear and required no changes, since it elicited the desired information. Since no changes were made, the data from the pilot studies were included in the main study.

3.3.2   Data collection

Qualitative researchers use different approaches for data collection. Henning (2005, p. 60) recommends that qualitative researchers use various methods, preferably two or three methods for collecting data. The use of various methods for data collection is referred to as method triangulation. The purpose of using method triangulation is to achieve a comprehensive understanding of the phenomenon and to ameliorate the inherent weaknesses associated with a particular method of data collection with the use of another complementing method. In addition, it assists with capturing a broad picture of the issue under investigation (Polit & Beck, 2012, p. 590).

The methods used for data collection in this study were focus group discussions (Phase 1), unstructured individual interviews (Phase 2) and field notes (Phases 1 and 2).

3.3.2.1   Focus group discussions (Phase 1)

The objective of Phase 1 was to elicit the youth learners' views about their expectations in respect of health care professionals leading youth victims of violence towards wellness in the community. The researcher acted as the facilitator for focus group discussions that were conducted in a private and comfortable room.

Theoretically, a focus group discussion is an interactive discussion between 6 to 8 preselected participants that focuses on a demarcated set of issues and is led by a facilitator or a moderator. Focus group discussions are commonly used for exploring research issues that are unclear or new topics about which little is known (Hennink *et al*., 2011, p. 136-137). The aim

of a focus group discussion enables a facilitator to get a broad range of views about a topic from the participants in a comfortable, permissive and non-threatening way. Furthermore, it allows participants to freely express themselves and to clarify their own views. Focus group discussions should last no longer than 60 to 90 minutes (Hennink *et al*., 2011, p. 136). It is recommended that a focus group should be homogenous; the participants should share similar characteristics with the purpose of encouraging positive group dynamics and being comfortable in one another's presence and feeling at ease with sharing their views in the company of their peers (Polit & Beck, 2012, p. 537).

In this study, the focus group discussions were voice recorded in order to comprehensively capture the exact words of the participants. Each of the sessions lasted about 60 minutes. All the focus group sessions started with the researcher introducing herself to the participants and providing an explanation of the study objectives. The participants were encouraged to ask questions to which the researcher would provide answers. They were also reminded of their right to withdraw from the study at any stage of the study. The youth were asked, '*What are your expectations with regard to health care professionals acting as leaders in addressing the problem of violence occurring among youth?'* Probing questions based on their responses were asked to explore their perceptions and to yield a wealth of responses (Section 3.3.3.4).

The researcher built rapport with the participants and made use of facilitative skills and techniques to elicit responses from them and made an effort to ensure that the discussions remained focused on the central objectives of the study. Field notes were taken during the sessions. The researcher informed the participants that a voice recorder would be used to capture their expressed perceptions and that field notes would be taken during the discussion.

3.3.2.2   Unstructured individual interviews (Phase 2)

The objective of Phase 2 of this study enabled the researcher to obtain information about the experiences of the health care professionals in guiding victims of youth violence towards wellness in their community. For that purpose, the researcher used unstructured individual interviews.

Unstructured individual interviews are discussions between a researcher who is the interviewer and an interviewee who is the research participant. Typically, unstructured interviews are described as being conversational in nature because the researcher usually does not use pre-set or predetermined questions during questioning. It often begins with the

interviewer asking an introductory question followed by subsequent questions that are based on the responses of the participant. These interviews are recommended when a researcher does not have a clear picture of the phenomenon under study (Polit & Beck, 2012, p. 536). They encourage participants to tell their stories the interviewer hardly interrupts them. The researcher chose to use unstructured interviews as a method of data collection from the health care professionals because they were highly knowledgeable, skilled and experienced in the provision of community health services.

The interview sessions were conducted in a private and conducive environment after working hours. Five of the interviews were conducted in the health care professionals' private office while two were carried out in a private space at the homes of the health care professional. Every unstructured interview session was voice recorded and the researcher also wrote down field notes. The researcher asked a central question posed to each of the health care professionals: *'Can you tell me about experiences in guiding and leading youth victims of violence towards their wellness?'* This core question was followed by further questioning (probing questions) based on their responses. They were allowed to express themselves freely. The interview sessions lasted for an average of one hour and thirty minutes and the researcher observed clear ethical standards in the same way it had been observed during the first phase of the study. The unstructured interviews proved to be beneficial because the participants gave a rich and in-depth description of their experiences.

3.3.2.3   Field notes

Field notes are an in-depth written account of the details, happenings and experiences of a researcher during the research process used to assist a qualitative researcher to recall and explore an interview more thoroughly (Given, 2008, p. 341). It can include information; such as the number of participants, their demographic characteristics, the setting, behaviour of the participants and the thoughts and feelings of the researcher (Myers, 2013, p. 144; Sharan, 2009, p. 130). They can also contain the summary or highlights of the conversations between the researcher and a participant during the interview process (Polit & Beck, 2012, p. 549). Maree (2010, p. 92) recommends that qualitative researchers should write down field notes during an interview in order to capture the key highlights of the interview and to note the non-verbal cues exhibited by the participants. According to him, this contributes to the accuracy of research findings. Nonetheless, Jacob and Furgerson (2012, p. 7) warn that a researcher should be careful when writing down field notes during the interview session in order to

avoid distraction from and interference with the natural flow of a discussion. Bogdan and Biklen (2007, p. 124) suggest that a researcher should write the field notes as soon as possible after an interview. While also supporting this view, Myers (2013, p. 144) advise that field notes should be recorded at the end of the day to enable the researcher not to forget the important matters that were discussed during the interviews on that day. According to Sharan (2009, p. 130), field notes should be written down in ways that are meaningful to the research study.

In this study, the researcher observed the participants during the interviews and noted both their verbal and nonverbal gestures; such as their tone of voice, facial expressions, body posture and level of eye contact. Furthermore, the researcher noted the location, date and time when the observations were made. The researcher initially wrote down sketchy field notes during the focus group discussions and the unstructured individual interviews to avoid distractions during the sessions. At the end of each session, these notes were comprehensively recorded. She also wrote down her personal experiences, thoughts, feelings and reflections about the study on a daily basis while she was in the research field.

3.3.3   The skills of the researcher

During the process of data collection, the researcher used different communication techniques and skills for effective communication between her and the participants. The techniques and skills are discussed in more detail.

3.3.3.1   Minimal verbal response

Kadushin and Kadushin (2013, p. 158) posit that an interviewer should make minimal verbal responses during an interview to avoid distracting and interrupting the interviewee. They further suggest that the interviewer can use minimal non-verbal encouragers, such as head nodding and verbal responses, such as 'hmm', 'uh-huh'; preferably at the end of a sentence to avoid interruption.

The researcher took special care to ensure that the participants did most of the talking during the interviews and discussions. The researcher gave the participants sufficient time to respond to the questions that they were asked and avoided interrupting them while they were speaking. She used minimal encouragers; such as 'hmm', 'uh-huh', 'okay' and 'interesting' during the interviews.

3.3.3.2 Active listening

Active listening is described as showing interest and giving complete attention to and focusing on what a person says. It is the key to a productive and effective interaction because it enables the interviewer to understand and clarify what is being said and to provide appropriate feedback (Miller & Meinzinger, 2014, p. 330).

In this study, the researcher ensured that she listened actively to the participants while they were making their contributions. This was done by maintaining eye-contact, occasionally nodding her head, and having an open and friendly disposition during every interview.

3.3.3.3 Clarifying

To clarify means to make something clearer or easier to understand (Oxford Advanced Learner's Dictionary, 2014). The researcher sought clarification from the participants in instances when discussions were contradictory, unclear, or vague. The aim was to ensure that the researcher accurately understood the ideas, thoughts and feelings of the participants.

3.3.3.4 Probing

Probing statements are queries that a researcher articulates to a participant during a discussion in order to gain more information about a particular issue or question (Burns & Grove, 2011, p. 545). Probing is a very important technique used in the collection of qualitative data because it supports the discussion process and also assists the researcher with clarifying issues and getting more details about the matter from the participants (Hennink *et al*., 2011, p. 161).

In this study, the researcher used probing statements, such as *'huh-huh' and 'is it?'* to stimulate and encourage the participants to continue talking. Furthermore, explanatory probing statements were also used; such as 'what do you mean by…?', 'Tell me more', 'Can you explain…?'

3.3.3.5 Silence

During interactions or communication between individuals, keeping quiet for short periods of time could prove to be an effective technique that promotes effective communication. A period of brief silence after questioning gives a person responding to a question time to think through the answer or response that he or she is going to provide. Hennink *et al*., (2011, p.

163) suggests that a researcher should remain silent for a period of five seconds after a participant has made a contribution. This time could give a participant more time to expand on the point he or she has made or for another participant to make a further contribution to what has just been said.

The researcher in this study used the technique of silence during interactions to encourage the participants to freely contribute to the discussion of the phenomenon.

3.3.3.6   Paraphrasing

Paraphrasing is a verbal response when a researcher states what the participant has said in another form or using different words without compromising the meaning of what has been said with the aim of increasing understanding and clarity (De Vos, Strydom, Fouché & Delport, 2011, p. 345).

In this study, the researcher used the paraphrasing technique by stating what the participants had said in her own words when it was necessary to seek clarification from the participants.

3.3.3.7   Summarising

Summarising is defined as a selective condensation of what has transpired during an interview over a period of time. It involves emphasising only the main points or ideas and leaving out the less important things. Summarising is important during an interview because it enables the interviewer to review the issues that have been discussed and to provide direction to the interview (Kadushin & Kadushin, 2013, p. 168). It gives the interviewees a sense of progress and creates an opportunity for them to focus on what they have already mentioned with the purpose of adding new ideas that they might think about (Ivey, Ivey & Zalaquett, 2010, p. 152).

In this study, the researcher summarised the key concepts and dimensions mentioned by the participants at the end of each interview to emphasise the important issues raised during the interview as accurately as possible. This was done to allow the participants to reflect on the key issues that they had communicated and to confirm and check whether the researcher correctly grasped the information provided by the participants.

3.3.4   Data analysis of Phases 1 and 2

Qualitative data analysis is described as a rigorous and iterative process when a researcher engages with the data collected in order to create meaning out of the data (Burns & Grove, 2011, p. 93). Recognising and filtering key concepts from the collected data are iterative processes in qualitative data analysis that are done inductively. The identified categories and themes must only emerge from the collected data and should not be based on assumptions prior to data collection (Denzin & Lincoln, 2011, p. 364). The focus is to gain a full understanding of the phenomenon and conceptualizing valid meanings from the phenomenon instead of providing general explanations or predictions. Though there are different approaches to qualitative data analysis (Green & Thorogood, 2009, p. 197), most approaches usually begin with the researcher getting immersed in, scrutinising, reducing and interpreting the data (Burns & Grove, 2011, p. 93). The following strategies were followed in this study.

3.3.4.1   Transcribing

The researcher transcribed the voice recordings verbatim (Hennink, et.al., 2011, p. 211) after she had listened to the voice recordings immediately after the interviews and several times thereafter. She also read through the field notes several times.

When the transcripts of the interviews were available, the researcher analysed the data from each phase of the study separately by using Tesch's (1990) coding technique (cited in Creswell, 2009, p. 186). The focus group and individual interviews were analysed together in phase 1, after which the interviews of phase 2 were analyse seperately. This technique comprise eight steps:

1.   Reading and re-reading the interview transcripts and field notes several times while making sense of it and writing down the ideas that come to the mind.

2.   Randomly choosing one transcript at a time, reading through it while asking questions such as, "What is this about?", "What is the underlying meaning?"   The researcher recorded her thoughts in the margin of the transcript.

3.   Listing all the main issues and clustering similar topics together.

4.   Shortening the topics into codes and placing the codes in the fitting areas of the transcript.

5.   Developing categories using the most descriptive wording for the topics and organising those that are related to one another.

6.   Finalising decisions on the categories and putting the codes in alphabetical order.

7.   Rearranging the categories to ensure a logical understanding.

8.   Recoding whenever necessary.

To ensure the credibility of the researcher data interpretations, an independent coder who was an experienced qualitative researcher and a university lecturer with a doctoral degree in nursing also analysed and interpreted the collected data. Afterwards, an inter-coder consensus meeting was held between the researcher and the independent coder to reach an agreement about the themes, categories and subcategories of the findings.

3.3.4.2   Use of 'thick descriptions'

An integral part of qualitative data analysis involves the provision of a rich or thick description of a phenomenon by exploring its deep meaning and peculiarities (Hennink, *et al.*, 2011, p. 239). The researcher sought to present a thick description of the participants by immersing herself in the natural setting of the participants with the view of understanding their perspectives, interpretations and experiences. The thick descriptions originated from the information provided by the participants and the context in which the study was conducted.

In this study, the researcher conducted a literature control after the data had been analysed. This was done by comparing the findings with knowledge from existing literature about the phenomenon (Henning, 2005, p. 27; Mouton; 2006, p. 103). Conducting a literature control allowed the findings to be re-contextualised in terms of and situated in the existing body of knowledge.

3.3.5   Phase 3: Development of the conceptual framework for health care professionals to lead youth victims of violence towards wellness

Phase 3 of this study focused on the construction of the conceptual framework for health care professionals to lead youth victims of violence towards wellness. The conceptual framework was developed using the adapted steps of Jabareen (2009, p. 54-62). (Section 1.6.3.2 and Table 1.1).

3.3.5.1 Identifying and naming themes and categories

This involved a thorough and separate examination of the data from Phases 1 and 2 to discover themes and categories that described the data the most accurately.

3.3.5.2 Deconstructing and categorising the concepts

This encompassed a critical re-look at the named themes, categories and sub-categories and their concluding statements to identify its characteristics and role with regard to the survey list of the Practice Orientated Theory of Dickoff *et al*. (1968).

3.3.5.3 Integrating concepts

The concepts from the findings of the youth and health care professionals were triangulated and integrated in one framework. The Practice Oriented Theory of Dickoff *et al*. (1968) was utilised in the Organization of the concepts.

3.3.5.4 Synthesis, re-synthesis and clarification of concepts

This step involved the description of the framework with the purpose of providing a comprehensive understanding of the phenomenon.

It is important to mention that conceptual frameworks are different from theoretical frameworks even though these terms are frequently interchanged in qualitative studies (Imenda, 2014, p.189). For instance, a conceptual framework consists of interwoven concepts that provide a complete understanding of a phenomenon. It also contains the assumptions, e.g. Dickoff *et al*. (1968) upon which a research study is based and encourages the development of a theory (Jabareen, 2009, p. 51). On the other hand, a theoretical framework may comprise a body of empirical literature or existing theories in literature (Green, 2008, p. 7; Sinclair, 2007, p. 39).

The survey list of the Practice Orientated Theory proposed by Dickoff *et al*. (1968) provided the reasoning map in this study for describing the conceptual framework (Section 1.6.2.2) by asking the following six questions:

1. Who or what performs the activity (agent)?
2. Who or what is the recipient of the activity (recipient)?
3. In what context is the activity performed (framework)?

4. What is the endpoint of the activity (terminus)?

5. What is the guiding procedure, technique or protocol (procedure)?

6. What is the energy source for the activity (dynamics)?

Dickoff *et al*. (1968, p. 423)

Table 3.4:   The thinking map adopted in the study

Concept	Meaning of concept in this study
Agents	Professional nurses, social workers and medical doctors They were responsible for performing the activity of leading youth victims of violence to wellness
Recipients	Youth victims of violence (youth who had been involved in one or more random acts of violent behaviour; such as physical combats, sexual abuse and rape caused by a person(s) who might be known or unknown to the youth)
Context	The context where the activity happened is the Genadendal community in the Western Cape Province of South Africa
Dynamics	The motivating factors required for successfully leading youth victims of violence towards wellness
Procedure	Guiding procedures / strategies for leading youth victims of violence towards wellness in the milieu of rural community health practice
Terminus	The terminus was the conceptual framework for leading the youth victims of violence towards wellness in the Genadendal community of the Western Cape Province, South Africa

3.3.6   Phase 4: Validation of the conceptual framework

Validation happens when the researcher share the findings of the study with the research participants to seek confirmation that the researcher's findings and impressions correspond with the views of the participants. It is also done to assess the reactions and comments of the research participants (Bryman, 2012, p. 391).

In *Phase 4* (final phase of the study), the developed conceptual framework was validated by the respondents and the comments they gave indicated that they agreed with the developed framework. The criteria used were based on the ones recommended by Pearson, Vaughan and

FitzGerald (2005, p. 226) for analysing and evaluating nursing models. These criteria checked for the clarity, adequacy, usefulness and significance of the conceptual framework. The report of the validation process is presented in Section 6.3.

3.4   REASONING STRATEGIES

Reasoning is described as the processing and organising of ideas in order to reach conclusions (Burns & Grove, 2011, p. 546). The reasoning strategies employed in this research study were inductive reasoning, deductive reasoning and synthesis.

3.4.1   Inductive reasoning

Babbie (2010, p. 22) states that inductive reasoning or induction involves the process of reasoning that departs from the specific to arrive at the general. This means that reasoning moves from a concrete or specific set of observations to the detection of a general theoretical pattern or form. In other words, the researcher 'observe a sample and then draw conclusions about the population from which the sample comes' (De Vos *et al.*, 2011, p. 49). Babbie (2010, p. 22) notes that inductive reasoning usually does not give conclusive reasons for the inference that has been drawn.

The researcher applied inductive reasoning during Phases 1 and 2 of this study. Following the collection of data about the experiences of the participants in relation to the phenomenon under study through the focus group discussions, unstructured individual interviews, observations and field notes; conclusions were drawn. This information was later conceptualised by conducting a literature control. Furthermore, inductive reasoning was used during the discussion of the findings of the study.

3.4.2   Deductive reasoning

Babbie describes the process of deductive reasoning or deduction as moving from the general to the specific: 'It moves from a pattern that may be logically or theoretically expected to observations that test whether the expected patter actually occurs' (Babbie, 2010, p. 23). Furthermore, Polit and Beck (2012, p. 11) define deductive reasoning as the process of developing specific predictions from general principles. Deductive reasoning was used in Phase 3 of this study.

3.4.3   Analysis

Analysis is defined as the thorough study or scrutiny of something in order to understand more about it (Oxford Advanced Learner's Dictionary, 2014). Analysis allows a researcher to separate a whole into its components and to examine and re-examine carefully the relationship that exists between the various parts and the whole. Furthermore, analysis allows one 'to clarify, refine, or sharpen concepts, statements or theories' (Walker & Avant, 2011, p. 64).

The researcher, as well as the researcher's supervisor and co-supervisor analysed the data generated from the study in order to obtain an in-depth understanding of the phenomenon under investigation. An independent coder also assisted with the analysis of the data collected during the focus group discussions and individual interviews and in the field notes.

3.4.4   Synthesis

Synthesis is the process of clustering or grouping and interrelating ideas from diverse sources to form a completely new picture of what is known or not in an area (Burns & Grove, 2011, p. 550). Synthesis is used for producing novel ideas when a phenomenon is unknown or unclear (Walker & Avant, 2011, p. 107-110).

In this study, the researcher synthesised the data collected during Phases 1 and 2 for the purpose of developing the original conceptual framework for health care professionals to lead youth victims of violence towards wellness.

3.4.5   Bracketing

Bracketing is a technique used in qualitative research where a researcher sets aside what is already known about the phenomenon under investigation (Burns & Grove, 2011, p. 533; Brink, Van der Walt & Van Rensburg, 2012, p. 122). Bracketing assists a researcher to avoid misinterpreting the phenomenon as it is being experienced by the participants (Burns & Grove, 2011, p. 96). The researcher employed the bracketing technique in this study by identifying and writing down what she already knew about the topic, as well as her personal principles, assumptions and preconceptions about the study before starting the process of data collection. The intention of bracketing was to limit personal bias and misrepresentation of the experiences of the participants.

3.4.6   Reflexivity

This is a process during which a qualitative researcher consciously acknowledges his or her personal thoughts and feelings that might influence the study. These thoughts and feelings are taken into account in the understanding of the study (Burns & Grove, 2011, p. 546; Green & Thorogood, 2009, p. 222). In the interpretive approach to research, it is acknowledged that research participants reflect their subjective views of the world and likewise does the researcher. Hence the researcher's background, emotions and position are key influences in the process of data collection and interpretation that the researcher needs to be aware of (Hennink *et al.*, 2011, p. 19; Polit & Beck, 2012, p. 534).

In this study, the researcher continually practised reflexivity in the research process by taking into account background and personal values that might have influenced the research procedure, particularly the processes of data collection, interpretation and presentation.

3.5   MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness is a term used in qualitative research to describe and evaluate the efforts made by a researcher to ensure that the research findings are described accurately. It is comparable to the standards of reliability and validity in quantitative research (Lincoln & Guba, 1985). The four initial criteria suggested by Lincoln and Guba (1985, p. 290-331) for ensuring the trustworthiness of the findings of qualitative research are *credibility, transferability, dependability* and *confirmability*. A fifth criterion, namely *authenticity* was later added by Guba and Lincoln (1994). These five criteria of trustworthiness were followed in this study.

3.5.1   Credibility

Credibility as viewed by Lincoln and Guba refers to the ways in which a researcher establishes confidence in the truth of the data collected and the interpretations of the data. Two key features are involved in credibility. Firstly, the study is carried out in a manner that safeguards the believability of the findings and secondly, taking steps to demonstrate credibility in the research report (Polit & Beck, 2012, p. 585).

Credibility was achieved in this study through the use of data triangulation (the researcher used different methods of data collection: Focus group discussions, unstructured individual interviews and field notes). The researcher regularly debriefed (peer debriefing) with her

research supervisor in order to discharge her personal feelings and anxieties related to the study and to acquire further insight. Peer debriefing assists with providing a control mechanism for the research process and keeping the researcher honest to his or her feelings and to the meanings or interpretations given to the research findings (Creswell, 2013, p. 251). Furthermore, the researcher also carried out reflexivity and member-checks with participants to verify the interpretation of the information collected.

Another aspect suggested by Patton (in Polit & Beck, 2012, p. 583) that should be considered when assessing the credibility of research findings is the credibility of the researcher, i.e. the authority of the researcher or the faith that can be placed in the researcher who conducts a study. The researcher of this study is a professional nurse-midwife with a Master's of Public Health degree and has more than seven years of experience in community and family health. The researcher was supervised by two senior academics who hold Ph.D. degrees and with vast knowledge and experience in community health and leadership studies. An independent coder who also holds Ph.D. degree with years of experienced in qualitative research assisted with the coding of the collected data.

- **Triangulation**

Triangulation is defined as the use of more than one method or source of data in a study of a particular phenomenon (Bryman, 2012, p. 717). Qualitative researchers employ triangulation in their studies in order to reach sound interpretations of the real world and also to increase the validity of their findings (Guion, Diehl, & McDonald, 2013; Mills, Durepos, & Wiebe, 2010).

Denzin (1989) (cited in Flick, 2014, p. 183-184) describes four types of triangulation: (i) data triangulation, (ii) investigator triangulation, (iii) theory triangulation and (iv) methodological triangulation. *Data triangulation* involves the use of different *sources* of information for data collection in terms of person, time, or space. *Investigator triangulation* comprises the use of several researchers in the same research process. Different researchers independently collect and analyse data about the same phenomenon. In a case where these researchers reach the same conclusion, the validity of the findings are increased. *Theory triangulation* includes the use of various paradigmatic and theoretical perspectives for the interpretation of data while *methodological triangulation* requires the use of multiple research methods in studying a phenomenon. The researcher in this study collected data using different triangulation

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approaches in order to reach a deep understanding and analysis of the research phenomenon. Information was gathered by using different sources (data triangulation). In the first phase of the study, information was collected from the youth victims of violence during focus group discussions whereas in the second phase information was collected from three categories of health care professionals (professional nurses, social workers and medical doctors) during unstructured individual interviews. Furthermore, information was augmented by the writing of field notes. The use of triangulation provided the researcher with a wealth of data.

3.5.2 Transferability

Another criterion that Lincoln and Guba emphasise in ensuring trustworthiness is transferability. Transferability refers to the extent in which the findings from one study can be applied or transferred to another research setting or participants with similar characteristics (Lincoln & Guba, 1985). As stated by Lincoln and Guba "thus the naturalist cannot specify the external validity of an inquiry; he or she can provide only the thick description necessary to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility" (p. 316).

In this study, the researcher ensured transferability by presenting a *rich* and *thick description* of the research participants, the context or setting of the research and the findings of the study. According to Stake (2010), "A description is rich if [sic] it provides abundant, interconnected details…" (p. 49). Creswell (2013, p. 252) explains that a researcher provides a thick description when he or she discloses details when describing a circumstance.

3.5.3 Dependability

The third criterion that Lincoln and Guba emphasise is dependability. Dependability is based on the stability (reliability) of data over a period of time and conditions, i.e. assessing whether the findings of the study can be replicated using the same or similar participants in the same or similar setting. Dependability is necessary for credibility of a research project (Polit & Beck, 2012, p. 585). In order to enhance the reliability of qualitative research, Creswell (2013, p. 253) suggests voice recording and verbatim transcribing of the interviews, writing detailed field notes and carefully cross-checking the transcripts of the interviews to make sure that there are no errors (Creswell, 2009, p. 191).

To achieve dependability in this study, the researcher provided a thorough description of the research methodology of the study, the interviews were transcribed verbatim and transcripts were cross-checked for errors. Also, the data collected were separately analysed by two independent coders. Afterwards, during an inter-coder meeting between the researcher and the independent coder an agreement was reached about the codes and themes of the study.

Table 3.5:   Summary of the strategies used in ensuring trustworthiness

Strategy	Criteria	Applicability
Credibility	Triangulation	**Theory triangulation** Use several paradigmatic perspectives and theories for conceptualisation (Denzin, 1989 cited in Flick, 2014, p. 183-184). The meta-theoretical assumptions of the study were adopted from the Theory of Health Promotion in Nursing (University of Johannesburg, 2009), the theoretical assumptions were adapted from the Health Promotion Model (Pender *et al.*, 2011) and the Practice Orientated Theory (Dickoff *et al.*, 1968) while the methodological assumptions were based on constructivism (Ultanir, 2012), a qualitative research design (Babbie, 2010; Creswell, 2009), Contextual Constructs Model underpinned in the Contextual Constructs Theory (Knight & Cross, 2012). The conceptual framework was developed using the adapted steps of Jabareen (2009). A literature control was carried out at the end of Phases 1 and 2 (Henning, 2005, p. 27; Mouton, 2006, p. 103). **Data triangulation** The use of data from different informants - youth, social workers, medical doctors and professional nurses (Denzin, 1989 cited in Flick, 2014, p. 183-184). **Methodological triangulation** The use of various methods for data collection: focus group discussions, unstructured individual interviews and field notes (Denzin, 1989 cited in Flick, 2014, p. 183-184)
	Reflexivity	The researcher constantly reflected on her perceptions about the study in order to remove personal biases and prejudices (Burns & Grove, 2011, p. 546; Green & Thorogood, 2009, p. 222).
	Member-checking	Member-checking was done to authenticate the information collected from the participants (Creswell, 2009, p. 191).

Strategy	Criteria	Applicability
	Peer debriefing	The researcher debriefed with her research supervisor after the first interviews were conducted (Creswell, 2013, p. 251).
	Authority of the researcher	The researcher is a professional nurse and midwife with a Master's of Public Health degree and more than seven years experience in community and family health. The researcher's supervisor and co-supervisor both hold doctorate degrees and have vast knowledge and experience in community health. The independent coder also holds a doctorate degree and is experienced in qualitative research data analysis (Polit & Beck, 2012).
Transferability	In-depth description	Presentation of a *rich* and *thick description* of the research participants, as well as a comprehensive description of the context or setting of the research and the findings of the study to possibly apply or transfer the findings from the study to another research setting or participants with similar characteristics (Creswell, 2013, p. 252; Lincoln & Guba, 1985)
Dependability	Thick description of research methodology	A thorough explanation of the research methodology used in conducting the study (Creswell, 2013, p. 252).
	Code-recode	The researcher and an independent coder analysed collected data which was followed by a consensus meeting or discussion to ensure inter-coder agreement (Creswell, 2009, p. 190).
	Audit trail	The researcher retained the voice-recordings, the field notes and the transcripts of the focus group discussions and the individual interviews (Lincoln & Guba, 1985)
Confirmability	Reflexivity	The researcher practised bracketing and reflexivity to eliminate all personal bias or prejudices that could influence the findings of the study (Burns & Grove, 2011, p. 546; Green & Thorogood, 2009, p. 222).
	Neutrality	The exact words of the participants were used as quotations in the discussion of the research findings (Lincoln & Guba, 1985).

Strategy	Criteria	Applicability
Authenticity	Fairness	The researcher precisely conveyed the tone of the feelings experienced by the research paricipants (Polit & Beck, 2012)

3.5.4   Confirmability

The fourth criterion that needs to be met to ascertain trustworthiness according to Lincoln and Guba is confirmability. Confirmability is a criterion that looks at how a researcher seeks to achieve objectivity in a qualitative research project, i.e. to establish whether the research findings indeed represent the information provided by the research participants (Brink *et al*., 2012, p. 127; Polit & Beck, 2012, p. 585).

As a way of ensuring confirmability in this study, the researcher practised bracketing and reflexivity to eliminate all personal bias or prejudices that could have influenced the findings of the study. Additionally, the exact words of the participants were used as quotations in the research report.

3.5.5   Authenticity

Guba and Lincoln (Guba & Lincoln, 1994) later on introduce authenticity as an additional and fifth criterion that establishes the trustworthiness of a research report. Authenticity is demonstrated when a researcher applies fairness during the research and faithfully suggests a range of different realities (Polit & Beck, 2012). In the context of this study, the researcher ensured authenticity by accurately conveying the tone of the feelings experienced by the paricipants.

3.6   ETHICAL CONSIDERATIONS

The word ethical is defined as "conforming to the standards of conduct of a given profession or group" (Babbie, 2010, p. 64). To prevent unprincipled research from being conducted, the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research was established in the United States under the 1974 National Research Act (Public Law 93-348). Similarly, the South African law that regulates ethical research is the National Health Act No. 61 (2003). A key responsibility of the commission was to define basic ethical principles that should underlie the conduct of research involving human subjects and to advance guidelines to assure that such research is conducted in accordance with stipulated principles. In 1978, the Commission published "Ethical Principles and Guidelines for the Protection of Human Subjects of Research", commonly referred to as the *Belmont Report*

(National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978)

A research proposal which included the problem statement, purpose, design and methodology of the research was firstly presented to a panel of academics and postgraduate students at the School of Nursing, University of the Western Cape for critical review. After the proposal presentation, corrections were made before it was submitted to the respective ethics review committees at a university. Ethical approval for conducting the study was received from both the ethical committees of the Faculty of Community and Health Sciences (CHS) and the Senate Research Committee of a university in the Western Cape, South Africa. The registered ethical clearance number 13/9/39 was allocated to this research project. Those research ethics committees conducted a formal assessment of the research protocol adopted in this study and ensured that the research process was going to be executed ethically in a manner that protected the rights of the research participants.

The ethical principles of the *Belmont Report* (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978) and the International Council of Nurses Code of Ethics for Nurses (International Council of Nurses, 2012) directed the ethical approach of this research study. These are based on the three fundamental ethical principles guiding research namely: *respect for persons, beneficence and justice*.

The principle of *respect for persons* implies that individuals are autonomous and that they have the right to decide whether they want to participate in a study or not, to withdraw from a study at any stage, to refuse to provide information and to ask questions relating to the study. *Beneficence* refers to the rights of participants to be protected from every form of physical, psychological, emotional, spiritual, economic, social and legal discomfort or harm. The principle of *justice* encompasses the participants' rights to fair selection and treatment. These three principles are anchored in the human rights perspective that acknowledges the protection of all human research participants' rights (Brink, Van der Walt & Van Rensburg, 2012, p. 35). These rights are discussed in more detail below.

3.6.1   Respect for informed consent

Informed consent is based on the principle that individuals should not be coerced, persuaded, or induced into participating in a research study against their will but they should rather

participate voluntarily with a complete understanding of the implications of participation in the research study (Green & Thorogood, 2009, p. 68).

Informed consent requires that the researcher discloses information to all prospective participants. When a prospective subject willingly decides to take part in a research study on his or her own volition without coercion or any undue influence after receiving complete information about the research study, it is regarded as voluntary informed consent. The participants in this study were also told that they were welcome to contact either the researcher or the research supervisor at any time when they had further questions about the study.

In this study, the researcher verbally provided all the potential participants with an adequate explanation about the aims and objectives, risks and benefits of the study, as well as the assurance of anonymity and confidentiality and an option to withdraw at any stage, and also answered all their questions. Additionally, information sheets with the same information were distributed to all the potential participants. All participants above the age of 18 years were required to sign a consent form while those below the age of 18 years, a signed assent form was also required to get permission from a parent or guardian before they could take part in the study.
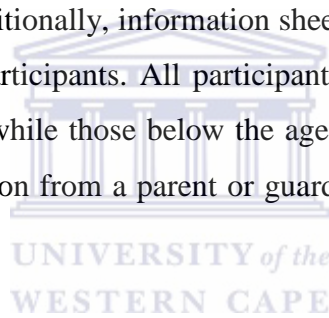
3.6.2 Right to privacy

Privacy is the freedom people have to determine the time, extent and general circumstances of sharing or withholding their private information from other people (Burns & Grove, 2011, p. 114). Oftentimes, social research requires that participants reveal private information about themselves. It is important that their privacy is respected and that they are not forced to participate in a research study (Babbie, 2010, p. 64).

The participants' privacy is considered to be protected when they are informed about the study and when they voluntarily give their consent to participate in the study and share private information with the researcher (Burns & Grove, 2011, p. 114).

In this study, the participants voluntarily consented to participate in the study. They were not coerced into disclosing information to the researcher.

3.6.3   Right to anonymity and confidentiality

In qualitative research, anonymity requires the removal of all information that identifies or traces the research participants. A researcher has to exclude any information that possibly could identify any participant from the interview transcripts and research report (Hennink *et al*., 2011, p. 71). Confidentiality is assured when a researcher who can identify the participants' responses chooses not to disclose such information (Babbie, 2010, p. 67).

In this study, the researcher protected the identity of the participants by allocating numbers to them to ensure their anonymity. Their names were not mentioned during the focus group discussions and unstructured individual interviews that were voice recorded, neither was it written on the transcripts and field notes. To maintain confidentiality, the researcher made sure that the data collected from the participants was strictly kept as confidential and not disclosed to other people. No other person except the researcher and her supervisor had access to the confidential information about the participants. Only they had access to the transcripts and voice recordings of the interviews that were securely protected by using password-protected files. The independent coder was given a copy of the transcripts without any details or information about the participants and signed a confidentiality agreement not to reveal any information about the research project.

The researcher had committed to destroying these records five years after the publication of the research report. The participants were also informed that the study would be analysed and reported anonymously and that all information provided by them would be kept confidential and that their quotations in the research report would not identify them.

3.6.4   Right to fair treatment

This right is based on the ethical principle of justice. According to this principle, research participants must be treated fairly (Burns & Grove, 2011, p. 114). In this study, the research participants were selected fairly and they were all treated with utmost dignity and respect. The findings from the study would also be shared with the participants prior to its publication in an accredited peer reviewed journal.

3.6.5   Right to protection from discomfort or harm

The right to protection from discomfort or harm in a research study is based on the ethical principle of *beneficence* which states that no participant should be harmed. It is recommended

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that all human research should never injure or cause damage in any form to the study participants, regardless of the fact that they volunteered to participate in the study (Burns & Grove, 2011, p. 114; Babbie, 2010, p. 65).

To ensure this, the participants in this study were not subjected to injury, stress, or discomfort. Arrangements were made with a counsellor for prompt management of any participant who experienced psychological discomfort due to the study.

3.7 SUMMARY

This chapter presents the research methodology of the study; it is also referred to as the procedural framework. The researcher *clearly* states the purpose and objectives of the study to reflect what the study aimed at achieving. The researcher could be viewed as a 'self-driven' cognitive entity in her own right and her influence on the research perspective of the project could be described as the researcher's developing "theoretical lens" (Knight & Cross, 2012). The involvement of a researcher's own influencing point of view is "inevitable" because a researcher's own individual mind-set, bias, skills and knowledge become an intrinsic part of the research process (Knight & Cross, 2012). Hennink *et al.* (2011, p. 11) propose that a researcher ought to exercise reflexivity to limit the researcher's personal influence, to contain any potential influences or biases in the research project.

The researcher had *sensibly* selected the methodological approach before it was presented and described systematically. Instead of using a quantitative design for this study, the researcher selected a qualitative, exploratory, descriptive and contextual design. The selected research design was congruent to the objectives and the research questions of the study. Also, it was appropriate for the worldview of the researcher (constructivist paradigm).

The researcher proceeded to the research field without any particular theoretical framework related to the phenomenon. The preparation of the research study field, pilot interviews, the methods used for data collection (focus group discussions, unstructured individual interviews and field notes), phases of the study and the data collection procedure were discussed *plainly* to give a rich representation according to appropriate theoretical and methodological sources. The researcher describes and reflects on the study setting, research population, sampling technique and sample used with a keen *commitment* to conveying all the characteristics of the research context and the study participants as clearly as possible and without any ambiguity.

The procedure for data analysis is clearly described. The researcher regards Tesch's (1990) method of analysis as appropriate due to the type of data that was collected during the interviews. The strategies for safeguarding trustworthiness are addressed and appropriately described in this chapter according to conventional measures that are acceptable in qualitative research. Also, the researcher describes the reasoning strategies that were used in processing and organising the ideas and in drawing conclusions in the study.

Finally, in this chapter the researcher *coherently* articulates the ethical standards that were employed during the research process to ensure that the study would be ethically executed without infringement or violation of the rights of the study participants.

CHAPTER 4

DISCUSSION OF FINDINGS FROM PHASE 1: YOUTH
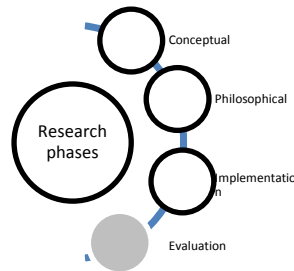
4.1   INTRODUCTION

The previous chapter presents a detailed description of the methodology that was used in conducting this research study. In this chapter, findings from the first phase of the study that focused on exploring the expectations of the youth with regard to health care professionals leading youth victims of violence towards wellness is discussed. This chapter begins with an overview of the fieldwork activities followed by the description of the demographic profile of the youth who participated in the FGDs. The demographic characteristics of the youth who participated in the FGDs were summarised in percentages and presented in Table 4.1. In addition, comprehensive discussions of the findings in conjunction with embedded empirical literature are offered to re-contextualise the findings in terms of existing literature. These findings are presented in a narrative format using *italicised* quotations from the FGDs.

4.2   OVERVIEW OF THE FIELDWORK ACTIVITIES

The nine FGDs were conducted over a period of one week in September 2013. Prior to data collection, the researcher prearranged the process by visiting the study site three days before data collection had started. The researcher was assisted by a key research collaborator who is an aboriginal resident in the community. The researcher was introduced to the gatekeepers in the community and the members of staff at the local high school. They were informed that the research had received ethical clearance and were given information sheets containing the details of the study. The principle of the school provided the researcher with a private room for conducting the FGDs. This room was conducive for conducting the FGDs because it was free from noise and distractions. It also had sufficient comfortable chairs and tables arranged in a circular fashion to accommodate each group of participants.

The researcher met with the learners at school and they were informed about the purpose and objectives of the study. Information sheets were distributed to the learners at the high school and the researcher homogenously selected potential participants who agreed to participate in the study and who were residents in the community. Learners in grade eight were considered too young and inexperienced while the ones in grade twelve were unavailable because they were busy with preparations for their forthcoming matriculation examinations. After participants were selected, those who were below 18 years old were given forms seeking permission from their parents or guardians to participate in the study. Once the participants assembled for the FGDs, the signed permission forms were collected and the participants also signed an assent form; participants who were 18 years and older signed a consent form. All the participants signed a binding focus group confidentiality form. The participants were encouraged to ask questions that were appropriately answered and they were reminded of their right to withdraw from the study at any stage. The researcher facilitated all the FGD sessions and each session lasted for an average of one hour. The participants could speak and understand English; therefore, the discussions were facilitated in English. Facilitative communication techniques (Chapter 2) were used. Likewise, the researcher practised bracketing and reflexivity to consciously recognise and avoid personal biases that could have influence the information provided. The discussions were focused on exploring the participants' understanding of the term wellness and their expectations in relation to health care professionals leading youth victims of violence towards wellness in their community. They appeared to be comfortable throughout the discussions and freely expressed their thoughts and ideas.

The discussions were voice recorded and the researcher also wrote down field notes to record the nonverbal cues of the participants and the main highlights of the discussions. The voice recordings were transcribed and the field notes were incorporated into the transcribed data with the purpose of recording the data collected as completely as possible.

The focus group discussions were conducted up to the point of data saturation, hence a total of nine FGDs were conducted.

4.3 COMPOSITION OF THE FOCUS GROUP DISCUSSIONS AND DEMOGRAPHIC PROFILE OF THE PARTICIPANTS

A total of nine focus group discussions were conducted amongst fifty eight youth participants attending the high school in the community (the study site). In the first FGD, there were six participants (3 females and 3 males). The second focus group comprised six participants (4 females and 2 males) while the third focus group was made up of seven participants (3 females and 4 males). All the participants who participated in the initial three FGDs were grade nine learners whereas the ones who participated in the fourth, fifth and sixth FGDs were grade ten learners. In the fourth discussion group, there were six participants (3 females and 3 males) similar to the fifth discussion group (3 females and 3 males) while the sixth FGD consisted of 4 females and 2 males. The seventh FGD comprised seven participants (5 females and 2 males) and the eighth discussion group was made up of six participants (4 females and 2 males). Finally, the ninth FGD conducted consisted of eight participants (6 females and 2 males). The participants were between the ages of 15 and not older than 19 years and the average age of the participants was 16.6 years. Table 4.1 shows the composition of each of the FGDs.

Table 4.1:   Composition of the nine focus group discussions

Grade level of participants	Description of participants			Number of participants per FGD
	Participants' code	Age (years)	Gender	
FG 1	P1	15	Female	6
(Grade nine learners)	P2	16	Female	
	P3	16	Male	
	P4	16	Female	
	P5	15	Male	
	P6	16	Male	
FG 2				6
	P1	17	Female	
(Grade nine learners)	P2	16	Male	
	P3	15	Female	
	P4	16	Female	
	P5	16	Male	
	P6	16	Female	7

Grade level of participants	Description of participants			Number of participants per FGD
	Participants' code	Age (years)	Gender	
FG 3				
(Grade nine learners)	P1	15	Male	
	P2	16	Male	
	P3	16	Male	
	P4	16	Female	
	P5	15	Female	
	P6	16	Female	6
	P7	16	Female	
FG 4				
(Grade ten learners)	P1	16	Female	
	P2	17	Male	
	P3	17	Male	
	P4	16	Male	
	P5	16	Female	6
FG 5	P6	16	Female	
(Grade ten learners)				
	P1	16	Female	
	P2	16	Male	
	P3	17	Female	
	P4	17	Male	6
	P5	17	Male	
FG 6	P6	17	Female	
(Grade ten learners)				
	P1	16	Male	
	P2	17	Female	
	P3	17	Female	7
	P4	16	Female	
FG 7	P5	17	Female	
(Grade eleven learners)	P6	16	Male	
	P1	17	Female	
	P2	17	Male	
	P3	18	Female	6
	P4	17	Female	

Grade level of participants	Description of participants			Number of participants per FGD
	Participants' code	Age (years)	Gender	
	P5	18	Female	
FG 8	P6	17	Female	
(Grade eleven learners)	P7	17	Male	
	P1	17	Female	8
	P2	19	Female	
	P3	18	Female	
	P4	17	Male	
	P5	17	Male	
FG 9	P6	17	Female	
(Grade eleven learners)				
	P1	17	Female	
	P2	17	Female	
	P3	17	Female	
	P4	17	Male	
	P5	18	Female	
	P6	18	Male	
	P7	17	Female	
	P8	17	Female	

The demographic profile of the youth participants indicates that sixty per cent (35) of all the participants were females and the remaining 23 were males. Twenty one of the participants were grade eleven learners, followed by nineteen grade nine learners and eighteen grade ten learners. Table 4.2 displays the summary of the demographic profile of the participants.

Table 4.2:   **Summary of the demographic profile of the youth participants (n = 58)**

Characteristic	Number (n) of participants
Age (years)	
15	4
16	21
17	29
18	3
19	1
Gender	
Male	23
Female	35
Grade level	
Nine	19
Ten	18
Eleven	21

4.4   EXPECTATIONS OF THE YOUTH BEING LED TOWARDS WELLNESS

The data collected during the focus group discussions were analysed and a central theme, four categories and many sub-categories emerged. The summary of the findings is presented in Table 4.3. Each of these categories and sub-categories in conjunction with the participants' supporting quotations and embedded literature are discussed. A concluding statement appears at the end of the discussion of each sub-category.

4.4.1   Central theme

The theme that emerged from the data analysis showed that the youth victims of violence understood the term wellness in their context and were aware of challenges in relation to wellness in their community, while having expectations of the health care professionals working in their community and supporting them towards wellness.

This central theme was clearly supported by four categories and 17 sub-categories. The categories identified were: (i) Dimensions of wellness related to healthy body, mind, spirit

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and positive interactions; (ii) Building a sound and trusting relationship; (iii) Common problems and issues of concern among youth in the community; and (iv) Guidance of youth to wellness (Table 4.3).

Table 4.3:   Categories and subcategories identified from data analysis in relation to the expectations of the youth

Category	Sub-category
1. Dimensions of wellness related to healthy body, mind, spirit and positive interactions	1.1. "Wellness" was described by youth as encompassing holistic wellbeing in relation to: 1.4.1 Healthy living 1.4.2 Not necessarily a lack of sickness / illness 1.4.3 Caring for oneself physically 1.4.4 Mind (psychological, emotional) and spiritual well-being as an essential part of attaining wellness 1.4.5 Healthy personality
2. Common problems among youth in the context of the community	2.1 Expressed views about issues of concern: 2.1.1 Drug abuse 2.1.2 Teenage pregnancy 2.1.3 Violent behaviour
3. Building a sound and trusting relationship	3.1 Youth expectations with regard to HCPs include: 3.1.1 Confidentiality and trust 3.1.2 Support 3.1.3 Information sharing 3.1.4 Professional attitudes
4. Guidance of youth to wellness	4.1 Youth expect HCPs to lead them through: 4.1.1 Establishing school programmes 4.1.2 Initiating community outreach programmes 4.1.3 Providing counselling services 4.1.4 Role modelling 4.1.5 Providing health education

4.4.2   Category 1: Dimensions of wellness related to healthy body, mind, spirit and positive interactions

Findings from the focus group discussions reflected that the youth were well-informed about wellness and gave their various interpretations of the term in the context of holistic wellbeing.

4.4.2.1   Sub-category 1: Healthy living

Healthy living is the practice of health-enhancing behaviour (Public Health Agency of Canada, 2013). In terms of young people, it consists of eating healthy diets, being physically active, maintaining a healthy weight and maintaining personal safety and mental wellbeing (Brunton & Thornton, 2010, p. 1). The youth participants in this study were of the view that wellness required the participation of an individual in a healthy lifestyle and health promoting activities; such as regular exercising, sporting activities and healthy eating. Participants perceived a healthy lifestyle as one that recognises the holistic nature of a person and how the person interacts with his or her environment to pursue wellness. For instance, one 16 year old male participant perceived wellness as a healthy lifestyle that involved regular physical activity and one that included emotional stability:

"I think it is about having a balanced life. You see, like after school you do practical things like soccer, karate, or something… and being emotionally stable" (FG2 P2).

A 16 year old female participant stated that in her own opinion, wellness meant living a well-adjusted life that included eating healthy food, exercising and avoiding a stressful life:

"I think that wellness is having a balanced life. Like maybe doing exercises, eating healthy and relaxing. Not stressing. It does not matter if things do not go your way (pause)*. That is wellness"* (FG2 P4).

Similarly, another youth participant (18 year old female) verbalised that for an individual to maintain a high level of energy, the individual needed take good care of his or her body by ensuring that he or she ate regular nutritious meals:

"Your body has to be well. You have to be eating well, exercising every day and not easily getting tired for you to say that a person is getting wellness" (FG7 P5).

A 16 years old male youth indicated that in addition to eating adequate healthy meals and participating in regular bodily exercises, wellness had to do with a person being goal-directed (mind dimension):

"What I understand by the term wellness is being healthy and being on the right track and eating right and doing exercise" (FG4 P1).

It was also specified that wellness included a lifestyle of a person making a conscious effort (volition) to live life in a way that promoted emotional wellness as was identified by a 17 year old male participant:

"I think and understand the term wellness to mean living an active life, keeping your being, like calm, physically and emotionally. Also, I think it means to work on your emotions during situations" (FG2 P1).

Another participant (17 year old male) stated that wellness entailed a lifestyle that was not associated with drug and alcohol abuse:

"Not to use drugs and drinking plenty [of] *alcohol. These things destroy your body and can kill you. You got to live right and you will be healthy, you see"* (FG5 P4).

There are so many benefits attributed to living a healthy lifestyle. Brunton and Thornton (2010, p. 1) pinpoint the importance of practising a healthy lifestyle, particularly among young people. According to these authors, healthy living improves the general quality of life and impacts on the holistic health and wellbeing of a person. For instance, it decreases the risk of diseases, such as cardiovascular diseases and diabetes. It is valuable to practise healthy living by starting early in life because during adolescence, youth are known to experiment with risky and unhealthy habits, such as smoking of cigarettes and excessive drinking of alcohol. Thus, encouraging young people to establish healthy living attitudes and the habits is advantageous because the habits learnt during the adolescent period tend to stay for a lifetime (Alters & Schiff, 2009, p. 23). Engaging in physical exercise has been documented to impact mental health positively by improving mood, self-confidence and self-worth (Biddle & Mutrie, 2008, p. 1).

Even though the youth participants in this study acknowledged the importance of a person maintaining a healthy lifestyle, exercising regularly and eating healthy foods; they revealed their disappointment that youth nowadays do not engage in exercise. According to one 17

year old female participant, most young people did not have a habit of exercising regularly even though it was necessary for them to be physically fit:

"Wellness also has to do with your body. You have to exercise properly. In my own opinion, children of these days do not do as much exercise" (FG7 P6).

The benefits of regular physical activity for youth include enhanced musculoskeletal strength, growth and development (Warburton, Nicol & Bredin, 2006, p. 801); better school performance (Rasberry, Lee, Robin, Laris, Russell, Coyle & Nihiser, 2011, p. S10); as well as a decrease in depressive signs and symptoms (Brown, Pearson, Braithwaite, Brown & Biddle, 2013, p. 195).

The finding in this study that young people did not practise the habit of regular exercise supported the reports of low prevalence of ideal physical activity and healthy diet among young people. For instance, a report by the World Health Organization (WHO) on the Health Behaviour in School-Aged Children in 35 countries of the WHO European Region and North America, reveals that over two thirds of the young people report not observing the recommended moderate-to-vigorous level of physical activity for 60 minutes five days per week (Currie, Zanotti, Morgan, Currie, DeLooze, Samdal & Smith, 2012). Similarly, a report by the American Heart Association conducted in the United States of America among youth ≤ 18 years old in grades nine to twelve shows that they do not engage in regular physical exercise, while 17.7% of the girls report that they have not engaged in at least one hour of moderate-to-vigorous exercise even once in the previous week; 10.0% of the boys report likewise. This is regardless of the recommendations that they should be involved in such physical activity five days per week. Less exercise could contribute to obesity. In America, 31.8% of all ages and ethnic groups of people are overweight and obese (Go, Mozaffarian, Roger, Benjamin, Berry, Borden & Bravata, 2013, p. e7). Obesity has also been reported to be a concern among South Africans. For example, it has been documented that seven out of ten women and four out of ten men in South Africa have significantly more body fat than what is considered as healthy (Malan, 2014).

Poor physical activity levels and obesity are risk factors for heart diseases, stroke and other vascular diseases in young people; similar to adults. This dispel the general belief that the manifestation of ideal health is higher in young people than in adults given the importance of the relationship between increasing age and the development of health conditions, such as

high blood pressure and high cholesterol levels (K. O'Brien, 2005; World Heart Federation, 2014). It is noteworthy that a family's socioeconomic status is an important predictor of the nutritional health of young people. Poverty may restrict a family's chance of adopting healthy lifestyle, such as eating adequate quantities of food and eating nutritious meals rich in fruit and vegetables.

- **Concluding statements**

From the findings on this sub-category of healthy living, the following concluding statements were made:

- The practice of a balanced healthy lifestyle that consists of eating adequate meals, exercising regularly and active involvement in physical activities.
- Wellness has to do with the recipient being focused and goal-directed towards being healthy.
- To attain wellness, the recipient makes a conscious effort (volition) to live life in a way that promotes physical and mental wellness and avoiding a stressful life.
- The recipient must be actively involved (participation) in the process of seeking and maintaining his or her wellness.

4.4.2.2 Sub-category 2: Not necessarily a lack of sickness / illness

Disease or illness has conventionally been defined as physical symptoms or problems caused by the presence of infectious or disease processes in the human body (Cassell, 2015, p. 29). Even though in their discussions, some of the youth victims of violence affirmed that wellness further included the absence of disease or illness in the body and the ability of the human body to fight diseases through a properly functioning immune system, some believed that it transcended the presence of illness in the body.

As an illustration, one 17 year old female participant stated that in her own understanding, wellness meant that an individual had a healthy immune system:

"It is when you do not have any sicknesses and you are living a healthy life and you have got a strong immune system. It is when you are healthy" (FG8 P1).

This same point of view was shared by another 18 year old female participant who specified that it meant that an individual had a healthy immune system that could fight common infections during the cold season:

"When you do not get sick in the [sic] *winter, like you don't cough and so on"* (FG8 P3).

Nonetheless, some other youth victims of violence accurately identified that wellness did not only imply the mere absence of disease and infirmities in the body, as one 15 year old female participant said:

"I think that it does not only mean when you do not have illness, because you can be sick and you still have wellness because you look good, you feel good and stuffs [sic] *like that… you know, it is when you have* [a] *focus in life"* (FG1 P1).

Similarly, another youth participant (16 year old male) stated:

"It is not just about having no sickness in your body because it is also about respecting other people and appreciating that other people have something you don't have and not being jealous of what the other person has" (FG6 P6).

This perception that wellness does not simply mean the absence of sickness in the body is remarkable because it shows that the youth indeed possess a holistic understanding of the concept of wellness. This perspective is shared by other renowned proponents of wellness like Dunn and Travis who describe transcending a mere lack of disease and illness as wellness (Miller, 2005, p. 88-91). Travis further emphasises that while a person may not have signs and symptoms of physical illness or disease, it is still possible for the person to be unwell and this can be part of the person in different ways; such as emotional states of depression, anxiety and loss of life focus. These states of being inadvertently predispose affected individuals to developing physical and mental illnesses. On the other hand, it is possible for a person to be physically ill while the individual is experiencing wellness, since he or she is managing and coping well with their illnesses (WellPeople, 2011).

Notably, wellness also encompasses psychological and social well-being and does not merely refer to the absence of illness and incorporates a concern for optimal health and wellbeing. It is defined as 'a way of life oriented [sic] toward optimal health in which the body, mind and

spirit are integrated by the individual to live life more fully within the human and natural community' (Myers *et al*., 2000, p. 252).

- **Concluding statements**

From the findings in the sub-category wellness not necessarily meant a lack of sickness / illness, the following concluding statements were made:

- Wellness can mean that an individual has a healthy immune system.
- Wellness transcends the mere absence of disease and illness.
- A good life perception and attitude are important factors for a person to experience wellness even when illness or disease is present in the body.

4.4.2.3   Sub-category 3: Caring for oneself physically

According to the Wellness Council of America (2008), self-care is the act of caring for oneself. Orem (1991, p. 117) describes self-care as "the practice of activities that individuals initiate and perform on their own behalf in maintaining life [and] health". Self-care is also referred to as activities of daily living (ADLs). Basic self-care activities include feeding oneself, bathing or showering, wearing clean clothes, toileting, personal hygiene and grooming (Roley, DeLany, Barrows, Brownrigg, Honaker, Sava & Talley, 2008).

There was a general agreement among the participants that wellness also included the practice of self-care activities; such as bathing, feeding, wearing clean gear and generally caring for the physical appearance. A female participant who was 17 years old emphasised ("was adamant" from field notes) that wellness involved a person practising personal hygiene:

"It is also about how you look and care for yourself. How you wash yourself, the clothes that you wear. To be well, you do not have to wear dirty clothes and shoes. You have to take care of your body every day" (FG8 P6).

Likewise, a 17 year old male participant reflected that wellness generally meant taking care of one's body (smiling and making gestures with his hands):

"It is how you look after your body; TLC [tender loving care]. *How you eat healthy and how you exercise"* (FG8 P5).

They also indicated that in assessing an individual's state of wellness, they would consider the outward physical appearance of the person in order to make up their minds about the state of that person's wellness. For instance, a 17 year old male participant specified that the initial thing he would do while assessing an individual's state of wellness would be for him to assess the individual's physical appearance or how he or she looked:

"For me, if I want to judge wellness, I will first of all look at the physical appearance to see if the person is clean or otherwise [sic]*. That is what I will first look at. Your clothes that you put on and your shoes must be okay and you have to be neat and tidy"* (FG7 P2).

Another 18 year old female participant stated that she would also do likewise:

"I will look at her [a youth victim of violence] *personal appearance to see whether her clothes are not dirty"* (FG7 P3).

A 17 year old female participant also revealed:

"It means you look after your body and you are clean and neat. You take care of your body and you do not wear dirty clothes. People will look at you when you are not clean and they will say that you are not alright" (FG5 P4).

It might be that these participants emphasised the physical appearance of an individual because as young people, there was a strong desire to be accepted and to be found appealing to other people, especially when it involved the opposite sex. It was clear that in assessing wellness, an individual's physical appearance was viewed as important. It was one of the fundamentals of practising a healthy lifestyle and should not be overlooked or discarded. It may be that these participants placed emphasis on the physical appearance of an individual because as young people, there is a strong desire to be acceptance and to be found appealing to others especially when it concerns the opposite sex. It is clear that in assessing wellness, an individual's physical appearance is viewed as important. It is one of the fundamentals of practicing a wellness lifestyle and should not be overlooked or disregarded. The advantages of individuals engaging in self-care practices have been well documented; it includes reduced stress levels increased sense of wellbeing and life satisfaction, improved health status, quality of life and better health outcomes (Buck *et al.*, 2012).

- **Concluding statements**

From the findings about the sub-category of caring for oneself, the following concluding statements were made:

- Wellness involves the practice of personal hygiene and self-care activities; such as bathing, feeding, dressing in clean clothes and toileting.
- It generally involves the care for one's physical appearance.
- An evaluation of the recipient's wellness can be done through an assessment of the outward physical appearance.
- The responsibility for wellness lies with the individual to care (look after) oneself and to self-manage and influence his or her health to wellness.

4.4.2.4 Sub-category 4: Mind (emotional, psychological) and spiritual wellbeing as an essential part of attaining wellness

Beyond healthy living, freedom from illness and disease and self-care; the youth participants in this study conceptualised emotional, psychological and spiritual wellbeing as an essential part of wellness. Roscoe (2009, p. 219) defines emotional wellbeing as the experience of awareness, security, the control of feelings and having a realistic and positive outlook on life and the future. It also includes the ability of a person to make a realistic assessment of his or her limitations, as well as being able to independently cope with stress. Emotional and psychological wellbeing are closely related to the mental domain. Psychological wellbeing (the intellect) includes having a focus in life, autonomy, self-acceptance, personal growth and development and experiencing and sharing positive associations with people (Rothmann & Ekkerd, 2007, p. 36). Volition as part of the mental domain is associated with logical reasoning and appropriate thought processes. Spiritual wellbeing, which is also referred to as spirituality, refers to an individual's awareness and connection with a being or force that is transcendent that gives a deep sense of wholeness; it also includes the values, principles and attitudes of the person (Neuman, 2011; Roehlkepartain, Ebstyne King, Wagener, & Benson, 2006). Spirituality does not necessarily express itself through religion, which is the devotion to the values, beliefs and doctrine of a community (Spurr, Berry & Walker, 2013, p. 223).

The youth participants highlighted the value of the mind. A 17 year old male participant ("pointing to his head": field notes) mentioned that wellness could also be associated with an individual having the right frame of mind. According to him, wellness means:

"When your mindset is right" (FG5 P5).

A different 17 year old male participant supported this opinion by stating that it was associated with a person having a principled outlook on life:

"I think wellness also has got to do with your mind-set" (FG8 P5).

Likewise, one 16 year old female participant said that wellness had to do with an individual who was resilient and optimistic about whatever situation he or she was in:

"You got to be strong and positive and think right things in your head and not stress about a thing" (FG2 P4).

Still, one 17 year old female commented that spiritual wellbeing was part of endurance and even when a person was going through difficulties, one still needed to remain positive and spiritual (prayerful) in order for one to handle the difficult situation:

"Like when you are going through a tough time, you must be able to withstand the situation, to be strong, to give yourself encouragement. Like when you are going through tough situations and knowing that you are going to be okay. Being spiritually strong is necessary because I know with God, things happen for a reason and with God you can handle it. You can always bow down on your knees and talk to him and he will give you help." She further added: *"I think wellness is also about living an active life, being emotionally, spiritually and physically stable and strong"* (FG2 P1).

This illustrates that spirituality could be viewed as a fundamental component of wellness among young people. Similar findings have been reported in other studies (Neuman, 2011; Spurr et al., 2013; Wahl, Cotton, & Harrison-Monroe, 2008) that show adolescents are spiritual and they tap into their religious belief system when confronted with critical life situations in a way that is similar to adults.

Spirituality assists the youth with mitigating negative circumstances while it supports the healing process. Cotton *et al.* (2009) used both quantitative and qualitative designs to examine the relationship between spirituality and coping with chronic health conditions, such as sickle cell disease among adolescents between 11 and 19 years and reported that coping is elevated for adolescents with higher levels of spirituality. A qualitative study by Pérez, Little and

Henrich (2009, p. 280) conducted among school-based adolescents experiencing depression reports that spirituality is an important factor in coping with depressive symptoms.

Furthermore, the youth participants in this study perceived wellness as displaying a balance between the physical, emotional (mind) and spiritual spheres of life. This perspective was evident when one 16 year old male participant described wellness holistically by stating in clear terms:

"I will break it up; the word means your physical wellbeing and everything. Like your whole body and soul" (FG3 P4).

Similarly, a different participant (a 17 year old female) said that the physical and the emotional aspects were inseparable:

"I personally think wellness is your physical health, your emotional health, because it all binds in one. That is what I think" (FG7 P1).

These assertions are noteworthy because it shows that the youth have a holistic view of wellness. Wellness is oftentimes defined as a holistic and multidimensional concept. The majority of wellness models (Adams, Bezner & Steinhardt, 1997; Crose, Nicholas, Gobble & Frank, 1992; Depken, 1994; Greenberg, 1985; Hettler, 1980b; Leafgren, 1990; Renger, Midyett, Mas, Erin, McDermott, Papenfuss & Eichling, 2000) describe it as encompassing the following dimensions: physical, social, mind (emotional, intellectual) and spiritual wellness that are interrelated and interacts in a synergistic and dynamic manner. Each of these dimensions is viewed as important and not a single dimension operates independently (Crose, Nicholas, Gobble & Frank, 1992). In other words, the sum of these dimensions is neither greater nor smaller than but equal to the whole.

- **Concluding statements**

From the findings of the sub-category about the mind (emotional, psychological) and spiritual well-being, the following concluding statements were made:

- Wellness of a youth victim of violence also encompasses the interrelated components of mind (emotional, psychological) and spiritual wellbeing.
- Emotional wellbeing is the experience of security, the control of feelings and having a realistic and positive outlook on life as well as the future. It includes the ability to

conduct a realistic self–assessment and set personal boundaries, as well as being able to independently cope with stress.

- Psychological wellbeing includes having a focus in life, autonomy, self-acceptance, personal growth and development and experiencing and sharing positive associations with people.

- Spirituality is the consciousness and connection of the recipient with a transcendent being or force(s) and does not necessarily express itself by practising a particular religion; it also includes the values, principles and attitudes of the person. In turn, these elements of spirituality provide the recipient with a deep sense of wholeness. Spirituality helps the recipient to handle negative situations and supports the healing process towards holistic wellness.

4.4.2.5   Sub-category 5: Healthy personality

Personality refers to an individual's characteristic pattern that creates a unique expression of thoughts, emotions and behaviour (Carducci, 2009, p. 37). Burger (2011, p. 4) defines personality as 'consistent behaviour patterns and intrapersonal processes originating within the individual'. He describes the intrapersonal processes to include emotional, motivational and the cognitive processes.

A healthy personality is defined as an individual having the ability to function well as a person, having sufficient knowledge of the self and self-acceptance, being able to cope with and manage the challenges of life, having people skills, as well as possessing a realistic perception and acceptance of reality (Lindhard, Dlamini & Barnard, 1987, p. 40). A healthy personality includes positive mental health because it is considered to be holistically vital for wellbeing, peace of mind, contentment, personal adjustment, emotional control, successful living and is fundamental to wellness (Lamers, Westerhof, Kovács & Bohlmeijer, 2012, p. 517).

It was clear that the youth in this study understood the dimensions of a healthy personality and they related it to wellness. During focus group discussions, they reflected that wellness was expressed as an understanding, acceptance and respect of oneself and the ability to relate well with other people. The following quotation from a 16 year old male participant demonstrated the role of self-acknowledgement:

"…Wellness means that you know yourself, you respect yourself and you are proud of the things that you can do" (FG1 P6).

Another youth participant who was also a 16 year old male felt that a person's personality is a reflection of the individual's state of wellness and that the individual also has to be friendly and sociable*:*

"A well person can interact with people. He has plenty of friends" (FG6 P1).

By the same token, a youth participant (19 year old female) detailed that the personality of a youth victim of violence could be pointing at an individual's true state when a health care professional is assessing the person's wellness:

"…the person's personality can show them if a person is well or not..." (FG8 P2).

For the youth victims of violence who participated in this study, maintaining healthy, non-threatening relationships with their peers was seen to be important and bullying was regarded as an undesirable characteristic. A 16 year old female participant shared her experience with bullying at school, since she was bullied for some time by one particular male learner ("with a concerned look on her face": field notes):

"He was bullying me for a long time and I couldn't take it. I had to report him to the teacher to make him stop it... you know man, a person who is bullying other people should not be referred to as being well because they are breaking apart somebody else" (FG1 P4).

This finding confirms the report of Burton and Leoschut (2013, p. 11) that learners at secondary schools in South Africa experience bullying from their peers while they are at school and as a result of the bullying, they were traumatised. Bullying comprises 'one or more people singling out and deliberately and repeatedly hurting or harming physically or mentally' (Centre for Justice and Crime Prevention & Department of Basic Education Republic of South Africa, 2012, p. 4). Reasons reported to be responsible for young people engaging in bullying include personality problems, inability to deal with feelings, history of bullying at home, seeking attention and wanting to feel important in order to develop the healthy personalities they desperately seek (Centre for Justice and Crime Prevention & Department of Basic Education Republic of South Africa, 2012, p. 9).

- **Concluding statements**

From the findings of the sub-category about a healthy personality, the following concluding statements were made:

- Self-acknowledgement should take place through knowing oneself, respecting oneself and to be proud of one's achievements.
- Wellness includes possessing and displaying a healthy personality that demonstrates consistent behaviour patterns and intrapersonal processes. Personality can be described on the basis of how emotionally stable, friendly, sociable, hard-working and refined a person is.
- A healthy personality is also considered to include positive mental health that is holistically vital for wellbeing, peace of mind, contentment, personal adjustment, emotional control and physical living.

4.4.3 Category 2: Common problems among youth in the context of the community

Substance abuse, teenage pregnancy and violent behaviour were the key issues reported to be affecting the youth living in the community of study. Accordingly, the sub-categories that emerged from the analysis of the data are independently discussed:

4.4.3.1 Sub-category 1: Alcohol and drug abuse

Substance abuse is "the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs" (World Health Organization, 2014, pp. 1). Commonly abused psychoactive substances include nicotine, caffeine, alcohol, marijuana, heroin, cocaine and methamphetamine. The metabolism of these substances in the human body can modify the awareness, disposition, reasoning, behaviour, or motor function of a person (World Health Organization, 2000, p. 3-16).

While referring to the disturbing issue of alcohol and methamphetamine (locally referred to as *'tik'* in the community) abuse among the youth in the community of study, a 16 years old male participant commented:

"…The youth here take a lot of alcohol and tik. They don't have much to do. You see, they are not busy. They need to help them and tell them to stop doing the wrong stuffs [sic]. *Their career is important. Someone should not be allowed to perish as a gangster. The nurses can help them to build their lives again and be focused"* (FG2 P2).

Another participant who was an 18 year old female also indicated that drug abuse was a huge problem affecting the young people in the community:

"…Drugs are destroying the youth… They take this dagga" (FG7 P3).

These findings are consistent with previous reports (Harker, Kader, Myers, Fakier, Parry, Flisher & Peltzer, 2009, p. 4; Plüdderman, Flisher, McKetin, Parry & Lombard, 2010) which suggest that the abuse of alcohol and methamphetamine is common in urban and rural areas in the Western Cape Province of South Africa, particularly among the coloured adolescents population. Further confirming the findings of this current study, a study conducted by Stein, Seedat, Herman, Moomal, Heeringa and Kessler (2008) in the Western Cape Province, report a considerably high prevalence rate (18.5%) of substance abuse. Drug abuse is not a problem common to the Western Cape Province only; it happens in the other provinces too. It has been documented that the most commonly abused drugs in the country are alcohol, marijuana (locally referred to as '*dagga*'), methamphetamine, heroin and cocaine (Pasche & Myers, 2012, p. 338; Plüdderman, *et al.*, 2010). Existing data suggests that a considerable number of South Africans abuse alcohol, especially during weekends (Department of Social Development, Republic of South Africa, 2013, p. 33). Heavy drinking has also been reported amongst the youth in the country. For example, the 2008 South African Youth Risk Behaviour Survey reports that an estimated 29% of youth engaged in binge drinking a month prior to conducting of the survey (Reddy, James, Sewpaul, Koopman, Funani, Sifunda & Josie, 2010).

The youth in this research study alluded to the reason why youth in the community abused drugs and alcohol. In their opinion, there were no recreational facilities to keep them positively engaged in the community. One 16 year old female stated that youth engages in substance abuse owing to idleness ("with a despondent look on her face": field notes):

"…we busy with alcohol, tik. There is no life here. There is nothing for us to do" (FG1 P4).

The view was also supported by another participant who was a 16 year old male:

"…youth do drugs in Genadendal because there is nothing [else] *to do…"* (FG1 P3).

This finding is thought-provoking; perhaps providing young people with recreational activities in the community would with keeping their minds off dangerous habits, such as substance abuse.

- **Concluding statements**

From the findings of the sub-category about alcohol and drug abuse, the following concluding statements were made:

- Alcohol and methamphetamine (tik) abuse is common in the community.
- Providing young people in the community with recreational facilities would keep them positively engaged and could curb the issue of alcohol and drug abuse.

4.4.3.2 Sub-category 2: Teenage pregnancy

Teenage pregnancy is defined as pregnancy occurring in a teenage girl, usually in the age range of 13-19 (UNICEF, 2008, pp. 1). In this study, in addition to the problem of substance abuse in their community, teenage pregnancy was pointed out by the youth who participated in the focus group discussions as another social problem common in their environment. A 17 year old female participant viewed teenage pregnancy and drug abuse as the main issues in the community:

"…Teenage pregnancies, drugs, these are the problems…" (FG9 P3).

Another participant (17 year old male) also supported the view that teenage pregnancy was common in the community:

"Teenage pregnancy is popular here. These girls are falling pregnant…" (FG4 P2).

A 16 year old female participant further disclosed that the young girls who became pregnant might also choose to drop out of school as a result of falling pregnant:

"…They get pregnant, they have the baby. They don't want to go to school…" (FG2 P6).

Likewise, an 18 year old female shared the same view:

"Many girls here in Genadendal are getting pregnant and don't go to school" (FG8 P3).

This finding is consistent with other reports that suggest that teenage pregnancy is common among young girls in South Africa and most of these pregnancies are unplanned. About 30% of the teenage girls are reported to having been pregnant; therefore, the situation is described as a social problem. Though the teenage pregnancy rate has been reported to have declined during the last few decades, it is still exceptionally high (Flanagan, Lince, Durao de Menezes & Mdlopane, 2013; Holt, Lince, Hargey, Struthers, Nkala, Mclntyre & Gray, 2012; Willan, 2013; Wood & Jewkes, 2006; World Health Organization, 2014a). Also, it has been reported that about 16 million teenage girls worldwide aged 15 to 19 years, typically in low- and middle-income countries give birth yearly and one out of every five girls has given birth by the age of 18. It is more likely to happen among poor, less educated and rural populations (World Health Organisation, 2012a).

Factors contributing to teenage pregnancy include risky sexual behaviour that may be the result of alcohol and drug use, low self-esteem, early marriage, low socioeconomic and educational level, sexual abuse, the lack of contraceptive use, as well as a lack of access to sexual and reproductive health education and services (Mchunu, Peltzer, Tutshana & Seutlwadi, 2012; Omar, Hasim, Muhammad, Jaffar, Hashim & Siraj, 2010; Pedrosa, Pires, Carvalho, Canavarro & Dattilio, 2011; UNICEF, 2008).

Consequences of teenage pregnancy not only affect the health of the pregnant girl but it also affects the health of her infant because the young girl's immature body has not yet developed fully to carry a baby. For example, infants of teenage mothers are more likely to have low birth weight. In addition, teenage pregnancy is one of the main contributors to deaths of mothers and children (World Health Organisation, 2012a) and can also lead to psychological disturbances, neglect, poor academic performances (UNICEF, 2008) and dropping out of school that reinforce the vicious cycle of consequences for young girls in relation to low socioeconomic status and poverty (Grant & Hallman, 2008). For instance, disturbance of the schooling of the teenage girl as a result of being pregnant, limits future job prospects and the chances of getting a well-paying job to be able to take care of herself, her baby and her entire family (UNFPA, 2013).

Currently, there are concerted efforts to empower and enlighten teenage girls in South Africa about the problems of teenage pregnancy and the ways of preventing such pregnancies (Department of Health, 2012; Jewkes, Morrell & Christofides, 2009).

- **Concluding statement**

From the findings of the sub-category about teenage pregnancy, the following concluding statement was made:

- Teenage pregnancy is common among young girls in the context of the community in this study.

4.4.3.3   Sub-category 3: Violent behaviour

Violence is viewed as the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation (Krug *et al*., 2002, p. 5). Youth violence is defined as the involvement of young people, either as victims or perpetrators, in incidents that involve the threat or use of physical force in the context of interpersonal, inter-communal or other conflict, and crime. This violence might be inflicted with or without a weapon and could result in physical injuries or death (Graham *et al*., 2010, p. 38).

The youth in this study indicated that youth engaged in interpersonal violence in their community; a situation that they find to be very disheartening. A 16 year old female participant stated that youth in the community engages in aggressive behaviour, particularly when under the influence of drugs and alcohol:

"The youth get very violent. They beat people up when they get drunk and have abused drugs. They also [are] *involved in fighting and taking people's things"* (FG4 P1).

A 19 year old female participant responded:

"They are also bullying children in [sic] *school... fighting. The big ones bully the smaller ones, the smaller ones younger than they are. They see that they can't fight back, so they take advantage of them. They do whatever they want to do to them"* (FG8 P2).

While further affirming their disappointment with the situation, some of the participants mentioned that certain individuals amongst the youth also physically assault their parents and the elderly in the community in a bid to dispossess them of their money which they will eventually use in the procurement of psychoactive substances. A 16 year old female participant revealed:

"Young children beat up their own parents and they are robbing the old people because they want to get easy money and buy alcohol and dagga. They don't want to go to school and they drop out. I am always asking why they are enjoying doing drugs. I have friends who take this stuff..." (FG5 P1).

Another 16 year old female participant stated that young girls are sexually assaulted as a result of violent behaviour:

"They fight over guys and when they are drugged. They fight to impress their friends... They get abused, raped" (FG5 P3).

There is possibility that the violent behaviour reported by the youth is a result of the involvement of young people in gangs. There have been reports of youth gangsters in many coloured communities in the Western Cape Province and most of the youth who belongs to gangs more often than not get entangled in substance abuse and when they are under the influence of these substances, they are inclined to engage in violent acts; such as fighting, bulling, robbery, sexual abuse and other forms of crimes, or even death. This finding also confirms the report by the Department of Correctional Services (2011) that 34% of the entire prison population in South Africa are youth under the age of 25 years and most of them have been incarcerated for aggressive crimes. Similarly, the 2008 annual report of the National Injury Mortality Surveillance System (NIMSS), shows that violence in the country is the principal cause of unnatural death among individuals between the ages of 15 and 34 years. Violence has been reported to contribute to disability-adjusted life years (DALY) , to a high burden on health care systems and significantly to health care costs in the country (Matzopoulos, *et al.*, 2008, pp. 177-185).

There is a strong association between the use of methamphetamine (tik) and violent behaviour, and the practice of risky sexual behaviour; such as multiple sexual partners, noncompliant condom use and transactional sex (Harker *et al*., 2009, p. 13).

- **Concluding statements**

From the findings of the sub-category about violent behaviour, the following concluding statements were made:

- Violent behaviour is common among young people in the context of this study.
- The situation affects the wellness of the youth in the community, for instance it causes mental and physical health problems.

4.4.4   Category 3: Building a sound and trusting relationship

Participants (youth victims of violence) had an expectation of a sound and trusting relationship with health care providers working in their community. The following three subcategories emerged from Category 2. They were confidentiality and trust, support, information giving and a respectful attitude.

4.4.4.1   Sub-category 1: Confidentiality and trust

Confidentiality means not disclosing information about a person without their consent or permission while trust has to do with the feeling or assurance that one can rely on another person (International Council of Nurses, 2012).

The participants stated that they viewed health care professionals as leaders in their community and also indicated that they value confidentiality about private information shared with the health care professionals. A youth participant (17 year old female) stated that youth who had been victims of violence would not want health care professionals to disclose their personal issues to other people who were not involved in their care:

"They must keep what I said private and I think all of us expect that it should be private" (FG9 P2).

Also, a 16 year old male participant voiced the need for respecting personal information:

"...we will appreciate it if they keep our secrets, secrets and not go telling everyone in Genadendal [about] *our problems. Everybody has got problems and we must all respect each other so that we don't hurt each other's feelings"* (FG4 P4).

Another participant who was a 17 year old female reiterated that health care professionals needed to maintain confidentiality:

"When you tell them your problems, they don't have to tell other people. That is not right, you see. I don't want them to do that" (FG7 P1).

It appeared that the youth victims might have had previous unpleasant experiences when they shared personal information (field notes); therefore, it became uncomfortable to disclose their personal information to health care professionals. Perhaps that was why it was reported that

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the youth generally had underutilised the available health care services in the context of this study.

All clients have a right to confidentiality. Confidentially builds trust and respect between clients and health care providers. It is even more important that clients trust their health care providers. Health care providers have an obligation to protect the privacy and confidentiality of their clients through non-disclosure of their personal health information (International Council of Nurses, 2012). When health care providers are trustworthy, clients would be far more likely to seek health care services and, therefore, they would provide complete and honest explanations of their problems and needs when they feel at ease, respected and secure in the company of their health care providers

- **Concluding statements**

From the findings of the sub-category about confidentiality and trust, the following concluding statements were made:

- An agent is a highly respected and influential individual in the community.
- An agent must provide confidential services to the recipient in a respectful and empathic manner.
- Confidential services build trust and respect between agent and recipient.

4.4.4.2   Sub-category 2: Support

To give support means to offer somebody assistance and encouragement in a practical way (Cambridge University Press, 2014b). When health care professionals support their clients, a sound and trusting relationship would develop between them (Ommen, Thuem, Pfaff & Janssen, 2011).

The youth victims of violence reported that they had high regard and a deep respect for health care professionals and stated that they expect them as leaders to be supportive in a compassionate and understanding manner. The perception that health care professionals were competent leaders who assisted with informed decision-making was mentioned by a 16 year old male participant who said:

"Health professionals will lead you into something that is right and not wrong. They will not lead you into taking drugs" (FG6 P1).

Similarly, a 17 year old female stated that social workers were supportive leaders in their community:

"Like when you [are] *going through problems, you can go and see a social worker and she will help you… they are always there ready to help…"* (FG 9 P1).

This research study has assumed that health care professionals are a significant part of the social environment of the youth victims of violence and they (health care professionals) occupy a position of authority and influence to lead persons to wellness. Leadership refers to the process when a leader uses his or her control, authority and influence to stimulate followers with the purpose of realising mutual goals (Jooste, 2009b). Leadership has been identified as an essential role of health care professionals because they have an ethical responsibility in practice to attend to the needs and concerns of their clients. As leaders, they have the character of change agents who lead clients towards health and wellness (Human Resources Institute, 2011, p. 3). Similarly, the Provincial Nursing Strategy of the Western Cape points out that health care professionals, such as nurse managers, should demonstrate their leadership capacity in practice (National Department of Health, 2009, p. 16). Given that the community views health care professionals as leaders, it is crucially important that nurses and other health care professionals become effective and participative leaders in order to validate their leadership roles and responsibilities, not only to their clients but also to their professions.

Support was regarded as a form of communication that involved talking and listening by both parties. A 17 year old female stated that health care professionals should provide support to the youth who were victims of violence early after a violent experience by providing counselling services:

"I think that they can start helping by talking about what we are experiencing… Talking always helps to give relief" (FG8 P6).

Similarly, a 17 year old male indicated the importance of the health care professionals showing compassion while leading youth victims of violence towards wellness in the statement:

"They must also be willing to give a listening ear and listen. When you tell people the right things to do they will want to do the right thing and not make a mess of their lives. They must help us youth to make our lives better here in Genadendal" (FG8 P4).

Generally speaking, health care professionals are educated, respected and high achieving helpers who look after the wellbeing of their patients and the community they serve. They are viewed as responsible and valued leaders by the community members and they wield a great amount of influence in the community.

However, some of the youth appeared not to be satisfied with the services they received from health professionals (field notes) and it was mentioned that support from health care professionals was lacking when needed and that a focus on service and people skills were expected. An 18 year old male participant shared an experience about visiting the clinic with an injury that resulted from a violent encounter with a friend but he did not get the immediate support which he anticipated to receive. According to him, the nurse on duty was not sympathetic to his dilemma:

"... I was left there in my pain, you see. I was really in pain" (FG9 P6).

He further disclosed his displeasure by stating:

"They should be there for you... They must be there not only for the pay at the end of the month... why should you become something if you don't have the people skills? They must be there not only for the pay at the end of the month" (FG9 P6).

People skills are the skills that enable people to communicate and deal with other people in a friendly and effective manner (Cambridge University Press, 2014a). These skills include listening attentively, being patient, consistent, flexible, confident and having a sense of humour. These skills are required for building a sound and trusting relationship between individuals (Boyle, 2012; Zaugg & Davies, 2013).

Another youth participant (a 17 year old male) complained about the lack of empathy by medical doctors:

"I expect them to go the extra mile and some doctors don't care. They have to imagine what their patients are going through..." (FG9 P4).

Empathy is defined as the 'cognitive attribute that involves an understanding of experiences, concerns and perspectives of another person, combined with a capacity to communicate this understanding' (Hojat, 2009, p. 412). Empathy is crucially important in health care provider-patient interactions because it leads to positive patient outcomes, as well as increased patient compliance and satisfaction (Gerdes & Segal, 2011; Hojat, 2009); particularly for the varying degrees of suffering that youth victims of violence experience. Cassell (2004, p. 32) define suffering as a state of severe distress associated with events that threaten the wholeness of person. In other words, suffering results from circumstances that negatively impacts the completeness of the person. It is, therefore, vital that health care professionals are empathic towards the youth victims of violence in order to promote their wellness.

- **Concluding statements**

From the findings of the sub-category about support, the following concluding statements were made:

- The youth victims of violence expect health care professionals to be supportive as leaders.
- Health care professionals are a significant part of the social environment of the youth victims of violence and they occupy a position of authority and influence to lead persons to wellness.
- The Provincial Nursing Strategy of the Western Cape Province recommends that health care professionals should demonstrate their leadership capacity in practice while legal documents guide health care professionals to understand their leadership responsibilities.
- People skills are required for building a sound and trusting relationship between individuals.
- Empathy is crucially important in health care provider-patient interactions in order to promote wellness.
- Agents are viewed by the recipients as competent health care professionals who assist with informed decision-making.
- The leadership process of the agents leading the recipients toward wellness begins at their first encounter. During the initial period immediately after an incident of violence, the agents should prepare the recipients promptly for wellness by "being there for them", therefore, the focus should be on availability and listening to their needs.

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4.4.4.3   Sub-category 3: Information sharing

Information sharing can be described as conveying facts, knowledge, details and ideas to individuals. Most commonly, it is the material provided to individuals that will be useful to them (Sharma & Petosa, 2014).

Trustworthy information from the health care professionals was reported as essential for engendering confidence and faith as stated by a 17 year old male participant:

"...Health care professionals are there to give information to us [youth]*… and help us to be calm and not to be afraid of all that is happening"* (FG2 P1).

Correct and adequate information from the health care professionals was expected by another 16 years old female participant:

"I expect them to also give us information on the right things and to warn us about the wrong things like drugs and alcohol" (FG2 P6).

Effective information sharing in the context of victims of violence could be based on therapeutic communication. VanServellen (2009, p. 50) defines therapeutic communication as expressing support, providing information and feedback and correcting distortions while providing hope. This type of communication helps clients to trust and collaborate with their health care providers. Therefore, its importance in all phases of client-provider interactions and relationships cannot be overemphasised (Butts & Rich, 2011, p. 281).

An 18 year old participant mentioned that she anticipated the health care professionals to reach out to youth at schools and in the community in general and giving health related information about the ways in which they can avoid self-destructive behaviour:

"I expect them not to only check up on us like taking blood pressure and things like that but I expect them to also come up to us and talk to us about things that has [sic] *to do with our body, how taking drugs can affect you, things like that because we do that without knowing the effect of it"* (FG7 P5).

The findings emphasises that communication could be an empowering process when health care professionals provide information as a precaution to becoming a victim of violence.

- **Concluding statements**

From the findings of the sub-category about information sharing, the following concluding statements were made:

- The youth needs to be provided with trustworthy (accurate, adequate, relevant) information and health education to foster a sound and trusting relationship.
- Therapeutic communication should be utilised by the agents while guiding the recipients with emotional support to stay calm and not to be afraid.
- Agents are expected to empower the recipients (youths) by providing them with accurate and complete information.
- During the initial phase of care, the agent should provide accurate information to the recipients about avoiding risky lifestyles and guide them with effective strategies that would support their coping with trauma. In turn, these coping strategies should accelerate their wellness.

4.4.4.4   Sub-category 4: Professional attitudes

Attitude has been described as the manner in which an individual perceives a person or a situation which determines the reaction or behaviour of the individual (Narayana & Rao, 2008, p. 29).

The youth participants could anticipate that health care professionals exhibited a professional attitude towards them. Sadly, the youth reported that some health care professionals displayed negative attitudes towards them by being rude. One 16 years old female reported:

"When you go to the clinic, the nurse is supposed to help you and not be rude to you and say, no, you were here last month because I go to the clinic and is was what I get there. Here in Genadendal, they are rude to you. I don't want them to be like that..." (FG1 P4).

A youth participant (17 year old male) specified that he expected medical doctors to act according to their roles as professionals. He stated that medical doctors should:

"Do a better job… Some of them are not so good. Some patients may not be happy with what the doctor did for them" (FG9 P4).

This finding is confirmed by previous studies (Ahanonu, 2014; Nalwadda, Mirembe, Umwesigye, Byamugisha & Faxelid, 2011; Wood & Jewkes, 2006) conducted in different African counties, including South Africa. It is suggested that health care professionals should treat young people with professional attitudes and provide them with dignified care when they visit the health care facilities.

Another youth (18 year old female) indicated that an attitude of "can wait" was reflected by a medical practitioner that was interpreted as a lack of passion for serving the community:

"If you go to the doctor and then they say you must come back later as they are on a break. Being on break is not a big thing if they aren't passionate about their work then it will show" (FG9; P5).

In building a sound and trusting relationship with their clients, health care professionals ought to show a passion and willingness to serve whenever the clinic is open (Small & Small, 2011). A true leader has a passion for his or her work and serving other people (Lekalakala-Mokgele, 2009, p. 325).

- **Concluding statements**

From the findings of the sub-category about professional attitudes, the following concluding statements were made:

- The agent needs to exhibit a professional attitude characterised by respect whenever attending to the recipient.
- Professional attitudes towards the recipients that are displayed in dignified care should be demonstrated by passion and a willingness to care.

4.4.5 Category 4: Guidance of youth victims of violence towards wellness

Findings from the analysis showed that the youth participants suggested approaches for health care professionals who are responsible for leading the youth victims of violence to wellness. The sub-categories under this broad category are (i) school programmes, (ii) community outreach programmes, (iii) counselling, (iv) role-modelling and (v) communication / information giving / health education.

4.4.5.1   Sub-category 1: Establishing school programmes

Schools are educational institutions where learners receive knowledge and skills for their development through quality instructional methods. Schools are also places where the holistic wellbeing (intellectual, physical, psychological, emotional, spiritual and social) of learners should be promoted (Pittman, n.d.). The youth in this study held a strong view that health care professionals should not only provide regular health care services to individuals at the health care facility but they should also focus on reaching out to the youth at schools to identify the ones who were victims of violence and to provide them with health services.

A 19 years old female participant expressed the opinion that health care professionals should provide self-management and counselling for youth victims at school:

"They can come to the school and help the kids that have been physically and mentally abused to give them advice on how to deal with it... I want them to start school programmes and help children to get fit and so on and to encourage them and give them advice on how to eat good foods and so on" (FG8 P2).

Another youth participant (an 18 year old female) mentioned that the outreach by the health care professionals would most likely be welcomed by their instructors:

"...They can come to the school and talk to us and help us. The teachers cannot stop them. They [youth] *take this dagga in* [sic] *school"* (FG7 P3).

The youth participants also stated that not only would the victims benefit from the school programmes but all youth learners would also benefit from these programmes when they were offered at school. One 17 year old male participant stated:

"I will say that even if it is once a week, the doctors and the nurses can come to the school and talk to the whole school and encourage them to eat well and have a healthy lifestyle and not bottle up the problem inside" (FG4 P3).

This finding is noteworthy because it agrees with recommendations made by the Centres for Disease Control and Prevention (CDCs) that health care professionals should promote the welfare of young people at schools while using an approach referred to as the Coordinated School Health approach aimed at improving and strengthening the wellbeing of young people at schools. The need for these programmes arose from the conviction that just like the family

unit; the school is an institution accountable for the growth and wellbeing of youth in the community. In addition, it is predicated on the conviction that problems such as violence, substance use and unhealthy lifestyle behaviour, including poor physical fitness can strongly impact on the positive educational accomplishments of the youth.

Therefore, the focus should be on promoting the physical, psychological, intellectual, emotional, social and spiritual wellbeing of youth victims of violence at schools. These victims could be assisted with avoiding unhealthy activities, such as substance abuse and adopting and practising health-promoting behaviour. It is also is necessary to mention that the provision of school health services at schools have many advantages that include the creation of opportunities for health education, screening for unreported victims of violence, treatment of minor conditions and ailments and counselling services for youth learners; especially for the ones who cannot be reached in the community. It becomes necessary that the South African Government focuses on introducing such services at schools.

- **Concluding statements**

From the findings of the sub-category about establishing school programmes, the following concluding statements were made:

- The agents should reach out to the youth at school in the community and screen the ones who are victims of violence, provide them with counselling and positive coping skills and encourage them to reflect on how to address their problems.
- Partnerships with instructors at schools, parents and guardians are important elements of leading youth victims of violence towards their wellness during school outreach programmes.

4.4.5.2   Sub-category 2: Initiating community outreach programmes

Community outreach programmes are planned activities or programmes designed to reach, support and meet the needs of community members; particularly individuals who are at risk because they may not use the available conventional health services (Southard, 2010, p.6). In health service delivery systems, community outreach programmes are usually implemented and coordinated by a multidisciplinary team of health professional; including social workers, community health nurses and medical doctors, nutritionists, psychologists and occupational therapists. These services range from health screening, outpatient treatment, health education

to promote healthy behaviour, substance abuse management, counselling and enhancing individual and family support capacities and skills to deal with traumatic life situations like the distress faced by victims of violence. It would facilitate referral of these persons to proper resources, such as social and legal services (Hansen-Turton, Miller & Greiner, 2009, p. 144; Mullner, 2009, p. 607).

The youth participants were in support of community outreach programmes and services by the health care professionals to lead the victims of violence towards wellness in their community. One 17 year old female stated that health care professionals can choose to conduct health education during community outreach programmes:

"They should go to different places in the community and tell the people about the bad stuffs [sic] *so that the people can know how they can make themselves well, to be better people and what they can do to be a better person"* (FG8 P6).

A16 year old female indicated that the multidisciplinary health care team should also focus on females who had been sexually assaulted:

"…They can start a programme in the community, like with the young girls who have been abused so that they will not do drugs and stuffs [sic] *like that"* (FG2 P6).

It was mentioned that a wellness centre could be established in their community and the focus of this centre should be on the youth, particularly on what they could do to achieve a healthy lifestyle that leads towards wellness. For instance, during the discussions one of the youth spoke out:

"They must do the programmes on how you can achieve the wellness. They should organise workshops for the youths on how to achieve wellness." (FG8 P2).

- **Concluding statements**

From the findings of the sub-category about initiating community outreach programmes, the following concluding statements were made:

- Community outreach programmes should be regularly organised by the agent to reach, support and meet the broader needs of community members as a preventive measure, particularly individuals who are most at risk.

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- Agents should implement community outreach programmes to distribute knowledge about wellness targeted at victimised youth in their community in partnership with other community stakeholders; such as community leaders, public health professionals, as well as government and non-governmental Organizations.

- A multifaceted and contextual approach is necessary to lead recipients to taking responsibility for their wellness.

- A participatory approach will enhance wellness in the community.

4.4.5.3   Sub-category 3: Providing counselling services

Counselling is "a professional relationship that empowers diverse individuals, families and groups to accomplish mental health, wellness, education and career goals" (American Counseling Association, 2014, pp. 2). It is a confidential relationship between the trained counsellor and the counselee and conducted on a one-on-one, couple, family, or group basis. Counselling services can be delivered during a single or multiple sessions in different ways, for example physical face-to-face interaction, telephone, or email (Evans, 2013, p.35 - 36).

The youth participants in this study were of the opinion that health care professionals should provide counselling for the youth who had been victims of violence. An 18 year old female participant stated:

"They can have sessions with us so that we can tell them our problems and experiences and they help can [sic] *us"*(FG8 P3).

Another participant (19 year old male) also shared the same opinion:

"For me, I think they have a lot to do (pauses)*, talking to us, helping us guiding and teaching us how to live good lives. You don't need to fight to get respect… you need to show the boys how to be good men"* (FG9 P6).

Though the youth recognised that counselling services were necessary in the guidance of youth victims of violence to wellness, the majority of them showed displeasure at the judgemental attitude of some health care professionals when they were counselling youth. An 18 year old female participant mentioned that when a young girl in the community who had been a rape victim or sexually assaulted was referred to a health care professional:

"They must protect her and listen to her. It is not fair to judge her and say that she was the cause of her rape and that she deserves it. What she needs is someone to speak to her and someone to support her and be there for her" (FG7 P5).

This finding confirms the report of Horvath and Brown (2009, p.46) that the experience of rape by any young girl or woman a very traumatising and it affects various aspects of the person. For instance, the blaming of rape victims significantly impacts on the psychological and emotional aspects of the person and might result in secondary victimisation (Eyssel & Bohner, 2010, p. 255; Strömwall, Alfredsson & Landström, 2013, p. 1579). It is, therefore, important that any health care professional who is caring for a victim of rape should do so in a considerate and non-judgemental manner and allow two-way communication to take place.

The youth mentioned that health care professionals should exhibit trust, confidentiality and respect during counselling of the victims of violence. For instance, an 18 year old female participant said that:

"If they do not talk to them nicely, they will not be able to help them. They have to help them to develop trust in them so that they can help them. They have to be patient because when you are heartbroken..." (FG8 P3).
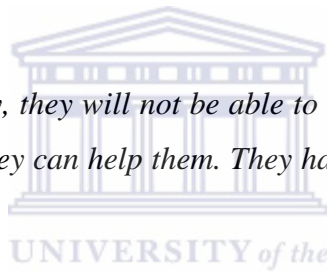
This finding is consistent with literature that indicates that a good counsellor must be a good listener and non-judgemental in his or her approach when offering counselling services to individuals, especially young people (Geldard & Geldard, 2010, p. 83; Green, 2010, p. 37; Kinra, 2008, p. 142).

- **Concluding statements**

From the findings of the sub-category about counselling, the following concluding statements were made:

- The provision of counselling services to recipients is an important opportunity for the agent to be non-judgemental during guidance toward wellness and providing the recipients with emotional support. This can take place during a single or multiple sessions in different ways; such as physical face-to-face interaction, telephoning, or emailing that make two-way communication possible.

- The agents should not only focus on the physical recovery of traumatised youth victims. Agents should also attend to their emotional (heart breaking), spiritual, social and psychological wellness.

4.4.5.4   Sub-category 4: Role modelling

An individual whose behavioural patterns or accomplishments is or can be emulated by other people, particularly young persons who regard such an individual as a role model (Dictionary.com, 2014). Role models are also referred to as guides or mentors. Health care professionals and teachers are examples of role models in society (Burns & Grove, 2011).

The youth victims of violence indicated that they viewed health care professionals as their role models and they wanted them to be exemplary leaders of a healthy lifestyle that promotes wellness. One 16 year old male participant said that he would love that health care professionals practise the same wellness behaviour that they tell the youth to practise (role model):

"…because they are the leaders, they should do what they expect us to do…" (FG2 P2),

and a 17 year old male participant stated:

"They need to lead us by example. Show us how to become better people" (FG7 P2).

An 18 year old male also felt that health care professionals should act as role models for the youth in the community:

"They should show us that they are also doing the things that they want us to do. You cannot tell me not to do something that you know you are doing because it is not right" (FG9 P6).

Furthermore, a 17 year old female indicated that health care professionals set good examples for them to emulate:

"They are setting an example for us. Like doctors and nurses, as they encourage us to do much better, as they help others… we learn to respect each other" (FG6 P2).

These findings support the view that role modelling is an important issue for health care professionals in all aspects of practice; whether in the clinical, educational, or research setting. For instance, the Provincial Nursing Strategy of the Western Cape Province states that the leadership capacity of health care professionals, such as nurse managers, should be demonstrated in health care practice (National Department of Health, 2009, p. 16).

Chism (2013, p. 48) states that "role modelling may be the most subtle form of leadership" for health care professionals. Although it is generally accepted that there is no single definition of leadership in literature, Jooste (2014, p. 284) describes leadership as the process of influencing the conduct or behaviour of individuals (e.g. through role modelling) in order to maximise their potential and to realise collective goals. Leadership is identified as an essential role of health care professionals because they have an ethical responsibility in practice to attend to the needs and concerns of their clients (Northhouse, 2010, p. 4). As leaders, they have the quality of being change agents and role models who lead clients towards health or wellness. Therefore, as good role models they should be warm, considerate, knowledgeable, empathic and be able to display self-reflection, emotional intelligence and self-leadership (Feltner, Mitchell, Norris & Wolfe, 2008; Jooste, 2014; O'Connor, 2008). In addition, they must act with integrity and have the ability to communicate well. Communicating well will therefore require of them to be 'proactive, honest and [practising] sensitive communication with clients, relatives and medical staff' (Philpott & Corrigan, 2006, p. 11). It is vitally important for health care professionals to be good at being role models for their patients, professional colleagues and the community in general.

- **Concluding statements**

From the findings of the sub-category about role modelling, the following concluding statements were made:

- A health care professional is a leader who acts as a role model.
- An empowering environment in which the agents as leaders and role models demonstrate the quality of being change agents for wellness is necessary for leading the recipients towards wellness.
- Role models have respect for other people.

4.4.5.5 Sub-category 5: Providing health education

Health education consists of "consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge and developing life skills, which are conducive to individual and community health" (World Health Organization, 2012, p. 13). It is an element of health promotion that focuses on "building individuals capacities through educational, motivational, skill-building and consciousness-raising techniques" (World Health Organization, 2012, p. 15).

The youth participants indicated that they needed educational support that would assist them with improving their health and avoiding negative influences, such as violence and substance abuse. For instance, one of the participants, a 16 year old female, described a state of harmony that required health education about the dangers of substance abuse to create a safe environment:

"I expect them to give us information on the right things and to warn us about the wrong things like drugs and alcohol" (FG2 P6).

Another 16 year old female stated that the she expected health care professionals to provide health education about how to avoid dangerous habits and lifestyles:

"They can provide us with information. Some people like to do the wrong stuff so they should help us set our minds away from the wrong stuffs and lead us in the right direction" (FG2 P6).

A 16 years old female felt that health care professionals should provide information about how to succeed academically:

"...coming to the school here and telling us to be focused and to read our books. It is when you are able to read your books and pass examinations in school that you will become successful. You do not have to get behind in your school work and you have to be positive" (FG5 P1).

Furthermore, a youth participant (16 year old male) stated:

"I want them to give me advice when I need it and guide me in the right way. I want them to tell me how to be healthy... They should tell the people in the community to live in peace with each other and stop fighting, say; they should stop taking tik because the effect of it is not good for their lives..." (FG4 P4).

Health education targeting young people can be implemented in the format of lectures, seminars, workshops and printed materials such as hand bills or fliers. Generally, it should entail the setting of goals and / or objectives for learning, providing information and materials in order to build the client's confidence and to assist the client adapt the prescribed behaviour. According to Tate (cited in Mohanna, Cottrell, Wall & Chambers, 2011, p. 20), good interpersonal communication skills are needed for the process of health education with clients.

- **Concluding statements**

From the findings of the sub-category about providing health education, the following concluding statements were made:

- The agent should take an active role in providing health education / information to the recipient in terms of community and legal resources.
- The agent should create a safe environment where peace exists and a "state of harmony" that would contribute to a satisfactory level of wellness.

4.5 THIRD STEP IN THE FRAMEWORK DEVELOPMENT PROCESS

Table 4.4 presents an overview of the categories, sub-categories, concluding statements of the findings from interviews with the youth. Step 3 in the development of the framework addressed the deconstructing and categorising of concepts. In this step, the themes and categories with the concluding statements were reviewed to identify main attributes, characteristics, roles and subsequently to organise the concepts according to their features. Concepts were then organised according to the survey list of the Practice Orientated Theory of Dickoff *et al*. (1968).

Table 4.4:   Categories and subcategories identified from data analysis about the expectations of the youth

Categories and sub-categories	Summary of concluding statements	Essential concepts in the conceptual framework
Dimensions of wellness related to healthy body, mind, spirit and positive interactions		
Healthy living	The practice of a balanced healthy lifestyle that consists of eating enough nutritious food, exercising regularly and being actively involved in physical activities Wellness includes the recipient being focused and goal-directed To attain wellness, the recipient makes conscious efforts (volition) to live life in a way that promotes physical and mental wellness and avoiding a stressful life The recipient must be actively involved (participation) in the process of seeking and maintaining his or her wellness	Terminus: Characteristic of wellness and healthy living Recipient: Being focused and goal directed Characteristic of self-restraint Holistic nature of the recipient Roles of shared responsibility and self-management in attaining wellness
Not necessarily the absence of sickness / illness	Wellness could mean an individual who has a healthy immune system Wellness transcends the mere absence of diseases and illnesses	Terminus: Characteristic of wellness is transcending Healthy immune system

Categories and sub-categories	Summary of concluding statements	Essential concepts in the conceptual framework
	A good life perception and attitude is important for a person to experience wellness even when illness or disease is present in the body	Good outlook on life
Caring for oneself physically	Wellness involves the practice of personal hygiene and self-care activities; such as bathing, feeding, dressing in clean clothes and toileting It generally involves the care of one's physical appearance An evaluation of the recipient's wellness can be done through an assessment of the outward physical appearance The responsibility for wellness lies with an individual to care (look after) oneself and to self-manage and influence their health to wellness	Terminus: Characteristic of wellness is self-care and self-responsibility Recipient: Role of self-management and self-responsibility in the physical domain Procedure: Physical assessment of wellness
Mind (psychological, emotional) and spiritual wellbeing as an essential part	Wellness of the youth victim of violence also encompasses the interrelated components of mind (emotional,	Terminus: Characteristic of wellness is to possess a healthy mind and

Categories and sub-categories	Summary of concluding statements	Essential concepts in the conceptual framework
of attaining wellness	psychological) and spiritual wellbeing of the recipients Emotional wellbeing is the experience of security, the control of feelings and having a realistic and positive view of life, as well as the future and also the ability of a person to do a realistic self-assessment and set boundaries, as well as being able to independently cope with stress Mental wellbeing relates to both the emotional and psychological states. It includes having a focus in life, autonomy, self-acceptance, personal growth and development and experiencing and sharing positive associations with people Spiritual wellbeing (spirituality) is the consciousness and connection of the recipient with a transcendent being or force(s) and does not necessarily manifest itself as the practice of a religion; it also includes the values, principles and attitudes of the person. This, in turn, provides the recipient with a deep sense of wholeness Spirituality helps the recipient to handle negative situations and supports the healing process towards holistic wellness	spirit (holistic) Recipient: Characteristics of the recipient are self-awareness and adaptability

Categories and sub-categories	Summary of concluding statements	Essential concepts in the conceptual framework
Healthy personality	Self-acknowledgement should take place through knowing oneself, respecting oneself and to be proud of achievements Wellness includes the recipient possessing and displaying a healthy personality, which is a demonstration of consistent behaviour patterns and intrapersonal processes. Personality can be described on the basis of how emotionally stable, friendly, sociable, hard-working and refined a person is A healthy personality is expressed in positive mental health which is considered important for holistic wellbeing, peace of mind, contentment, personal adjustment, emotional control and physical living	Terminus: Characteristic of wellness is to have a healthy personality through demonstrating consistent behaviour patterns and intrapersonal processes Recipient: Practice self-acknowledgement
Common problems among youth in the context of the community		
Alcohol and drug abuse	Alcohol and methamphetamine (tik) abuse is common in the community Providing young people in the community with recreational facilities will keep them positively engaged and curb the	Context: Contextual reality include alcohol and drug (methamphetamine) abuse

Categories and sub-categories	Summary of concluding statements	Essential concepts in the conceptual framework
	issue of alcohol and drug abuse	Procedure: Recreational activities
Teenage pregnancy	Teenage pregnancy is common among young girls in the context or community of study	Context: Contextual reality includes teenage pregnancy
Violent behaviour	Violent behaviour is common among young people in the context This situation affects the wellness of the youth in the community, for instance it causes mental and physical health problems	Context: Contextual reality includes youth violence
Building a sound and trusting relationship		
Confidentiality and trust	An agent is a highly respected and influential individual in the community An agent must provide confidential services for the recipient in a respectful and empathic manner	Agent: Being trustworthy and empathic Procedure:

Categories and sub-categories	Summary of concluding statements	Essential concepts in the conceptual framework
	Confidential services build trust and respect between the agents and the recipients	Confidential service facilitates the leadership of the youth victims of violence toward wellness
Support	The youth victims of violence expect health care professionals to be supportive as leaders	Agents:
		To be a leader (authority and influence) and providing support to the recipients
	Health care professionals are a significant part of the social environment of the youth victims of violence and they occupy a position of authority and influence to lead persons to wellness	Having people skills
		Being empathic
		Being competent
	The Provincial Nursing Strategy of the Western Cape Province recommends that health care professionals should demonstrate their leadership capacity in practice and legal documents guide health care professionals to understand their leadership responsibilities	
		Context:
		Policies and procedures
	People skills are required for building a sound and trusting relationship between individuals	Legal and ethical framework
	Empathy is important in health care provider-patient interactions in order to promote wellness	
		Procedure:
	Agents are viewed by the recipients as competent health care professionals who assist with informed decision-making	Provision of information to guide informed decision-

Categories and sub-categories	Summary of concluding statements	Essential concepts in the conceptual framework
	The leadership process when the agents lead the recipients toward wellness starts at their first encounter. During the initial period following an incident of violence, the agents should prepare the recipients promptly for wellness by "being there for them", therefore, the focus should be on availability and listening to their needs	making Procedure: Initial phase – being there for them, available and listen
Information sharing by the team	Trustworthy (accurate, adequate, relevant) information must be given to youth to nurture a sound and trusting relationship Therapeutic communication should be utilised by the agents in guiding the recipients through emotional support to stay calm and not to be afraid Agents are expected to empower the recipients by providing them with accurate and complete information that will serve as a precaution for being a victim of violence In an initial phase of care, the agent should provide the recipients with accurate information on how to avoid risky lifestyles and guide them with effective strategies necessary for coping with trauma; this will in turn support	Procedure: Information management Therapeutic and two-way communication Nurturing a sound and trusting relationship Providing emotional support Coping skills Agents: The agent has an empowerment role

Categories and sub-categories	Summary of concluding statements	Essential concepts in the conceptual framework
	their wellness	Dynamics: Empowerment
Professional attitudes	The agent needs to exhibit a professional attitude characterised by respect whenever attending to the recipient Professional attitudes towards the recipients' dignified care and demonstrated through passion and willingness to care.	Agents: Should be professional
Guidance of youth to wellness		
School programmes	The agents should reach out to in-school youth in the community and screen the ones who are victims of	Procedure:

Categories and sub-categories	Summary of concluding statements	Essential concepts in the conceptual framework
	violence, provide them with counselling and positive coping skills and encourage reflection on their problems to be addressed Partnerships with instructors at schools, parents and guardians are important in leading youth victims of violence towards their wellness in school outreach programmes	School outreach programming Screening for unreported youth victims of violence Counselling Positive coping skills Agents: The agent has the role of a collaborator Dynamics: Participative leadership Partnership
Initiating community outreach programmes	Community outreach programmes should be regularly organised by the agent to reach, support and meet the broader needs of community members; particularly individuals who are most at risk, as a preventive measure Agents should implement community outreach services programmes to distribute knowledge about wellness targeted at victimised youth in their community in partnership with other community stakeholders; such as	Procedure: Community outreach programmes Counselling Screening Positive coping skills

Categories and sub-categories	Summary of concluding statements	Essential concepts in the conceptual framework
	community leaders, public health professionals, as well as government and non-governmental Organizations A multifaceted and contextual approach is necessary to lead recipients towards taking part in their responsibility for wellness A participatory approach will enhance wellness in the community	Agent: The agent has the role of a collaborator The agent needs to be synergistic in order to carry out role as a collaborator Dynamics: Shared responsibility among stakeholders is important Participative leadership is supporting the leadership of the recipients to wellness
Providing counselling services	The provision of counselling services to recipients is an important aspect of the agent in being non-judgemental during guidance toward wellness that can provide them with emotional support. This can be provided through a single or multiple sessions in different ways; such as physical face-to-face interaction, telephoning, or emailing that allows two-way communication to take place	Procedure: Counselling Follow-up Agent: Characteristic of the agent is to be emotionally intelligent

Categories and sub-categories	Summary of concluding statements	Essential concepts in the conceptual framework
	The agents should not only focus on the physical recovery of traumatised youth victims but also on their emotional (heart breaking), spiritual, social and psychological wellness	and perceptive
Role-modelling	A health care professional is a leader who acts as a role model An empowering environment where the agents as leaders and role models demonstrate the quality of being change agents for wellness is necessary in the leadership of the recipients towards wellness Role models have respect for other people	Agent: Role modelling is a responsibility of the agent Should act as change agents Dynamics: Active participation Empowerment - context Shared responsibility
Giving health education	The agent should play an active role in providing health education / information to the recipient with regard to community and legal resources The agent should create a safe environment where peace exists and a "state of harmony" that will contribute to a state of wellness	Agent: Role of the agent is to empower the recipient

4.6 SUMMARY

This chapter describes the findings of the focus group discussions that were conducted among the youth victims of violence (Phase 1 of the study). The findings revealed that the youth victims of violence understood what wellness meant and they described it holistically to include healthy living, transcending a mere absence of illness or sickness in the body, practising self-care habits such as personal hygiene and grooming, wellbeing of the mind (psychological, emotional) and spiritual wellbeing and having a balanced personality and interpersonal processes. Also, they appeared to be aware and concerned about the issues; such as substance abuse, teenage pregnancy and violent behaviour that are prevalent in their community. They indicated that they expected health care professionals in their community to be supportive and to demonstrate their leadership in guiding youth victims towards wellness through school and community outreach programmes, provision of confidential and respectful counselling services, role-modelling and the provision of health education. These findings are discussed comprehensively and supported by a literature control. The chapter ends with introducing the third step in development of the framework, addressing the deconstruction of the findings and categorising the concepts according to Dickoff *et al*. (1968).

In the following chapter, findings from the unstructured individual interviews conducted amongst the health care professionals (Phase 2 of the study) are discussed and contextualised by means of supporting literature.

CHAPTER 5

DISCUSSION OF FINDINGS FROM PHASE 2: HEALTH CARE PROFESSIONALS
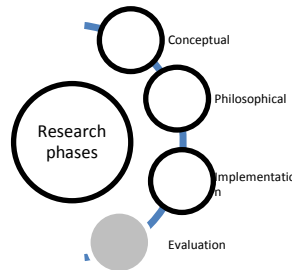
5.1 INTRODUCTION

In the previous chapter, a discussion of the findings from Phase 1 of the study that focused on exploring the expectations of the youth in relation to health care professionals guiding youth victims of violence towards wellness and supporting literature are presented. In this chapter, the findings of the second phase of the study are provided. The objective is to explore the experiences of the health care professionals while leading youth victims of violence towards wellness.

This chapter begins with an overview of the field work activities that culminated in the individual interviews of the health care professionals. A description of interviewees' demographic profile is presented before the findings that emerged after data analysis had been conducted. The findings are presented in a narrative form using excerpts from the interviews with the health care professionals.

5.2 OVERVIEW OF THE FIELDWORK ACTIVITIES

Preceding the conducting of the individual interviews with the health care professionals, the researcher telephonically contacted each one of them working at the study site to schedule an appointment for the interview. All of them were receptive and willing to be interviewed. Hence, convenient interview times and locations were booked with them. When meeting each one of them, they were informed about the purpose and objectives of the study and were also given the information sheets containing a full description of the study. They were also required to sign consent form to grant permission for the interviews to take place.

The researcher conducted unstructured individual interviews in English to collect data from the health care professionals who were very knowledgeable and experienced in providing health care services among the population. One broad introductory question was asked to each one of the interviewees: *'Can you tell me about experiences in guiding and leading youth victims of violence towards wellness?'* Subsequently, probing questions were asked that followed their responses. The interviewees' were allowed to freely tell their stories without the researcher interrupting them. The researcher wrote down field notes during the interviews. Those notes were expanded directly after each interview.

Data saturation was reached after seven unstructured individual interviews were conducted among the health care professionals.

5.3   DEMOGRAPHIC PROFILE OF THE HEALTH CARE PROFESSIONALS

Of the seven health care professionals who participated in the unstructured individual interviews, two were professional nurses, three were medical doctors and two were social workers. The average age of the health care professionals was 44.1years. Five of them were females and two were males. Two of them had been working in the community for two years, two for four years, one for six years and another one for 10 years. Table 5.1 shows the summary of the profile of the health care professionals.

Table 5.1:   **Characteristics of the health care professionals**

Interviewee's Code	Type of health care professional	Age (years)	Gender	Number of years working in the community
Intw.1	Medical doctor	72	Male	10
Intw.2	Social worker	31	Female	6
Intw.3	Social worker	29	Female	2
Intw.4	Professional nurse	42	Female	7
Intw.5	Medical doctor	35	Female	4
Intw.6	Medical doctor	45	Male	4
Intw.7	Professional nurse	55	Female	2

5.4 EXPERIENCES OF THE HEALTH CARE PROFESSIONALS

5.4.1 Central theme

The central theme that emerged from the analysis of the individual interviews was that the health care professionals recognised the fact that wellness was very important. However, they felt that guiding youth victims of violence toward wellness was a challenging process. This central theme was reinforced by three categories: (i) points of view about wellness, (ii) barriers to leading youth victims of violence towards wellness and (iii) guidance to leading youth victims to wellness (Table 5.2). These categories and their sub-categories are discussed in the light of supporting empirical literature.

Table 5.2:   Categories and subcategories about the experiences of the health care professionals

Category	Sub-category
1. Points of view about wellness	1.1. Different holistic points of view about the term wellness: 1.1.1 A holistic view of a person 1.1.2 Resilience 1.1.3 Healthy lifestyle
2. Barriers to leading youth victims of violence towards wellness (context)	2.1 HCPs report challenges to lead youth victims of violence towards wellness as follows: 2.1.1 Youth issues Violent behaviour Drug and substance abuse 2.1.2 Unsupervised youth 2.1.3 Parental and socioeconomic issues 2.1.4 Attitudes of staff 2.1.5 Lack of structures 2.1.6 Lack of human resources 2.1.7 Process of guiding youth victims to wellness

Category	Sub-category
3. Guidance to leading youth victims to wellness	3.1 HCP report on strategies to assist with guiding youth of victims to wellness 3.1.1 Support Support groups Support from community / family Counselling services 3.1.2 Recreational activities 3.1.3 Competent staff to work with youth victims of violence 3.1.4 Team leadership

5.4.2   Category 1: Point of view about wellness

The health care professionals held different perspectives of wellness and they described wellness as a multidimensional concept. While some of them viewed the concept of wellness as the whole person, other HCPs who viewed the concept in terms of resilience and the practice of a healthy lifestyle; it was very much similar to the reports of the youth who participated in the focus group discussions during Phase 1 of the study.

5.4.2.1   Sub-category 1: A holistic view of a person

A holistic approach views parts of a whole as closely connected in a manner that they cannot exist independently. In health care practice, it involves the management of the whole person as opposed to focusing on the signs and symptoms of a sickness or illness only (Oxford Dictionaries, 2014b).

The health care professionals indicated that to understand wellness completely, one should have the ability to see the patient as a holistic being made up of interrelated bio-psycho-social-spiritual features; the body, mind and spirit. For example, one of the interviewed health care professionals (a medical doctor) pointed out that wellness occurred when there was equilibrium in these areas and that as a health professional, it was necessary to view the patient that way in order give efficient care.

"You've got to look at the patient as a whole person which I think is body, mind and spirit. You can't just treat [the] *body, you can't just treat emotions and you can't just treat spirit.*

You've got to have a balance between the three. So, my understanding of wellness is when you have wellness in all three of those areas. That is what true wellness is" (Intw. 5).

A social worker also described wellness holistically by stating:

"Wellness, I feel, has to do with having stability in your life, to be well spiritually, physically and emotionally, to have a balance in your body, mind and spirit... you need to see your client as a unified being having these various parts" (Intw. 3).

Another health care professional (a medical doctor) stated that wellness consisted of a balance between the biological, psychological and social areas that are well integrated:

"Wellness encompasses various aspects of a human being, the bio, psycho and socio. And if all of those are in harmony, then you can say that a person is experiencing wellness. Any of those being out of balance, then certainly there has to be intervention in terms of addressing those particular issues so that the person can reach an equilibrium state where wellness can be experienced in full... It also means to be biologically and psychologically intact and obviously, the social circumstances need to be in harmony as well" (Intw. 6).

Furthermore, a professional nurse echoed that wellness included the person and his environment:

"Wellness, I will say, is concerning your patients' health, their body, mind and spirit and taking proper care of their environment. I usually tell the girls (referring to the home based carers) *when they get to a house that they must scan that house, you know, scan that house. It's no use saying you have to take your medicine and wash yourself when your bed is untidy. You must see to that too. It's not just that the patient looks good, the environment must always be good, you know... it's all part of it"* (Intw. 7).

This holistic view of a person reported by the health care professionals in this study supports the meta-theoretical assumption made by the researcher in Chapter 1 of this study based on the Theory of Health Promotion in Nursing (University of Johannesburg, 2009, pp. 4-6). The assumption is based on the principle that a person is a holistic being who functions in a cooperative and integrative manner with the internal and external environment. The internal environment comprises the body, mind and spirit while the external environment comprises the physical, social and spiritual dimensions of the person. Furthermore, it identifies with the theory of holistic nursing practice that promotes the comprehensive wellness of clients and

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views a person as an integrated and interrelated whole comprising the bio-psycho-social-spiritual (body, mind and spirit) dimensions. Dossey and Keegan (2009, p. 4) define holistic nursing as "all nursing practice that has healing the whole person as its goal". Holistic practice allows health care professionals to facilitate the responses of person to heal and to achieve wholeness and wellness.

Martha Rogers (1914 – 1994) describes a person as a unified whole and views human beings as consisting of the body, mind and spirit and consisting of an open system that is constantly interacting with the environment. In her view, the goal of nursing should be to promote a unified interaction between the various parts of the person and his environment and she further identifies that the primary aim of nursing is to promote the health and wellness of individuals (Alligood, 2014, p. 232).

This holistic perspective of person is important because it assists health care providers to appreciate the human experience of illness, health, wellness as complicated and dynamic, particularly when guiding victims of violence on their wellness journey. In addition, it assists them to be aware of the interconnectedness of these three parts of a person and to focus on the totality of an individual and to become therapeutic partners with their clients while integrating wellness approaches and empowering them.

- **Concluding statements**

From the findings of the sub-category about a holistic view of a person, the following concluding statements were made:

- Wellness is equipoised in three areas of a person; the body, mind and spirit.
- Wellness consists of a balance between the internal (biological, psychological, spiritual) and external (social) areas that are well integrated.
- The agent should have a holistic perspective of the recipient when leading him or her to wellness.

5.4.2.2   Sub-category 2: Resilience

According to the Merriam-Webster Dictionary (2014), resilience is the ability of a person to be strong, healthy, or successful again following the occurrence of something bad. In the Nursing Interventions Classification (NIC), the term resilience is described as "a pattern of

positive responses to an adverse situation or crisis that is sufficient for optimizing human potential and can be strengthened" (Bulechek, Butcher, Dochterman & Wagner, 2013, p. 536). Resilience is associated with an individual's ability to cope with suffering such as from violence.

Findings from this study showed that the health care professionals viewed wellness as resilience which involved an individual having the qualities that allow him or her to cope with unbearably difficult situations. For instance, one of the health professionals (a medical doctor) commented during an interview that a healthy individual should be able to cope well during trying times:

"…it depends on who is the person who is to evaluate the other one to see whether he or she is experiencing wellness. My perception of wellness could be totally different from somebody else. To me, that a person can deal with his or her circumstances well no matter how difficult, to be able to cope with his or her circumstances well and manage it and be able to live around those troublesome moments and circumstances and then experience, you know, wellness. Learning is very important, continuous learning and development which is a very important part of being a person who is intact" (Intw. 6).

A social worker also shared the same view:

"I think it also means that every part of your life is in balance; that you are not able to let things get out of hand even in bad situations which are part of life. Like even when stuffs [sic] you don't expect come up, you should still keep on going on no matter what, to pick yourself up and continue with life. So, I think it really means when you can withstand things in the face of chaos" (Intw. 3).

These findings support key theoretical assumptions upon which the researcher based the current study (Chapter 1). The assumption suggests that the various parts of a person (bio-psycho-social-spiritual) interact with the environment and as time passes, these interaction change. Secondly, it proposes that a person seeks dynamic ways of directing and controlling his or her individual behaviour, including the experience of community violence that could interfere with the homeostatic milieu of the person.

In addition, resilience promotes healing and health care professionals are in a unique position to lead clients, individuals and families towards wellness through processes of healing.

Resilience assists clients to transcend their suffering and move to wellness. Healing is a multidimensional concept that is described as a process that enables a person to become whole in the physical, emotional, cognitive and spiritual domains. Dossey and Keegan (2009, p. 48) define healing as "a process of bringing together aspects of one's self, body-mind-spirit, at deeper levels of inner knowing, leading toward integration and balance with each aspect having equal importance and value". All persons have the potential to be healed and restored and to be resilient.

In community health practice, health care professionals have an important role in promoting resilience among clients and the community that they serve. In addition to treating physical injuries, they could assist clients to cope with the psychological consequences; for example anxiety, depression and post-traumatic stress that may be the result of stressful situations like youth who experiences violence (Allender, Rector & Warner, 2014, p. 555-556). They can assist the victims of violence by teaching them problem-solving skills and ways of circumventing stress, caring for them, showing concern and warmth, as well as developing and strengthening their coping skills in a way that ensures optimism and a high level of wellness. Likewise, the community could be steered to support the youth victims affected by violence. By doing that, health care professionals would enable the youth victims to recover from their traumatised state of being to continue living life with a sense of hope and mastery.

- **Concluding statements**

From the findings of the sub-category about resilience, the following concluding statements were made:

- Wellness involves an individual having the qualities that allow him or her to rise above difficult situations (resilience).
- The agent could lead the recipients to transcend traumatic experiences and move towards healing and a high level of wellness.
- The various parts of a person (bio-psycho-social-spiritual) interact with the environment and change as time passes.
- A person seeks dynamic ways of directing and controlling their individual behaviour, including the experience of community violence that interferes with the homeostatic milieu of a person.

- Resilience promotes healing and health care professionals are in a unique position to lead clients, individuals and families towards wellness through processes of healing.

5.4.2.3   Sub-category 3: Healthy lifestyle

A healthy lifestyle refers to the pattern of an individual's behavioural choices and practices that promote and maintain personal health and wellbeing. The practice of a healthy lifestyle has been related to lower levels of illness or disease and high levels of wellness among individuals. Loef and Walach (2012, p. 164) suggest the following as important considerations for a healthy lifestyle: maintaining an ideal body weight (BMI 18.5–25kg/m^2), not currently smoking or never smoked, exercising and being physically active (ca. 3.5 hours/week), following a healthy diet rich in vegetables and fruit and consuming alcohol cautiously (5–15g/d for women and 5–30g/d for men).

From the findings, it was clear that the health care professionals interviewed in this study were very concerned about the health promotion behaviour that their clients practiced. For instance, one of them (a professional nurse) described wellness as the practice of a healthy lifestyle that should involve the avoidance of health damaging habits like eating unhealthy food, smoking cigarettes, abusing alcohol and drugs and living in poor environmental conditions:

"…also the hygiene, the person's lifestyle and habits like not smoking, using drugs and drinking alcohol, eating well and not living in poor circumstances and generally living a healthy lifestyle and keeping fit always" (Intw. 4).

A medical doctor stated:

"…consciously taking care of yourself and focusing on your health habits. You can expect different forms of wellness, different degrees of wellness at different times of your life… But you see, some have an acceptance of a lower level of wellness as being okay and some have a really high expectation and sometimes almost too high and unrealistic of how well they should be and I think it's important too, to try and find that balance somewhere. For example, a forty year old diabetic who should have an acceptance of the fact that they are forty and don't feel too well already whereas I think the patient should feel better than they do. Then we get some patients who are eighty and they find something wrong with their stomach, then they want to have a big operation for gastric cancer" (Intw. 5).

Also, in their explanations of wellness, some of the participants stated that they had been actively involved in educating their clients on health promotion. A medical doctor stated:

"I think it is mainly the experiences that a person has of their own wellness that is the most important thing. When a patient walks in through my door with their worries, I examine them to find out what they need and I seriously talk to them about prevention. By the end of our session, they usually leave here feeling better" (Intw. 1).

An excerpt from a professional nurse also supported this view of encouraging clients to be involved in health promotion activities:

"We don't want our people to get a stroke or HIV, that's why we talk and talk promotion and prevention and all that... We want our people to be healthy. Like I said, we are doing promotion and prevention; they must be healthy and we don't want them to be sick and then wellness comes in. They must be healthy" (Intw. 7).

It could be that the health care professionals stated their concern about their clients getting a stroke because cardiovascular diseases are common among the adult population. Likewise, HIV is a major public health issue in South Africa and there are continual efforts by the government and other stakeholders to tackle this problem in the community.

- **Concluding statement**

From the findings of the sub-category about a healthy lifestyle, the following concluding statements were made:

- Wellness includes the practice of a healthy lifestyle; such as avoidance of health damaging habits like eating unhealthy food, smoking cigarettes, abusing alcohol and drugs and living in poor environmental conditions.
- All health care professionals should be involved in promoting the wellness of the youth.
- Wellness includes taking care of oneself and focusing on healthy habits.
- Wellness differs at different times of one's life.

5.4.3   Category 2: Barriers to leading youth victims of violence towards wellness

The health care professionals identified hindrances that they encountered while leading youth victims of violence to wellness in their community. These barriers were violent behaviour and

substance abuse amongst the youth, unsupervised youth, low socioeconomic circumstances of most of the parents in the community, negative attitudes of staff members, inadequate structures and human resources and a challenging process of guiding the victims of violence towards wellness.

5.4.3.1   Sub-category 1: Youth issues (violent behaviour, drug and substance abuse)

The health care professionals appeared to be frustrated with the problem of youth violence in their community (field notes) and they mentioned that these violent behavioural patterns amongst the youth cause a huge barrier to guiding them towards holistic wellness. They also indicated that aggression and nonchalant attitudes played a huge role in causing violent behaviour among young people. For instance, one of the medical doctors interviewed articulated a concern about the issue of violent behaviour among young people in the community, particularly since it appeared that the young people did not understand the repercussions of their actions:

"...adolescent[s] *are violent towards other adolescents in this community and I don't think that there is always that understanding that my actions have consequences and I'm going to feel the heat of those consequences. So, there is this impulsiveness, maybe due to not having much grounded emotional growth. So, you get upset because these kids who now have these experiences that make them grapple..."* (Intw. 5).

A social worker shared the same view as the medical doctor and (with a disheartened look on her face: field notes) stated further that it appeared to her as though a good proportion of the young people living in the community were delinquent:

"...they don't think of the problems they are causing for us to manage, they want to fight with other children and then they get into trouble... Sometimes, they steal other children's stuff and become violent with one another" (Intw. 3).

It was also reported that violent behaviour had been observed among young people at the high school. For example, a professional nurse who was working in the primary health care at the time of the interview stated aggressive behaviour was not uncommon among the learners in the community high school:

"...So, that is one of the main problems even in the school also. Some of the students are aggressive" (Intw. 4).

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She continued by relating a story of a serious case of violence among youth learners at the high school that resulted in a serious medical emergency. She said she was called upon by the school authority to come and attend to these youngsters who had engaged in a serious violent fight over a disagreement while in their classroom. In the very own words of the health care professional, she said:

"…he hit the other with a stick or something in the class and one of them was lying there unconscious" (Intw. 4).

In addition, it was mentioned by the health care professionals interviewed that drug and substance abuse; particularly the abuse of alcohol, cannabis (*dagga*) and methamphetamine (*tik*) among the youth population was rife in the community. It created a situation that left them helpless even though they were very willing to assist and guide the youth to long-lasting wellness. For instance, one of the medical doctors repeatedly said he felt helpless about the problem of substance abuse in the community:

"Drug and alcohol use is enormous in this community… it is a big problem here" (Intw. 5).

This view was shared by a professional nurse who reported that the social problems recorded in the community could be linked to the use of cannabis among many youth in the local community:

"…the cause of the social problems that we've got here is the drug problem… One of the famous drugs that we have got here is the dagga, cannabis and it is like every child is smoking that stuff… There are so many children here that are smoking dagga" (Intw. 4).

Another health care professional (a medical doctor) pointed out that alcohol abuse and the use of tik were the main driving factors for youth violence in the community. He stated:

"The common cause of violence among the youth is alcohol and methamphetamine…" (Intw.1).

One health care professional (a professional nurse) implicated the use of methamphetamine as the cause for the large numbers of youth violence victims who reported to the clinic for services:

"Tik, I mean that is a big issue, it's the major factor causing violence in general and violence amongst youth... Many of them become violent and come [for] *treatment and it is a big challenge for us, you see"* (Intw. 6).

Interestingly, these findings are similar to the reports of violent behaviour, drug and substance use by the youth in the community of study that were described by the youth who participated in the focus group discussions of this study. It further confirms previous reports that violence and substance abuse among youth constitute a huge problem among youth in South Africa, including in the Western Cape Province (Department of Social Development Republic of South Africa, 2013, p. 33; Harker *et al*., 2009, p. 4; Pasche & Myers, 2012, p. 338; Plüdderman *et al*., 2010).

- **Concluding statements**

From the findings of the sub-category about youth issues (violent behaviour, drug and substance abuse), the following concluding statements were made:

- Violent behavioural patterns are common among youth in the community.
- The agents should manage their frustrations with the problem of youth violence in their community (context), a situation that causes a huge barrier to guiding the recipients towards wellness.
- The abuse of substances; such as alcohol and cannabis (*dagga*) and methamphetamine (tik) is rampant in the community and this is the leading cause of youth violence in the community.

5.4.3.2   Sub-category 2: Unsupervised youth

Parental neglect and abandonment coupled with substance abuse was also highlighted by the health care professionals as being an obstacle in the community. A medical doctor indicated that lack of early maternal care and support encouraged violence among young people:

"It comes from the lack of attention towards the children, especially during the early years. Hopefully, the mothers can try and learn how to actually look after children. I mean, learn to give support to their children. To try and read to them, take them to the library or play with them constructively..." (Intw. 1).

One of the social workers stated that violence was common in the community because many of the young people were left unsupervised during the weekends and many of them went out to socialise with friends and then they might get attacked and end up being victims:

"...the children are mostly unsupervised over the weekend and they go drinking and partying with their friends. In most cases, that is when the violence occurs among their peer groups. Also, the issues that they are confronted with every day, in fact, it's all that and the things that they are dealing with in their daily life. Some parents are in jail and the children are getting frustrated and becoming violent among each other" (Intw. 3).

Another social worker shared the same perspective that the high number of violent attacks was as a result of lack of parental supervision coupled with substance abuse:

"Mostly, it happens if there is no parental supervision and everyone can come into the house or lots of substance abuse..." (Intw. 2).

This finding supports the reports by the Department of Social Development, Republic of South Africa (2013, p. 33) and the 2008 South African Youth Risk Behaviour Survey report (Reddy *et al*., 2010) which state that substance abuse and youth violence are common in the community during weekends.

When parents fail to provide the appropriate and necessary guidance and supervision for their children, it could contribute to their children's inclination to abuse substances, such as drugs and alcohol. For instance, it could result from them keeping the company of other people who abuse such substances or it might be a reaction to going through some psychological or emotional need for love and acceptance. Also, when a young person is put in the care of an abusive adult, the child is very likely to be abused or exploited by the adult and this could go unrecognised for a long period of time. Hence, there is a need for young people to be supervised appropriately by responsible parents who would also model responsible behaviour for their children. Also, it may be necessary that young children are taken care of by trusted and responsible adults.

- **Concluding statement**

From the findings of the sub-category about unsupervised youth, the following concluding statement was made:

- Parental supervision of youth, particularly during weekends, is a way of combatting some of the causes of violence in the community.

5.4.3.3   Sub-category 3: Parental socio-economic issues

The low economic status of most of the community members was stated as one of the barriers that challenged the health care professionals in leading youth in the community towards wellness. To illustrate this, one of the medical doctors interviewed indicated that most of the mothers who were still teenagers also survived on the grants received for the care of their children:

"…the majority of the people here are living on social benefits. It is either that they are living on social benefits for their children or the mothers are living on the disability grant, social grant…" (Intw. 1).

He continued by saying that oftentimes that lead to domestic violence in the family. For instance, in a situation where the father of a child whose mother received a disability grant expected to help spending the social grant that the mother collected:

"…and the man who doesn't usually directly receive the benefits, demands the benefits while the mother who has actually been given the money by the social services has to try and protect it and that leads to violence…" (Intw. 1).

In addition, some of the health care professionals mentioned that the breakdown of the traditional father-mother-children family structure resulted in single parenthood, especially mother-headed homes in the community was another important factor responsible for violence in the context. One of the health care professionals (a social worker) argued that this situation is further complicated when some of those single mothers had an unhealthy control over their children:

"Many single mothers taking care of their children and they can't do much… These children join gangs and do violent stuffs [sic]*… Then the children who are mini adults are now kept small because of very maternalistic* [sic] *dominance. You know, these mothers are quite dominant sometimes and it's because the fathers are long gone…"* (Intw. 2).

- **Concluding statement**

From the findings of the sub-category about parental socioeconomic issues, the following concluding statement was made:

- The socio-economic issues in the community (context) lead to violence that constitutes a barrier for the agents in leading the youth in the community towards wellness.

5.4.3.4 Sub-category 4: Attitudes of staff members

In general, the health care professionals interviewed were unhappy about the attitudes of some of their colleagues towards young people in the community who visited the primary health clinic for violence victim management services. One of the social workers mentioned that some of the health care professionals responsible for treating the youth who had been victims of violence were unprofessional:

"I can tell you that some people (referring to the health care professionals) *are having a difficult time with these youth when they come and it is not positive. These youth are very sensitive and they know when you are not kind to them. You need to be trained on how to deal with young people with problems"* (Intw. 3).

Likewise, a professional nurse acknowledged that the attitude of health care professionals was a critical factor that influenced their leadership of the youth victims of violence:

"We are considered as leaders in the community... our attitudes as health care professionals if it is not right towards them then we would put them in the wrong direction" (Intw. 4).

A medical doctor revealed that as a result of the negative attitudes of some health care professionals, some of the youth victims of violence went elsewhere in the hope of finding more helpful services:

"I mean the clinic [the community clinic at the study site] *here is unfortunately not a supportive clinic for them* [youth victims of violence]*... because they all go to the clinic in* [another location] *and it's because of the attitude of the staff in the clinic"* (Intw. 1).

Similar reports appear in previous studies that the negative unprofessional attitude of health professionals becomes a barrier between the available health services and young people. There is a common agreement and understanding among all health professions; including

nursing, social work and medical professions that professional behaviour is an important element of good and decent practice.

Furthermore, there is a need for promoting patient-centred professionalism in the provision of health services to youth victims of violence. The concept of patient-centred professionalism entails respect of clients' rights and treating clients with utmost dignity. In other words, it is a concept that puts a high premium on how patients are valued, respected and treated. These elements include the use of good communication skills as well as providing accessible, rapid, well-organised, friendly and respectful services (Hutchings, Rapport, Wright, Doel & Wainwright, 2010; Hutchings & Rapport, 2012).

- **Concluding statements**

From the findings of the sub-category about attitudes of staff members, the following concluding statements were made:

- There is a need for the agents to be leaders who demonstrate professional behaviour and attitudes to lead and provide supportive professional services to the recipients on their road to wellness.
- The agents need to be trained how to lead youth.
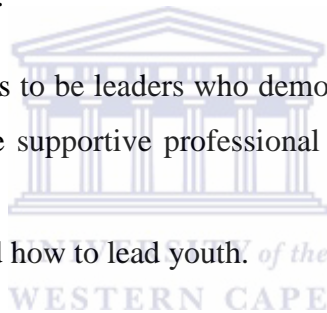
5.4.3.5 Sub-category 5: Inadequate structures

The health care professionals mentioned that another factor that made the process of guiding the youth victims of violence towards wellness cumbersome was the lack of recreational amenities for young people in the community to keep them positively engaged. As a result, the health care professionals were of the view that the youth did not get enough opportunity to actualise their full potential. A professional nurse stated (with enormous concern in the tone of her voice: field notes):

"…there are no facilities for these youngsters in the community, a recreational place, hall, or facility for them where they can go and play say like table tennis …there is nothing for the kids to do to assist them... they are stagnated. They don't see further. Our youngsters have no future" (Intw. 7).

Another health care professional, a medical doctor, mentioned to the contributing factor of inadequate development in the area:

"…We don't see proper human development in our villages, in our towns. The main reason is that community members and community leaders… they don't work towards a proper youth development programme…" (Intw. 6).

Furthermore, they stated that they faced challenges while supporting victims of violence at the primary health clinic in the community because the facility in the community did not offer its services at a convenient time, particularly in the evenings and during weekends; a time when the majority of members of the community sought medical services. An example, one of them (a medical doctor) stated that there was no provision for offering services during peak violence periods, i.e. the period when most of the cases of violence occurred:

"…There is absolutely no support and if anybody needs health care after four o'clock in the afternoon or the other two days in a week, say on a Saturday or on a Sunday, all they can do is to phone an ambulance to take them to the hospital. That's a huge problem in terms of health care. And you know, there should be a service at least in the morning on Saturdays and Sundays until 7-8.00pm at night because that is when all the people actually use the health care service".

He suggested that the opening hour of the clinic should be extended and that the public image of the community clinic should be improved:

"Lengthen the hours that they are actually in the clinic and foster and encourage an environment whereby the population at large or the community see the clinic as a place of receptivity" (Intw. 1).

Likewise, a social worker stated that the office where she worked from in the community was not very conducive to the management of the victims of violence. She also attested to the fact that apart from the facility not having enough space to accommodate the group therapy sessions, young people often did not visit because of the fear of stigmatisation associated with visiting the social development office:

"…this environment is not big enough for the group sessions and stuffs [sic] *like that. And normally, the children don't feel free to come to our office because of the stigma of coming here…"* (Intw. 3).

This situation no doubt would affect the services provided by the social workers, hence the need for the current situation to be addressed.

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One medical doctor suggested that there should be a good referral system and record keeping:

"Get your referral system proper and record; record the victims on a database" (Intw. 6).

He also mentioned that current resources should be properly utilised even though more was required:

"Use the existing resources but use it as a collective and not individually... but if we pull resources much more can be done" (Intw. 6).

- **Concluding statements**

From the findings of the sub-category about inadequate structures, the following concluding statements were made:

- Recreational amenities for young people in the community are needed to keep them actively and positively engaged. The youth should get the opportunity to actualise their full potential.
- Flexible opening hours of the primary health clinic in the community is needed during times when the majority of the victims of violence seek medical services.
- Youth development programmes are needed to support youth and to create a safe space and to allay the fear of stigmatisation associated with visiting the social development office.

5.4.3.6 Sub-category 6: Inadequate human resources

Another issue raised by the health professionals was inadequate health personnel, such as social workers and professional counsellors, to assist with providing effective and well-organised care for clients who were victims of violence in order to lead them to holistic wellness. As a result, they felt frustrated because sometimes they were stuck in situations where they could not offer much assistance.

For instance, one of the medical doctors stated that professional nurses were in a challenging position to provide efficient and effective care and leadership for victims of violence; however, they are encumbered with their huge workload that did not leave them with much time to do so:

"And also, you know that they are overstretched. They haven't got time to really sit and hold somebody's hand and say that and that and to actually support them whereas that is what the people actually need, particularly the girls…" (Intw. 1).

The abovementioned observation by the medical doctor was confirmed by a professional nurse who said*:*

"Just that we need more nurses here in the clinic… if they provide more nurses then we can do a lot…" (Intw. 4).

One of the medical doctors interviewed indicated that the ideal health care professional who should provide comprehensive leadership and guidance for the youth victims of violence towards their wellness would be the social worker. However, he pin-pointed the problem of staff shortage as being a challenge:

"To activate the social workers and the community based workers, to tackle their [the youth victims of violence] *problems, to go right deep to the social circumstances. But the resources are very, very sparse you know… and that is not the ideal"* (Intw. 6).

Nonetheless, a social worker declared that even though they would have loved to be totally involved in leading those victims to their wellness, there were a few of them and they were overstrained, hence they were unable to give their utmost best to the youth victims of violence:

"In some cases, we do too little to help the victim to wellness because there are so many role players involved and you give your responsibility to someone else…" (Intw. 2).

From the findings, it is clear that health professionals have interrelated roles in a team to support victims of violence in their community. Therefore, for leadership of the youth victims of violence towards wellness, it is important that there is a sufficient number of health care professionals; such as professional nurses, medical doctors, social workers, physiotherapists, occupational therapists, professional counsellors and psychologists working at the primary health care level.

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- **Concluding statements**

From the findings of the sub-category about inadequate of structures, the following concluding statements were made:

- An adequate number professional nurses is needed to support victims of violence in times of need.
- A team approach should be followed to support the victims of violence, e.g. by professional nurses, community health workers and social workers to create an optimal health care environment.

5.4.3.7   Sub-category 7: Challenging process of guiding youth victims to wellness

An important finding of this study was the fact that the health professionals find the process of guiding youth who had been victims of violence in their community towards wellness to be demanding, emotionally draining and very taxing. For instance, one of the health professionals (a medical doctor) interviewed had this to say during the interview:

"…To counsel an adolescent victim of violence, that's going to take a lot of time, to sit and really get to the bottom of the issue, that's going to take a lot of energy, a lot of time and to win their trust, that's going to take time and then you see their wants. You need to walk the road with that person and that's going to take a lot of time. I mean the energy…" (Intw. 5).

The health care professionals stated that the process of leading a victim of violence to wellness took a long period of time before it could be concluded. For example, a medical doctor emphasised that point of view by stating:

"It is something that takes a long process" (Intw. 5).

Additionally, a professional nurse mentioned that the journey to wellness for the youth victims of violence is contingent on the stage of development of the victim and that the process might even take years:

"In most instances, it depends on their age and sometimes it takes long, months, sometimes years" (Intw. 4).

This finding evidently shows that the health care professionals are experiencing challenges in guiding youth victims of violence towards wellness, thus indicating the need for health professionals to receive training in the ways of managing youth who are victims of violence.

- **Concluding statements**

From the findings of the sub-category about the challenging process of guiding youth victims to wellness, the following concluding statements were made:

- The process of guiding the youth needs time management and building a sound and trusting relationship with the youth.
- The process of leading youth victims of violence to wellness is continual and time consuming.

5.4.4   Category 3: Guidance to lead youth victims to wellness

Findings from this current study revealed that the health care professionals were interested in the wellbeing of the young people in their community, including the ones who had been victims of violence. They offered strategies that would assist with leading and guiding youth victims of violence towards wellness. The proffered strategies were supportive services, recreational activities, dedicated staff members to work with the youth victims of violence and a team approach.

5.4.4.1   Sub-category 1: Support (counselling services, community / family support and support groups)

Haber (2013, p. 316 - 317) defines support as the care, help, assistance, love, or consideration by a person to another individual. This type of support can either be received from a health care professional, spouse, family member, friend, or a neighbour.

The health care professionals stated that it was crucial to offer the youth victims of violence physical and emotional support. For example, a medical doctor maintained that even though the process of attaining wellness could take a long while, it was essential to start the leadership process by providing immediate physical treatment, followed by emotional support and also to be genuinely interested in the wellbeing of the victims:

"You begin by treating them, then you need to know the victims, you need to know them personally and you need to have regular contact with them" (Intw. 6).

Building a lasting personal relationship involves the provision of physical and emotional support (Boyle, 2012; Zaugg & Davies, 2013).

Furthermore, the majority of the health care professionals interviewed in this study admitted that it was essential for the victims to receive counselling services from health care professionals as a form of support in order to propel the youth victims on their wellness journeys and to aid their recovery process. A professional nurse indicated this view:

"I will say talking, talking, talking and not stop talking" (Intw. 4).

By the same token, a medical doctor said that it would be most supportive and valuable to have a professional counsellor committed to assisting the youth victims:

"That could be helpful if there was a counsellor or somebody as I said from the community dedicated to the adolescents victims, it would be very useful... for them to have a safe place for them to go, to have a counsellor talk to them, to have access to social services, safe house care of course..." (Intw. 5).

Evans (2013, p. 35) defines counselling as a confidential interaction between a qualified counsellor and a counselee aimed at promoting and enhancing wellbeing. Similarly, the American Counseling Association (2014, pp. 2) describes counselling as "a professional relationship that empowers diverse individuals, families and groups to accomplish mental health, wellness, education and career goals". Counselling is an important aspect of providing support for individuals who have experienced traumatic life events. Therefore, it is essential that professional counsellors are well integrated into the existing health care system or better still, youth who have been victims of violence can be referred to professional counsellors to seek support for their wellbeing. Apart from the fact that counselling provides an opportunity for emotional support, it also assists the counselee with receiving information needed to make informed decisions and clarifying myths and misconceptions. In addition, health professionals, such as nurses and social workers could also play a role in providing counselling services for the youth victims of violence.

A social worker also supported this view and further mentioned that it was necessary for the youth victims of violence to have a safe place to go to where they could receive assistance.

"…I think that there must be a place where the children can go to and speak to someone when they have problems…" (Intw. 3).

In general, most of the health care professionals stated that a strong social network (friends and family), as well as the entire community would be helpful in guiding the victims of violence towards wellness. According to one of the professional nurses interviewed:

"There also has to be support from the entire community" (Intw. 4).

Similarly, the other professional nurse suggested:

"Family support is also important and having friends. The social network is very important" (Intw.7).

One of the medical doctors recommended that the unreported youth victims of violence in the community could also be reached through community outreach programmes:

"You can reach them in the community too, like going to do talks about how to protect yourself [from violent attacks]*; you can go do screening…"* (Intw. 6).

The above findings are noteworthy because they were also recognised and reported by the youth victims of violence interviewed during Phase 1 of this study as important strategies for guiding youth who had been victims of violence to wellness. Also, perhaps the health care professionals saw the need for a strong social support network because they observed that young people who had been victims of violence were often blamed for the violence they experienced by the same people who were expected to support them.

Victim blaming (Eyssel & Bohner, 2010, p. 255; Strömwall, Alfredsson & Landström, 2013, p. 1579) has been reported to be associated with many problems. For example, a young girl who has been sexually exploited might suffer in silence and not seek help because she is afraid that when she discloses, her family and community members would blame her for the occurrence of the sexual abuse. As such, a young girl may prefer to condone or tolerate the abuse. This could predispose her to psychological problems; such as depression, anxiety, anger, low self-esteem, shame, emotional numbness, suicidal thoughts, nightmares, self-blame and guilt, difficulties with concentration, restlessness, fear and other post-traumatic stress disorders. She might also experience   behavioural problems; such as increased

substance (alcohol and drugs) use and abuse, dropping out of school and poor work performance (Rape Crisis, 2014b).

The health care professionals interviewed in this study also acknowledged that support groups were needed in the process of guiding the youth victims of violence towards wellness. For example, one of the social workers encouraged the use of support groups during group therapies:

"We can help… and also have support groups for them also" (Intw. 3).

Support groups can be described as groups of individuals with similar stressful or traumatic experiences who get together under the guidance of a trained facilitator so that those of them who have a more positive experience or coping ability can provide support and guidance to other members with the purpose of promoting healing and empowerment (Gabriel, 2010). This usually motivates the ones who are having difficulty to better adapt to their individual situations or circumstances. Using support groups could assist with improving the emotional wellbeing of the victims of violence (Baker & Sauber, 2013). For health care professionals to offer support, it means that they not only offer advice and counselling to the youth who are victims of violence but they should be genuinely concerned about needs and feelings of the youth. They must also help them to solve their individual problems in a dynamically constructive manner. This is very important for the victims to gain autonomy and achieve recovery and wellness as rapidly as possible. Providing support for youth victims of violence is very important in the management of people who have been traumatised in any way and that includes the ones who have been victims of violence.

- **Concluding statements**

From the findings of the sub-category about support, the following concluding statements were made:

- The agents have a responsibility to provide a safe place and support programmes to the youth victims of violence.
- A counselling group is a very essential part of support; it propels them along their wellness journeys and aids their recovery process.

- A strong social network (support from friends, associates and family members, as well as the entire community) is helpful and will accelerate the wellbeing of the victims of violence.

- Agents should assist the recipients to solve their individual problems in a dynamically constructive manner. This is very important for the victims to gain autonomy and achieve recovery and wellness as rapidly as possible.

5.4.4.2   Sub-category 2: Recreational activities

Recreation is defined as an activity that an individual carries out for the purpose of entertainment and relaxation which is often done in one's leisure time (Leitner & Leitner, 2012, p. 13). These activities can either be done actively or passively, indoors or outdoors. Examples of recreational activities include sporting activities like playing football, cycling, lawn tennis and swimming among a host of many other recreational activities (Oak, 2012).

In this study, the health care professionals pointed out that an important aspect that needs to be considered in leading youth victims of violence towards wellness is the use of recreational activities to relieve stress. For example, a professional nurse stated that instead of the youth being idle and indulging in self-destructive habits like substance abuse, recreational activities could be used during therapy to engage the youth victims productively and to deal with stress:

"There has to be other ways of keeping these youth busy so that they can become fully well and balanced. There can be something like a swimming pool and things like that to help them relax…" (Intw. 4).

A medical doctor suggested that the Department of Social Development of South Africa should organise programmes targeted at the youth victims of violence in the community:

"…The people who should organise support programmes for youth victims of violence are the department of social development… You really need to get down to the grass root level to tackle the problem of youth violence" (Intw. 1).

It appears that the health care professionals were suggesting that therapeutic recreation would be of great benefit to the victims of violence. Therapeutic recreation is defined as "a holistic process that purposefully uses recreation and experiential interventions to bring about a change – either social, emotional, intellectual, physical or spiritual – in an effort to improve the health status, functional capacities and quality of life" (Carter & Van Andel, 2011, p. 9).

The involvement in recreational activities has been documented to be beneficial for the physical, as well as the psychological wellbeing of a person. In other words, it holistically involves the body, the mind and the spirit (Kerr, Dattilo & O'Sullivan, 2012, p. 279). Some of the benefits of recreation include reduction of stress levels, improved relaxation, encouragement to socialise with other people and the refilling and renewal of energy levels (Carter & Van Andel, 2011, p. 14). Carter and Van Andel (2011, p. 11) recommend the use of therapeutic recreation in promoting the wellness of individuals; such as the ones who abuse substances, eating disorders, as well as individuals who have been traumatised as a result of abuse and violence.

At the beginning of the study, the researcher made one of the key assumptions based on the Heath Promotion Model of Nola Pender that person's value positive growth and they usually seek out ways of living an individually satisfactory and balanced life and that this process could be facilitated by the leadership of health care professionals. Thus, health care professionals in particular and social workers should encourage the use of therapeutic recreation in promoting the social, emotional, intellectual, physical, and spiritual wellbeing of the victims of violence to bring about their holistic wellness.

In the same vein, another health care professional suggested that recreational programmes should be organised for the young people in the community, including the ones who had been victims of violence as an avenue for promoting their wellness:

"So, maybe we can help the youngsters with the events so that maybe they can be involved so that they can also feel that they are important, you know… We need a hall that the children and we can come together…" (Intw. 7).

This finding is supported by the findings from the focus group discussions in which the young people who participated also emphasised the need for taking part in recreational activities and for such facilities to be made available for them in the community. It is, therefore, important that this situation is addressed in the community.

- **Concluding statements**

From the findings of the sub-category about recreational activities, the following concluding statements were made:

- Youth should be involved in recreational activities to feel a sense of self-worth.

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- The agents should encourage the practice of recreation among the victims of violence in order to help them relieve stress that will in turn promote wellness.

5.4.4.3   Sub-category 3: Competent staff to work with youth victims of violence

Competence is the possession of essential information, skills and   attitudes required to efficiently perform professional roles and responsibilities (Shapiro, Miller & White, 2006, p. 115).

Some of the health care professionals mentioned the need for having competent staff specifically charged with the responsibility of providing care to the youth victims of violence. For example, one of them (a medical doctor) stated that preferably specific health care professionals should be assigned to care for the victims:

"What you ideally want is to have specific individuals, health care professionals, that [sic] *will focus only on those victims."* (Intw.6).

Furthermore, he mentioned the importance of having professional counsellors particularly trained to counsel victims of violence:

"…If we could have more counsellors, that would be fantastic and counsellors who are specifically trained to pick these things up and to help them, that would be even better…" (Intw. 6).

Another health care professional (a professional nurse) supported this point of view by indicating that there was a need to have focused health care professionals committed to assisting the youth victims of violence:

"…you need people who can work with them individually as well as [in] *a group, you know, to address their fears and anxieties…"* (Intw. 4).

The importance of competent staff to work with young people in the health care setting cannot be overstated. Bunkers (2009) posit that professionals, including health care professionals, need to be competent in order to capably comply with their responsibilities to their clients. Also, it assists with providing efficient services to youth victims of violence.

- **Concluding statements**

From the findings of the sub-category about staff to work with youth victims of violence, the following concluding statements were made:

- Competent and dedicated health care professionals need to be assigned to specifically provide care to the youth victims of violence.
- Professionals should take an active role in providing counselling for victims of violence.

5.4.4.4 Sub-category 4: Team leadership

A team is defined as a group of individuals possessing complementary skills who collectively work collaboratively at a particular task or assignment (Oxford Learner's Dictionary, 2014). Interdisciplinary teams in medical practice consist of several health care professionals such as nurses, medical doctors and social workers who independently attend to the concerns of a patient by concentrating on the areas in which they specialise. An interdisciplinary team approach encompasses all members of a team functioning cooperatively towards achieving a common goal.

All the health care professionals viewed an interdisciplinary team approach as a valid strategy for the guidance of the youth victims of violence in order to enable those youth victims of violence to reach wellness. For instance, one of the professionals mentioned that there was a need for health care professionals to work in partnership during the process of guiding the youth victims towards wellness:

"…we need to work together towards solutions (a vision) *and see what we can do for the person to get over this traumatic experience because I can only work towards a certain point."* (Intw. 4).

A medical doctor reflected and also supported the importance of collaboration among all health care professionals:

"I think a team approach is the most vital… health care professionals need to think broader, to try and activate others (influence)*… everyone has to be involved"* (Intw. 5).

A professional nurse stated that all health care professionals should lead towards a vision:

"…as a health care professional you have to do your best towards youth to lead them towards the right direction…" (Intw. 4).

Likewise, a social worker maintained that teamwork is important and that it should be done in partnership with the youth victims of violence:

"Everyone has to be engaged and to play their own part well for us to achieve success… you cannot isolate the children themselves because they have a role to play" (Intw. 3).

This finding is significant because it supports the view of Otis-Green and Fineberg (2010, p. 1225) that health care professionals are expected to work in a team environment and that they should be duly skilled in effective communication, advocacy, conflict resolution and shared leadership. Thus it is necessary to enhance the skills of health care professionals involved in the guidance of the youth victims of violence.

- **Concluding statements**

From the findings of the sub-category about team leadership, the following concluding statements were made:

- In an interdisciplinary team, participative leadership should be maintained with a vision to lead youth victims of violence towards wellness.
- The team needs to collaborate and involve all the stakeholders to have a shared vision for moving together in the right direction.

5.5 THIRD STEP OF THE DEVELOPMENT OF THE FRAMEWORK

The aim of this phase followed the findings from the individual interviews with the health care professionals. It required a review of the themes and categories and the concluding statements with the purpose of identifying its main attributes, characteristics, roles and subsequently, to identify essential concepts to form part of the conceptual framework. Concepts derived at were organised according to the survey list of the Practice Orientated Theory of Dickoff *et al.* (1968).

Table 5.3: Overview of the findings from Phase 2 used in developing the conceptual framework

Categories and sub-categories	Summary of concluding statements	Concepts for the conceptual framework
Point of view about wellness		
The holistic view of a person	Wellness is equipoise in three areas of the person; that is the body, mind and spirit Wellness consists of a balance between the internal (biological, psychological, spiritual) and external (social) areas that are well integrated The agent should view the recipient from a holistic perspective when leading him or her to wellness	Agent: A holistic view Terminus: Characteristics of wellness is balance between the internal (biological, psychological, spiritual) and external (social) domains
Resilience	Wellness involves an individual having the quality that allows him or her to rise above difficult situations (resilience) The agent can lead the recipients to transcend traumatic experiences through support and leading them towards healing and a high level of wellness	Terminus: Resilience Agent: Supportive role to play in leading the recipients to wellness Procedure: Support
Healthy lifestyle	Wellness includes the practice of a healthy lifestyle and the avoidance of health damaging habit like eating unhealthy food, smoking cigarettes, the abuse of alcohol and drugs and living in poor environmental conditions	Terminus: A healthy lifestyle

Barriers to leading youth victims of violence towards wellness		
Youth issues (violent behaviour, teenage pregnancies, drug and substance abuse)	Violent behavioural patterns are common among youth in the community The agents are frustrated with the problem of youth violence in their community (context); a situation that causes a huge barrier to guiding the recipients towards wellness There is a rampant abuse of substances; such as alcohol and cannabis (*dagga*) and methamphetamine (*tik*) in the community. Substance abuse is the leading cause of youth violence in the community	Context: Alcohol and drug abuse (cannabis and methamphetamine) are the main causes of youth violence in the context.
Unsupervised youth	Poor parental supervision of youth, particularly during weekends is one of the causes of violence in the community, demonstrating the need for parents to carry their part of the responsibility	Context: Poor parental supervision of youth during weekends could lead to youth involvement in violence
Parental socio-economic issues	The socio-economic issues in the community (context) lead to violence that constitutes a barrier to the agents when leading youth in the community towards wellness	Context: Socio-economic issues (context) lead to violence
Attitudes of staff	There is a need for the agents to be leaders who demonstrate professional behaviour and attitudes to lead and provide supportive professional services to the recipients to speed up their wellness There is a need for the agents to be trained how to lead youth	Agent: Professional behaviour Require training in leading the youth Procedure: Supportive professional services Youth programmes

Inadequate structures	Recreational amenities for young people in the community are needed to keep them actively and positively engaged. The youth should get the opportunity to actualise their full potential Flexible operating hours of the primary health clinic in the community are needed during times when the majority of the victims of violence seek medical services Youth development programmes should support youth to create a safe space and to allay the fear of stigmatisation associated with visiting the social development office	Procedure: Recreational activities Youth development programmes Context: Flexible operating hours of the primary health clinic in the community
Inadequate human resources	Adequate professional nurses are needed to support victims of violence in times of need Shared leadership should be practised where victims of violence should be supported; e.g. by professional nurses, community health workers and social workers to create an optimal health care environment	Dynamics: Participative leadership
Challenging process of guiding youth victims to wellness	The process of guiding the youth requires time management and building a sound and trusting relationship with the youth The process of leading to wellness is continual and happens over a period of time	Agent: Should build a trusting relationship with the youth Procedure: Continual process
Guidance to lead youth victims of violence to wellness		
Support (counselling services, community / family support and support groups)	The agents have a responsibility to provide a safe place and support services to the youth victims of violence A counselling group is a very essential part of support; it propels them along their wellness journey and aids their recovery process A strong social network (support from friends, associates and family members, as well as the entire community) is helpful and assists with supporting the wellbeing of the victims of violence	Agent: Has a supportive and empowerment role Procedure: Counselling Support groups Social support (family and friends) Community support

	Agents should assist the recipients to solve their individual problems in a dynamically constructive manner. This is very important for the victims to gain autonomy and to achieve recovery and wellness as rapidly as possible	
Recreational activities	The agents should encourage the practice of recreation among the victims of violence in order to help them relieve stress that will in turn promote wellness Youth should be involved in recreational activities to feel important (self-worth)	Procedure: Recreational activities
Staff to work with youth victims of violence	Competent and dedicated health care professionals need to be assigned to specifically provide care to the youth victims of violence. Professional counsellors should take an active role in providing counselling to victims of violence	Agent: Competent and dedicated Dynamics: Active participation
Team leadership	Interdisciplinary team leadership should be maintained with a vision towards wellness The team needs to collaborate and involve all stakeholders to have a shared vision for moving together in the right direction	Agent: Should have a vision Has a collaborative role and, therefore, should be synergistic Dynamics: Shared responsibility and participative leadership

5.6 SUMMARY

In this chapter, the findings from the individual interviews with health care professionals are described in conjunction with supporting empirical literature. There are three main categories discussed, namely the points of view about wellness, the barriers to leading youth victims of violence towards wellness and guidance to lead youth victims to wellness. The points of view about wellness as described by the health care professionals relate to a holistic view of a person, resilience and practising a healthy lifestyle. The identified barriers to leading youth victims of violence towards wellness are violent behaviour, drug and substance abuse amongst the youth, parental socioeconomic issues, negative attitudes of staff members, inadequate structures and human resources and a challenging process of guiding the youth victims of violence towards wellness. The health care professionals also described and suggested strategies that could be used by health care professionals in leading the youth victims of violence towards wellness. The strategies suggested by the health care professionals are provision of support (counselling services, family and community, support groups), recreational activities, dedicated staff to work with the youth victims of violence and a team approach.

Both the findings from the focus group discussions (Phase 1) and the individual interviews (Phase 2) reveal that the youth victims of violence and health care professionals understood what wellness means. However, it is clear that the health care professionals are facing challenges in leading the youth victims towards wellness.

In Chapter 6, the original conceptual framework is presented that could be used to lead youth victims of violence towards their wellness in the rural community of Genadendal. The survey list of Dickoff *et al*. (1968:423) served as the guide for the description of the framework.

CHAPTER 6

CONCEPTUAL FRAMEWORK FOR HEALTH CARE PROFESSIONALS TO LEAD YOUTH VICTIMS OF VIOLENCE TOWARD WELLNESS
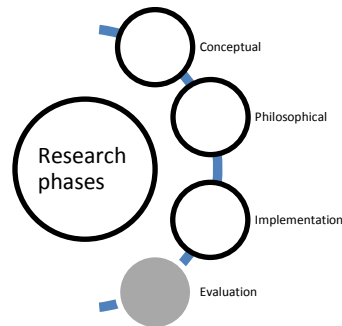
6.1   INTRODUCTION

The previous two chapters (Chapters 4 and 5) describe the findings from the youth and the health care professionals. The findings used to develop the conceptual framework are presented in Table 4.4 and Table 5.3. This chapter essentially focuses on describing the conceptual framework to be used by health care professionals to lead and guide youth victims towards wellness in a rural community of the Western Cape Province, South Africa.

- **Development of the framework**

Step 4 of developing the conceptual framework was to triangulate and integrate the key concepts from the findings of the youth (Chapter 4) and health professionals (Chapter 5). This step used the survey list of the Practice Orientated Theory of Dickoff *et al*. (1968) to organise the concepts (the reasoning map for linking and mapping the identified concepts) (Figure 6.1). The key concepts in the conceptual framework are supported by the concluding statements and supporting literature. In addition, the framework is grounded in the assumptions of the researcher (Chapter 1).

The survey list of Dickoff *et al*. (1968) was utilised in this study as the reasoning map for describing the conceptual framework for understanding how health care professional lead youth victims of violence towards their wellness in a rural community of the Western Cape Province, South Africa. This survey list intends to provide answers to six key questions for prescriptive theory (Meleis, 2012, p. 129). These questions are:

1. Who or what performs the activity (agent)?

2. Who or what is the recipient of the activity (recipient)?

3. In what context is the activity performed (framework)?

4. What is the energy source for the activity (dynamics)?

5. What is the guiding procedure, technique, or protocol of the activity (procedure)?

6. What is the endpoint of the activity (terminus)? (Dickoff *et al.*, 1968, p. 423).

In this study, the questions above were asked from the perspective of the activity being leading youth victims of violence towards their wellness. These six concepts (agent, recipient, context, dynamics, procedure and terminus) formed the integral parts of the conceptual framework.

Figure 6.1 shows the integrated framework, using the findings from the youth (Phase 1) and the health professionals (Phase 2) of the study.

Step 5 in developing the framework was synthesis, re-synthesis and making sense; synthesised concepts into a framework. This step dealt with describing the framework (Section 6.2).
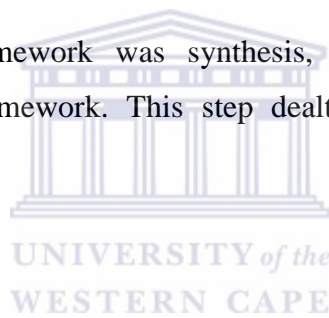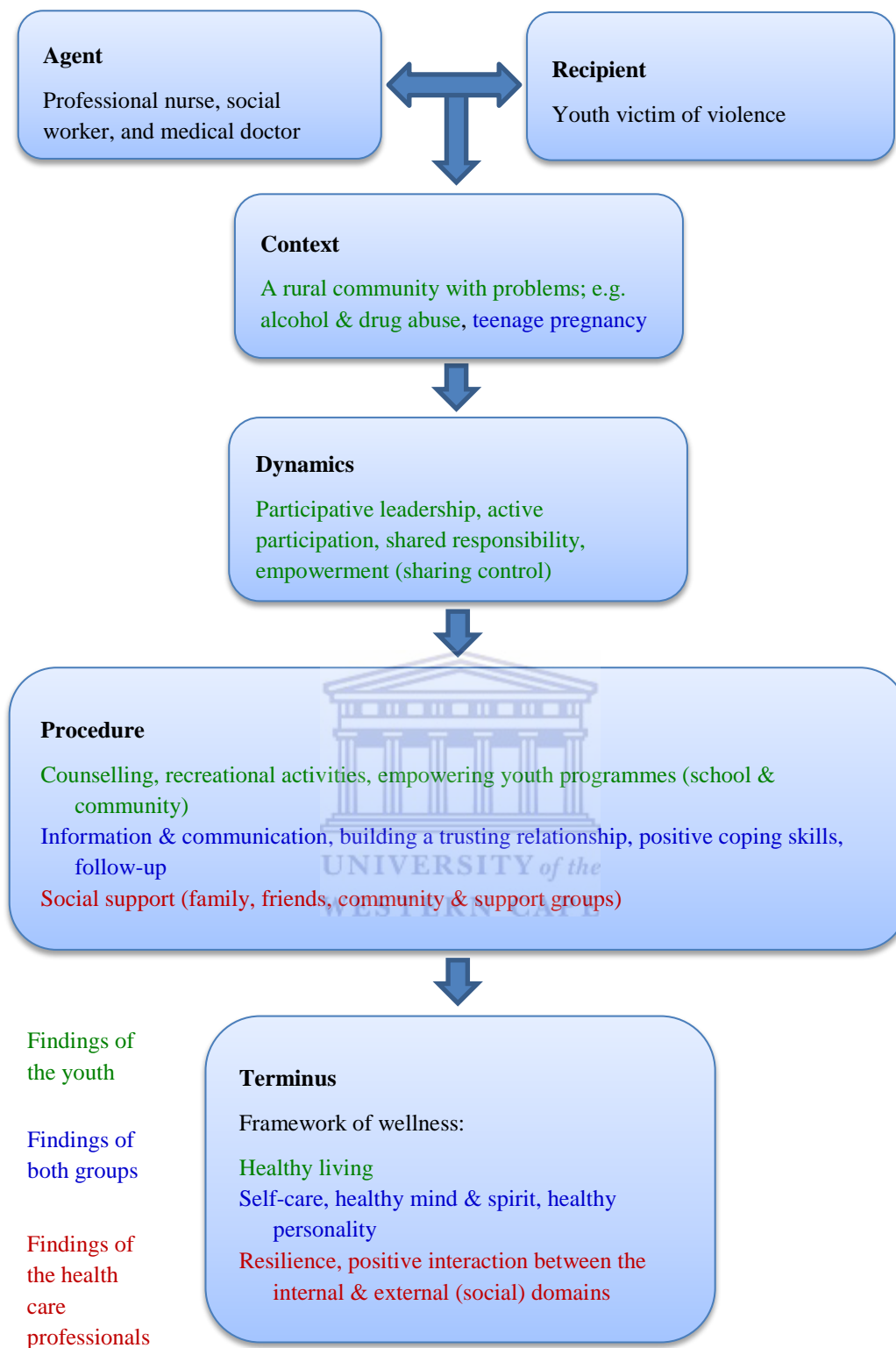
Figure 6.1: **The framework for leading youth victims of violence towards wellness with the integrated findings from the youth and health care professional participants**

6.2 CONCEPTUAL FRAMEWORK

6.2.1 Who or what performs the activity (agent)?

The agent that has the responsibility of leading youth victims of violence towards wellness is a health care professional working in a rural community. Agents (professional nurse, medical doctor, social worker) work as members of a multidisciplinary team to lead a recipient (youth victim of violence) to wellness.

External environment

Physical:

    Rural community

Social:

    Human resources (health care professionals), values

Spiritual:

    Religion Spirituality, values and principles

Internal environment

Spirit
Conscience, relationship with God, and values and principles

Body
Approachable, charisma

Mind
Emotional intelligence, perceptive

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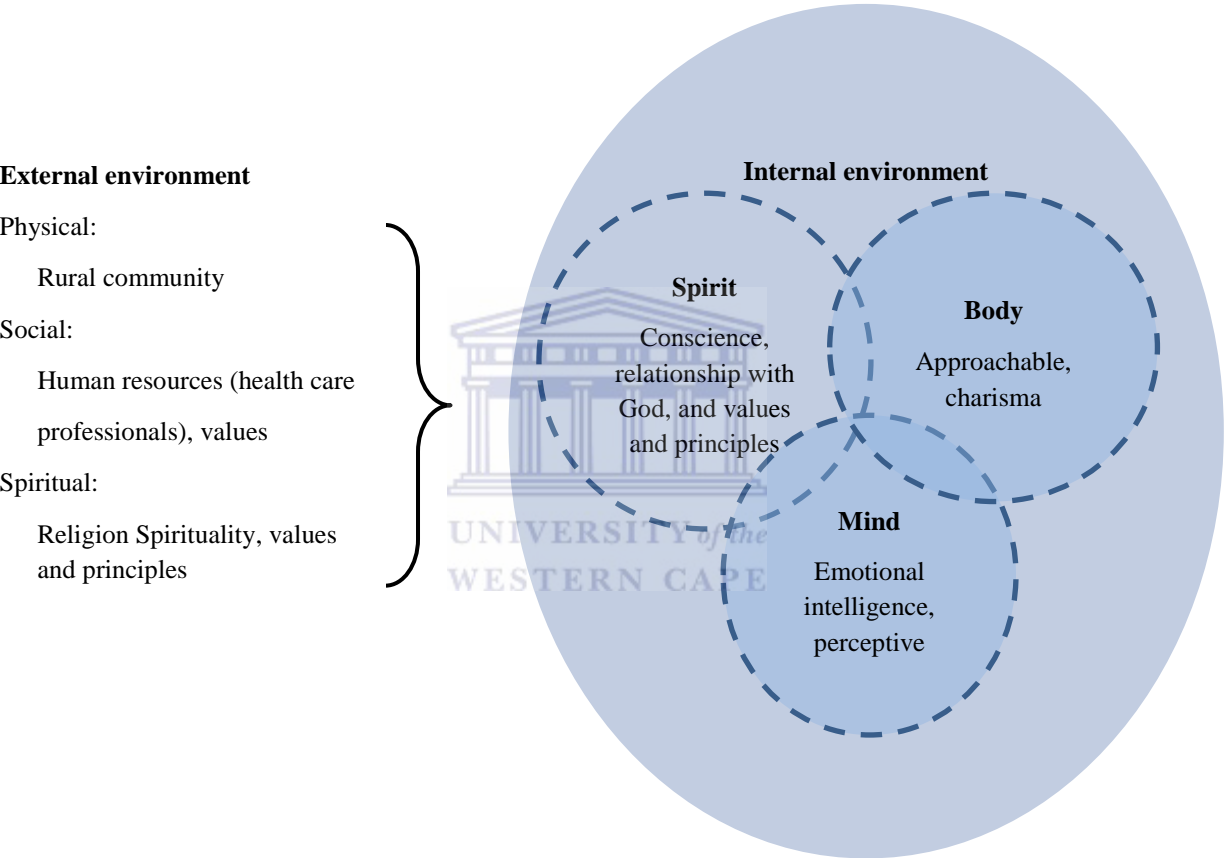
Figure 6.2:   The environment of the agent

The agent (professional nurse, medical doctor and social worker) is a holistic being who operates in an interactive and integrative manner in the environment of a rural community with youth victims of violence. An agent should have adequate knowledge, skills and values to support youth victims towards wellness. The knowledge of the agent is encapsulated in being a qualified health care provider assumed to be competent after having acquired the requisite knowledge and skills during his or her professional training. The skills of the agent

are demonstrated in his or her ability to empower, to support, to be a role model and to collaborate with other agents. Values are inherent to professionalism.

The internal environment of the agent is made up of three components which are body, mind and spirit (Figure 6.2). The agent portrays an approachable charisma, physically showing that he or she has an ear that listens. He / she is emotionally intelligent and perceptive to the expectations of the youth. The mind comprises the emotional and intellectual processes of the agent, e.g. emotional intelligence and volitional processes (conducting an evaluation of the recipient's wellness to take a decision). The spirit takes account of the agent's conscience and awareness of being non-judgemental towards other people, abiding by principles of ethics, and it is assumed that every person has a relationship with God.

The agent interacts with the external environment (context) of a South African rural community (Section 3.2.4.1) with its unique human resources, values and religious practices. To function well while leading the recipients towards wellness, the agent should be able to optimally integrate the functioning of both the internal and the external environment. The agent is expected to incorporate resources that are within his external environment. Braithwaite (2006, p. 1724) suggests that the balance between these two environments facilitates the optimum wellbeing of an agent.

Professional nurses and other agents are regarded as valuable leaders in their communities and having the capacity to influence individuals (youth) in their community by sharing responsibilities. The agent should follow a participatory leadership style in addressing the expectations of the youth to long-lasting holistic wellbeing. Participatory leadership between the medical doctor, social worker, professional nurse (multi-disciplinary team) and recipient is essential to collectively inspire a shared vision and self-determination. Participative leadership requires individuals to act collaboratively towards achieving a common goal and creating meanings of the situations they are confronted with. In other words, participative leadership does not revolve around one single individual; rather every member of the team assumes a different task, role and responsibilities with the purpose of accomplishing a shared goal (MBA Brief, 2014, pp. 1). The agent has different roles to play in order to actualise this goal. In addition, the agent should also have certain qualities that equip him to carry out the specific roles (Figure 6.3). The agent as a leader has various roles to support and lead recipients towards wellness. These roles are empowerment, engendering support, role modelling and collaboration.

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6.2.1.1 The role of the agent

To fulfil the empowerment role, an agent should be able to share relevant, accurate and adequate information by means of health education of the recipients, as well as other members of the community that he or she serves. Information could include facts about the effects of violence on the youth, ways of dealing and coping with trauma associated with violence and how to live a healthy lifestyle. Kaur and Garg (2008, p.73-76) mention that the role of health care professionals in the leadership of youth victims of violence include creating awareness by distributing useful and innovative educational pamphlets and audio-visual materials. Empowerment is further enhanced by dispelling myths, misconceptions and by providing feedback to the youth in the community.

The supportive role of an agent could be achieved by providing emotional support and substantial helpful services; such as counselling services to prevent victim-blaming behaviour, use of support groups and giving practical assistance to victims and their family members. Similarly, an agent is expected to display positive attitudes by respecting the recipient, maintaining confidentiality and building trust. The World Health Organization (2014b) emphasises the important roles health care professionals have to play in the care of victims of violence, particularly of female victims. These roles include carrying out personalised screening among their clients to identify the ones with violence issues and abusive patterns, providing victims with non-judgmental supportive counselling services, general screening of persons in the community, keeping record of injuries and trauma cases, protecting the privacy of the victims and ensuring confidentiality, as well as referring or linking the victims to resources in their community (World Health Organisation, 1997, 2014b).

Role modelling is a function that an agent is expected to perform in order to successfully lead the youth victims of violence to wellness. Role modelling could be described as the demonstration of a behavioural pattern that is worthy of emulation (Burns & Grove, 2011). In the very words of some of the youth victims of violence in this study, role modelling in terms of a healthy life style means 'to lead us by example' and 'to show that they are also doing the things that they want us to do'.

Agents also play an important role in collaborating and establishing meaningful partnerships with other professionals and Organizations. They could partner with other stakeholders; such

as other members of the health care team, community members and leaders, religious Organizations, funding agencies, international Organizations, community-based Organizations, as well as governmental and non-governmental Organizations in their immediate and external environment. They could even partner with international Organizations, including multilateral and bilateral agencies. This should be done with the aim of addressing the needs of the youth victims of violence in their community.

Executing the role of a participative leader and empowering youth by means of support, collaboration and role modelling, certain characteristics are needed. These characteristics include competence, a vision, empathy, perception, courage, emotional intelligence, professionalism and synergy.

6.2.1.2   The characteristics of the agent as a leader

Based on the findings from the focus group discussions and unstructured individual interviews conducted in this study, it is clear that an agent should have certain leadership qualities in order to perform his or her role as an agent who practises participatory leadership to guide the recipients towards wellness.

- **Competence**

Competence is an essential quality that an agent should hold. It depends on the requisite knowledge, skills and attitude that is needed to carry out professional roles and responsibilities efficiently (Shapiro, Miller & White, 2006, p. 115). For instance, an agent should have a sound knowledge about screening youth for violence and understanding the role of health care providers in violence management, including the necessary procedures that can be used in guidance towards wellness. Self-awareness, self-management and a high self-esteem and confidence are important aspects of competency that an agent should demonstrate (Bunkers, 2009, p. 32). Even so, competency does not imply that an agent knows it all. Instead, it means that the agent has a good understanding of his or her capabilities and expertise, as well as being aware of the point when the expertise and knowledge of other experts should be sought and utilised in order to meet set goals (McKinney, 2007, pp. 2).

- **Having a vision**

Vision is the ability to think about and have foresight and plan for the future, using intelligence and the creative power or imagination (Macmillian Dictionary, 2014). An agent

should be able to inspire a shared vision in a recipient which in turn will serve to guide and provide a focus to the recipient. Also, the leader should endeavour to continually communicate this vision in an understandable and creative manner (Jooste & Minnaar, 2009, p. 358).

- **Empathy**

The participants in this study stated that they expected the agents to *'give a listening ear'* and to *'imagine what their patients are going through'*. Boykin, Schoenhofer and Valentine (2014, p. 111) support the view that nurses, medical doctors and all other health care professionals should be compassionate towards their clients. This empathic quality implies that they show a reasonable level of concern and consideration for the circumstances in the world of the recipient. Therefore, an agent should intentionally and genuinely be empathic toward the recipients in order to encourage engagement with the healing process.

- **Perceptive**

An agent also needs to be perceptive. He or she should be sensitive, insightful and observant with the purpose of being able to accurately decipher and identify the unique needs, goals, motivational factors and demands of each individual youth victim of violence. Parse (2008, p. 373) reckons it is necessary for an agent to have good insight into the individual needs of the recipient and also to display a sense of fair mindedness and respect for the recipient in order to execute his or her leadership role effectively. Thus, the agent should always be attentive and vigilant when dealing with youth clients who have experienced trauma as a result of being exposed to violence (Northouse, 2012, p. 89).

- **Change agent**

An agent should have an attitude of and commitment to innovation to develop strategies and plans that set in motion positive behavioural changes needed for wellness in the recipient (Grol, Wensing, Eccles & Davis, 2013, p. 20). For example, an agent could target informational empowerment at the specific needs of a recipient to enable the recipient to make decisions that would bring about behaviour change and the adoption a healthy lifestyle.

- **Courage**

Jooste (2009, p. 5) mentions that agents as leaders should be bold and dauntless in their endeavours, especially during the times when they are faced with difficulties and challenges. During the leadership process of the youth victims towards their wellness, an agent should be aware that he or she could be faced with difficulties that require courage to surmount. One way of overcoming these challenges is to identify innovative ways to, e.g. make decisions and solve problems. Therefore, an efficient agent should be brave and courageous and be able to tackle initiatives that are required for successful leadership outcomes. It is also necessary that an agent soldiers on with the conviction and expectation that the set goal of a lifestyle of wellness for the recipient will be accomplished and a satisfactory outcome is inevitable (DuBrin, 2012, p. 511).

- **Emotional intelligence**

Emotional intelligence is 'concerned with a person's ability to understand his or her own and other's emotions and then [being able to] apply this understanding to life's tasks' (Northouse, 2012, p. 91). It is important, therefore, that an agent should demonstrate emotional intelligence in order to have the ability of effectively carrying out the task of leadership of the youth victims of violence towards wellness. For instance, an agent should carefully in identify his or her personal biases or prejudices that could influence quality of care and need to make a conscious effort to practise reflexivity in order not to compromise the quality of the care he or she provides to victims of violence when they seek health care services.

- **Professionalism**

Health care professionals should seize every opportunity they have with the patient to exude professionalism in their daily practice. While there is no universal agreement about a definition of professionalism within the context of health care delivery, Stern (cited in Health Professions Council, 2012, p. 14) describes the following as principles of professionalism in health care that all health care professionals can subscribe to: *Excellence* is practice that is personal, commendable and of a high quality. *Accountability* includes competence and a commitment to standards of practice. *Humanism* is the demonstration of kindness, compassion, respect and integrity in practice. *Altruism* is the display of unselfish regard for other people and always acting in the best interest of clients. The aim of professionalism in health care should be to create positive experiences for all service users, including the youth.

This aim could also be accomplished by embodying *trustworthiness* and *confidentiality*. To be trustworthy, means that an agent should be honest and be a person that could be entrusted with the 'secrets' or confidential information about the youth. An agent also should be able to inspire trust in the recipient and to similarly trust the recipients in order to create a sense of harmony (Jooste & Minnaar, 2009, p. 358).

- **Synergy**

To function synergistically with all stakeholders an agent should be agreeable, understanding and supportive. Synergistic leadership describes a situation where two or more individuals work collaboratively as a team to produce an enhanced result as opposed to individual efforts of a lesser standard (Irby, Brown & Yang, 2009, p. 94). This quality of an agent is defined as the ability to collaborate and work with people other than members of the health team, e.g. legal practitioners, law enforcement officers and community members –in general towards the attainment of the collective goal of wellness for the recipient.

Roles

Leadership
Empowerment
Support
Role modelling
Collaboration

Agent

Characteristics

Competence
Possessing vision
Empathy
Perceptive
Change agent
Courageous
Emotional intelligence
Professionalism
Synergistic
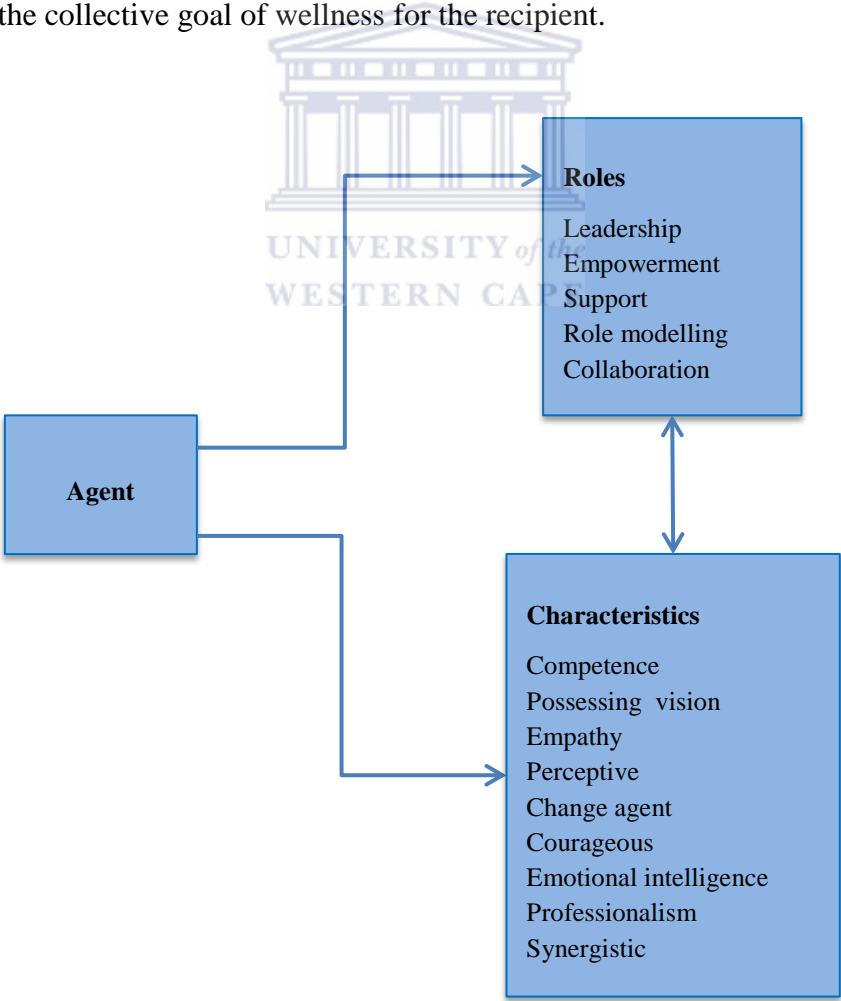
Figure 6.3:   Roles and characteristics of an agent

6.2.2   Who or what is the recipient of an activity?

A recipient is an individual who receives information from a sender (Basavanthappa, 2009, p. 931). In this study, the recipients refer to the youth who has been victims of violence that led to physical, mental and spiritual health problems. They expect to be supported by the health care professionals (the agents) in order to attain wellness.

A recipient is regarded as a holistic being who is in constant interaction with both the internal and external environment. There are three distinctive constituents of the internal environment of a recipient, namely body, mind and spirit. The body refers to the physical and physiological processes of the recipient that could be achieved by maintaining a healthy lifestyle (for example, eating nutritious meals, exercising regularly and participating in active physical activities and maintaining a healthy body weight) and self-care (bathing, feeding, dressing and toileting). The mind encompasses emotional and volitional processes of the recipient (self-awareness, a strong focus, self-restraint and resilience) while the spirit is the container of a recipient's belief system and presumed connection with God that might find expression in religious practice.

The external environment of a recipient includes three aspects. The social part refers to the accessible human resources; such as family, friends, support groups and health care professionals (agents). The spiritual component contains values and principles and considers religion practices in the community while the rural community where a recipient resides represents the physical part (Figure 6.4). A recipient is assumed to utilise the external resources present in his or her environment to attain wellness (University of Johannesburg, 2009, p. 4-6).

A recipient has certain responsibilities in this interactional process and should be able to demonstrate certain characteristics that would propel him or her successfully along the wellness journey towards attaining optimum health (Figure 6.5).

6.2.2.1   The role of the recipient

In the agent-recipient relationship, the leadership of the agents (professional nurse, medical doctor, social worker) influences the recipient to perform activities of self-management and shared-responsibility to enable him or her to attain wellness.

External environment

Physical:

    Rural community

Social:

    Family, friends, support groups, health care professionals (professional nurses, social workers, and medical doctors)

Spiritual:

    Religion

    Spirituality, values and principles

Internal environment

Spirit

Conscience, relationship with God

Spirituality, values and principles

Body

Self-care, healthy lifestyle

Mind

Self-awareness, strong focus, self-restraint, resilience
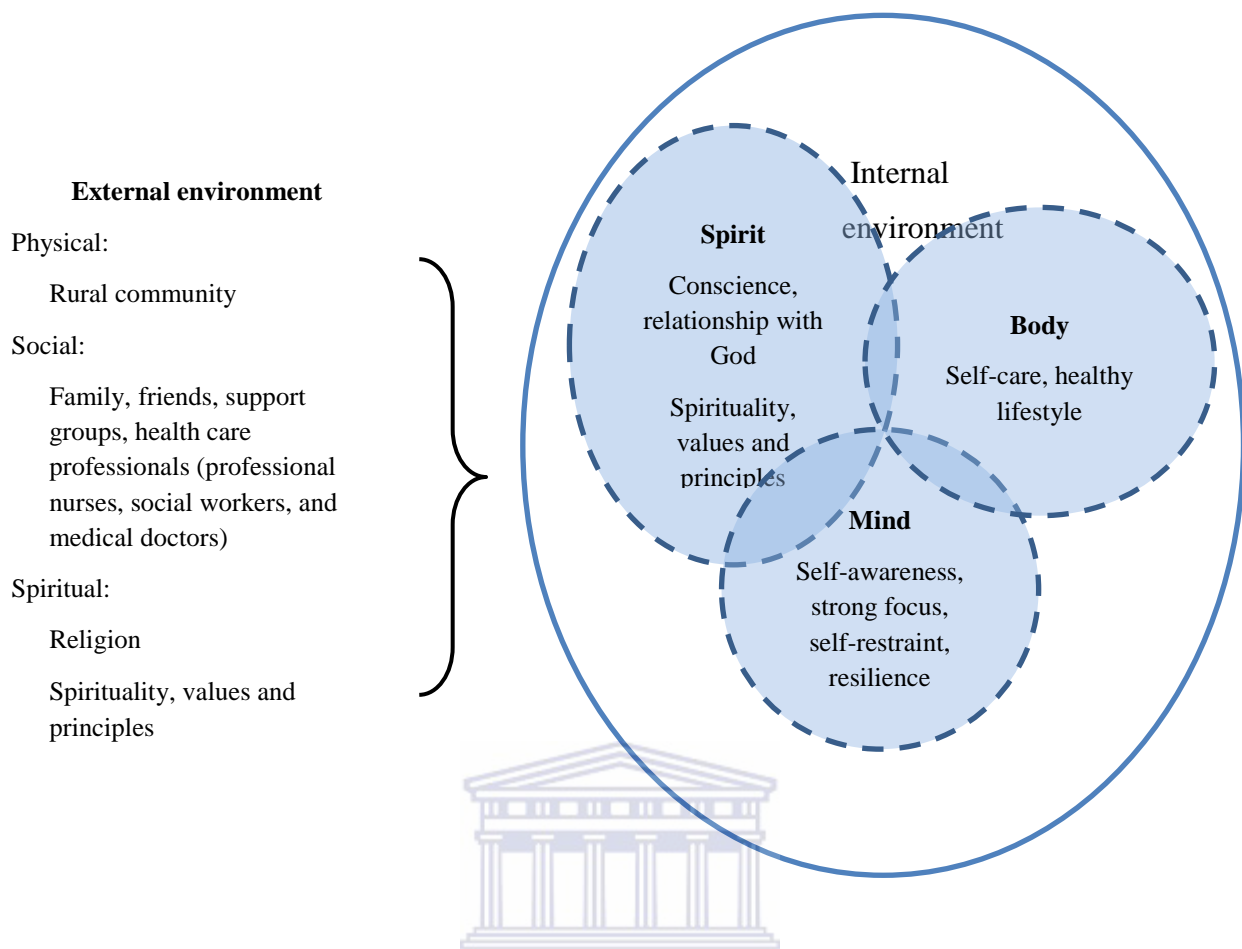
Figure 6.4: **The environment of the recipient**

The self-management role of a recipient should be demonstrated when the recipient takes responsibility for his or her wellness after being empowered and supported by an agent. The active role of a recipient in a participative leadership process is important because it enables the recipient's wellness to be conceivable. For example, after a recipient is counselled and empowered by the agent through the sharing of information and skills about coping with the stress of being a victim of violence and achieving and maintaining a healthy lifestyle, the recipient should be able to apply these skills and knowledge to his or her own life. The onus still rests on the recipient to strive towards wellness by being actively involved in the participative leadership process. It is based on the assumption that the recipient possesses the ability to reflect and be aware of the self and to initiate behaviour change needed for wellness (Alligood, 2014; Pender *et al*., 2011). The recipient could actively practise self-management by carry out self-care, eating nutritious meals, exercising regularly and maintaining social ties with family members, friends and support groups.

The recipient and the agent have shared responsibilities in the participative leadership process aimed at leading the recipient to wellness. Therefore, the recipient is expected to be a proactive follower who shares responsibility with the agent functioning as the leader. A proactive followership is not the servant and an agent is not the master who gives orders to the recipient with the expectation that the recipient ought to follow them blindly. Rather, it is a relationship characterised by an agent and a recipient *partnering* with each other in identifying the unique needs of the recipient, setting targets and working towards the achievement and evaluation of common goals (DuBrin, 2012, p. 27). It can be defined as 'a free act of surrendering and acting in accord with what is being called for in a given situation [and] this requires insight, forethought, physical and mental discipline and the ability to put the understanding into action' (Maroosis, 2008, p. 23). For this relationship to have an impact, the recipient should respect the authority of the agent and value his or her competence. Likewise, the agent should respect the recipient and trust him or her to take ownership of the responsibilities that are assigned to him or her (Bligh, 2011, p. 431). This notion aligns with the assumption of the researcher that health care professionals are an important part of the social environment and they have the authority, knowledge and skills to lead persons to wellness.

Even though the general goal of the leadership process is for the recipient to attain wellness, it would also be advantageous when the agent and the recipient have a reciprocal relationship (Maroosis, 2008, p. 24). The recipient and the agent mutually benefit, i.e. the agent benefits from modelling a healthy lifestyle and the recipient practises a healthy lifestyle.

6.2.2.2 The characteristics of a recipient

For a recipient to execute the self-management and shared responsibility role and to be successfully led towards wellness, the recipient needs to acquire certain important characteristics. These characteristics are being focused, goal-directed, self-aware, self-acknowledgement, self-restraint and adaptability.

- **Being focused**

To be focused means to pay attention or to concentrate on an activity or interest without being distracted (Oxford Dictionaries, 2014a). It is necessary that a recipient remains focused on the ultimate goal of attaining wellness. This means that the recipient has to constantly, in the words of the participants in this study, *be calm* and *not stressing*.

Nevertheless, a recipient needs to be cognisant of the fact that the journey towards wellness could be challenging and might take quite some time to accomplish; it requires the recipient's patience. Also, the recipient should understand that when he or she falters along the way or fails to meet a set target, it is not the end of the world. He or she can get back on track and continue to aim towards the goal of wellness.

- **Goal-directedness**

Goal-directedness is the ability to exhibit purposive behaviour through conscious thought and intent (Marien, Aarts & Custers, 2012, p. 277). When a recipient is goal-directed, it means that the recipient has to be motivated while adopting behaviour that promotes wellness. Behaviour that promotes wellness includes caring for oneself, caring for one's body, living a healthy life, eating healthy and exercising and not abusing drugs and alcohol.

- **Self-awareness**

Self-awareness is the consciousness of the self that a person reaches after a comprehensive process of deep reflection, insight and feedback. It is usually done to discover ways of improving personal effectiveness (DuBrin, 2012, p. 511). Self-awareness was described in this study to mean 'that you know yourself, you respect yourself'.

A recipient should, therefore, identify his or her strengths and weaknesses during a process of reflection and should also realistically explore and identify the deep internal issues that might obviate the attainment of wellness. For example, a recipient should be aware of personal coping mechanisms and sources of internal conflicts or stressors and dysfunctional behaviour. By practising self-awareness, a recipient could positively encourage and influence him or herself in a way that would enable him or her to direct energy and efforts towards accomplishing activities that will promote wellness.

- **Practising self-acknowledgement**

Self-acknowledgement refers to self-validation and recognition of one's efforts, achievements, or accomplishments. It assists a person to appreciate individual uniqueness, builds self-esteem and encourages continuous self-improvement (Sung, 2014). It means that one should be proud of the things that one can do. Along the journey towards wellness, a

recipient should regularly recognise and acknowledge his or her accomplishments, for instance after achieving a set target like getting physically fit.

- **Self-restraint**

Self-restraint is the resolve or willpower that a person shows to control him or herself and to stay focused on attaining an important goal. A recipient's ability to exhibit self-restraint is an important part of self-management (DuBrin, 2012, p. 511). A recipient should demonstrate self-restraint with the view of attaining the goal of wellness. To promote self-restraint in a recipient, it is essential that the recipient displays a reasonable amount of commitment and dedication to own personal wellness-related convictions.
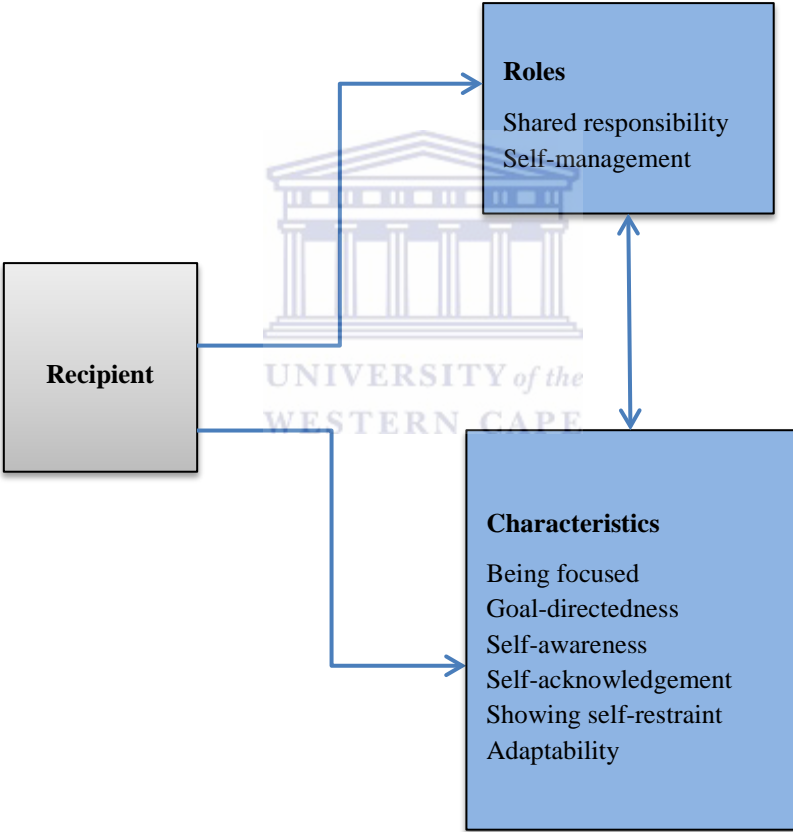
Figure 6.5:   Roles and characteristics of the recipient

- **Adaptability**

Another important attribute of a recipient is the characteristic of being adaptable to stress and change. Adaptability is the willingness of a recipient to be flexible and amenable to transformation (Rumsey, 2012, p. 380) while change means that a recipient is no longer the traumatised victim. Youth victims of violence go through a tough time; therefore, they need the ability to adjust while developing psychological and spiritual strength. Furthermore, it might become necessary for a recipient to change behavioural patterns when they are unhealthy or not supporting wellness by adopting a healthy lifestyle, for example when a recipient is stressed or depressed and the recipient could either apply spiritual strength, or practise other wellness habits, e.g. healthy eating and exercising. A recipient who experiences spiritual strength might adapt to a situation and experience wellness.

6.2.3   In what context is the activity performed (framework)?

Youth victims of violence live in the rural community of Genadendal in the Western Cape Province of South Africa. Their context comprises contextual realities, the Western Cape Province and national health care environment.

The context includes direct interactions in the community between the agents and the recipients. Support to youth victims of violence towards wellness could be provided individually, in a group (a programme) that involves the health care clinic, at school and in family structures.
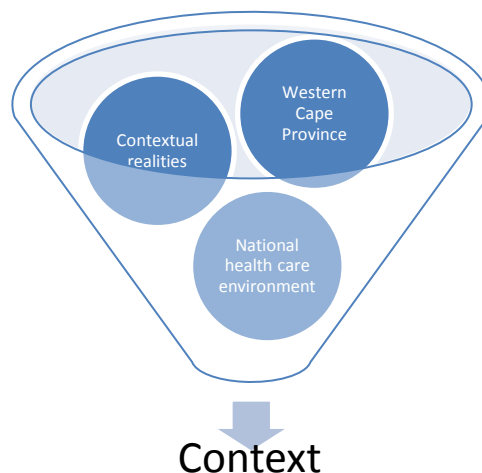
Figure 6.6:   Context

6.2.3.1   Contextual realities

In the community of study, there is a high level of violent fights, sexual assault, teenage pregnancy, alcohol and drug abuse (particularly methamphetamine / *tik*) among the youth. The abuse of alcohol and methamphetamine and the low socio-economic status of the majority of the community members were associated with the occurrence of violence in the community. This situation resulted in a high caseload of youth victims of violence reporting to the health care facility in the community.

Hence, the health care professionals involved in leading the youth victims of violence in the community experience frustration with managing the youth victims of violence due to factors; such as high numbers of violence-based injuries, heavy workload, shortage of skilled manpower, inadequate resources and rampant alcohol and substance abuse in the community. Further compounding this situation is the notion held by some of the health care professionals that the process of guiding the youth victims of violence towards wellness is cumbersome and time consuming even though they expressed genuine concern for the wellbeing of the youth in the community.

The focus of participative leadership (agents and recipients) should be on providing an enabling environment for attaining the wellness of the youth victims of violence in the community. This can be achieved when the agents pay particular attention to the unique needs of each individual youth victim by identifying the strengths and capabilities of recipients. Also, it is important that the Organizational structure at the health facilities is supportive and facilitate the provision of quality care services. There has to be clear statements of the values and mission statement guiding practice, for example values that support the provision of quality and efficient services to clients and their families. Health care professionals should also partner and collaborate as a multidisciplinary team with the purpose of fully utilising the unique knowledge and skills of each professional for the benefit of the recipients. The agents and the recipients should be sufficiently motivated in the process and it is important that a healthy relationship exists between them. Some of the ways in which agents could promote this kind of environment are providing care in a friendly, sensitive, respectful, empathic and caring manner; and ensuring that the privacy and confidentiality of the recipient is maintained. Such an environment would build trust and respect amongst the agents and the recipients. Therapeutic two-way communication should be used during interactions between

the agent and the recipient by showing support, providing information and feedback, altering distortions and providing hope (Van Servellen 2009, p. 50).

Furthermore, there is a need to build the capacity of staff members by conducting regular training about being responsive to the needs of the victims and to lead them to wellness. For example, health care professionals should receive training on participative leadership with the aim of equipping them sufficiently to function in their position of leadership as health professionals. Furthermore, as it was pointed out in the findings of the study, there is a need to have enough staff members (adequate resources) who are dedicated to leading the youth victims of violence. When the necessary resources are made available, it becomes much easier for the agents to carry out their leadership roles, for example the availability of teaching aids for health education or the required personnel for counselling.

6.2.3.2   Western Cape Province

The Western Cape Department of Health (WCDH) is responsible for financing health packages (district health services) in the Western Cape Province of South Africa. Therefore, it is expedient that health care professionals who manage the youth victims of violence partner with the WCDH in leading youth victims of violence toward wellness.

The *Health care 2030: The Road to Wellness* (2014) is the current strategic approach that the WCDH promotes to increase the wellness of the people residing in the Western Cape Province of South Africa, including youth victims of violence. The approach is based on important legislative frameworks and policies such as the 1996 Constitution of the Republic of South Africa, the 2010 Negotiated Service Delivery Agreement, the 2010 Re-engineering Primary Health Care, the 2011 National Development Plan (NDP) and the 2011 Provincial Strategic Plan of the Western Cape. An important area for leading youth victims of violence towards wellness is promoting and encouraging healthy lifestyles. This is emphasised in the service platform proposed by the *Health care 2030: The Road to Wellness* approach that seeks to strengthen primary health care (PHC) delivery (Western Cape Department of Health, 2014).

The primary health care approach plays a central role in the development of the South African population. The general aim of leading the youth who have been victims of violence to wellness is to achieve the goal of ultimate health in the community that is necessary for a healthy nation and society. The primary health care approach supports the preventive,

curative, rehabilitative and educational wellness needs of the youth victims of violence to promote their physical, psychological, emotional and social health and wellbeing (Hattingh, Dreyer & Roos, 2012, p. 7). Primary health care is defined as:

> *'essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination'* (WHO/ UNICEF, 1978, p. 2)

At the international conference on primary health care held in Alma Ata in September 1978, a vital call for the adoption and implementation of the primary health care approach by governments by all nations of the world and especially the developing nations was made. Primary health care services include health education on predominant health challenges and the management of injuries and common diseases (Hattingh, Dreyer & Roos, 2012, p. 71; WHO / UNICEF, 1978, p. 2). Thus, health care professionals should work collaboratively with support from the WCDH, community members, nongovernmental Organizations, international Organizations, such as the World Health Organization and UNICEF, as well as with multilateral and bilateral agencies and funding agencies (WHO / UNICEF, 1978, p. 3).

It is important at the provincial level that sustainable structures, mechanisms and processes are created by the WCDH in local communities to benefit the health of the youth victims of violence and the entire community. Financing community development projects would ensure benefits for all members of a community. These projects should be implemented in partnership with the community at all stages to ensure their interactive participation. To promote active support, participation and sustainability; the community should be permitted to identify their own unique needs and be involved in the designing, planning, monitoring and evaluation processes of the community projects (Sullivan, 2004, p. 2).

6.2.3.3   National health care environment

This environment examines the policy and legislative frameworks at the national level. The awareness, understanding and application of the principles entrenched in these policy and legislative frameworks is needed for the leadership of youth victims of violence (recipients) by the health care professionals (agents).

While there exists several other policy documents and legislative frameworks that could serve as a guide for the agents in executing their leadership and guidance roles of youth victims of violence towards wellness, the following policy and legislative frameworks for South Africa are considered to be important:

- The Constitution of the Republic of South Africa, Act No. 108 of 1996;
- The Batho Pele Principles of 1996;
- The National Health Act of South Africa, No. 61 of 2003; and the
- Integrated Victim Empowerment Policy Guidelines of 2007.

The Bill of Rights (Chapter 2 of the Constitution of the Republic of South Africa, Act No. 108 of 1996) stipulates the fundamental rights of all South Africans in the country, including the youth who has been victims of violence. Among these rights are the rights to dignity, equality, freedom of expression and association, as well as access to information, housing and social and health care services (Department of Justice and Constitutional Development, n.d., p. 5).

The youth victims of violence are aware of their fundamental rights and they expect that the health care professionals would show them respect and provide them with confidential and supportive services. Hence, it is crucial that health care professionals recognise the fact that the youth victims of violence like every other client have rights that they should respect and they should seek to provide them with confidential and supportive services and they should avoid judgemental attitudes like victim blaming.

Also stipulated in the constitution are the objects of the local government and municipality that include supporting a safe and healthy environment, providing sustainable services to communities in a manner that will promote their social and economic development and encouraging the participation of communities and community Organizations in the matters concerning them (Department of Justice and Constitutional Development, n.d.-a, p. 74). This should be the focus of the government while providing management services to the victims of violence.

- **The Batho Pele Principles of 1996**

The *Batho Pele* (meaning 'people first') principles call for health care professionals to deliver quality services to the youth victims of violence based on the principles of access, efficiency,

effectiveness and equity while giving consideration to the stipulated high professional and ethical standards. There are eight *Batho Pele* principles that serve as the standard policy and legislative framework for service delivery in the public service.

1. **Consultation:** This principle recommends that the youth victims of violence should be asked about the quality of public services that they receive and they ought to be given the opportunity to choose from a range of available services, if possible.

2. **Service standards:** This principle emphasises the need for the youth victims of violence to be adequately informed about the level and quality of service they are going to receive in order for them to anticipate such services and to evaluate whether or not they have received the services agreed upon.

3. **Access:** This principle emphasises the need for equal access to quality services by the youth victims of violence.

4. **Courtesy:** This principle stresses the need for the youth victims of violence to be treated with respect, thoughtfulness and concern by public servants.

5. **Information:** This principle emphasises the need for the youth victims of violence to be given complete and true information about the services they are eligible to access, for instance providing information at the point of delivery or on websites of Organizations.

6. **Openness and transparency:** This principle underscores the importance of the youth victims of violence being informed about the leadership, processes and operations of the local, provincial and national sectors of government.

7. **Redress:** This principle underlines the right of the youth victims of violence to complain when they do not receive the standard of service they expect to be provided, to request the reasons for such poor service, and to expect a prompt and effective solution or answer to their complaint.

8. **Value for money:** This principle points out the importance of delivering efficient and cost-effective public services the youth victims of violence to ensure that they receive proper value for their money (Independent Police Investigaqtive Directorate Republic of South Africa, n.d.).

- **The National Health Act of South Africa, No. 61 of 2003**

The National Health Act of South Africa, No. 61 of 2003 is the legal document that offers the framework for providing an organised and consistent health system in the country. The act takes into consideration the obligations provided by the Constitution of the Republic of South Africa (Department of Health, 2004; Health Systems Trust, 2014), as well as other relevant national, provincial and local government laws related to it, including the terms of the Health Service Professions Act, No. 56 of 1974, the Nursing Act, No. 50 of 1978 and the Allied Health Professions Act, No 63 of 1982.

In the first chapter of the National Health Act, it is clearly stated that all health care providers working in the public sector should seek to deliver health services in a reasonable and justifiable manner within the ambit of the resources available to them. This includes the provision of quality and efficient health care services to the youth who have been victims of violence. Another key objective stated in the Act is the need for the national department and all provincial departments and municipalities to ensure equality of health services in the country by providing primary health care services (Department of Health, 2004). Additionally, other sections of the National Health Act like Chapter 2 emphasises the rights and duties of users and health care personnel, including the right to emergency treatment, the right to participation in decisions and the right to confidential services. Chapters 3 and 4 stipulate the general functions of the national and provincial departments.

- **Integrated Victim Empowerment Policy Guidelines of 2007**

The Integrated Victim Empowerment Policy Guidelines are a legislative framework developed by the Department of Social Development of South Africa in partnership with the Departments of Health, Education, Justice, Correctional Services and the South African Police Service to support and assist people who have suffered trauma, harm and quantifiable damage as a result of crime, violence, human accident, or natural disaster. These policy guidelines serve as a framework to aid efficient and effective service provision to victims based on the principles of human rights, human dignity, empowerment, participation, self-determination, efficiency, effectiveness, justice, accountability and a multi-disciplinary approach (Department of Social Development, 2007, p. 3-9). The target groups for victim empowerment in this policy include youth, women, children, alcohol and drug abusers, families and communities in general..

Furthermore, common interventions are specified. The interventions recommended for the empowerment of victims by all sectors are awareness creation, building skills, programmes and services development, teaching and training of workforce and clients, research, monitoring and evaluation and enabling structures for management (Department of Social Development, 2007, p. 20). The guidelines also recognise the multidisciplinary approach to victim empowerment and explain the roles and responsibilities of different stakeholders, including health care professionals working for the Departments of Health and Social Development.

The guidelines state that health care professionals ought to provide certain services to victims of crime and violence who approach clinics, primary health care centres, hospitals, or crisis centres for assistance which include but are not limited to information, emergency and continual medical and medico-legal services, contraceptives, anti-retroviral treatment, psychological services (where available) and referral to other relevant service providers. It also stipulates the dual role of the Department for Social Development of the coordination and facilitation of support to victims. These roles are expected to be carried out in collaboration with non-governmental Organizations and community-based Organizations. Victims ought to have access to at least the provision of information, counselling services, shelters (where available), reconciliation programmes and referral to other services (Department of Social Development, 2007, p. 24-25).

6.2.4   What is the energy source for the activity (dynamics)?

The dynamics are the essential motivating and supporting factors that the agents need to lead the recipients toward wellness (Meleis, 2012, p. 130). Figure 6.7 shows the important dynamics required to lead the youth victims of violence towards wellness.
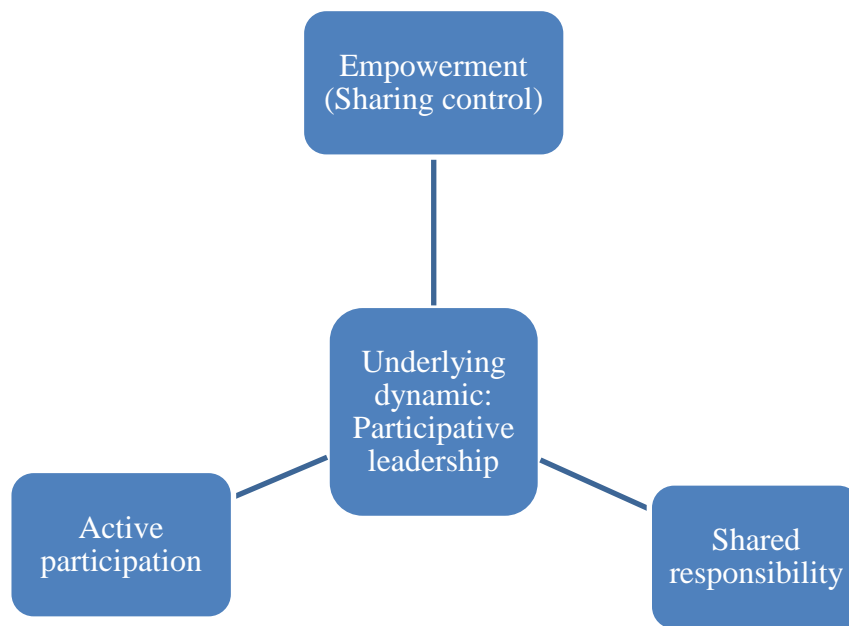
Figure 6.7: **Underlying dynamic of participative leadership**

Participative leadership is the underlying dynamic that promotes the attainment of wellness for the youth victims of violence.

6.2.4.1 Participative leadership

Participative leadership involves the agents and the recipients to actively work towards a common vision (wellness). This means that the agents and the recipients collaboratively identify the objectives and strategies that are necessary for the accomplishment of the shared vision (MBA Brief, 2014, pp.1). The shared vision should be viewed in the context that leading youth victims to wellness require changes that might happen slowly. Participative leadership is based on "democratic principles of connection, cooperation, inclusion, ownership, agreement, mutual benefit and support among leaders and followers in the interactional process of leadership" (Bass & Bass, 2008, p. 461).

The benefits of using participative leadership include:

- The promotion of positive relationships and the development of trust (Miao, Newman & Huang, 2014; Sauer, 2011).

- Commitment and a team spirit between the agent and the recipient because the recipient grasps that the leadership of the agent originates from genuine interest and concern (Benoliel & Somech, 2014; Miao, Newman, Schwarz & Xu, 2013).

Participative leadership entails the facilitation of (i) empowerment (sharing of control), (ii) active participation and (iii) shared responsibility between the agent and the recipient that create an enabling environment for them to achieve their shared vision.

6.2.4.2 Empowerment (sharing of control)

Empowerment is defined as 'a dynamic process on interaction between the follower and the leader (with personal characteristics and leadership skills) during motivation, power sharing and participative decision making, both working within a management and leadership structure, with the aim of accomplishing a power balance' (Jooste, 2009, p. 222). The principles of empowerment that should be considered by professionals who are promoting wellness according to Keleher (2007, p. 147) are encouraging a sense of bonding and connection, sensitivity and respect for culture, strengthening participation, increasing individuals' skills and control over resources, identifying obstacles and enablers to empowerment interventions, as well as stimulating advocacy and leadership development.

Empowerment serves the purpose of improving the mental capacity of the recipient that enables him or her to solve problems and to make informed decisions. Furthermore, it encourages the feeling of autonomy and confidence and increases the ability of the recipient to think creatively and augments the capacity to cope with stress. These processes collectively accelerate the journey to psychological and emotional wellbeing and encourage positive behavioural changes to practise a sustainable healthy lifestyle (Bortoluzzi, Caporale & Palese, 2014; Fong & Snape, 2013).

A participative leader (agent), therefore, should endeavour to empower the recipients intellectually and psychologically with the purpose of contributing to the mitigation of tensions and boosting the morale of the recipients. This could be achieved by sharing knowledge or information, counselling, providing support and encouragement, encouraging the thoughtful expression of spiritual principles and participation in religious activities, modelling of a healthy lifestyle and organising youth development programmes for the recipients. The strategies for empowerment should be chosen and tailored to meet the needs and preferences of the recipients (Ozer, Newlan, Douglas & Hubbard, 2013).

6.2.4.3 Active participation

Active participation is defined by the European Environment Information and Observation Network (2014) as the involvement of an individual or a group in activities or issues affecting them with the purpose of wielding influence. This means that in active participation, participants do not passively carry out the instructions of other people. Rather, they act purposefully to influence the dynamics in a particular context. The foundational principle of active participation is based on the recognition of the rights of individuals to autonomy, to participation in activities and to independent association (Collins, 2012). The documented benefits of patients actively participating in their personal wellbeing include improved independence, self-direction, self-belief and self-confidence, empowerment, development of caring skills and better treatment outcomes and recovery (Buchanan, Peterson & Falkmer, 2014, p. 5; Vahdat, Hamzehgardeshi, Hessam & Hamzehgardeshi, 2014, p. 3).

The recipient's self-management role requires that the recipient should actively participate in self-managing his or own wellness with the purpose of developing self-efficacy (Daft & Marcic, 2011, p. 395). The recipient needs the ability to take concrete steps in implementing the plan or course of action (jointly developed by the recipient and the agent) that would propel him towards achieving the common vision of wellness. For instance, he or she should actively engage in self-care, exercise, recreational activities, consciously select and prepare healthy and adequate meals, and ponder about values and principles when in spiritual distress.

The agent should also be an active participant in leading the recipient to wellness and should view the recipient as an equally active participant in the leadership relationship. They should encourage the recipients to take active responsibility for their own wellness and support them by exhibiting professional attitudes that would encourage the active participation of the recipient in the process. The agents should ensure that the recipients are prepared and equipped with the necessary knowledge they require to make informed decisions, for example sufficient awareness and understanding of self-management and aspects of their personal lives that influence their self-management choices.

6.2.4.4 Shared responsibility

Shared responsibility means that all participants in a leadership process are collectively allowed to influence the process and to volunteer their individual skills and resources to achieve tasks and assignments. It enhances the efficacy and accountability of a teamwork that

intends to achieve a shared vision (Wahlstrom & Louis, 2008). It is based on a commitment to shared values, a shared purpose, mutual accountability, encouragement of collective learning, openness and relationship building (Hoberecht, 2014).

Strategies for achieving shared responsibility include developing a shared vision and mission, utilising individual talents and capacities, improving communication and decision making and monitoring progress regularly (Shiparski & Payne, 2010).

Shared responsibility is another critical part of the dynamics required for leading the youth victims of violence towards wellness. It means that the agent and the recipient are equally responsible for actualising the shared vision of wellness for the recipient. Shared responsibility promotes a shared purpose, sense of belonging, connectedness, accountability, shared control and facilitates the achievement of the vision of wellness (Singer, Burgers, Friedberg, Rosenthal, Leape & Schneider, 2011). To exemplify shared responsibility, the agent should involve the recipient in setting objectives, problem solving and decision making. In turn, this process would influence the recipient to take responsibility for his or her well-being. The agreed upon objectives for attaining the shared vision should be clear, specific, realistic, measurable and time bound. It is important that these objectives are every so often reviewed to track the progress towards the attainment of wellness.

6.2.5   What is the guiding procedure, technique or protocol (procedure)?

The guiding procedures are the blueprint for carrying out an activity (Dickoff *et al*., 1968, p. 423; Meleis, 2012, p. 130). Health care professionals (agents) use these strategies to lead and guide the youth victims of violence (recipients) towards wellness.

Table 6.1:   Procedure

- Counselling training
- Building a trusting relationship
- Information sharing and communication
- Developing and encouraging positive coping skills
- Recreational activities
- Social support (family, friends and community, support groups)

The procedures that health care professionals should use to lead or guide youth victims of violence towards wellness are providing counselling services, building a sound and trusting relationship, information sharing and communication, developing and encouraging positive coping skills, participating in recreational activities, using social support (family, friends and community, support groups), tracking of progress and empowering youth programmes (at school and in the community) (Table 6.1).

6.2.5.1 Provision of counselling services

Counselling refers to "a professional relationship that empowers diverse individuals, families and groups to accomplish mental health, wellness, education and career goals" (American Counseling Association, 2014, pp. 2). Evans (2013, p. 35) defines it as a confidential interaction between a qualified counsellor and a counselee aimed at promoting and enhancing wellbeing. The ethical principles for counselling include respect for the client's rights, trustworthiness, a commitment to promoting the client's well-being and avoiding harm to the client, the fair and impartial treatment of all clients and the provision of adequate services and practitioner's self-respect (British Association for Counselling & Psychotherapy, 2010). A good counsellor usually is being empathic, approachable, warm and caring, knowledgeable, a good listener, understanding, non-judgemental, confidential, friendly, calm, respectful, objective, sincere, honest and trustworthy, open-minded, patient, considerate, tolerant, sensitive and flexible (Geldard & Geldard, 2010, p. 83; Green, 2010, p. 37; Kinra, 2008, p. 142). Counselling services could be provided during single or multiple sessions and in different ways, for example by means of either physical face-to-face interaction, telephone conversation, or email correspondence (Evans, 2013, p.35 - 36). It could be provided on an individual and / or group (e.g. with family members present) basis. Tracking progress usually happens during a telephonic conversation between the councillor and the recipient.

Counselling assists with providing valuable care, support and positive coping skills for youth, who has been victims of violence with the view of assisting them with assessing and dealing with their traumatic experiences. Victims of violence (recipients) experience substantial amounts of psychological trauma or distress as a result of the incidence of violence. The agent should, therefore, be supportive and provide the recipient with non-judgemental confidential counselling. His aim should be to alleviate the detrimental effects caused by the traumatic experience on the victim and to enable the recipient to deal with the psychological trauma or distress associated with the incidence of violence. For instance, during counselling, the youth

victim of violence should be allowed to express him or herself freely, fears and anxiety should be allayed and reassurance should be given. Also, the health care professional should be empathic and avoid blaming the victim for being responsible or contributing to the violent incident and referrals should be made to other professionals for further management when it becomes necessary.

Apart from the fact that counselling provides an opportunity for emotional support, it also assists the recipient with gaining information that might be needed when making informed decisions. The ideal situation would be for the recipient to receive *ample* counselling from the agent, starting at their first contact to enhance the immediate reactions and subsequently to address long-term crisis reactions. It is important that the agent bears in mind that the leadership of the recipient towards wellness is a process that could take a long period of time. Therefore, it is important that continual counselling support should be provided to the recipient in order for him or her to attain wellness.

6.2.5.2   Building a sound and trusting relationship

Building a sound and trusting relationship refers to creating a lasting and enduring personal relationship that is based on genuine trust and respect by adequately providing physical, psychological, spiritual and emotional support (Zaugg & Davies, 2013). To build a sound and trusting relationship with their clients, health care professionals are expected to show passion, enthusiasm and willingness to serve (Lekalakala-Mokgele, 2009, p. 325).

The interpersonal interaction between the agent and recipient engenders support and trust that improve the responses of the recipient to the approach of participative leadership. A true leader has a passion for supporting and serving other people (Lekalakala-Mokgele, 2009, p. 325). A true leader embraces listening attentively; being confident, patient, consistent and flexible; as well as having a sense of humour (Boyle, 2012; Zaugg & Davies, 2013). Also, health care professionals should have people skills in order to build a sound and trusting relationship. People skills enable health care professionals to communicate and deal with other people. When the agent creates a trusting environment, it makes it possible for the agent and the recipient to collectively face challenges without fear or intimidation and it increases the potential for personal change. It would promote a positive interpersonal relationship between the agent and the recipient that might improve the recipient's experience of wellness. The agent should build a sound and trusting relationship by listening and respecting the

recipient, being approachable and available, showing empathy, being trustworthy and non-judgemental and maintaining confidentiality by protection of the recipient's privacy. Information sharing and providing support would also assist with building a sound and trusting relationship between the agent and the recipient.

It is important to keep in mind that building a strong and trusting relationship is a process that could occur over a prolonged period of time of mutual exchange between the agent and the recipient (Miao, Newman & Huang, 2014).

6.2.5.3   Information sharing and communication

The principles of information sharing and communication include respecting and listening carefully to the client, respect, spending sufficient time, being sensitive to the values and customs of the client and providing specific information as and when required (Kuo *et al*., 2012, p. 301).

Effective information sharing in the context of victims of violence should be based on therapeutic communication. VanServellen (2009, p. 50) defines therapeutic communication as expressing support, providing information and feedback and correcting distortions while providing hope. This type of communication assists clients with trusting and collaborating with their health care providers, therefore, its importance should be emphasised during all phases of client-provider interactions and relationships (Butts & Rich, 2011, p. 281). Health care professionals should use therapeutic communication for guiding their clients and the families of their clients towards holistic wellness, violence prevention, as well as adopting a healthy lifestyle and behaviour. It should be the foundation of the delivery of client-focused care. Roter and Hall cited in VanServellen (2009, p. 83-84) suggest that client-focused communication skills that encourage therapeutic communication include identifying and meeting the emotional needs of the client, assisting the client to reflect and gain insight into his or her situation and contributing to general wellbeing. It is necessary that the recipient receives relevant, accurate and adequate information and health education from the agent. This gives the recipient an opportunity to learn, improve knowledge and dispel myths and misconceptions because during information sharing, the recipient might express gaps in knowledge and receive feedback from the agent.

Information shared or communicated to the recipient could include the importance of eating nutritious meals, practising self-care, as well as avoiding aggressive behaviour and dangerous

habits (e.g. alcohol and drug abuse, risky sexual behaviour) and lifestyles (e.g. lack of exercise and recreational activities). In addition, the recipient should receive information about where to access comprehensive services; such as alcohol and substance abuse treatment, employment and legal aid. A recipient could get health education during one-on-one conversations with an agent or by using IEC (information education communication) materials; such as audio-visual presentations, hand bills, or fliers. The process of health education requires the agent to be knowledgeable and to demonstrate good interpersonal communication skills.

6.2.5.4   Developing and encouraging positive coping skills

Coping skills refer to the specific efforts that a person makes to deal and adapt to the disadvantages encountered in life or stressful situations (Fritscher, 2012). Stressors are circumstances that threaten or are perceived to threaten an individual's state of wellbeing and most certainly challenge the coping abilities of the person (Weiten, Lloyd, Dunn & Hammer, 2009, p. 71).

Coping skills can either be negative or positive. Negative coping skills oftentimes worsen the stressful situation although they might offer some short term relief or distraction. Examples include anger, violence and the abuse of alcohol and drugs. On the other hand, positive coping skills assist an individual to live through the situation at almost the same level as a person who is not faced with the same situation (Fritscher, 2012). Positive coping strategies include positive self-talk (positivity); humour (seeing the lighter side of things); writing down the experience for deep reflection; forgiveness; exercise; meditation; prayerfulness (spiritual contemplation); deep breathing to ease muscular tension; and seeking support from family, friends, religious leader, counsellor, or psychiatrist (Weiten *et al*., 2009).

Victims of violence experience substantial amounts of psychological trauma or distress as a result of the incidence of violence as early as the time they reach a health care facility. This significantly affects their general health in addition to the physical wounds or injury and pain that they might experience. These effects are usually more intense in youth victims who previously experienced violence, chronic stress, abuse and neglect (Corbin, Rich, Bloom, Delgado, Rich & Wilson, 2011, p. 512-516). They might experience acute stress reactions (ASRs) that mainly are characterised by dissociative feelings; such as confusion, apathy, fear, nervousness, palpitations, sweating, blushing and memory loss during the first 48 hours after

the traumatic incidence. When these ASRs are not well managed, the victim might start experiencing acute stress disorders (ASDs) that are characterised by symptoms; such as extreme panic, stress or pain, irritability, anxiety, reliving an experience, insomnia and loss of mental concentration (Foa, Zoellner & Feeny, 2006; Sijbrandij, Olff, Reitsma, Carlier, de Vries & Gersons, 2007). When ASDs are not well treated or managed, these symptoms becomes protracted to a point where it might develop into posttraumatic stress disorder (PTSD) (Bryant, Friedman, Spiegel, Ursano & Strain, 2011, p. 336-337).

Therefore, the agent should be supportive and assist the recipient to develop positive coping skills to manage or deal with the emotional stress and trauma associated with being a victim of violence. These skills would assist in propelling the youth victim of violence towards the wellness.

6.2.5.5   Encouraging the practice of recreational activities

Recreational activities are activities that are carried out for the purpose of entertainment and relaxation and are most frequently done during leisure time (Leitner & Leitner, 2012, p. 13). Activities; such as football, basketball, rugby, athletics and aerobics are examples of physical recreational activities (Oak, 2012).

Recreation is an integral part of attaining wellness for all sectors of a population, including the youth. The benefits of young people participating in sport and other recreational activities include improved physical and mental wellbeing, development of social and cognitive skills, positive attitudes towards learning, increased community cohesion and decreased crime and violence. Furthermore, it has been reported that the association between recreational programmes and health services could assist with improving the uptake of services, as well as contributing to successful positive behavioural change (Lonsdale, Wilkinson, Armstrong, McClay, Clerke & Cook, 2011; Ruhanen & Whitford, 2011; Rynne & Rossi, 2012; Ware & Meredith, 2013). Principles of facilitating successful recreational programmes encompasses cultural appropriateness, practicability, inclusion of the community in the planning and implementation of programmes with the purpose of enhancing engagement and sustainability, low cost to participants and arranging activities at times that are convenient (Ware & Meredith, 2013, p. 3).

For example, recreational activities for the recipients in a community should be organised after school hours, or during weekends and school holidays. Activities; such as mountain

hiking, running, football and rugby are likely to be acceptable to the youth because these activities are associated with the cultural and traditional values of the community. The agent should also encourage the recipient to practise recreational activities during their leisure time. Examples of leisure activities to focus on could be e.g. knitting. Encouraging the practice of recreational activities gives the recipients the opportunity to actualise their full potential and to deal with stress by keeping them actively and positively engaged. It could curb the abuse of alcohol and drugs.

6.2.5.6   Social support (family, friends and support groups)

Social support is the assistance or help that individuals receive from other people (MacArthur Research Network on SES and Health, 2008). Family, friends and formal groups; such as a religious and community groups, or social club are obvious sources of social support (Towey, 2014). The use of a social support system is an important strategy for coping and dealing with stressful life events. It is documented to improve physical and psychological wellbeing, sense of belonging and companionship, control, self-esteem and perceived support availability. Stress-buffering processes also involve these mechanisms for distressed individuals (Thoits, 2011, p. 145)

Social support is commonly categorised into three forms; namely emotional, instrumental and informational support. Emotional support relates to the feelings of love, concern and self-worth; for example through talking, encouragement and positive feedback. Instrumental support relates to the tangible assistance from other people; for example money, labour and time. Informational support comprises the support received from the sharing of information, suggestions and facts (MacArthur Research Network on SES and Health, 2008).

The agent should, therefore, encourage the recipient to activate his or her support system to promote the emotional, psychological and spiritual wellbeing of the recipient. This can be through the support they receive from their family members and/or friends during the difficult time of dealing with their stressful and traumatic situations. The recipient should also be linked with support groups through group therapies. Support groups are necessary in the process of leading the recipients to wellness because they serve as an avenue for empowerment and offer the recipient with the chance of receiving practical assistance from those who have successfully recovered from similar traumatic or stressful experiences. In addition, the support of the entire community for the youth victims of violence should be

encouraged to assist the recipient in attaining wellness and the recipient should be provided with appropriate support services present in the community.

6.2.5.7 Follow-up

Brand and Stiggelbout (2013, p. 225) describe follow-up (tracking) as the regular monitoring of a patient's health status with the purpose of objectively improving the health and quality of life of the patient as much as possible. It has been reported that patients value health care providers' tracking services because it creates an avenue for them to receive information, expert reassurance and an opportunity to give feedback and a chance to promote the continuity of care that significantly contribute to a recipient's physical, emotional and psychological recovery (Suman, Field & Rowan, 2009).

Tracking should be a fundamental part of the leadership process because it provides an opportunity to assess the responsiveness to therapy and the progress the recipient is making on the wellness journey. During a routine follow-up, the agent could assess the progress of the recipient, screen for health risks, offer health education and provide information about required resources (Whiteside & Cunningham, 2009, p. 120). Approaches for tracking the victims of violence could include routine check-ups or appointments, home visitations by skilled peer volunteers or social workers, as well as technological communication; such as phone calls, web chats and emails.

6.2.5.8 Empowering youth programmes (at school and in the community)

Empowering programmes for the youth could be offered in the format of sports and recreation programmes, youth forums / club and peer mentoring programmes (O'Brien, Paradies, Reilly, Shoemborn, Crumpen & Briggs, 2009). These programmes can be organised for the youth at school and / or in the community. This avenue could be used to provide them with relevant information about living a lifestyle that promotes wellness; it is an important mechanism for developing and sustaining healthy communities. Organising health education programmes may achieve this objective. The health education programmes may include strategies for self-management, coping with stress, understanding holistic wellness, straight talk about alcohol and drug use, dealing with eating disorders and inactivity, dealing with bullying among young people, living a healthy lifestyle, as well as building and sustaining a wellness milieu for the youth at schools and in the community. Programmes may require recreational areas for youth in the community to use after school hours.

Programmes should also provide the youth with opportunities to develop and demonstrate their leadership capabilities (Ware & Meredith, 2013, p. 8). In addition, programmes can also be organised for families to provide them with skills they require for supporting their family members during difficult and stressful circumstances.

It will be helpful if the agents collaborate with other stakeholders; e.g. teachers, parents and guardians, as well as governmental and non-governmental Organizations in designing, planning and implementing programmes for leading youth victims of violence towards wellness in their community.

6.2.6   What is the endpoint of the activity (terminus)?

The endpoint of the activity in this study comprises the wellness of the youth victim of violence as a result of the participative leadership of the health care professionals. Wellness is a holistic way of life characterised by a healthy mind (psychological, emotional) and spirit, healthy living, self-care, resilience, healthy personality and positive interaction between the internal (biological, psychological, spiritual) and external (social) domains.

Table 6.2:   Terminus (wellness)

6.2.6.1   Healthy mind and spirit

Wellness is characterised by a healthy mind (psychological and emotional wellbeing) and spiritual wellbeing. Psychological wellbeing includes intellectual capabilities; such as focus, the ability to reason logically, autonomy and self-acceptance (Rothmann & Ekkerd, 2007, p. 36). Emotional wellbeing includes the experience of awareness, security, control of feelings, having a realistic view of life and the future and realistic self-assessment and personal boundaries, and being able to independently cope with stress (Roscoe, 2009, p. 219). Spiritual wellbeing is the awareness and connection with a transcendent being or force(s) in an invisible dimension that provides a deep sense of wholeness. It includes the values, principles

and attitudes of a person (Neuman, 2011; Roehlkepartain *et al*., 2006). Spirituality assists a recipient with mitigating negative situations and supports the healing process towards holistic wellness.

6.2.6.2   Healthy living

Healthy living is the practice of health enhancing behaviour (Public Health Agency of Canada, 2013). It involves a commitment to a healthy lifestyle that consists of eating nutritional meals, not abusing drugs and alcohol, regular exercise and actively engaging in physical activities. It also means having a positive outlook while being focused on the vision of wellness whether or not illness or disease is present in the body, i.e. transcending the mere absence of illness or disease in the body.

The recipient, therefore, should make conscious efforts (goal-directedness) to live a healthy lifestyle that promote physical, mental and social well-being.

6.2.6.3   Self-care

Self-care refers to the act of caring for oneself (Wellness Council of America, 2008). Basic self-care activities include feeding oneself, bathing or showering, dressing in clean clothes, toileting, personal hygiene and grooming (Roley *et al*., 2008). The advantages of individuals engaging in self-care practices are well documented; it includes reduced stress levels, an increased sense of wellbeing and life satisfaction, improved health status, quality of life and better health outcomes (Buck, Lee, Moser, Albert, Lennie, Bentley & Worrall-Carter, 2012; Coulter & Ellins, 2006; DeSilva, 2011; Seto, Leonard, Cafazzo, Masino, Barnsley & Ross, 2011; Stark, Hoekstra, Lindstrom & Barton, 2012).

Wellness includes the practice of self-care activities and safeguarding personal safety. Self-care is also referred to as activities of daily living (Roley *et al*., 2008).

6.2.6.4   Resilience

Resilience is the capability of an individual to remain strong and healthy or successful following an unpleasant life event or incident (Merriam-Webster Dictionary, 2014). Literature describes resilience as "a pattern of positive responses to an adverse situation or crisis that is sufficient for optimizing human potential and can be strengthened" (Bulechek *et al*., 2013, p. 536). Resilience contributes to the process of an individual attaining or regaining wellness

following the occurrence of disturbing and unsettling life events; such as natural disasters, failures, manmade accidents, or violent attacks (Barker, Ramirez-Marquez & Rocco, 2013).

The wellness of an individual expresses itself in the quality that he or she has to rise above difficult situations and traumatic experiences. The availability of support could assist an individual to be resilient and to attain wellness.

6.2.6.5 Healthy personality

Personality is defined as 'consistent behaviour patterns and intrapersonal processes originating within the individual' (Burger, 2011, p. 4). It is depicted by how emotionally stable, friendly, sociable, hard-working and refined a person is. A person with a healthy personality is well adjusted and able to function well as a person and in the company of other people, has sufficient knowledge about the self and self-acceptance, possesses a realistic perception and acceptance of reality and is able to cope with and manage the challenges of life (Lindhard, Dlamini & Barnard, 1987, p. 40).

A healthy personality is another characteristic of wellness, since it is based on consistent behavioural patterns. A person with a healthy personality respects him or herself and is aware of his or her strengths and weaknesses. The person is proud of personal achievements and able to practise self-acknowledgement. A healthy personality includes calmness, friendliness, emotional stability and sociability. A healthy personality is fundamental to wellness because it promotes personal adjustment, emotional control, successful living and peace of mind and contentment (Lamers *et al*., 2012, p. 517).

6.2.6.6 Positive interaction between the internal (body, spirit, mind) and external (social) domains

Wellness includes an individual's capacity to positively interact with the external (social) environment (Flaherty, 2013). The individual should be able to utilise the support of the available resources; e.g. health care professionals, family members and friends in his or her environment to promote his social and general wellbeing. Social wellbeing includes an individual's experience and sharing of positive associations with people that are a critical part of the wellness experience.

The complete conceptual framework is represented in Figure 6.8.

Physical, spiritual, and social environment

Agent **Recipient**

Roles
Leadership, Empowerment Support, Role-modelling, Collaboration

Characteristics
Competence, Vision, Empathy, Perceptive, Change agent, Courageous, Emotional Intelligence, Professionalism, Synergistic

Spirit
Conscience, Relationship with God

Mind
Emotional Intelligence, Perceptive

Body
Approachable, Charisma

Spirit
Conscience, Relationship with God

Mind
Self-awareness, Strong focus, Self-restraint, Resilience

Body
Self-care, Healthy lifestyle

Roles
Shared responsibility Shared management

Characteristics
Focused, Goal-directedness, Self-awareness, Self-acknowledgement, Self-restraint, Adaptability

Contextual realities

Western Cape Province

National health care environment

Policies and legislative frameworks

Context

Social and religious environment

Empowerment (Sharing control)

Underlying dynamic:
Participative leadership

Active participation

Shared responsibility

Procedure

- Counselling training
- Building a trusting relationship
- Information sharing and communication
- Developing and encouraging positive coping skills
- Recreational activities

- Social support (family, friends and community, support groups)
- Follow-up (Tracking)
- Empowering youth programmes (school and community)

Terminus (Wellness)

Healthy mind (psychological, emotional) and spirit, healthy living, self-care, resilience, healthy personality, and positive interaction between the internal (biological, psychological, spiritual) and external (social) domains
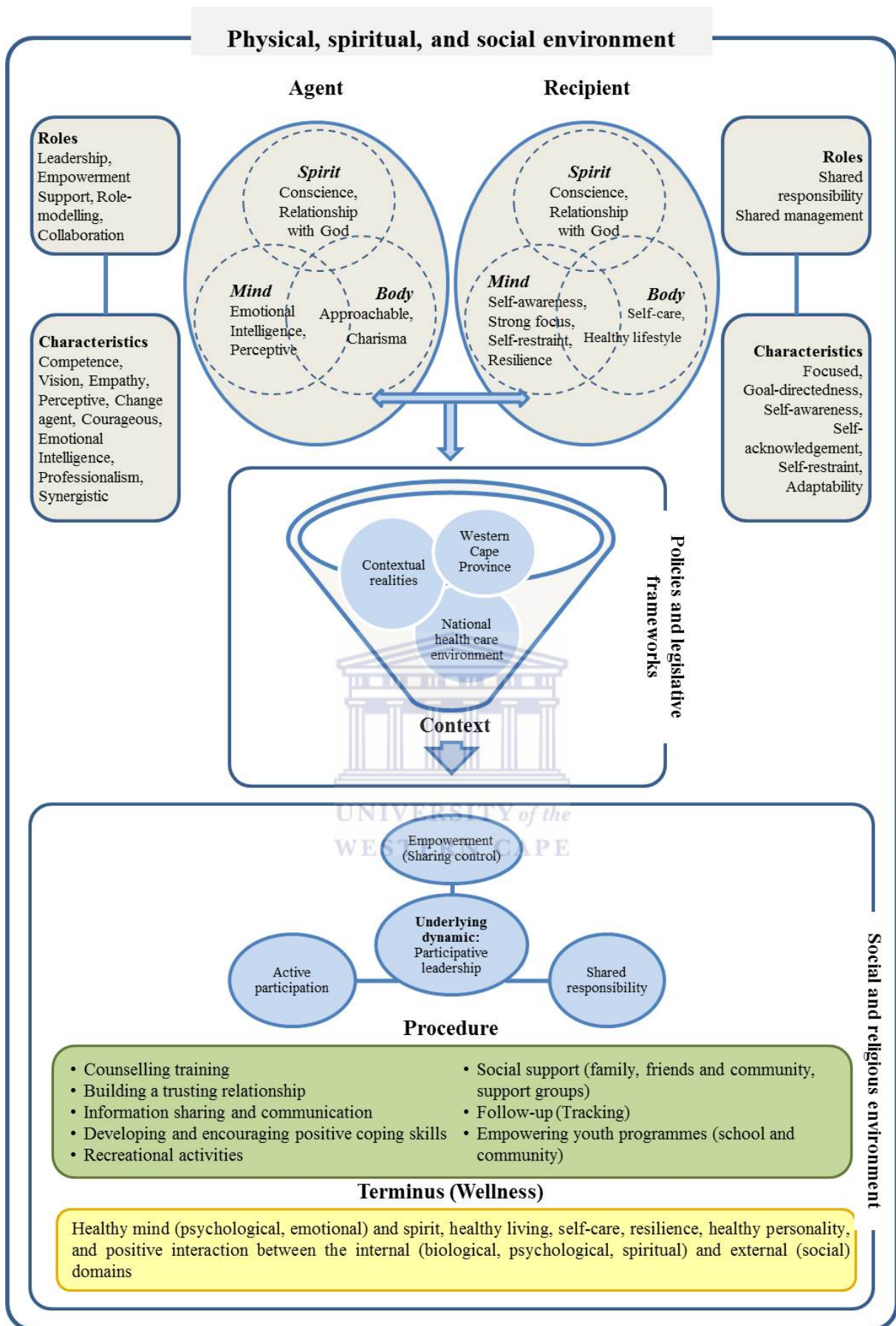
Figure 6.8: **Framework for leading youth victims of violence towards wellness**

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6.3   VALIDATION OF THE CONCEPTUAL FRAMEWORK

Validation involves the provision of the findings from the study to the research participants to seek confirmation that the researcher's findings and impressions corresponds with those of the participants. It is also done to provide an opportunity to assess the reactions and comments of the research participants whether the developed framework would address their needs (Bryman, 2012, p. 391).

The final phase of this study (Phase 4) which addressed Step 6 of developing a conceptual framework, as adapted from Jabareen (2009, p. 54-62), was to validate the proposed conceptual framework with the youth and health care professionals to ensure that the described concepts made sense to the study participants.

Hence, some of the youth and the health care professionals who had earlier participated in the study validated the developed framework.

Twenty one youth participants and five health care professionals who participated in the study validated the developed framework. The researcher returned to the study site in September 2014 and presented the findings to 2 groups of youth in a private classroom at a high school. The presentation and validation took around 60 minutes with each group. The health care professionals were interviewed individually at the health clinic and presented with the framework (around 30 minutes each).

The criteria for validation included the clarity, adequacy, usefulness and significance of the conceptual framework. Pearson, Vaughan and FitzGerald (2005, p. 226) suggest these criteria for the evaluation of nursing frameworks / models. The participants were asked whether the concepts described in the framework were clear and whether the developed framework would be able to address the needs of youth victims of violence in terms of leading them to wellness. They were also asked whether in their opinion the framework was useful and would make an important contribution to health care practice.

The study participants gave a number of responses during the validation process and in general the feedback was positive; therefore, no revision of the framework was necessary. The main theme that emerged from the responses was that the framework reflected participative leadership to be used by the health care professionals in leading the youth victims of violence

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to wellness. On the other hand, the framework enhanced self-ownership of the youth towards their wellness.

The following are some examples of their responses in relation to the questions they were asked.

6.3.1 Does the framework address the needs of youth victims of violence?

The participants were of the opinion that the framework addressed the needs of the youth victims of violence in their community. For instance, one participant indicated that the framework will assist with providing information to the youth in the community:

'Yes, I think so because if you are going to help the youth in Genadendal, you have to give them information. When they get the knowledge, they will be educated on how to take care of themselves because some of them don't know and it will be like a source of help to them'.

A different participant expressed the view that the implementation of the framework could assist with addressing the common youth problems (contextual realities) in the community:

'I think this framework can be used in helping the youth in the community to solve their problems'.
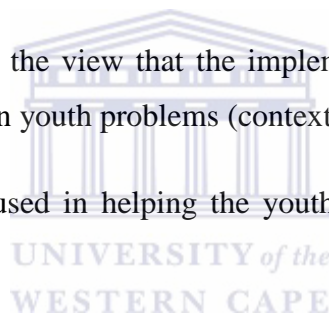
6.3.2 The developed conceptual framework is offered to be used by health care professionals in the leadership of the youth victims of violence towards wellness; will the developed strategies be sufficient for the purpose it sets out to achieve?

Participants were of the opinion that the developed framework was adequate and offered important strategies that would be useful for health care professionals to use in leading the youth victims of violence towards wellness in their community. For example, a participant stated that counselling the youth victims of violence would assist in resolving the emotional problems associated with being a victim of violence:

'…So, like counselling can help curb their anxieties… discussing these issues will help them open up'.

Another participant mentioned the importance of encouraging recreational activities for the youth victims of violence to attain wellness:

'Fun activities will help the youth in a positive way to enjoy relax and not stress them up'.

6.3.3 Is the conceptual framework useful to community health practice?

It was perceived by the participants that the developed framework would make an important contribution to community health practice. One participant indicated:

'Yes, I think so. It is useful to the community because it will help the community members to improve their wellbeing'.

Another participant stated that the developed framework would be valuable in assisting health care providers to work with the youth in the community:

'I... because it is not everyone that wants to work with the youth... so, I think this framework may assist the health care providers on how to work with the youth in the community'.

6.3.4 Does the conceptual framework make an important contribution to health care practice?

The participants mentioned that the framework made significant contributions to health care practice. For instance, a participant reflected:

'Personally, I think this is valuable work that has been done. I hope the input will help the youths that have been victims of violence'.

The participants were convinced that the developed participative leadership framework was adequate and offered important strategies for health care professionals to use in the leadership of the youth victims of violence towards wellness in their community.

6.4 SUMMARY

This chapter describes the participative leadership conceptual framework to be used by health care professionals in leading the youth victims of violence towards wellness in their community. The framework is based on the findings from the focus group discussions conducted among the youth victims of violence, the unstructured individual interviews carried out among health care professionals working in the community of study, as well as empirical literature.

The survey list of Dickoff *et al*. (1968, p. 423) comprising six key components (agent, recipient, framework, dynamics, procedure and terminus) serves as the guide for the discussion of the conceptual framework. The *agent* (professional nurse, medical doctor, social worker) is identified as a leader having the roles of leadership, empowerment, engendering support, role modelling and collaboration. In addition, the findings emphasise the characteristics that should enable an agent to carry out the identified roles; namely competence, vision, empathy, perceptiveness, change agent, courage, emotional intelligence, professionalism and synergy. Similarly, in the agent-recipient relationship the recipient is expected to carry out the roles of self-management and shared responsibility to enable him or her to attain wellness. The necessary characteristics of the *recipients* are being focused, goal-directed, self-aware, self-acknowledgement, showing self-restraint and adaptability. The researcher discusses the *context* of the study while reflecting on the contextual realities in the community of the study environment (high level of violent fights, sexual assault, teenage pregnancy, alcohol and drug abuse – particularly methamphetamine / tik – amongst the youth). Also, she reflects on the context and describes it in relation to current policy and legislative frameworks at provincial level in the Western Cape Province and at the national level. The *underlying dynamic* necessary for attainment of the shared vision of wellness for the youth victims of violence is described as the participative leadership approach. Participative leadership entails empowerment (sharing of control), active participation and shared responsibility between the agent and the recipient. The *procedure* to be used by the agents are the provision of counselling services, building a sound and trusting relationship, information sharing and communication, developing and encouraging positive coping skills, recreational activities, using social support (family, friends and community support groups), follow-up (tracking) and empowering youth programmes at school and in the community in general. The description of the *terminus* (wellness) comprises the characteristics of a healthy mind (psychological, emotional) and spirit, healthy living, self-care, resilience, healthy personality and positive interaction between the internal and external (social) domains.

To end the chapter, the process that was used in validating the developed framework is described to reflect the responses of the study participants. In the following chapter, the conclusions, limitations and recommendations of the study are discussed.

CHAPTER 7

CONCLUSIONS, GUIDELINES FOR IMPLEMENTATION OF THE FRAMEWORK, LIMITATIONS AND RECOMMENDATIONS OF THE STUDY
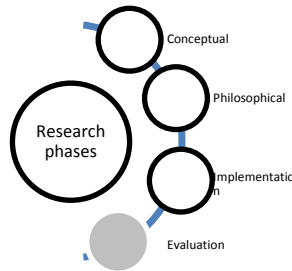
7.1 INTRODUCTION

In the previous chapter the developed conceptual framework describing the leadership of youth victims of violence towards wellness by health care professionals is discussed by using the survey list proposed by Dickoff *et al*. (1968, p. 423). In this chapter, the overview of the research process, conclusions of the study, dissemination plan, guidelines for the implementation of the framework, the limitations of the research, as well as the recommendations of the study are presented.

7.2 OVERVIEW OF THE RESEARCH PROCESS AND CONCLUSION

The purpose of this qualitative study was to develop a conceptual framework that can be utilised in gaining a better insight into the ways in which health care professionals can lead youth victims of violence towards wellness in the community of Genadendal. Three objectives were set; namely to explore and describe the expectations of the youth victims of violence with regard to health care professionals leading youth victims of violence towards wellness in the community of study (Phase 1 of the study); to explore and describe the experiences of health care professionals while they were leading youth victims of violence towards wellness (Phase 2 of the study); and to develop a conceptual framework for health care professionals to lead youth victims of violence towards wellness (Phase 3 of the study). The first objective was achieved by conducting nine focus group discussions amongst 58 (23 males and 35 females) youth victims of violence with an average age of 16.6 years who were attending the high school at the study site. After data had been collected and analysed, it was

clear from the findings that the youth participants had high regard and respect for the health care professionals working in their community in terms of the support they received towards wellness. They stated that they expected health care professionals to provide them with information about achieving wellness, providing supportive counselling services, respecting them and providing confidential services, organising youth programmes at school and in the community in general and being good role models for them to emulate.

Equally, the second objective was realised because the findings from the unstructured individual interviews carried out amongst seven health care professionals (two professional nurses, three medical doctors and two social workers) with an average age of 45.6 years revealed that even though they acknowledged that the importance of the concept of wellness for the youth victims of violence, they nonetheless were of the opinion that the process of leading or guiding youth victims of violence towards wellness was cumbersome and challenging. Thus, they indicated the barriers they were facing in leading youth victims of violence towards wellness in the context that included violent behaviour, drug and substance abuse, parental and socioeconomic issues and unsupervised youth, negative attitudes of some staff members, inadequate structures and human resources and the process of guiding youth victims to wellness. In addition, they proffered the following as strategies that would assist with guiding or leading the youth victims to wellness: counselling services, support groups, support from community / family, recreational activities, sufficient human resources to work with youth victims of violence and the use of a multidisciplinary team approach.

The findings from objectives 1 and 2 were synthesised to achieve the third objective of the study which was the development of a conceptual framework for health care professionals to lead youth victims of violence towards wellness. The survey list Dickoff *et al*. (1968) was utilised as the reasoning map for describing the developed conceptual framework by using six key elements; namely agent, recipient, context, dynamics, procedure and terminus. The agent as a leader was identified as having different roles in leading the recipients (youth victims of violence) towards wellness. These roles were empowerment, engendering support, role modelling and collaboration. Similarly, the self-management and shared-responsibility roles of the recipients were identified. The contextual realities in the community included high levels of teenage pregnancy, alcohol and drug abuse (particularly methamphetamine / *tik*), violent fights and sexual assault amongst the youth. The identified procedures were counselling, recreational activities, information and communication, building a sound and

trusting relationship, positive coping skills, follow-up (tracking), social support (family, friends, support groups and community), as well as youth programmes at school and in the community in general. From the framework, wellness was described as encompassing healthy living, self-care, healthy mind and spirit, healthy personality, resilience and positive interaction between the internal and external (social) domains.

The last objective was to validate the developed framework among the research participants. This objective was equally achieved because the framework was later on validated by the research participants and there was no need for modifications to be made to the framework.

In conclusion, the most important underlying dynamic that was identified in this study for leading the youth victims of violence towards wellness was participative leadership that included active participation, shared responsibility and empowerment (sharing control).

Such an approach would provide the support health care professionals (professional nurses, medical doctors and social workers) need to realise the important role they play in leading the youth victims of violence towards wellness and in addressing the issues affecting them. Accordingly, health care professionals should focus on meeting the wellness needs of youth victims of violence in an efficient and coordinated manner. They should take responsibility for providing leadership to the youth victims of violence in addition to their other professional responsibilities. They should involve the youth victims in problem solving and decision making. The family members of the victims and other sources of support should also be integrated into the interactive leadership process.

Furthermore, health care professionals through a participative leadership process should collaborate among themselves and all other stakeholders in the community. There is a need for them to meet regularly to evaluate their vision of leading the youth victims of violence to wellness. Finally, it is necessary that health care professionals receive sufficient support to assist them with carrying out the various activities aimed at promoting the wellness of youth victims of violence.

7.3   DISSEMINATION PLAN AND DEVELOPMENT OF GUIDELINES

The developed framework is the first of its kind advanced to be used by professional nurses, medical doctors and social workers in leading youth victims of violence to wellness. It is unique because it integrates findings from these categories of health care professionals and as

well as the youth victims of violence themselves. It appears to be a useful tool for promoting wellness among youth victims of violence. Though developed to be used in the specific rural context, it can be adopted in contexts with similar contextual realities.

7.3.1   Dissemination plan

The researcher supported by her research supervisor will disseminate the developed framework in the following ways:

- It will be communicated to the Western Cape Department of Health in writing for endorsement. This would be done to seek support and to encourage successful implementation.

- It will be made accessible to the target population (the youth, professional nurses, medical doctors and social workers in the rural community). For instance, it will be printed out and circulated to them.

- The framework will be used in facilitating training programmes for the youth and health care professionals in the community (i.e. a one-week training programme for health care professionals and a one-week training programme for the youth in the rural community).

- It will be presented at seminars and workshops organised by the different categories of professionals involved in the leadership of the youth victims of violence.

- It will also be shared with other scholars and academic peers through presentations at scientific research conferences organised both nationally and internationally.

- The findings will be published in a peer-reviewed journal that is available online to further increase the accessibility.

- The framework should become part of the health care environment setting in Genadendal (rural community) and will be used as a document for strategic planning.

- It is expected that the framework will form part of the service learning component for training of student nurses at the School of Nursing, University of the Western Cape, South Africa.

After a period of about 12 months, the researcher will evaluate the framework and the feedback from the evaluation process will be used to further refine the framework. All stakeholders will be informed of any new revision of the framework.

7.3.2   Development of guidelines for implementation of the framework

Guidelines are defined as statements stipulating the rules and principles by which a person is guided in taking a future course of action (The Free Dictionary by Farlex, 2014). The following guidelines are proffered to be used in guiding the implementation of the developed context-specific framework aimed at leading the youth victims of violence towards wellness.

The structure that is used in the presentation of each of the guidelines includes the goal formulation, the expected outcome and the recommendations of the guideline.

- **Goal formulation:** This describes the purpose of each component of the stipulated guidelines. The goal provides direction to what the guideline should focus on or what it sets out to achieve at the end of the activity that will be carried out.

- **Outcome:** This defines the expected outcome for the stipulated guideline. It will aid the implementer to know what is expected to be achieved at the end of the implementation of the framework.

- **Recommendations of the guideline:** These recommendations provide clear and specific instructions about how each guideline should be implemented. These instructions describe the recommendations for the agent, as well as the recommendations for the recipient.

7.3.3   Guidelines for the implementation of the framework

7.3.3.1   Guideline 1: Crisis intervention provision for the youth victim of violence

- **Goal**

The goal of this guideline is for the agent to provide adequate support to the recipient as soon as possible after the traumatic incident to initiate the process of recovery that eventually will lead to wellness.

- **Outcome**

The outcome of this guideline enables the recipient to verbalise the receipt of sufficient support from the agent.

- **Recommendations for the agent**

When a youth victim of violence presents at the primary health care clinic, the agent (professional nurse or medical doctor) should:

- Provide privacy.

- Adopt a friendly and respectful approach and assure the youth victim of confidentiality; this will initiate a strong and trusting relationship.

- Record present and past history (i.e. socio-demographic, family, medical) from the youth victim of violence or a significant other when victim is unable to engage in a discussion due to acute stress reactions.

- Conduct a complete head-to-toe examination.

- Collect criminal or forensic evidence (usually collected by either a forensic nurse or medical doctor).

- Provide physical medical / nursing care, e.g. treatment of physical injuries, STI prophylaxis, anxiolytics and anti-stress drugs.

- Assess youth victim's insight into present violent traumatic incident or experience.

- Allow the youth victim of violence to express self freely without unnecessary interruptions.

- Allay expressed fears and anxiety by dispelling myths and misconceptions, showing empathy and offering reassurance of wellness.

- Avoid blaming the victim for being responsible or contributing to the violent incident. Doing this would be uncalled for and counterproductive. The health care professional's role is not to be judgemental but to provide care to the victim of violence.

- Refer the client to a social worker for further management.

- Record the care provided and booking of next appointment for follow-up (tracking).

- Ensure that the youth victim of violence has a safe place to go. For instance, if the victim is unable to go home, arrangement for safe accommodation should be made for the victim. When the victim is discharged to go home, the social worker should endeavour to contact the youth victim at home.

- **Recommendations for the recipient**

The recipient has to:

- Be aware that he / she has the right to receive confidential and supportive services from the health care professional. This will assist with ensuring that the right to receiving quality health care services is protected.
- Participate in and contribute to making decisions affecting their wellness.
- Seek information, as well as clarification from the health care professional about his / her care.
- Accept responsibility for attaining and maintaining wellness.

7.3.3.2   Guideline 2: Empowerment of the youth victim of violence for wellness

- **Goal**

The goal of this guideline is for the agent to equip the recipient with the knowledge and skills that will promote wellness. This will empower the recipient with a clear understanding of the vision of wellness that he / she should attain.

- **Outcome**

The outcome is that the agent would describe the elements of wellness to the recipient, the practices that enhance the attainment of wellness and positive coping skills to propel him or her on his / her wellness journey.

- **Recommendations for the agent**

The agent should:

- Adopt a friendly and respectful approach and assure youth victim of confidentiality.
- Collect information from the recipient to identify risk factors, for example history of alcohol and drug abuse, early childhood difficulties and maladjustment, previous involvement with the child social support system, observing or experiencing violence in the home environment and problems with law enforcement agents.
- Assess and also familiarise the youth victim of violence (and family members when they are available) about the possible symptoms of ASDs and PSDs, for example

nightmares, flashbacks, insomnia, avoidance, jumpiness and mood changes. Encourage him /her to contact a health care professional should these symptoms persist.

- Assess client's willingness and readiness for the wellness journey.
- Provide the recipient with adequate information about the important elements of wellness (healthy mind and spirit, healthy living, self-care, resilience, healthy personality and positive social interaction).
- Encourage the practice of wellness (e.g. eating healthy meals and engaging in recreational activities).
- Assist the youth victim of violence to explore ways to remain healthy and safe.
- Consider the views of the recipient to ensure active participation in the problem solving and decision making processes.
- Provide supportive therapy (e.g. therapeutic counselling for victim, health education, positive stress coping skills, family counselling and support group) and allow the youth victim of violence to express self freely without interrupting unnecessarily. Also allay expressed fears or anxiety, show empathy and avoid blaming the victim.
- Record the care provided.
- Regularly follow-up (track) the youth victims of violence to confirm continued progress, for instance every fortnight.
- Refer to other professionals for further management when necessary.

- **Recommendations for the recipient**

The recipient should:

- Actively be involved in the process by carrying out the activities that will facilitate and enhance his / her wellness.
- Seek information and support from the agent to enable him / her to make informed decision about own wellness.
- Participate actively in the problem solving and decision-making process concerning his / her wellness.
- Focus on attaining the vision of wellness.
- Be open and adaptable in order to attain wellness.
- Accept responsibility for attaining and maintaining wellness.

7.3.3.3 Guideline 3: Organise programmes for the youth in the community

- **Goal**

The goal of this guideline is to establish programmes for the youth residing in a rural community to enable them to attain and maintain wellness.

- **Outcome**

The outcome of this guideline is empowering outreach programmes to be established at school and in the community for the youth in the community.

- **Recommendations for the agent**

The agent should*:*

- Organise appropriate youth programmes and support services for the youth to enable their active participation.
- Inaugurate a wellness club for the youth at school. The focus should be on empowering them with the requisite knowledge and skills for attaining and maintaining wellness, as well as coping with issues with regard to being a youth victim of violence.
- Have regular meetings with the youth to explore ways that would enhance their wellness, for example meeting with the youth at school once in a month.
- Engage the youth in decision making to promote active participation.
- Organise wellness awareness campaigns for young people in the community.
- Maintain a comprehensive record of each organised programme because it will assist with the evaluation of the programme.

- **Recommendations for the recipient**

The recipient should:

- Be informed about their rights to participate in programmes organised for the youth.
- Negotiate with the agent about programmes that they consider will be most beneficial to them.

- Be actively involved in the programmes established to promote wellness among the youth.

- Accept responsibility for own wellness.

7.3.3.4 Guideline 4: Kindle support for youth wellness programmes in the community

- **Goal**

The goal of this guideline is for the agent to engender support from stakeholders to promote programme implementation for the youth in the community to enhance their wellness.

- **Outcome**

The outcome of this guideline is for the agent to engender support for the programmes that will enhance the attainment of wellness among the youth in the community.

- **Recommendations for the agent**

- Collaborate with all stakeholders who are expected to be involved in putting into practice the programmes aimed at promoting youth wellness in the community.

- Create awareness for wellness and seeking support of all members of the community, e.g. through regular meetings, gaining their views and contributions about programmes that will be organised for the youth in the community.

- Utilise a multidisciplinary approach in programming.

- Encourage a participative leadership approach in the programmes designed to lead the youth victims of violence to wellness in the community.

- **Recommendations for the recipient**

The recipient should:

- Be an active participant in the processes that are designed to engender support because the recipient is also a stakeholder.

7.3.3.5 Guideline 5: Evaluate the impact of the programmes

- **Goal**

The goal of this guideline is to assess the impact of the programmes organised in order to assess impact of the programmes designed to promote the wellness of the youth.

- **Outcome**

The outcome of this guideline is for the implemented programmes to be successfully and comprehensively evaluated.

- **Recommendations for the agent**

The agent should:

- Conduct an evaluation of the programmes aimed at promoting wellness 12 months after implementation to give opportunity for feedback and possible revision.
- Utilise a participative approach by involving stakeholders in the evaluation process of the framework.

- **Recommendations for the recipient**

The recipient should be:

- Participating in the evaluation process to ensure comprehensiveness of the evaluation process.

7.4 LIMITATIONS OF THE RESEARCH

The limitation of this current study is the fact the findings are not generalizable for various reasons. Firstly, the study was conducted in a single rural community of the Western Cape Province, South Africa which is not representative of the entire population. Secondly, though the study incorporated all health care professionals (social workers, medical doctors and professional nurses) working at the health care facility of the study site and selected number of youth victims of violence attending a high school in the community of study, it did not

include out-of-school youth victims who may have different perspectives or experiences from the in-school youth victims of violence.

7.5 RECOMMENDATIONS OF THE RESEARCH

The following recommendations are suggested as a result of the findings from this study.

7.5.1 Community health practice

- There is a need for strong partnerships and collaboration between the health care professionals working at the community health care facilities and other stakeholders, such as government and not-for-profit Organizations.

- There is a need for increased commitment among all health care professionals providing community health services to their leadership roles in leading youth victims of violence to wellness in the community, since the youth reports that they expect them to be good role models and demonstrate their leadership capabilities.

- Health care professionals should regularly update their knowledge about leading the youth victims to wellness. This approach will enhance their competence and confidence.

- Community outreach programmes should be organised by health care professionals for both in-school and out-of-school youth in the community. Programmes can be focused on violence prevention, screening for violence related and other health issues and health education about the ways of promoting a healthy lifestyle.

- It is important that the Western Cape Department of Health should invest in the wellness of the youth victims of violence by providing them with educational, social and economic support. They should make available the necessary number of health care professionals; such as professional nurses, medical doctors, social workers, physiotherapists, occupational therapists, counsellors and psychologists to work at the primary health care level. All these health professionals have interrelated roles in supporting victims of violence in their community.

- It becomes necessary that the Government of South Africa focuses on introducing school health services at schools.

- In-service training of health care professionals; such as professional nurses, medical doctors and social workers organised by the Western Cape Department of Health and Department of Social Development on effective and efficient ways of managing youth who have been victims of violence. Furthermore, extend the operating hours of the

clinics to 16:00 and weekends, since the health care professionals reported that the vast majority of the violent attacks occur in the evenings and during weekends.

7.5.2   Nursing education

The findings of this study have implications for health care education and training, including nursing education. It is recommended that there should be:

- An increased focus in the curricula on creating awareness about the problems of substance abuse and youth violence at both the undergraduate and postgraduate levels in order to prepare professionals how to effectively respond to the needs of the youth. Priority should be given to instilling the values of participative leadership in the students prior to completing their professional nursing training, since this will to equip them for their leadership roles in the community.

- Nursing education institutions can also motivate to the South African Nursing Council to introduce a training programme for registration of an additional qualification as a school nurse practitioner.

7.5.3   Nursing research

Given the fact that there were a few professional nurses in the community of study, a large number of nurses could not be recruited into this current study. It will be interesting to duplicate this study using only professional nurses. Will this population alone yield categories and subcategories similar to those reported by the other categories of health care professionals (medical doctors and social workers) interviewed in this study, or will the findings be totally different? These and many other questions come to mind.

7.6 SUMMARY

This chapter concludes the research report of the study. In the chapter, an overview of the research process is provided and the conclusions from the findings of the study are presented. To enable the researcher to describe these competently, she constantly has adapted and refined her theoretical lens (Knight & Cross, 2012) and *coherently* describes the conclusions in relation to the main objectives that were set out to be achieved in the study. The researcher maintained her *commitment* to conduct the research study as she reflected on the *importance* and *impact* of the study. The guidelines that should be used in the implementation of the developed framework are emphasised while paying particular attention to the background of

the study. This approach is used because the researcher supports a pragmatic approach to programming. The researcher remained *transparent* and presented as clearly as possible the limitations that were encountered in conducting this research study.

Finally, the researcher offers recommendations for improving community health practice, nursing education and nursing research. These recommendations are made in such a way that they resonate with the findings of the study and the researcher's knowledge and expertise.

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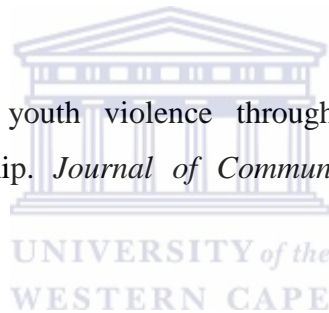
ANNEXURE A: ETHICAL CLEARANCE LETTER

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

UNIVERSITY *of the*
WESTERN CAPE

30 October 2013

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:
Ms EL Ahanonu (School of Nursing)

Research Project:	A framework for healthcare professionals to lead youth victims of violence towards wellness in Genadendal community of the Western Cape.
Registration no:	13/9/39

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Private Bag X17, Bellville 7535, South Africa
T: +27 21 959 2988/2948 . F: +27 21 959 3170
E: pjosias@uwc.ac.za
www.uwc.ac.za

A place of quality,
a place to grow, from hope
to action through knowledge

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 3024, Fax: +27 21-959 2679

E-mail: eahanonu@uwc.ac.za

INFORMATION SHEET

Project Title: Development of a framework for Health care Professionals to Lead Youth Victims of Violence towards Wellness in a Rural Community of the Western Cape

What is this study about?

This is a research project being conducted by Ezihe Loretta Ahanonu and supervised by Prof Karien Jooste and Dr F Waggie at a university of the Western Cape. We are inviting you to participate in this research project because you have a wealth of knowledge and experience in youth violence.   The purpose of this research project is to explore and describe the expectations of the youth with regards to health care professionals leading youth victims of violence to wellness and also to describe the experiences of health care professionals in leading youth victims of violence towards wellness so as to develop a framework for health care professionals to lead youth victims of violence towards wellness in the community.

What will I be asked to do if I agree to participate?

Individual interviews will be conducted in a comfortable and private room at the health care facility. Written consent for the interviews and for voice recordings will also be needed. The researcher will take written field notes during the interviews. You will be asked an open-ended question: Can you tell me about your experiences in leading youth victims of violence

towards wellness? How can health care professionals be supported to take the lead in addressing violence among the   youth I the community? This will be followed by probing questions to stimulate the collection of a rich data. The interview will not last longer than 60 minutes.

Would my participation in this study be kept confidential?

We will do our best to keep your personal information confidential. To help protect your confidentiality:

- Pseudonyms (false names) will be used instead of real names and you will not be required to write down your address or any other confidential detail.
- All voice-taped interviews and transcripts of the interviews will be securely protected by the principal researcher using password-protected computer files and locked cabinet that cannot be accessed by other persons except for the supervisor and an independent coder. These will be kept for five years after the results of the project have been published before it will be destroyed.
- No information provided by you will be made public without your consent.
- When we write a report or article about this research project, your identity will be protected to the maximum extent possible.

What are the risks of this research?

You will not in any way be subjected to any risk, injury, stress or discomfort throughout conduct of this research. Should you experience any psychological problem as a result of the study during interviewing, the session will immediately be discontinued and prompt referral made to a counsellor or psychologist.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about how health care professionals lead youth victims of violence towards wellness. We hope that in the future, other people might benefit from this study through improved understanding of how health care professionals lead youth victims of violence towards wellness

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you choose to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

Is any assistance available if I am negatively affected by participating in this study?

You will be referred for counselling if you experience any psychological/emotional distress occurring as a result of this study.

What if I have questions?

This research is being conducted by Miss Ezihe Ahanonu at a university of the Western Cape. If you have any questions about the research study itself, please contact Ezihe Ahanonu on phone number +27 078 672 3224 or by using email- eahanonu@uwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:
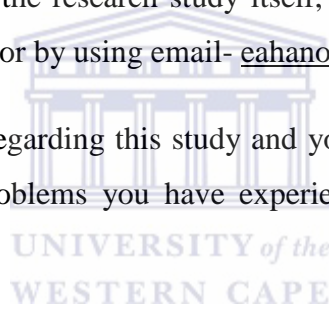
Prof Karien Jooste

The Director School of Nursing

Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: +27 21-959 2274

Fax: +27 21-959 2679

Email: kjooste@uwc.ac.za

Dean of the Faculty of Community and Health Sciences

Prof Jose Frantz   021 9592631

Email: jfrantz@uwc.ac.za

University of the Western Cape

Private Bag X17

Bellville 7535

This research has been approved by a university of the Western Cape's Senate Research Committee and Ethics Committee.

ANNEXURE C   FOCUS GROUP CONFIDENTIALITY BINDING FORM

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2760, Fax: 27 21-959 3683

E-mail: eahanonu@uwc.ac.za

FOCUS GROUP CONFIDENTIALITY BINDING FORM

Title of Research Project: Development of a framework for Health care Professionals to Lead Youth Victims of Violence towards Wellness in a Rural Community of the Western Cape

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I agree to be voice-taped during my participation in the study. I also agree not to disclose any information that was discussed during the group discussion.

Participant's name: …………………………………………………………………

Participant's signature: …………………………………………………………..

Witness's name: …………………………………………………………………

Witness's signature: …………………………………………………………

Date: …………………………………………………………………………..

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact any of the following persons listed below:

The Principal Investigator

Ezihe Ahanonu

University of the Western Cape

Private Bag X17, Bellville 7535

Cell: +27 078 672 3224

Email: eahanonu@uwc.ac.za

Prof Karien Jooste

The Director School of Nursing

Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: +27 21-959 2274

Fax: +27 21-959 2679

Email: kjooste@uwc.ac.za

ANNEXURE D: **ASSENT FORM / FOCUS GROUP CONFIDENTIALITY BINDING FORM (YOUTH MEMBERS YOUNGER THAN 18 YEARS)**

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2760, Fax: 27 21-959 3683

E-mail: eahanonu@uwc.ac.za

ASSENT

FOCUS GROUP CONFIDENTIALITY BINDING FORM

Title of Research Project: Development of a framework for Health care Professionals to Lead Youth Victims of Violence towards Wellness in a Rural Community of the Western Cape

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I agree to be voice-taped during my participation in the study. I also agree not to disclose any information that was discussed during the group discussion.

Participant's name: …………………………………………………………

Participant's signature: …………………………………………………………

Witness's name: …………………………………………………………………

Witness's signature: ……………………………………………………………….

Date: …………………………………………………………………………..

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact any of the following persons listed below:

The Principal Investigator

Ezihe Ahanonu

University of the Western Cape

Private Bag X17, Bellville 7535

Cell: +27 078 672 3224

Email: eahanonu@uwc.ac.za

Prof Karien Jooste

The Director School of Nursing

Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: +27 21-959 2274

Fax: +27 21-959 2679

Email: kjooste@uwc.ac.za

ANNEXURE E: PERMISSION LETTER FROM PARENTS
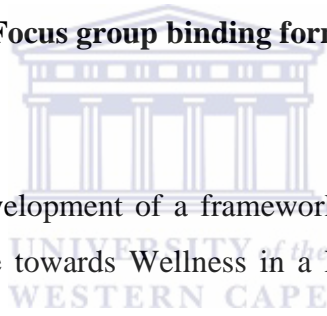
UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2760, Fax: 27 21-959 3683

E-mail: eahanonu@uwc.ac.za

PERMISSION FORM

Focus group binding form

Title of Research Project: Development of a framework for Health care Professionals to Lead Youth Victims of Violence towards Wellness in a Rural Community of the Western Cape

The study has been described to me and my child in a language that I understand. I freely and voluntarily agree that my child …………………… (Name) participate in the study. My questions about the study have been answered. I understand that my child's identity will not be disclosed and that he/she may withdraw from the study without giving a reason at any time and this will not negatively affect him/her in any way. I give permission that my child may be voice-taped during his/her participation in the study. I agree that my child should not disclose any information that was discussed during the group discussion.

Parent's name: …………………………………………………………..

Parents signature: ………………………………………………………….

Witness's name: …………………………………………………………..

Witness's signature: …………………………………………………………

Date: …………………………………………………………………………..

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact any of the following persons listed below:

The Principal Investigator

Ezihe Ahanonu

University of the Western Cape

Private Bag X17, Bellville 7535

Cell: +27 078 672 3224

Email: eahanonu@uwc.ac.za

Prof K. Jooste

The Director School of Nursing

Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: +27 21-959 2274

Fax: +27 21-959 2679

Email: kjooste@uwc.ac.za

ANNEXURE F: **WRITTEN INFORMED CONSENT (HEALTH CARE PROFESSIONALS)**

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2760, Fax: 27 21-959 3683

E-mail: eahanonu@uwc.ac.za

INFORMED CONSENT FORM

Title of Research Project: Development of a framework for Health care Professionals to Lead Youth Victims of Violence towards Wellness in a rural Community of the Western Cape

The study has been described to me in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I agree to be voice-taped during my participation in the study. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name: …………………………………………………………….

Participant's signature: …………………………………………………………..

Witness's name: …………………………………………………………………...

Witness's signature: …………………………………………………………….

Date: …………………………………………………………………………...

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact any of the following persons listed below:

The Principal Investigator

Ezihe Ahanonu

University of the Western Cape

Private Bag X17, Bellville 7535

Cell: +27 078 672 3224

Email: eahanonu@uwc.ac.za

Prof K. Jooste

The Director School of Nursing

Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: +27 21-959 2274

Fax: +27 21-959 2679

Email: kjooste@uwc.ac.za

ANNEXURE G: INTERVIEW GUIDE FOR INDIVIDUAL INTERVIEWS WITH HEALTH CARE PROFESSIONALS

1.   Can you tell me about your understanding of the term wellness?

2.   How do you experience your *guidance* of the youth community?

3.   How can health care professionals *guide* (lead) youth victims of violence towards their wellness?

Specific probing questions will be asked as information emerges

- Tell me more…
- What do you mean by…?

ANNEXURE H: INTERVIEW GUIDE FOR FOCUS GROUP DISCUSSION WITH THE YOUTH

1.   What do you understand under the term "your wellness"?

2.   What are your expectations with regard to health care professionals *guiding* youth towards wellness?

3.   Tell me about what you expect from health care professionals *to guide you* towards your wellness.

Specific probing questions will be asked as information emerges.

•   Tell me more…

•   What do you mean?

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 3024, Fax: +27 21-959 2679

E-mail: eahanonu@uwc.ac.za

Superintendent-General of Health,

Western Cape Department of Health

Western Cape Province

South Africa

Dear Sir,

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY HEALTH CARE FACILITIES IN A COMMUNITY OF THE WESTERN CAPE

I write to seek your permission to conduct a research study in your health care facilities in [name withheld] community. I am a Miss Ezihe Loretta Ahanonu a postgraduate student in the school of nursing, university of the Western Cape, studying to fulfil the requirements for a doctoral degree in nursing. My research study is titled: '*A framework for health care professionals to lead youth victims of violence towards wellness in a rural community of the*

Western Cape. The study is being supervised by Professor K. Jooste and Dr F. Waggie of a university of the Western Cape.

The aim of this qualitative study is to develop a framework for health care professionals to lead youth victims of violence towards wellness in their community. The objectives are:

- To explore and describe the expectations of the youth with regards to health care professionals leading youth victims of violence towards wellness in the community.
- To explore and describe the experiences of health care professionals in leading youth victims of violence towards wellness in their community.
- To develop a framework for health care professionals to lead youth victims of violence towards wellness.

The design that will be used for this study will be qualitative using an exploratory, descriptive and contextual approach. The target population for this study will consist of youth and health care professionals (professional nurses, doctors and social workers) in the health care facilities. A purposive, non-probability sampling technique will be used to select the youth in the community and health care professionals who are knowledgeable and have experience on the phenomenon under study. Individual interviews will be conducted in a comfortable and private room among the health care professionals at the health care facility.

We will do our best to keep personal information confidential pseudonyms (false names) will be used instead of real names. All voice-taped interviews and transcripts of the interviews will be securely protected by the principal researcher using password-protected computer files and locked cabinet that cannot be accessed by other persons except for the supervisor and an independent coder. These will be kept for five years after the results of the project have been published before it will be destroyed. Participants will not in any way be subjected to any risk, injury, stress or discomfort throughout conduct of this research. Findings from this study will help the investigator learn more about how health care professionals lead youth victims of violence towards wellness. We hope that in the future, other people might benefit from this study through improved understanding of how health care professionals lead youth victims of violence towards wellness**.** Information acquired during this research project will be shared with all participants prior to public dissemination. Results of the study will be published in an accredited peer review journal.

Thank you very much for your cooperation

Yours sincerely,

Ezihe Ahanonu

Student Number: 3315076

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact any of the following persons listed below:

The Principal Investigator

Ezihe Ahanonu

University of the Western Cape

Private Bag X17, Bellville 7535

Cell: +27 078 672 3224

Email: eahanonu@uwc.ac.za

Prof Karien Jooste

The Director School of Nursing

Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: +27 21-959 2274

Fax: +27 21-959 2679

Email: kjooste@uwc.ac.za

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 3024, Fax: +27 21-959 2679

E-mail: eahanonu@uwc.ac.za

The Head,

Western Cape Education Department

Western Cape Province

South Africa

Dear Sir,

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY IN THE HIGH SCHOOL IN [Name withheld] COMMUNITY OF THE WESTERN CAPE

I write to seek your permission to conduct a research study in your High School. I am a Miss Ezihe Loretta Ahanonu a postgraduate student in the School of Nursing, University of the Western Cape, studying to fulfil the requirements for a Doctoral Degree in Nursing. My research study is titled: *'development of a framework for Health care Professionals to Lead Youth Victims of Violence towards Wellness in a rural Community of the Western Cape.* The

study is being supervised by Professor K. Jooste and Dr F Waggie of a university of The Western Cape.

The aim of this qualitative study is to develop a framework for health care professionals to lead youth victims of violence towards wellness in the community of study. The objectives are:

- To explore and describe the expectations of the youth with regards to health care professionals leading youth victims of violence towards wellness in their community.
- To explore and describe the experiences of health care professionals in leading youth victims of violence towards wellness in their community.
- To develop a framework for health care professionals to lead youth victims of violence towards wellness.

The design that will be used for this study will be qualitative using an exploratory, descriptive and contextual approach. The target population for this study will consist of youth in a High School and health care professionals (professional nurses, doctors and social workers) in the health care facilities in the community of study.

For the youth, a purposive, non-probability sampling technique will be used to select them in the High School. Focus groups will be conducted in a comfortable and private room at the school in a classroom arranged with you. A focus group will not be longer than an hour. Focus groups with each of the ages 15 to 22 will be separately conducted.

We will do our best to keep personal information confidential pseudonyms (false names) will be used instead of real names. Participants will sign a focus group binding form and youth under 18 years of age will sign an assent form and parents a permission form to allow youth less than 18 years to partake. All voice-taped interviews and transcripts of the interviews will be securely protected by the principal researcher using password-protected computer files and locked cabinet that cannot be accessed by other persons except for the supervisor and an independent coder. These will be kept for five years after the results of the project have been published before it will be destroyed. It will be avoided that participants will in any way be subjected to any risk, injury, stress or discomfort throughout conduct of this research. If needed, participants will be referred to a councillor. Findings from this study will help the investigator learn more about how health care professionals lead youth victims of violence towards wellness. We hope that in the future, other people might benefit from this study

through improved understanding of how health care professionals lead youth victims of violence towards wellness**.** Information acquired during this research project will be shared with all participants prior to public dissemination. Results of the study will be published in an accredited peer review journal.

Thank you very much for your cooperation

Yours sincerely,

Ezihe Ahanonu

Student Number: 3315076

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact any of the following persons listed below:

The Principal Investigator

Ezihe Ahanonu

University of the Western Cape

Private Bag X17, Bellville 7535

Cell: +27 078 672 3224

Email: eahanonu@uwc.ac.za

Prof Karien Jooste

The Director School of Nursing

Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: +27 21-959 2274

Fax: +27 21-959 2679

Email: kjooste@uwc.ac.za

ANNEXURE K: PERMISSION LETTER FOR THE HIGH SCHOOL

University of the Western Cape

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 3024, Fax: +27 21-959 2679

E-mail: eahanonu@uwc.ac.za

The Head,

[Name withheld] High School

Western Cape Province

South Africa

Dear Sir,

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY IN A HIGH SCHOOL IN A COMMUNITY OF THE WESTERN CAPE

I write to seek your permission to conduct a research study in your High School. I am a Miss Ezihe Loretta Ahanonu a postgraduate student in the School of Nursing, University of the Western Cape, studying to fulfil the requirements for a Doctoral Degree in Nursing. My research study is titled: *'Development of a framework for Health care Professionals to Lead Youth Victims of Violence towards Wellness in a Rural Community of the Western Cape.* The study is being supervised by Professor K. Jooste and Dr F Waggie of a university of The Western Cape.

The aim of this qualitative study is to develop a framework for health care professionals to lead youth victims of violence towards wellness in the community of study. The objectives are:

- To explore and describe the expectations of the youth with regards to health care professionals leading youth victims of violence towards wellness in the community.

- To explore and describe the experiences of health care professionals in leading youth victims of violence towards wellness in their community.

- To develop a framework for health care professionals to lead youth victims of violence towards wellness.

The design that will be used for this study will be qualitative using an exploratory, descriptive and contextual approach. The target population for this study will consist of youth in a High School and health care professionals (professional nurses, doctors and social workers) in the health care facilities in the community.

For the youth, a purposive, non-probability sampling technique will be used to select them in the high school. Focus groups will be conducted in a comfortable and private room at the school in a classroom arranged with you. A focus group will not be longer than an hour. Focus groups with each of the ages 15 to 22 will be separately conducted.

We will do our best to keep personal information confidential pseudonyms (false names) will be used instead of real names. Participants will sign a focus group binding form and youth under 18 years of age will sign an assent form and parents a permission form to allow youth less than 18 years to partake. All voice-taped interviews and transcripts of the interviews will be securely protected by the principal researcher using password-protected computer files and locked cabinet that cannot be accessed by other persons except for the supervisor and an independent coder. These will be kept for five years after the results of the project have been published before it will be destroyed. It will be avoided that participants will in any way be subjected to any risk, injury, stress or discomfort throughout conduct of this research. If needed, participants will be referred to a councillor. Findings from this study will help the investigator learn more about how health care professionals lead youth victims of violence towards wellness. We hope that in the future, other people might benefit from this study through improved understanding of how health care professionals lead youth victims of violence towards wellness. Information acquired during this research project will be shared

with all participants prior to public dissemination. Results of the study will be published in an accredited peer review journal.

Thank you very much for your cooperation

Yours sincerely,

Ezihe Ahanonu

Student Number: 3315076

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact any of the following persons listed below:

The Principal Investigator

Ezihe Ahanonu

University of the Western Cape

Private Bag X17, Bellville 7535

Cell: +27 078 672 3224

Email: eahanonu@uwc.ac.za

Prof Karien Jooste

The Director School of Nursing

Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: +27 21-959 2274

Fax: +27 21-959 2679

Email: kjooste@uwc.ac.za

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 3024, Fax: +27 21-959 2679

E-mail: eahanonu@uwc.ac.za

The Head,

G. community clinic

Western Cape Province

South Africa

UNIVERSITY *of the*
WESTERN CAPE

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY IN A COMMUNITY OF THE WESTERN CAPE

I have received permission from the DOH to conduct a research study in your health care facility. I am a Miss Ezihe Loretta Ahanonu a postgraduate student in the School of Nursing, University of the Western Cape, studying to fulfil the requirements for a Doctoral Degree in Nursing. My research study is titled: *'Development of a framework for Health care Professionals to Lead Youth Victims of Violence towards Wellness in a rural community of the Western Cape.* The study is being supervised by Professor K. Jooste and Dr F Waggie of a university of the Western Cape.

The aim of this qualitative study is to develop a framework for health care professionals to lead youth victims of violence towards wellness in the community. The objectives are:

- To explore and describe the expectations of the youth with regards to health care professionals leading youth victims of violence towards wellness in the community.

- To explore and describe the experiences of health care professionals in leading youth victims of violence towards wellness in their community.

- To develop a framework for health care professionals to lead youth victims of violence towards wellness.

The design that will be used for this study will be qualitative using an exploratory, descriptive and contextual approach. The target population for this study will consist of youth and health care professionals (professional nurses, doctors and social workers) in your health care facility. Individual interviews will be conducted in a comfortable and private room among the health care professionals at the health care facility.

We will do our best to keep personal information confidential pseudonyms (false names) will be used instead of real names. All voice-taped interviews and transcripts of the interviews will be securely protected by the principal researcher using password-protected computer files and locked cabinet that cannot be accessed by other persons except for the supervisor and an independent coder. These will be kept for five years after the results of the project have been published before it will be destroyed. Participants will not in any way be subjected to any risk, injury, stress or discomfort throughout conduct of this research. Findings from this study will help the investigator learn more about how health care professionals lead youth victims of violence towards wellness. We hope that in the future, other people might benefit from this study through improved understanding of how health care professionals lead youth victims of violence towards wellness. Information acquired during this research project will be shared with all participants prior to public dissemination. Results of the study will be published in an accredited peer review journal.

Thank you very much for your cooperation

Yours sincerely,

Ezihe Ahanonu

Student Number: 3315076

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact any of the following persons listed below:

The Principal Investigator

Ezihe Ahanonu

University of the Western Cape

Private Bag X17, Bellville 7535

Cell: +27 078 672 3224

Email: eahanonu@uwc.ac.za

Prof Karien Jooste

The Director School of Nursing

Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: +27 21-959 2274

Fax: +27 21-959 2679

Email: kjooste@uwc.ac.za

ANNEXURE M: CERTIFICATE FROM AN INDEPENDENT CODER

Qualitative Data Analysis

Doctoral in Nursing Science
E. Loretta Ahanonu

THIS IS TO CERTIFY THAT

Dr. Annie Temane has co-coded the following qualitative data:

7 Individual Qualitative Interviews & 9 Focus Group Interviews

For the study:

DEVELOPMENT OF A FRAMEWORK FOR HEALTHCARE PROFESSIONALS TO LEAD YOUTH VICTIMS OF VIOLENCE TOWARDS WELLNESS IN GENADENDAL COMMUNITY OF THE WESTERN CAPE

I declare that the candidate and I have reached consensus on the major themes, categories and codes reflected by the data during a consensus discussion. I further declare that adequate data saturation was achieved as evidenced by repeating themes.

Annie Temane

M.A.Temane (D.Cur; Research Methodology)

annie.temane@gmail.com

ANNEXURE N: TURN IT IN SUBMISSION RECEIPT

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ANNEXURE O: EDITING CONFIRMATION LETTER

* The stars that tell the spade when to dig and the seeds when to grow *

* Isilimela – iinkwenkwezi ezixelela umhlakulo ukuba mawembe nembewu ukuba mayikhule*

<div align="right">
P O Box 65251
Erasmusrand
0165
</div>

08 December 2014

Dear Ms Ezihe Ahanonu

**CONFIRMATION OF EDITING THE THESIS WITH THE TITLE
<u>DEVELOPMENT OF A FRAMEWORK FOR HEALTH CARE
PROFESSIONALS TO LEAD YOUTH VICTIMS OF VIOLENCE TOWARDS
WELLNESS IN THE GENADENDAL COMMUNITY OF THE WESTERN
CAPE</u>**

I hereby confirm that I have edited the abovementioned document as requested.

Please pay particular attention to the editing notes AH01 to AH155 for your revision.

The tracks copy of the document contains all the changes I have effected while the edited copy is a clean copy with the changes removed. Kindly make any further changes to the edited copy since I have effected minor editing changes after removing the changes from the tracks copy. The tracks copy should only be used for reference purposes.

Please note that it remains your responsibility to supply references according to the convention that is used at your institution of learning.

You are more than welcome to send me the document again to perform final editing should it be necessary.

Kind regards

André Hills
083 501 4124