BARRIERS TO LEADING YOUTH VICTIMS OF VIOLENCE TOWARDS WELLNESS AT A COMMUNITY IN THE WESTERN CAPE PROVINCE OF SOUTH AFRICA

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ABSTRACT

Youth violence is one of the key contributors to the burden of disease and injuries in South Africa. This article is aimed at describing the barriers experienced by healthcare professionals with regards to leading youth victims of violence to wellness. The findings presented are part of a larger qualitative study investigating healthcare professionals' leadership experiences with youth victims of violence at a selected community in the Western Cape Province of South Africa. A qualitative, exploratory, descriptive and contextual design was adopted. Data collection was done using unstructured individual interviews among all the seven healthcare professionals (two professional nurses, three medical doctors and two social workers) who provide healthcare services

for youth victims of violence in the community. Trustworthiness was ensured throughout data collection and collected data were analysed by means of open coding. Ethical clearance was received from an ethical review committee prior to the conduct of the study. Barriers encountered by healthcare professionals while supporting the youth victims included environmental, relational, structural and procedural barriers. Environmental barriers encompassed prevalent violent behaviours; drug and substance abuse among the youth in the community while relational had to do with attitudes of staff. Structural barriers involved inadequate structures and human resources, and procedural barriers comprised the challenging process of guiding the youth victims to wellness. This study demonstrated that healthcare professionals experience challenges in leading youth victims of violence to wellness in their community. Useful information on how they can lead them to wellness is required particularly in resource-poor settings.

Keywords: barriers, healthcare professionals, wellness, youth violence, youth victim of violence

INTRODUCTION AND BACKGROUND

The issue of youth violence has been widely discussed in South Africa and is regarded as one of the major and most difficult challenges facing the country (Govender, Matzopoulos, Makanga & Corrigall, 2012:303). For example, in the *National Strategic Plan for Nursing Education, Training and Practice*, it is highlighted that violence contributes to high levels of morbidity and mortality among populations (National Department of Health, 2012:2). Also, the 2008 annual report of the National Injury Mortality Surveillance System (NIMSS) reveals 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 (National Injury Mortality Surveillance System, 2010:5–8).

Dynamics reported to be related with violence in the country include disruption in social structures (particularly in families), resulting in poor parenting skills required for raising healthy non-violent children, a post-apartheid violence legacy that remains entrenched 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 (Social Development Department and the World Bank, 2012).

No doubt healthcare professionals such as nurses, doctors and social workers have an important role to play in safeguarding and improving the health status of the youth

in society. Snider and Lee (2007:167–168) draw attention to the need for healthcare workers to demonstrate their leadership capabilities by leading youth victims of violence towards wellness. Stipulated in the *Provincial Nursing Strategy of the Western Cape* is the need for the leadership capability of healthcare professionals to be demonstrated in practice (National Department of Health, 2009:16). Furthermore, in the strategic document *Healthcare 2030: The Road to Wellness*, the Government of the Western Cape of South Africa declared its commitment to increasing the wellness of the people living in the Province in line with the shift from a curative model of illness and disease treatment to one of prevention and wellness promotion. This no doubt is targeted at addressing the problems faced by majority of the youth in the province. To fulfil this pledge, the government identified its key focus areas of intervention to include violence and injuries prevention, and promotion of healthy lifestyles among all populations, including the youth through the leadership of healthcare professionals (Western Cape Department of Health, 2014:19). However, one question that needs to be asked is: what are the experiences of healthcare professionals in leading youth, particularly those who have been victims of violence to wellness.

Statement of the research problem

Youths who have experienced violence are at an increased risk of suffering from severe physical, psychological and emotional illnesses (McDonald & Richmond, 2010:833; Souverein, Ward, Visser & Burton, 2015:18). Therefore, health promotion programmes focusing on improving the wellbeing of this category of youth are especially important. Nevertheless, efforts to advance wellness programmes for this population may encounter difficulties. It was thus crucial in the process of developing a framework, which can be utilised by healthcare professionals in leading youth victims of violence to wellness, to explore the experiences of healthcare professionals in leading youth victims of violence towards wellness in their community. As a result, the research question for this study was: What are the experiences of healthcare professionals in leading youth victims of violence towards wellness?

Purpose of the study

The purpose of this study was to explore the experiences of healthcare professionals in leading youth victims of violence towards wellness in order to identify barriers or obstacles they encounter when leading youth victims of violence towards wellness at a community in the Western Cape Province of South Africa.

Theoretical foundation of the study

This study was founded on the theoretical assumptions of the Health Promotion Model that was developed to improve holistic wellness among persons. The model identifies the holistic nature of a person and describes how an individual networks with his or her environment to pursue wellness (Pender, Murdaugh & Parsons, 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 healthcare professionals in leading persons towards wellness. The fundamental assumptions of Pender's Health Promotion Model adapted for this study included that: 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; and healthcare professionals are an important part of the social environment and they have authority to lead persons to wellness.

RESEARCH METHODOLOGY

Research design

This study employed a qualitative, exploratory, descriptive and contextual design. A qualitative design was adopted since it permits the conduct of an in-depth investigation of a phenomenon through the collection of rich narrative data while using a flexible approach to understand and give meaning to the experiences of the participants (Polit & Beck, 2006:508). An exploratory research design allows research to create new facts and gathering new information or ideas (Babbie, 2010:92). *A descriptive* research design allows a researcher to describe circumstances and events as they occur naturally (Johnson & Christensen, 2012:584) and provides a precise interpretation of situations in order to explain what exists (Burns & Grove, 2011:256). *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, 2007:62). This study was contextual in nature because it was limited to the experiences of healthcare professionals at a rural community in South Africa.

Population and sampling

The target population for this study encompassed all healthcare professionals who provide healthcare services for youth victims of violence in the selected community of study. A purposive, non-probability sampling technique was employed in selecting the healthcare professionals who participated in the study. Purposive sampling refers

to the selection of respondents that will generate the necessary data to meet the objective of a study (Polit & Beck, 2012:517). *Healthcare professionals* who were viewed to be eligible to participate in this study had to have a minimum of two years of experience working in the community at the time of the study.

Data collection

We conducted unstructured individual interviews with seven (7) purposefully selected healthcare professionals working in the community of study in October, 2013. The sample comprised three (3) medical doctors, two (2) social workers and two (2) professional nurses. Unstructured individual interviews were chosen as the method of data collection since it they are considered to be valuable when the phenomenon under investigation is unclear (Polit & Beck, 2012:536). 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. During the unstructured individual interviews, the healthcare professionals were allowed to freely describe their experiences with youth who had been victims of violence in their community. Field notes were also taken during the interviews. Data collection continued up till the point of data saturation and each of the interviews did not last more than an hour.

Data analysis

Qualitative data analysis is an iterative process of collecting and evaluating the data at the same time with the purpose of maximising the meaning of the data (Creswell, 2009:183; Polit & Beck, 2012:556). In this study, data analysis involved transcription of the voice recordings of the interviews and writing up of field notes. The steps of Tesch's coding technique (Creswell, 2009:186) were used for analysis of the data. Two independent coders analysed the data followed by an inter-coder consensus meeting to reach an agreement about the coding.

Trustworthiness

To ensure trustworthiness of the collected data, Guba and Lincoln's strategies of credibility, transferability, dependability, confirmability and authenticity were applied (Guba & Lincoln, 1994).

ETHICAL CONSIDERATIONS

Ethical approval to conduct this study was granted by the Higher Degrees Committee of the Faculty of Community and Health Sciences, University of the Western Cape,

South Africa (registration number 13/9/39). Permission was obtained from the relevant authorities and the head of the healthcare facilities. The ethical principles of the *Belmont report* (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978) directed the ethical approach of this research study based on the three fundamental ethical principles guiding research namely: *respect for persons, beneficence and justice*.

RESEARCH FINDINGS

Participants' demographic profile

The average age of the respondents was 44.1 years. 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 1 below shows the summary of the demographic profile of the healthcare professionals.

Table 1: Demographic profile of the healthcare professionals

Interviewee's Code	Type of healthcare 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

Barriers to leading youth victims of violence towards wellness

The findings indicated that the healthcare professionals were experiencing barriers in leading the youth victims of violence towards wellness in their community. These barriers were categorised into four categories: (i) environmental barrier (ii) relational barrier (iii) structural barrier and (ii) procedural barrier. Each category and its corresponding sub-categories in combination with the participants' quotations and embedded literature are discussed below. Table 2 below shows the summary of these categories and sub- categories.

Table 2:   Categories and sub-categories generated from the study

Category	Subcategory
Environmental barriers	Violent behaviour Drug and substance abuse Parental socioeconomic issues
Relational barriers	Unsupervised youth Attitudes of staff
Structural barriers	Lack / inadequate structures Inadequate human resources
Procedural barriers	Process of guiding youth victims to wellness

Environmental barriers

The respondents identified difficulties that they encountered in their environment (community) while leading youth victims of violence to wellness. These barriers were youth issues such as violent behaviour and substance abuse amongst including parental socioeconomic issues in the community.

Violent behaviour

The healthcare professionals seemed exasperated with the problem of youth violence in their community and they revealed that violent behavioural patterns among the youth cause a huge barrier to guiding them towards holistic wellness. For instance, one social worker (with a disheartened look on her face: field notes) stated that it appeared to her as though a good proportion of the young people living in the community were violent and 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.

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 healthcare at the time of the interview, stated that 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.'* 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 healthcare professional, she said: *'... he hit the other with a stick or something in the class and one of them was lying there unconscious'*. This finding supports the report of the *2012 National School Violence Study in South Africa*, which highlighted that the levels of violence among youth in schools are very high (Burton & Leoschut, 2013)

Drug and substance abuse

The healthcare professionals interviewed stated that drug and substance abuse particularly the abuse of alcohol, cannabis (dagga) and methamphetamine (tik) among the youth population was rife in the community, a situation that has 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.' 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.

Another healthcare 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.'* Interestingly, these findings are similar to the reports of violent behaviour, drug and substance use 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, 2013:33).

Parental socio-economic issues

The low economic status of most of the community members was stated as another barrier that challenged the healthcare professionals in leading youth in the community towards wellness. To illustrate this, for example, 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.

In addition, some of the healthcare 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 healthcare 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 ... .

Relational barriers

The relational barrier identified by the respondents resonated with difficulties with unsupervised youth and the negative attitudes of staff members.

Unsupervised youth

Unsupervised youth resulting from parental relationships due to neglect and/or abandonment coupled with substance abuse was also highlighted by the healthcare professionals as being an obstacle in the community. For instance, 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 ... .

One of the social workers stated 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.'* This finding supports the reports by the Department of Social Development, Republic of South Africa (2013:33) and the 2008 *South African Youth Risk Behaviour Survey* report, which state that substance abuse and youth violence are common in the community during weekends.

Attitudes of staff members

All the healthcare 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 healthcare professionals responsible for treating the youth who had been victims of violence were unprofessional:

> I can tell you that some people [referring to the healthcare 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.

Likewise, a professional nurse acknowledged that the attitude of healthcare 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 healthcare professionals if it is not right towards them then we would put them in the wrong direction.' 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 need for promoting patient-centred professionalism in the provision of health services to youth victims of violence. This entails respect of clients' rights and treating clients with utmost dignity (Hutchings & Rapport, 2012).

Structural barriers

The structural barriers identified had to do with lack/inadequate infrastructures and manpower. The findings supporting these are discussed below.

Lack of/Inadequate structures

It was mentioned by the healthcare professionals that another important barrier 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 healthcare 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.

Another healthcare 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.

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 ... .*' This situation no doubt would affect the services provided by the social workers, hence the need for the current situation to be addressed.

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 due to their huge workload, which 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.

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.' A social worker also 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.' 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 healthcare professionals such as professional nurses, medical doctors, social workers, physiotherapists, occupational therapists, professional counsellors and psychologists working at the primary healthcare level.

Relational barriers

The relational barriers had to do with a challenging process of guiding youth victims to wellness.

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 ... .

The healthcare 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.' 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.' This finding evidently shows that the healthcare 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.

CONCLUSION

This study has established that healthcare professionals experience challenges in leading youth victims of violence to wellness in their community.

RECOMMENDATIONS

Based on the findings of this study, it is necessary that healthcare professionals and other stakeholders work together in ameliorating the barriers that hamper the leadership of the youth victims of violence to wellness in the community.

LIMITATIONS OF THE STUDY

The sample size of 7 healthcare professionals interviewed imposes limitations regarding the generalisability of the research findings.

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