STRATEGIES TO FACILITATE APPLICATION OF SOCIOLOGY OF DEVELOPMENT TO NURSING PRACTICE

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DEDICATION

I dedicate this dissertation to my late parents who, when raising me, instilled a sense of responsibility and taught me to always strive for success and not to surrender. Their sweet memories remain with me and I will never forget them.

Further, I dedicate this dissertation to my late brother Efraim and my loving sisters, who partook in caring for me during my high school life and have thus contributed to this achievement.

DECLARATION

I declare that "Strategies to facilitate the application of Sociology of Development to nursing practice" is my own work and the sources used and quoted have been acknowledged by means of text citation and bibliography.

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SUMMARY

Nursing practice is a living body of knowledge derived from different disciplines, i.e. biological, psychological and social. From the social sciences, Sociology of Development is one of the sources of knowledge used in nursing practice.

Student nurses in Namibia have been taught Sociology of Development since 1987 at the diploma level. The content of sociology motivates the pivotal role of nurses as resource persons who enhance and promote the social upliftment of the people of Namibia. Health care and education is necessary for the development of people. If society does not benefit from the education and practice of nurses, then the teaching of sociology of development is meaningless.

There is no scientific evidence on how knowledge from Sociology of Development is being utilised in nursing practice, because there is no study report available on the integration of this content into nursing practice.

The purpose of this study is the development of strategies to facilitate the application of Sociology of Development to nursing practice.

A quantitative descriptive design was used to determine the extent to which registered nurses apply Sociology of Development in nursing practice. For data collection, the questionnaire method was employed.

The study population was comprised of registered nurses who were taught Sociology of Development and were practicing in the four training hospital in Namibia. The sample was selected by means of systematic random sampling.

The study was conducted in three phases. Phase one was the exploration of possible challenges to the application of Sociology of Development in nursing practice. The data collected during this empirical

phase were statistically analysed and described to ascertain whether there is any significant difference between the independent and dependent variables of the dichotomy groupings. Comments on the questions where open coded and summarised.

The second phase was the development of the conceptual framework upon which strategies are to be based. The third phase was the development and description of the strategies.

The exploration of the possible challenges in the application of Sociology of Development to nursing practice has revealed that there were areas where application has been successful but also that there are weaknesses identified on the side of registered nurses and challenges revealed in their comments on health facilities and the health care delivery system. Strategies have been developed based on these findings to facilitate application of the content in nursing practice.

Conclusions were made and recommendations were given to the Ministry of Health where these registered nurses practice and also to the University of Namibia (UNAM) where nurses are trained and taught Sociology of Development.

This study has made two major contributions to the body of knowledge in nursing practice as well as to applied Sociology of Development. The contributions are: A conceptual framework for the development of strategies that facilitate the application of sociology of development to nursing practice and the strategies which were formulated.

The strategies formulated in this study are not conclusive. There is room for additional ideas on how best the content can be made practically applicable not only to nursing science but to other health-science professions.

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CHAPTER 1: INTRODUCTION AND BACKGROUND TO THE PROBLEM

1.1 INTRODUCTION

Nursing practice is a living body of knowledge, derived from different disciplines. These disciplines

are interrelated and interdependent. In isolation each discipline is sterile without the others. Human beings are multi-dimensional, physical, physiological, social, cultural and spiritual in nature. These different aspects of human beings require different approaches from nurses when caring for their patients. Nurses do not practice their profession in a vacuum, but they practice based on the knowledge they acquire in their educational training with respect to the dimensions of humanity as mentioned above.

Nurses are members of the society and the communities they serve. By applying knowledge to their practice they are not only helping others but also themselves because when they are ill or have close relatives who need health care, the nurses attending to them use knowledge acquired from theoretical learning.

The practical significance of Sociology lies in: Understanding the social situation; awareness of cultural differences; assessment of the effects of policies that increase self-knowledge; and the person/sociologist's role in society (Giddens, 2006, pp 22 – 23).

The field of Sociology covers the social and cultural dimensions of human beings.

1.2 BACKGROUND TO THE PROBLEM

Student nurses in Namibia have studied sociology as a subject since 1986. Sociology is a subject as well as a discipline in which nurses learn to gain a better understanding of society, by equipping

themselves with practical and analytical skills as they relate to health issues, in this case, in Namibia.

"Social factors are important to patient care. Sociology has its place in nurse education." says Mike Brennan (2004, p 25). "It contributes to the understanding of social and non-medical factors that affect the experience of health and illness and adds to the academic profile of nursing, it makes the profession more attractive for prospective applicants and provides increased opportunities for career development which is an improvement on nurse education of the past." All the afore-mentioned aspects are indicators of development taking place within nursing practice.

The general aims and objectives of the sociological study in nursing care:

- To understand the concept of sociology and its relevance to nursing in Namibia;
- To analyse contemporary Namibian society by applying sociological theories critically;
- To acquire practical skills through understanding social research; and
- To understand and apply knowledge acquired in the issue of health in developing societies by focusing on:
    - Dynamics of population change; and
    - Social and industrial development dynamics and influences of society on health behaviour (UNAM, 1995, p 318).

Most of these issues and dynamics are attended to in the study of Sociology of Development and can have an influence on the development of nursing science.

Sociology should not just be seen as a theory but a basis for nursing practice. "Nursing and Sociology have a well-established association - a marriage which is far from harmonious"(Allen, 2001, p 386).

There are different modules which student nurses study during their training. Amongst those are the introduction to sociology which deals with concepts and theories/perspectives; application of social research; social problems; social demography, sociology of health and sociology of development which focused on in this study. It deals with the dynamics of social and industrial development on the Namibian people and how the government and non-governmental organisations facilitate general development to improve the health status of the Namibian nation and how these development processes influence health care given by nurses (UNAM, 1995, p 327).

Again, according to the paper by Allen and Pilnick (2005, p 691-692) it was stated that "Heath *et al* (2003) note that health work has undergone sustained change over the 20 to 30 years with much of this change driven by the introduction of new technology and, particularly, computerisation. These new equipment and health care delivery systems influence and may constrain the way in which illness is identified, managed and treated."

During the period of 1986 – 1995 Sociology of Development had only emphasised the theories of development, colonialism and exploration of the third world, and the influences of the World Bank and International Monetary system on the development of the periphery countries like Namibia. The application of this content was more political, economical and social, with little emphasis on the applicability to nursing care.

Since 1996 the department of sociology, particularly the lecturers for Sociology for Nurses, have changed the content of Sociology of Development to place more emphasis on development with regard to:

- Women and children;
- The disabled; and
- Education and development.

This change has given nurses a new direction for viewing social development in society within the context of nursing care. With the implementation of the Primary Health Care approach in the beginning of the 1990s, more emphasis was also placed on social development and change as it affects health and health-related issues. The health care delivery system is viewed from an economic, political, social and health point of view. The role of health workers in health development is also emphasised.

Major health-related issues which have an impact on the development of society are, for example, HIV/AIDS, tuberculosis and malaria, because they affect people of all age ranges, they affect the productivity of people in the employment market, and they affect the utilisation of resources to care for the affected and infected.

Adversely, social development may have an impact on the health of society as seen in the cases of hypertension, diabetes mellitus and coronary artery diseases as a result of lifestyle and social habits.

Furthermore, recovery from certain illnesses may be slow, or unrelated to the increase in virulence of bacteria or viruses, but rather be due to increased levels of tension brought about by rapid change or lack of means to deal with aspects of the dynamic conditions in society.

According to the researcher's experience and observation, the Government of Namibia is achieving its

goals, by implementing changes in its different sectors, where the Ministry of Health and Social Services is a major sector. The Government endeavours to improve living standards in collaboration with other Ministries to improve diet, health care delivery system (changing approach), housing provision, immunisation, environmental health hazards, better sanitation and human waste disposal as well as better education to improve nutrition. It also looks into new ways of producing and storing food. All of these efforts are the aspects of social development that Sociology of Development deals with.

In its document entitled Vision 2030 (2001, pp 19-24, 34), the Government has highlighted the aspects to be considered for social and health development, such as people's quality of life, healthy lifestyle, healthy human environment, wealth and economy and equity and gender equality.

Cultural, social, political and economic changes are made easier for the health professional if he/she makes an effort to adapt. If rigidity is present, she or he will do more harm to the health care situation and profession. Therefore, the health care professional must understand human needs, motivations, aspirations and roles (Searle & Pera, 1995, p 445). Every human being should be cared for holistically. Holism provides potential progress for the development of nursing knowledge and practice. The study of Sociology is essential for the provision of holistic care and development of nursing practice (Birchenall & Birchenall, 1998, p6). This leads to the topic of Sociology of Development.

Sociology of Development has been taught since 1987 until present to nursing students doing Diplomas in comprehensive Nursing Science. These registered nurses were trained at three UNAM campuses,

Windhoek in Khomas region, Oshakati in Oshana region and Onandjokwe in Oshikoto region. Since the time the subject had been taught, a total number of 1099 student nurses had completed their training between 1989 and 2001.

The number of students who completed their studies every year can be seen in the table below.

Table 1.1: Number of completions of training with Sociology of Development as a subject in the curriculum from 1989 – 2001 (FMHS Statistics, 2002).

Year of completion	**Number of students who completed training**		
	Windhoek	**Oshakati/Onandjokwe**	**TOTAL**
1989	45	15	**60**
1990	65	20	**85**
1991	80	20	**100**
1992	76	40	**116**
1993	55	26	**81**
1994	68	44	**112**
1995	68	44	**112**
1996	73	30	**103**

1997	47	58	**105**
1998	38	40	**78**
1999	14	24	**38**
2000	39	28	**67**
2001	21	21	**42**
TOTAL	**689**	**410**	**1099**

The table refers to the number of nurses who have so far completed their training however, not all of these nurses are employed in the health facilities of the Ministry of Health and Social Services or at training hospitals.

Health services are being offered by a variety of health workers, but nurses usually form the biggest group of health-care workers in any country and also in Namibia. Therefore, it becomes apparent that nurses not only need to know, and to understand or analyse critically, but they also need to apply the knowledge and skills acquired in understanding or analysis of sociological issues in practice. Sharp (Allen, 2001, p 388) 'has problematised the value of sociological knowledge to nursing practice', because according to him sociology has a multi-paradigmatic character and cannot be utilised for action-based practice such as nursing. Porter disputes him by arguing that 'nursing practice is inherently reflexive and as such is perfectly compatible with sociological knowledge'.

The motivation for this study addresses the issue of transferring knowledge from the place of learning (the university) to the place of work (nursing practice). Burns & Grove (1993: 4), hold that studies of

such transfer can problematise the way a curriculum is implemented and thus advance knowledge of both practice and teaching. Therefore, we can expect nurses to apply what they learn in Sociology of Development into nursing practice.

1.3 PROBLEM STATEMENT

Sociology of Development subject or course content motivates the pivotal role of nurses as resource persons who enhance and promote social upliftment of themselves and the people of Namibia. The content of this course just like other sections is meant to be applied to and integrated with their nursing practice. De Laune and Ladner (2002) argue that nurses derive knowledge from various disciplinary fields. To this end sociology of development is offered to nurses with the purpose of them applying and relating it to development taking place in their practice.

It is, however, uncertain to what extent the curriculum of Sociology of Development provides nurses with the ability to contribute to the changes needed in developing people because there is no scientific evidence or indication on how this acquired knowledge is utilised in nursing practice. This is because there is no study reports available about research conducted on this specific content, to see how development theories are integrated into the aspects of nursing practice.

Health care and education are pivotal to the development of people and it is problematic if nurses are not trained and educated to contribute to the development of society through the provision of safe

health care and education. If society does not benefit from the education and practice of nurses, then the teaching of Sociology of Development is questionable and meaningless.

The following serves as an example: Community members complain that patients are not well informed about intervention done on them, for example, surgical procedures and nursing care. If patients are not well informed they might give consent for procedures when they might not otherwise have done so, or go unprepared for treatment, because the appropriate explanation was not provided.

Another example: Problems occur when nurses are expected to critically observe the condition of patients /clients and make decisions to refer patients. Specific examples are in the cases of abuse of women and children. If nurses are unable to observe and recognise these, patients end up suffering.

It also appears as if an internalisation of concepts such as accountability and sensitivity to the plight and needs of patients and clients does not reflect in nurses' behaviour and practice. Patients' human needs are ignored which results in harmful nursing practice, for example, delayed referral of women who are in prolonged labour which leads to harmful delivery and loss of babies, as in some cases that have been heard by the Nursing Board Disciplinary Committee at its Disciplinary Hearings.

1.4 THE RESEARCH QUESTIONS

On the basis of the statement of the problem, the following questions serve to guide the study:

- Is the knowledge acquired in **Sociology of Development** during training and education being applied to the practice of nursing?

- What are the strengths and weaknesses of nurses in the application of Sociology of Development to nursing practice?

- What strategies need to be formulated to enhance the application of **Sociology of Development** to nursing practice?

1.5 PURPOSE AND OBJECTIVES OF THE STUDY

1.5.1 Purpose

The purpose of this study is to develop strategies to assist registered nurses to apply the content of "**the Sociology of Development"** in Nursing Science to nursing practice.

1.5.2 Objectives of the study

The objectives of this study are therefore the following:

- To explore and describe the application of **Sociology of Development** in nursing science practice by registered nurses who have completed a four-year Diplomas at UNAM.
- To identify the weaknesses and strengths in the application of such knowledge.
- To develop and describe strategies to facilitate application of **Sociology of Development** to nursing practice.

1.6 PARADIGMS FOR THE STUDY

According to Babbie (2001, p 42), a paradigm is the fundamental frame of reference we use to organise our observations and reasoning, that is a basic set of beliefs (assumptions) that guides inquiries. It is a set of propositions or a mental window relating to the researcher for viewing how the social world works (Bailey, 1994, p 26; De Laune and Ladner, 2002, p 30).

The research paradigms for this research study, which serve as a frame of reference, are based on Marxism and Functionalism. These perspectives will be discussed more on chapter 2. The methodological paradigm used in this study is the quantitative approach, which is a positivistic study. Even if Marxism falls under the critical paradigm where triangulation is viewed to be the most appropriate way of study, and symbolic interactionism is seen to be better understood by making use of the qualitative approach, for the purposes of a study based on the application of knowledge, the quantitative approach is found to be the most applicable one.

Paradigms can be explained at three levels, these being ontological, epistemological and axiological assumptions.

Ontological assumptions involve human nature, society, the nature of history, the status of mental entities, observable and material phenomena, causality and intentionality of human action, which is the nature of reality. There is a curriculum that covers topics about the Sociology of Development and it needs to be applied. Many factors influence human behavior and also human health. Development in societies with different cultural practices, socio-economical standings and political views influence the way health is catered for (Mouton, 1998, pp 26, 37, 123-124).

Epistemological assumptions involve the nature of the knowledge on the content of the ‘truth’, that is,

what constitutes good information or valid results. This aspect influences decisions in the formulation of the problem.

Relationships between the inquirer and that which is being studied can be highlighted when the lecturer acts as a facilitator in the process of learning, makes the content interesting and meaningful to the students she is guiding, making the knowledge a valuable part of the curriculum (Mouton, 1998, pp 26, 37-39,123).

Axiological assumptions are concerned with the role of values. There are many different cultural beliefs and values that are exercised by different societies. Health and health care are influenced by culture and society with their shared values and beliefs. In assisting people from diverse cultures, nurses need to remember that patients' cultural backgrounds determine their concerns and losses. These will then influence their behaviour and practices related to health, and determine the care they may need. These values also shape their views, whether commonly or differently (Creasia & Parker, 1996, pp 287, 290). Some traditional attitudes are more oriented towards the curative than the preventative and some cultural practices may encourage disease transmission. The following examples are evidence of this statement: Some ways of preparing food are unhygienic and can lead to diarrhoeal diseases, or some nutritional foods should be avoided during pregnancy (eggs and some yellow fruits like oranges), for fear of yellow discoloration of the skin (thinking of jaundice).

Traditional healing systems which involve cutting the human body (foreskin of the penis, pieces from the vulva and many others), with contaminated instruments and under unhygienic conditions and traditional sexual behaviour which promotes unsafe sex, are the major factors which promote

transmission of infections (STIs and AIDS) in Namibian society.

In some cultures women are not allowed freedom of choice. These choices could be vitally important to their lives like the decision to own houses or to undergo surgical intervention for family planning.

The methodological paradigm involves the way in which the research method is selected and used. For this study a quantitative approach is used because it is more convenient. From the positivistic paradigm point of view knowledge is there, is objective and waits to be detected through experience (Sarantakos, 1998, p 36). Knowledge about Sociology of Development is taught and then needs to be found in practice. The truth is there and it needs to be confirmed through empirical investigation.

1.7 DEFINITIONS OF TERMINOLOGY

The concepts and terms used in this study are defined as they are applicable to the study, i.e. operational definitions are given.

Application: The act of applying or making use of relevant substances or materials; or to put close to or in contact with (Fowler, 1978, p 33); or the action of putting something in operation (Pearsall, 1999, p 64). In this study it means making use of knowledge from sociology of development when practicing nursing.

Development: The developing growth stage of advancement (Fowler, 1978, p 228); the event

constituting a new stage of a changing situation (Pearsall, 1999, p 392); or the process of growth and differentiation (Miller & Keane, 1987, p 342).

Facilitate: In this respect to facilitate indicates the action of allowing or assisting something to happen or to occur, while facilitation is the action of assisting the process to take place or the implementation to materialise. To assist nurses to make use of sociological knowledge in their practice.

Knowledge: Information and skills acquired through experience or education; or the sum of what is known (Pearsall, 1999, p 786). Knowledge of sociology of development acquired by nurses that is relevant to their practice.

Nursing practice: The acts of practicing nursing skills relevant to caring for patients and clients in a health care environment. According to the American Nurses' Association, nursing practice can be defined as follows: "The performance for compensation of professional services requiring substantial specialising knowledge of the biological, physical, behavioral, psychological and sociological sciences and of nursing theory as a basis for assessment, diagnosis, planning, intervention, and evaluation in the promotion and maintenance of health; case finding and management of illness, injury or infirmity; the restoration of optimum function or the achievement of dignified death. Nursing practice includes administration, teaching, counselling, supervision, delegation and evaluation of practice and execution of medical regimen" (Miller & Keane, 1978, p 872).

Nursing science: A body of knowledge that is contained in the theoretical and practical part of nursing that forms the basis for practicing the nursing profession.

Sociology: In this study, the concept of sociology is accepted as indicated by authors Smelser (1984, p. 1) and Goode (1984, p 3), as a systematic study of social life, a scientific study of human interactions that is a study people's lives. According to Rousseck and Warren (1968) sociology is defined as a systematic study of human beings in their group relationships, which can be two people talking on the street corner, the members of a team or the people of a whole nation together.

Sociology of Development: According to Gordon Marshall (1998), Sociology of Development is "the application of social theory and analysis to societies (usually in the Third World) which are undergoing a late transition to capitalist industrialisation. It has been particularly concerned with analysing the social effects of development on class relations and on social groups such as the peasantry and the urban poor."

It can also be defined as a study or section in sociology that views the social changes that take place in society or part of society. In this study society is the community and the nurse practitioners in particular with emphasis on aspects of women and children, the disabled and education and development in general.

Strategy: Strategies are actual skills and activities that are undertaken to perform actions; or the plans made by top managers and their corporate strategy advisers, where they are matters of policy that precede actions (Leopold *et al*, 1999, p 23). Strategies to be formulated to assist registered nurses on how to use knowledge derived from sociology of nurses into nursing practice

1.8 SUMMARY

This chapter has introduced the nature of the study to be conducted. The topic to be studied is derived from the sociological field on social development. This course is taught to student nurses who are completing the Diploma in Nursing and Midwifery Sciences.

The topic was chosen to investigate the nature of the application of Sociology of Development to nursing practice. The researcher provided a background to the study to make readers aware of the nature of the problem. The statement of the problem addresses the point, which motivated the researcher to decide on the type of study and what the study is meant to achieve. It was observed and noted that the extent to which the knowledge derived from Sociology of Development is applied to nursing practice is not known, and the application of such knowledge is unclear in the clinical environment where registered nurses who have completed this course are practicing. The research population and the information sample for the study were ring-fenced.

To pave the way for investigation, the researcher has stated the objectives, which point out the direction for moving when searching for information. The research questions formulated act as guidance for stating the objectives to be achieved.

A fundamental frame of reference was selected as a paradigm on which the researcher will organise the

observations and reasoning for the study. This was based on the three perspectives, from which information is studied in Sociology of Development, which are modernisation, dependency and interactionism or humanism. The research paradigm to be used in this study is the positivistic approach as highlighted in this chapter, which uses the quantitative methodology.

The key concepts from the study topic were clarified and defined in this chapter to make readers aware of what the topic really addresses. In the next chapter, the researcher will look into the conceptual framework for this study and review existing literature, research reports and supporting evidence from other sciences, which is relevant to the topic.

CHAPTER 2: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.1 INTRODUCTION

Research as a scientific process requires practical activities based on theoretical explanation. Without a foundation on which to build, the whole process is doomed. Any research topic and problem to be studied have roots in theories formulated or studies done by others at a certain period of time. Some origins or sources are known and identified while some may be latent.

Literature review enables the researcher to identify the core concepts that form the basis of the study. Literature review is thus conducted based on the concepts, which guide the study and whose framework is the foundation of the study.

2.2 The purpose of THE literature review

Due to the fact that no previous research has been done on this topic, different objectives for the literature review are more appropriate (Mouton, 1998, p 111).

The objectives of the literature review for this study are to:

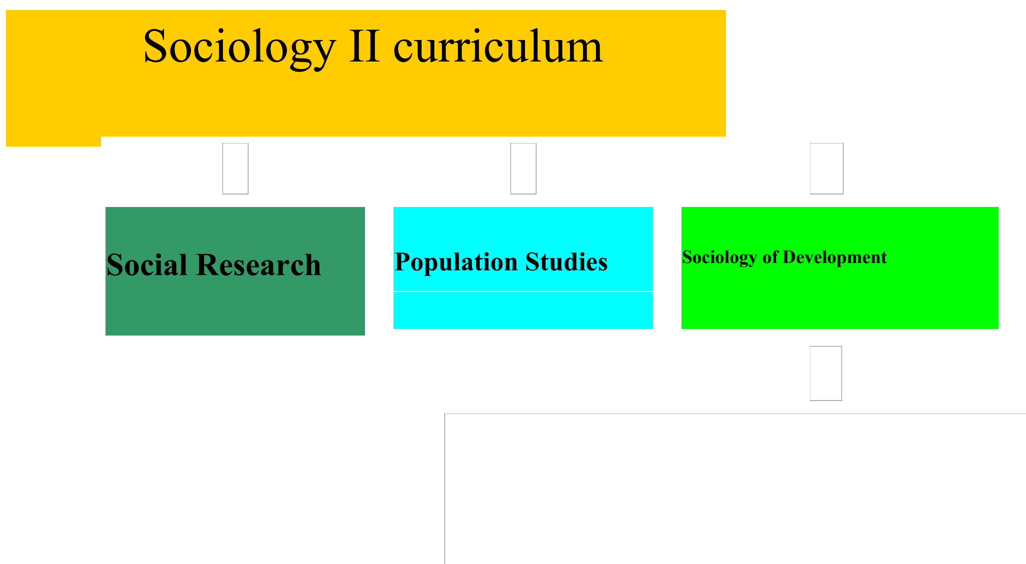
- Determine the principles of sociology of development in nursing practice;
- Investigate the contributions that social development may make to the practice of nursing and to the curriculum that nurses follow;
- Determine any value, knowledge and skills that the course provides in the nursing curriculum.
- Investigate whether there is any relationship between social development theories and nursing practice.
- Provide the theoretical framework for the study of the problem and the interpretation of the findings, identify the gaps in the knowledge about the topic, provide new knowledge on the

topic, and provide the researcher with boundaries for the study (Mellish & Brink, 1990, p 344).

2.3 Conceptual Framework FOR THE STUDY

Conceptualisation is about analysis of the key concepts in the study that underlie the theoretical framework that guides the research (Mouton, 1998, p 109 – 110).

Figure 2.1 Conceptual framework for the study



Three theories can be applied to the nursing profession and influence different aspects of nursing practice. Nursing is continuously undergoing change and development. Some aspects result in advantageous change of practice, leading to reshaping and remoulding.

Nursing practice is dynamic, and the ways in which tasks are performed change continuously, nevertheless, in some circumstances, nurses remain dependent on others' practices and issues, which may hamper them from individual thinking, reasoning and independent decision-making. An example

of the latter is the process of hierarchical arrangement or order, where seniority and authority are entrusted into the hands of a few health workers at the top of the structure.

2.3.1 Broad conceptual framework of the study

Conceptual frameworks in studies serve as frame of reference for observation and data collection. Frameworks are also provided for data analysis and they make it easier for the researcher to arrive at conclusions (Mouton, 1996, p 196). Conceptual frameworks deal with abstractions (concepts) that are systematically assembled by virtue of their relevance to common themes (Polit & Hungler, 1997, p 117).

For the purpose of this study, there are concepts to be considered that serve as the framework for the study, which include the curriculum of Sociology of Development, the three development theories; modernisation theory derived from the functionalist perspective; dependency theory derived from the Marxist theory which is a component of the conflict perspective; and the theory of development and consciousness which derives from interactionism. The other concepts which need to be addressed concern the relationship between development and health, as well as development theories in relation to the development of health in Namibia. These aspects are discussed and presented below.

2.3.2 Curriculum

2.3.2.1 Application of curriculum

The influence that Sociology of Development has on the practice of nursing is contained in the learning

objectives as stated in the first chapter.

For clarity with regard to the literature review the objectives of the study of this curriculum can be repeated as follows:

Students are expected to be able to:

- Describe the main characteristics of pre-colonial societies in Africa and other developing countries;
- Describe the impact of developed countries' colonialism on socio-structural and socio-economic development in Namibian society from the point of view of dependency theory;
- Discuss the main theoretical approaches to understand modern industrial development from the modernisation theory point of view; and
- Analyse the attempts being made by the government and NGO's to facilitate general development and improvement of health status in Namibia (UNAM FMHS Revised Curriculum, 1995, p 327).

These objectives have to be realised and there is a need for certain guiding principles in achieving that goal. There are general principles that apply to the selection of the learning experience no matter what the objectives may be.

For the given objectives to be attained as they are stated above, the student must have the experiences that give him the opportunity to practice the kind of behaviour implied by the objective. The student has to develop skills by being exposed to the practice that leads to the skills. If the student is exposed to social development in the health care delivery system, he or she can develop skills on how to collate that knowledge into his nursing practice, for example, food production projects that help community members to fight poverty and hunger, and at the same time eat that food to remain healthy.

The same learning experience will usually bring about several outcomes. In solving health problems,

the student gains further information, for example on attitudes towards the importance of public health procedures.

The teacher, in this case the lecturer, needs to be on the lookout for possible undesirable outcomes that may develop from learning experiences aimed at other purposes. An example would be the income-generating projects where people brew alcoholic beverages that are harmful to the human body.

The content of courses can change behaviour, which implies development in morals, culture or interactions. Introduction of desirable course content causes growth of knowledge and skills, progress towards widening the horizons of nurses and steers them away from experiences that will have the effect of closing them down (Kelly, 1999, pp. 88-93).

2.3.2.2 Curriculum content

The curriculum designed for Sociology of Development for student nurses has the following characteristics:

- A general overview of development and definitions to clarify the concepts;
- Modernisation as a development process with reference to different theorists who contributed to this theory;
- Dependency and underdevelopment as a process of development with special reference to what happens between countries in the world or between people in the same country/society;
- Interactionism or humanism referring to development as a process of consciousness of those affected and involved in such a development;
- The role of the governmental sectors in the Namibian development process with special reference to development of women;
- The role of NGO's (Non-Governmental Organisations) in the Namibian development process with special reference to development of women; and
- The impact of social development on the health of the Namibian people from all the above-stated approaches.

This curriculum content puts nurses on a new path which emphasises (social) development of society within the context of nursing care.

Nursing training in Namibia has changed its curriculum since the inception of the Diploma in Nursing (General, Psychiatry and Community Health) and Midwifery Science in 1986. Nurses used to undergo training in a Diploma comprised of four major courses/subjects i.e. General Nursing, Community Health, Psychiatric Nursing and Midwifery Sciences.

It was found that there should be other applied courses relevant to the study of nursing such as Ethos of Nursing and Professional Practice, which form the basis for practicing the four sciences, with Scientific Foundation of Nursing as a core component in which nurses learn anatomical knowledge, biological principles, and the physiological and chemical changes that occur in the body and their application to comprehensive health care.

The necessity to include sociology as a subject was also identified in 1985 when the curriculum for a Diploma in Nursing (General, Community Health, Psychiatry) and Midwifery Science was developed. The sociological study was divided into six modules one of which is Sociology of Development which explain dynamic changes in society.

The Government of the Republic of Namibia showed its commitment to the maintenance of health of the citizens of its country by adopting the Primary Health Care approach. It has also declared its mission to achieve health for all by the year 2000 and beyond, by minimising and addressing major

health threats for example, HIV/AIDS and the social differences Namibia is faced with.

The effort of achieving health for all by the year 2000 and beyond is a collaborative one in which all government and public sectors strive for the same goal. Nursing education should therefore also address this issue by means of the different subjects taught. Sociology of Development is therefore, no exception to the application of knowledge acquired in nursing practice (MOHSS, 1992). The application of such knowledge will in turn influence the practice of nursing. To be able to understand the different development theories, it is firstly necessary to understand the general meaning of development.

2.3.3 General overview of development

The starting point in analysis of Sociology of Development is the concept ‘development’ itself. Defining development is not an easy task. Definitions of the concept usually take three forms:

- Firstly, development as a state of being of a given society as a social system, therefore it can be defined as “a process of improvement with respect to a set of values or indicators” (Colman and Nixon, 1986, p 2).
- Secondly it can be defined as a relational or relative concept, that is, a state of societal being conceived of in terms of comparisons to conditions in other societies. When comparing the relative levels of development of different countries, development is conceived of as a comparative state of being with respect to a set of values and indicators (Mabogunje, 1989).
- Thirdly, development can be defined as a combination of the two definitions above.

Three theorists have endeavoured to define development, each from their own perspective. They are Dudley Seers, Gunnar Myrdal and Paul Streeten. In their definitions of development similarities and differences were identified.

Dudley Seers (1969), defines development as a process of not only satisfying the material needs of human beings (economic growth) but also making available conditions in which a given country's people have adequate access to food and jobs, while inequalities between them are reduced. This definition focuses on the question of what is happening to poverty unemployment and inequality.

Dudley Seers sees development as touching the universal core of human existence, because it realises the potential for the human personality and for people to become self-reliant. His definition considers five objectives or criteria:

- Adequate family income to cater for food, clothing shelter and footwear;
- Jobs which help people to develop a sense of self-worth and obtain wealth;
- Raising literacy to reduce inequality;
- National self-reliance and independence; and
- Opportunities to participate in governments' decisions at grassroots level (Mabogunje, 1989, p 36).

The above aspects are very important and also influence nursing practice. Without these, nursing practice would also be hampered, as nurses would be faced with many health challenges, working under difficult conditions, for example, lack of adequate and proper health facilities.

Gunnar Myrdal (1968), sees development as a comprehensive process invoking total political commitment, which fully mobilises a whole given society. For him development is the 'movement of the whole social system upward' (Mabogunje, 1989, p 46). Such a movement can be highlighted in the following criteria that give an indication as to whether development is occurring or not:

- Rationality;
- Development and a development plan;
- Rise of the level of living;
- Social and economic equalisation;

- Improved institutions and attitudes;
- National consolidation;
- National independence;
- Democracy at the grassroots level; and
- Social discipline to stamp out corruption (Mabogunje, 1989, p 46).

For nursing practice these criteria need to be observed in order for nursing to keep pace with modern developments. These criteria are in many ways similar to those of Seers.

Paul Streeten (1968), defines development on the basis of the Basic-Need Approach to Economic Development as highlighted in his "Development Dichotomies" (World Development Vol. II No. 10, 1983). 'Development means modernisation and modernisation means transformation of human beings'. Development is seen as an objective and as a process, both embracing a change in the fundamental attitudes to life and work, in social, cultural and political institutions. Streeten mentions that this process aims at satisfying basic human needs where progress is expected in:

- Output and incomes;
- Conditions of production;
- Levels of living (i.e. nutrition, housing, health and education);
- Attitudes towards work; and
- Policymaking.

Criteria like these can be utilised by nurses when examining their own lives as well as for the lives of those they are caring for in the health care facilities.

Streeten's Basic Needs Approach (BNA) is similar to the hermeneutic approach which looks into development as a move to increase humanness, satisfy human needs and create the conditions for the realisation of everyone's personality (Coetzee, 1989, p 153).

It also relates to the list of criteria by Nerfin (1977) for the fulfilment of non-material needs like togetherness, long-term friendship, leisure time, new challenges (as in health challenges) creativity and self-reliance, joy, meaningful life and total well being (Coetzee, 1989, pp 101-102).

Social development makes room for nursing or health development as well. Nursing education undergoes change to prepare nurses for practice among the members of developing or changing communities. The curriculum changes, more courses are added and more specialisations are introduced.

Throughout the world, development of countries is also seen from different spheres and world organisations combine efforts to bring about development. A report compiled by the World Health Organisation (WHO), the United Nations Development Programme (UNDP) and the World Bank (no date given) has highlighted important developments achieved by powerful nations including those in the field of health (Meguid, 2001, p 14).

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The World Health Organisation has looked into countries' performance with regard to infant mortality from 1952 to 1992 (a forty year period). The World Health report of 1999 indicated improvements in four countries as predicted in the 1992 report, these being, Botswana, Cape Verde, Kenya and Mauritius. All other listed countries had infant mortality rates, which were higher than predicted (WHO 1999). This comparison indicates the contrast between health development and underdevelopment (Meguid, 2001, pp 13-15).

In the afore-mentioned development programme the goal was to reduce poverty, which in turn influences health. Sustainable development does not only generate economic growth but also distributes its benefits equitably, which regenerates the environment rather than marginalising it. Sustainable development gives priority to poor people, expanding their choices and opportunities, and provides for their participation in the decisions, which affect them. Such development is pro-poor, pro-nature, pro-women and pro-children (UNDP, 1998 in Meguid, 2001, p 16).

Development involves people, and is a process for three categories of respondents namely: the policy makers; theorists (scientists); and the "ordinary masses". The third category of respondents is normally at the receiving end and does not take part in formulation of policies affecting them (Coetzee, 1989, p 123).

The development of society includes the design and implementation of humanist development under three criteria, which are creative participation, bringing (raising) to consciousness and reflexivity (Coetzee, 1989, p 128). This goes together with the four dimensions of the primary health care approach, which involves concepts like accessibility, affordability, equity and community involvement (MoHSS, 1992).

Sociology of Development focuses on the dynamics of social and industrial development in Namibia, and is theoretical while also exploring the main approaches to understanding industrial development and modernisation. The theoretical foundation allows for an in-depth analysis of colonialism (dependency theory), modernisation and its impact on health status in Namibia (UNAM, 1995, p 132).

In the above-mentioned module nurses learn to understand the characteristics of huge imbalances and disparities with respect to access to resources and services (UNAM, 1995, p 327), analysis of any changes and differences between the pre and post-independence health-care delivery system. By anticipating the dynamics of social change, it empowers nurses to be able to identify the influences that such developments may have on practice in nursing and the whole care delivery system.

This development can be considered as the development of the self, whereby the nurse develops additional ways of knowing and new skills for communicating with others, while applying these skills to real life. She develops skills not only in communication by speaking but also writing skills that can lead to greater productivity, self confidence and appreciation for her ability to work with other people from diverse backgrounds (Drago-Severson, 2004, pp 18-19, 129, 162, 178).

In the next instance the development theories from the three perspectives as mentioned earlier in this chapter, need to be examined. The functionalist perspective, deals with development as a process of modernisation. The conflict perspective (in its Marxist version), considers development to be a process, of both development and underdevelopment simultaneously, which leads to dependency. Under humanism or interactionism as it is known, development takes place in people's consciousness, that is, it becomes a process in mind of people as they interact with each other.

2.3.4 The sociological theories of development

The general view on development was expressed above without specific classification. Development is

not viewed in the same way by all sociologists or theorists. There are many views from different perspectives for explanation of how development takes place within societies. For the study of Sociology of Development by nurses, three main theories are selected and these are presented below.

2.3.4.1 Modernisation as a process of development

In functionalism, development is seen as a process of modernisation and the theory is therefore termed modernisation theory, and also known as convergence theory, according to McNall & McNall (1992) and WW Rostow(1960). System theory (functionalism) through its modernisation process creates an image of an orderly system with equilibrium based on comparison with biological organisms and using biological language were homeostasis is achieved. As Dunlop states in "Employee Relation" (Hollinshead, Nicholls and Tailby, 1999, pp 29-34) collective agreement influences and shapes employee relations at any given moment and into the future, until such time that a new set of agreements displaces it.

According to modernisation theory, development is seen as a process of social change from a traditional to a modern state. This change is about achievement and a transition from a traditional to a modern society through a process of cultural diffusion from more advanced sectors of the world, that have been exposed to modernity (Webster, 1990, pp 50-52; Hoogvelt, 1978, pp 50-51).

Zapf (2004, pp 1-2) defines modernisation as a mechanism of inclusion, value pluralism, differentiation and status upgrading (i.e. welfare development) and refers to the basic institutions mentioned by Talcott Parsons, these being basic societal inventions namely competitive democracy, the market

economy, mass consumption and the welfare state.

The idea of modernisation as a form of development from the centre (outside) to the less developed world is not exclusive to Western capitalism. Namibian nurses find themselves in the less developed world. Development in this case is seen as a process of economic growth, which makes provision for social reconstruction with respect to provision of freedom, equality, fraternity, satisfaction of basic needs, and general community growth.

Modernisation is in this case regarded as a bearer of salvation and total satisfaction of human needs. Modernisation is related to improvement and progress. It can never take place without any elements of progress although it may also lead to erosion (Coetzee, 1989, pp 4, 7). Namibia as a country in general and nursing practice in Namibia in particular also experience elements of progress and erosion simultaneously due to the development process.

This process is found to go hand in hand with redistribution, meeting basic needs, having basic services, alleviating suffering, participating in the development process consensually and being inspired by new values and norms in the state of science and technology for implementation of the future which is also applicable to nursing practice (Coetzee, 1989, pp 9, 180).

Whether change is progression or regression, it will affect the nursing care provided to those in need of it and cause change in the type of nursing practice rendered (Mellish, 1988, p 18). Mellish further mentions that scientific and technological development has occurred. Medical science has developed extensively with an increase in the numbers of medical (nursing) practitioners to total population

(Mellish, 1988, pp 21 – 22). These are all part of social development.

Nursing as a profession, is characterised by the use of theories from the sciences and other field of learning relevant to its practice. These theories are derived from the biological, physical, medical and social sciences (such as Sociology and Social Work) (Mellish, 1988, p 74).

Several theorists have contributed to modernisation theory in a number of ways. In this study, four sociological theories on social change are discussed, namely, the ideas of Emile Durkheim, Talcott Parsons, Max Weber and WW Rostow.

i) The theory of the division of labour in society

Emile Durkheim is known for his writing on the "Division of Labour". As a French man, who lived from 1858 –1917, he was the first professor of Sociology to sit in the academic chair for that discipline. His approach is evolutionary and comparative. He stated that societies develop from a simple state to a complex one, from being small to big or large-scale modern state of being. Traditional societies function according to "mechanical solidarity" while modern societies function according to "organic solidarity with advanced technology and economic complexity, urbanisation and industrialisation (Webster, 1990, p 44).

In Namibia nursing services has developed from a simple form to a more comprehensive one. Van Dyk (1997, pp 12-13) outlines this development in her History book. She mentions the importance of the

services rendered by missionaries between 1800 and 1899 in particular by the London Missionary Society and Rhenish Mission Society (1997,pp 58-64). The latter-mentioned missionaries were followed by the Roman Catholic Mission and the Finnish Mission, especially in the North of the country. The mission played important roles in health care and also in the training of nurses. Nurses were trained as auxiliary nurses (1997, pp 74, 104 105) and later fully enrolled nurses under the South African Nursing Council. Upgrading of qualifications was later achieved by training professional nurses and midwives from 1960 in Windhoek (1997, p 105) and from 1967 in Owambo at the Oshakati State Hospital (1997, p 111). This training laid the foundation for the training of many cadres until University training was started at South African Universities and later at the University of Namibia (1986), where nurses can even obtain their degrees up to Doctoral levels. This is in line with Durkheim's conception of expanding complexity as societies evolve.

A traditional society has a limited division of labour and a modern society a progressive and extensive division of labour that can be compared to the delegation of duties in nursing. In modern society there is differentiation of structures (sectors), and specification of functions (specialisation) (Webster, 1990, p 45; Giddens, 2006, pp 707, 710, 713; Haralambos, 1995, pp 184-186, 907; Allan, 2005, pp 133, 137). The same situation is observable in nursing practice in Namibia where nurses specialise in different disciplines and are trained at the University of Namibia or at universities in other countries.

By differentiation, Durkheim meant that individuals are not the same and because they are different, they achieve consensus in the form of complementary agreement. Each new phase of differentiation requires solidarity and integrity of society. Organic solidarity can be compared to the organs of the human body, which are different, but still work together (Allan, 2005, p 102). This type of change takes place as shifts in the social density of society. When social density changes social differentiation

occurs because of the struggle for survival. The division of labour then becomes more complex and creates interdependency among people (Watson, 1990). Nowadays, nursing practice in Namibia is based on differentiated training at university level. In practice, nurses are allocated into units of different facilities and case managements. They therefore need specialised knowledge and skills to deal with specific cases. A nurse in a maternity unit has different functions from one in a psychiatric unit as far as observation, assessment, nursing diagnosis and care are concerned.

ii) The Five Pattern Variables

Talcott Parsons also made a contribution to the theories of development by developing the concept of "pattern variables" which denote an alternative pattern of value orientation in the role expectations of actors in a social system. In these dichotomies a semantic and typological analysis was made whereby five contrasting pairs of value orientations are set out which reflect behaviour and role relationships of the individual actors in societies. The five pattern variables are discussed in pairs according to the two types of societies found to be on a polar line of representation in the development process. These five pattern variables are:

- Affectivity versus affective neutrality;
- Collective orientation versus self orientation;
- Ascription versus achievement;
- Generality versus specificity; and
- Individualism versus universalism (Coetzee, 1989, p 25).

These variables are concerned with the following:

- The motivational basis of action in the role relationship;
- The value standard of the role content;
- The evaluation of the role incumbent; and
- The scope of the role relationship.

The motivational basis deals with variables of affectivity versus affective neutrality and collective orientation versus self – orientation. On affectivity, Parsons describes how the people in society react emotionally to affairs that do not affect them personally, such as the death of a neighbour, which can prevent them from fulfilling their daily activities. In contrast, affective neutrality is typical of modern societies where people are affected by events of their own personal concerns, for example, the death of a member of the family. Nurses are expected to respond according to affective neutrality in order to cater for the needs of everyone without being biased.

Collective orientation is observed in societies that are traditional, where people cooperate to get work done together, while people in modern societies are characterised by self–orientation, where they are concerned with jobs that benefit them only.

The value standard of role content addresses the issue of role obligation in societies. In traditional societies, roles are fulfilled according to particular relationships between the members of society, where particular attributes are considered such as kinship and relatives. In such circumstances a person is accorded status if he/she is related to the person who holds or has held such status, for example

traditional leaders.

In modern societies people acquire status only on the basis of certain achievements or if they have fulfilled certain requirements, for example to become a teacher, a nurse or even a minister in the government sector, where the serves all who are in need of her/his service.

The evaluation of role incumbent looks into the issue of achievement only and does not ascribe status on the basis of relationships as in the previous description.

Finally, modern society is characterised by functions that are based on specification and specialisation in such roles and not just on functioning in a general context which is what happens in traditional societies where one person can assume different roles at the same time (Hoogvelt, 1986, pp 55 – 57). Nurses provide nursing care as their specialisation and differ from musicians or technicians even when they are functioning in one sector or health care unit.

iii) The Protestant ethic and the spirit of capitalism

Weber's work on "The Protestant Ethic and the Spirit of Capitalism" has direct relevance to contemporary theorising about development. It is a coherent tradition of application to non-western society and to empirical research.

According to Weber "the appearance of Capitalism – rationality of production with a view to indefinitely increasing in production – required human attitude which can only be supported by an ethic

of world by asceticism" (Aron, 1979, p 227). He defines capitalism as "an economic system that harnesses free labour machines and rational profit seeking entrepreneurs in the context of an organised market to the quest for profit that is reinvested in order to expand the business" (Young, 1983, p 95). Weber points out the influence of Protestantism in especially the Calvinistic and Puritanistic societies. These sects went on to develop the idea of vocation, that is, an occupation for each person to praise and glorify God (Stockard, 1997, p 16).

Rationality, which is akin to the protestant ethic, indicates a separation between tradition and modernity. This rationality facilitated the emergence of capitalism and modernity through the successful expansion and spreading of the capitalist mode of production.

Weber's book stresses the role of Protestantism especially of Calvinism in the development of capitalism. Capitalism is the backbone of nursing care, therefore it is the backbone of nursing practice. Without capital no health care can be delivered and no nurses can practice.

Calvin criticised the catholic practice of penitence and formulated his own religious doctrine of predestination, which says that people's destinies are already determined while on earth. A person cannot do anything to influence his destiny.

Though there is no possibility of changing pre-destination, a person should try to struggle for a sign of God's blessing on earth. This struggle brings about social change as a form of development. Investing capital, working hard, not wasting profit on luxuries but re-investing it, in praise to God. This leads to the successful accumulation of capital and can be understood as God's blessing and a hint of positive

destiny (Stockard, 1997,p 16). The same principle of hard work and not wasting resources is applicable to nurses with regard to patient care during their clinical practice.

Rationalisation makes this practice possible and changes people's mentality from mysticism or magic to scientific. This type of change is economic and cultural change. This religious concern was shared by many Protestants and helped to fashion the work ethic in Europe, which led to the development of modern capitalist society (Webster, 1990, 46 – 48). For the latter reason Weber is said to have believed that change in individuals' motivations and beliefs, influenced the advent of capitalism. The issue of reinvestment is not an automatic one, but depends on individual will to reinvest. People concentrate on long-term economic success (Stockard, 1997, p15). A nurse in practice needs motivation and belief in what he/she is practicing, in order to achieve service goals by utilising capitalism.

iv) The five stages of development

Modernisation theory developed in the mid 20th century largely due to the work of Walt Whitman Rostow who stated that economic development encourages political development and the two become compatible (http://faculty.hope.edu/toppen.pol242/pages/theory/topic1.htm, accessed 10/6/2006).

Rostow describes development from the structural-functionalist point of view. He sees social change as a process of diffusion and innovation, which allows social institutions/structures to increase their capacity for adaptation towards an equilibrium of greater consensus. Through orientation, nurses adapt to the practical situation and find the ways in which they can practice better nursing to achieve their goal, which is a "healthy mind and healthy nation."

In his writing, Rostow (1960) “The stages of Economic Growth: A non-communist manifesto”, a five stage model of how less developed countries develop into wealthy nations was captured. Rostow’s development concept is based on the model of modernity, modernisation being a process of change towards the condition of modernity.

Modernity implies:

- Conceiving social change as progress and progress as a process of linear and continuous change;
- Conceiving development primarily as economic and mostly in terms of growing national product and public services; and
- Modern social structures within the frame of social stratification and specialisation of functions.

Rostow explains development in terms of “stages of growth” which are a harsh break with colonial exploitation in several continents. Rostow identifies the five stages of development that can be used to classify societies as less developed, developing and developed countries. Those stages are:

- The traditional stage;
- The transitional stage or the preconditions for take-off;
- Take-off into economic growth;
- The drive to maturity; and
- High–mass consumption.

During all these stages, certain societal changes are observed. From the traditional stage with no growth or signs of development observed, the next stage is entered into where the economy is growing, differentiation and technology is introduced into society, followed by western ideas and economic progress with investment of no less than 10%, the building up of national infrastructure in communication, transport and social services like health and education. This marks the transitional stage.

The third stage follows with overcoming of barriers to economic growth, more investment, manufacturing and mechanisation with increased capital accumulation. Industries begin to appear. Growth becomes self-sustaining and technology improves and becomes secure.

The fourth stage of growth known as the drive to maturity is characterised by production of wealth on a more self-sustaining basis. This improves social welfare (e.g. health and education). Investment rises from 10-20% of national income and the economy finds its feet in the international arena.

The fifth stage of high mass consumption looks at further advancement and consolidation. Wealth can be concentrated in individual consumption, or be channelled into welfare and used to build up global power. All these changes that take place at the different stages of development are mirrored in the health sectors, which include changes in nursing practice to keep up with the community development.

There are a number of critiques of modernisation theory. It is criticised for its cultural bias (and discredited for being pro-West) because it was written during the time when only the United States and Europe were considered “advanced” (retrieved and accessed from

http://www.tcw.utwente.nl/theorieenoverzicht/Theory%20clusters/Media on 10/6/2006). The Latin American countries, for example were considered undeveloped and found modernisation to be inapplicable to their situation and at that time the same applied to African and other peripheral countries. This is the reason why dependency theory came into being (http://faculty.hope.edu/toppen.pol242/pages/theory/topic1.htm, accessed on 10/6/2006).

2.3.4.2 Dependency as a process of development

Dependency and underdevelopment are terms, which are dealt with simultaneously in the description of Andre Gunder Frank's theory as set out below (McNall & McNall, 1992, 461). Development or social change according to this perspective is seen as a process whereby one society or group develops at the expense of another, while the latter does not develop or could even be viewed as being underdeveloped. The developing society becomes ever richer, more advanced and attracts more benefits while the other country/society or group becomes poorer, less developed or under-developed (Webster, 1990, p 85).

According to this perspective, development is viewed in terms of the relationship between two or more societies. This relationship is characterised by one society being dominant, oppressive and exploitative. Whatever is being produced or achieved is shared unequally and unevenly.

The relationship of inequality can be viewed as a spectrum where the disadvantaged group falls on one end and the advantaged group on the other. This creates a state in which one group or society is dependent on another on an exploitative basis, therefore the theory is known as dependency theory.

Dependent countries are those, which lack the capacity for autonomous growth, and they lack this because their structures are dependent ones. This interrelationship leads to a situation where some countries expand at a faster rate than others, while others lag behind and only manage to reflect the growth of their dominating neighbours. Dependency as a limiting factor does not only set the margin for development but also determines the type of development in the dependent countries (Coetzee, 1989, pp 56 – 57).

This relationship advances in such a way that the exploited and dominated side becomes dissatisfied and struggles for its rights and benefits. This struggling leads to contradictions, which create conflict. Conflict is thus inherent in such societies where inequality, domination and exploitation are prominent. That is why the theory of dependency is born out of a structural theory known as conflict theory.

To come back to development, dependency theory deals with the type of development which is dependent, leading to underdevelopment, related to suffering, poverty, and causing some members of society especially women and children to lag behind.

For an understanding of dependency from the development point of view, a grasp of the inner meaning as highlighted in the general description of the theory is required.

Paul Streeten (1979) redefines development as an attack on the social evils found in the world, these being malnutrition, disease, illiteracy, slums, unemployment and inequality.

The decline in living standards and increase in unemployment have an impact on the incidence of suicide, divorce and admission to prisons (Cohen & Kennedy, 2000, p 139). All the consequences of dependency affect the health of society and put more burdens on the health care delivery system where nurses practice. Health care services need to develop in order to fulfill the health needs of society and thus nursing practice has to be shaped according to those needs. Nursing education therefore undergoes change or development to equip nurses with the necessary knowledge and skills for practice.

Dependency has developed from exploitation, which has taken place through three different stages or phases, the merchant capitalism, colonialism and neo-colonialism.

During the era of merchant capitalism, traders or merchants came from their countries to trade with countries in the new world. These trading relationships were exploitative and involved an exchange of goods of low quality for raw materials and sometimes slaves. The result of these trading relationships was poverty, underdevelopment, underpopulation and death.

The colonial phase was born out of trade, when traders started to settle in countries of the new world in order to exploit them more effectively. The colonies served as sources of raw materials needed in first world countries, but these raw materials were procured at low prices and sold at a profit, creating increasing wealth in the first world. This accumulation of capital by westerners led to further underdevelopment and poverty in the new or third world. This situation has caused the third world to remain dependent on first world countries for its existence and survival.

The neo-colonial phase is a new phase of colonialism, where third world countries have political independence, but they still depend on the first world economies because their own economies have been exploited and depleted, causing low economic development rates (Webster, 1990, pp 70–80).

Uneven development may be the result of industrialisation, urbanisation and commercialisation. The rural poor become tied to global markets and are unable to produce for subsistence or even for consumption in local market. This leads to food insecurity (Cohen & Kennedy, 2000, p 141).

Examining the work of a proponent of this theory, Andre Gunder Frank, the concept of dependency can be further explored. According to So (1990, p 92), Frank has played an important role in spreading the ideas of the dependency school.

Every stage of the dependency and exploitation process poses a challenge to the heath care delivery system and to nursing education as well.

i) Frank's theory of third world dependency

Andre Gunder Frank(1960's) is of the opinion that persistent poverty in the third world is a reflection of its 'dependency'. He argues that the eras of merchant trade and colonialism laid the basis for exploitation of raw materials.

During these phases the imperial powers were the intermediaries between rich purchasers and poor (peasant) producers. These intermediaries functioned between the people of the third world countries and merchants, helping merchants to expropriate wealth from the colonies.

The people of the third world “suffered the chronic deprivation as their surplus production is taken from them in the local rural region and transferred to the rich farmers and merchants in their own country and then on abroad” (Webster, 1990, p 85).

This was a chain of dependency from the highly advanced centres (metropolises) with their subordinates in the periphery (satellites), by means of which raw materials and wealth were passed upward within the nation and then internationally. This is what Frank means by development (in the centre) and underdevelopment (in the periphery) occurring simultaneously.

He also states that even if there is some kind of development that occurs in third world countries, it remains a “dependent” development. A solution to this problem according to him is to break the chain of dependency through socialist revolution to remove the comprador elite (Webster, 1990, pp 85 – 86).

The impact of exploitation on the community can also be observed in nursing practice. Stated differently, in many countries, nurses in practical spheres, including nurses in Namibia, are subjected to exploitation by high ranking officials, supervisors and their employers.

2.3.4.3 Development as a process of consciousness

In the theory of interactionism, development is seen as a process, which takes place in people's consciousness, and that development is for people by people. Due to the fact that development takes place when people become aware of changes within their social environment, human beings are constantly confronted with negotiations, which are concerned with what is happening in their society. Development is a change in social reality and people know and understand that reality.

Development from this perspective is seen as a process by which society is constantly engaged in fashioning its ways of life. For a humanist thinker, change does not mean replacement of one structure by another, but rather the ongoing construction of communal life as an intersubjective process of consciousness.

i) Assumptions on the problem of development

There are several assumptions to this theory. All these assumptions are applicable to nurses, to nursing education and nursing practice as well. The assumptions are summarised and discussed below.

- **Social reality is rooted in consciousness:**

People live consciously, and assign meanings to their relationship with the world around them and with themselves. For them, society is a process of negotiation, in which meaning is constantly assigned to what goes on around them. People, including nurses, are aware of the alternatives and know various

possible directions from which they can choose (Coetzee, 1989, p 110).

- **Social reality is of necessity incomplete:**

A creative person will never find a complete world but constantly construct his or her world. This is done in conjunction with others and never in isolation, therefore constant negotiation is necessary. Social symbols are completed in the human mind and people experience these same symbols differently. In this view life is a continuous dialogue (Coetzee, 1989, p 111).

- **A human being is co-responsible for society:**

Negotiation within society leads to a situation where all human beings are kept responsible for its existence. When exercising freedom of choice people become responsible for the decisions that they make.

- **As a process of consciousness, social reality operates dialogically:**

This statement by implication refers to the implementation of consciousness and therefore, of necessity, to the construction of a dialogical structure for society. Development can therefore be formulated as a process whereby a conscious effort is made to establish a way of life in society, which is dialogical of nature (Coetzee, 1989, pp 119, 120).

ii) Humanist development can be implemented as a strategy

For design and implementation of humanist strategy certain criteria are identified:

- **Creative participation:**

Those involved in development participate in their own process. Plans should not come from outside but from within. Planning should be human-oriented, and not result–oriented. All sectors affected by change should be fully involved.

In nursing, there is a constant reminder of community involvement, which forms the main component of Primary Health Care (MOHSS, 1992, p 5). Community involvement and participation in the planning of primary health care facilities ensures that real needs are met, that potential is developed within the community, and that communities are made less dependent. By means of the latter, public commitment and trust are promoted. The requirements for community involvement are political commitment, availability of basic infrastructure (facilities and staff), logistical support from outside and the ability to establish local government structures or local organisations to run these affairs (Gilbert et al, 1996, p 179).

Factors affecting full participation should be considered. Every person should exercise his own right and ability and plans should not be forced upon people.

- **Bringing to consciousness:**

All respondents should be made aware of the impact of the development programme. This implies that external factors must be assimilated into the consciousness of respondents. Creative participation

cannot take place if respondents are not made aware of their own fate and the importance of their involvement in the development programme. This process brings forth the true sense of development, which goes hand in hand with an experience of marginality or anomie because the condition of bad faith is never painless. Human beings have the ability to criticise themselves and change the meaning that they have assigned to certain symbols and circumstances.

The Basic Needs Approach (BNA) and the dialogical intervention approach can be used as a strategy for development.

- **Reflexivity:**

Reflexivity refers to the fact that, in terms of the humanist approach, social reality is always becoming (open) reality in the sense that it is "uncompleted". In the process of development, all the respondents should tackle their task in a spirit of humility, in the knowledge that even the best arrangement is subject to constant re-evaluation. The development of dialogical consciousness increases the degree of reflexivity (Coetzee, 1989, pp 122-128).

The relationship between the perspectives of sociology, the general theories and the theories of development can be explained in table form as set out below by the researcher.

Table 2.1: Illustration to indicate the set-up of perspectives and theories used to explain the process of social development as per curriculum

PERSPECTIVE	FUNCTIONALISM	CONFLICT/MARXISM	INTERACTIONISM
Theories of Development	Modernisation	Dependency	Development as a process of consciousness
Values	Highlights: Change for the better Simple to complex Small to big/large With specialisation Specification and change in attitudes of community members	Exposes: Relationship in development With regard to development and underdevelopment With dependency Suffering, poverty and lagging behind of women and children	Emphasises: Development in the consciousness of the people Constant exchange of ideas with basic needs approach to all people (including women)
Knowledge	Change in nursing science from where to now, new development current practice, personal development (including practicing nurses)	Nursing science and other professions Scope of practice to nurses: inter-professional relationship	Awareness, self-concept, negotiation, dialogical living together and community participation

2.4 Women in development

In African society, women have lesser status than men. There are many factors that have influenced

traditional sex roles in Southern Africa. The first well-known factor is colonialism. Colonialism has impacted African society in two ways:

- It subordinated indigenous social structures to those of Europe. Traditional African sex roles which favoured men were strengthened by European rulers who were patriarchal in their orientation.
- It turned Southern African into a large-scale producer of minerals and agricultural products, which were exported to Europe and North America. It led to urbanisation, with urban areas being characterised by a higher ratio of men to women than rural area. Thus the sex ratio was affected.

Rural women work longer and harder and do more manual labour thus struggling against formidable obstacles, compared to men and even other women in urban area. The responsibilities of women differ according to age, country and region. In the Okavango region women's domestic tasks differ according to their position in the family, their age and their number of children. Older and much younger women do not work (Sociology lecture notes).

The world system (globalisation) brings about more poverty. According to the UN Copenhagen Summit on Social Development in March 1995, more than one billion people in the world live in degrading poverty and disproportionately more are women, children, single parents, unemployed, disabled and elderly people (Cohen & Kennedy, 2000, p 137).

Even though women are in subordinate positions, they work harder than men in the reproductive, productive and community spheres but receive less benefits than men. The role of women in contemporary society is vast but women's benefits are low compared to those of men. They are

most often subjected to income inequality and cannot promote their own self-interests. Such conditions adversely affect the health status of women (Wallace & Wolf, 1999, pp 418 – 419).

Moser uses two approaches to women in development, these being Practical Gender Needs (PGN) and Strategic Gender Needs (SGN). PGN are needs that help women to perform their subordinate roles. These include provision of water or food to family, housing and other basic needs. SGN are needs which can lead to transformation of the roles between men and women, and can thus lead to equality.

In the Namibian National Gender Policy (NGP) and the National Plan of Action on Gender (NPAG) in 1998, the issue of women and development was highlighted. These two documents also addressed the problems of the disabled. The main issues covered in the documents are:

- Poverty and rural development;
- Education and training;
- Reproductive health;
- Violence against women and children;
- Economic empowerment;
- Power and decision-making;
- Information and communication;
- The environment;
- The girl-child; and

- Legal affairs.

The Department of Women Affairs monitors the progress of women and men under the policy (NGP & NPAG, 1998, pp 1-2).

In rural areas women are mainly producers as already stated in previous discussion. Women in Namibia do not have as much access to economic power as men do, therefore they are affected by poverty. The same applies to persons with disabilities, who do not have as much access to economic opportunities. The government of Namibia has promised to reduce unemployment amongst women and to help women stay employed on a long-term basis in sectors such as agriculture, mining and fishing. This strategy requires both the governmental and private sectors to improve health education and social services for girls and women, especially the disabled. On the basis of these issues the Gender Fund was established (NGP & NPAG, 1998, pp 3-4).

The issue of unemployment affecting women more than men, has been raised by Popenoe (1998), who indicates that in South Africa, for example, the unemployment rate ranges between 20% and 60% with a 25% 'formal' unemployment rate. Unemployment is higher for the rural population than for the urban and higher for women than men in race categories. This is highlighted in figure 2.2 shown below (Popenoe, 1998, 376).

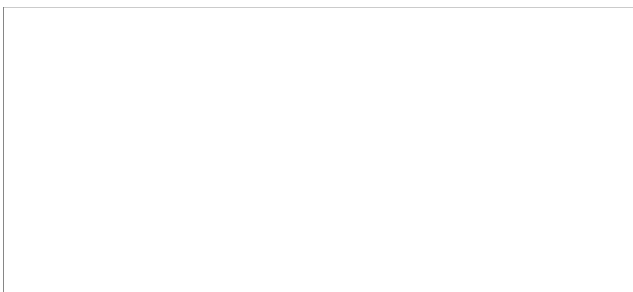


Figure 2.2: Unemployment by gender and population group in South Africa

The picture, though not exactly the same as in Namibia, explains the issue of gender discrimination against women (Popenoe et al, 1998, pp 375-376). According to Finnemore and Cunningham, the participation of women in the South African labour force increased from 23% in 1960 to 39% in 1994. This development was seen as a sign of broader demographic and occupational change (Popenoe et al, 1998, p 387).

Likewise, in America unemployment amongst women has historically also been based on discrimination. Women wanted to work but could not find employment. According to the U.S. Bureau of Census', Statistical Abstract of the United States 1976, in 1950 the total number of married women in the labour force 23.8%, 30.5% in 1960 and 58.5% in 1991 (Lauer 1995: 272).

It is also mentioned that in America women attempt to achieve a greater degree of equality in career advancement, but people tend to evaluate jobs in terms of the gender of workers. Women's work tends to be valued lower than men's work (Lauer, 1995, p 274). Women's work is also not observable, because it is mostly performed at home (Coltrane, 2000, p 57).

In Africa, women are viewed in terms of the power process and structure in their communities. Men are the heads of families and the owners of properties which are mostly produced by women. Women have to submit to what the head of the family wants done or accomplished, but they have no right to own property. That is why women in Africa are mostly the poorest of all members of society, and usually even poorer than their sons or grandsons (Kayongo-Male and Onyango, 1994, pp 27-28).

Parenting and gender inequality in many countries is also prevalent. Girls are encouraged to be kind and caring while boys are encouraged to be independent and aggressive and these characteristics are carried into adulthood. Nowadays it has become acceptable for boys in families to be raised to be caring and responsible fathers (Coltrane, 2000, pp 129-130). As families become industrialised and urbanised, poor families change from proletariat to bourgeoisie as part of the process of transformation and the relationship between men and women also changes accordingly (Burguiere, Klapisch-Zubar, Segalen and Sonabend, 1996, pp 378 – 399).

In Namibia gender balance in education and training has been considered when formulating gender policy. Women have the right to safe sex and a satisfying sex life and have freedom to decide when to have sex (NGP &NPAG 1998, pp 5, 7-8).

Violence against women in all sectors, whether sexual, physical or emotional, is rife in Namibia and bills aimed at combating such violence have been passed. Examples are the Rape Bill, the Domestic Violence Bill which have been tabled and the Women and Child Protection Units which have been established in all regions in the country (NGP & NPAG, 1998, pp 11, 13).

Domestic violence is violence that takes place within the family or inside the home. Domestic violence is sometimes called "battering". When it takes place between husband and wife, it is called "wife abuse" or “spouse abuse”. When children are the victims, it is referred to as "child abuse" (LAC, 2005, p 6).

Domestic violence is one of Namibia's most serious human rights problems. Medical personnel interviewed in a recent study indicated that almost half of the women and children that they treat show signs of being victims of domestic violence (LAC, 2005, p 7).

A study of police dockets shows that at least one-fifth of all violent crimes in Namibia occur within domestic relationships. The elimination of domestic violence would go a long way towards making Namibia a more peaceful society.

2.4.1 What causes domestic violence?

Sometimes people who are experiencing problems, such as unemployment or financial worries, take their frustrations out on women and children. Alcohol and drug abuse can also contribute to abuse. Abusers sometimes come from homes where they were also abused. Abuse of women and children is considered by some people to be socially acceptable. Children are small and weak. Sometimes people abuse them because they want to feel powerful and strong (Schoolnet, Rehoboth 2006).

A study done through the Usakos School Project has revealed the causes of abuse of women and children. In many cases handled daily by the police in Windhoek, jealousy contributes a great deal to the abuse of women and children. Sometimes alcohol also contributes to the abuse of women. Some men try to drink their problems away and vent their frustrations by beating up their wives and children.

In some cases, drug abuse also contributes to the abuse of women. When a man feels that his ego is being threatened, and while under the influence of drugs he is more likely to hurt a woman in order to soothe his ego, which is no way of showing that a men are superior.

Abuse can also be caused by the husband’s jealousy towards children, because they get all the attention from his wife. In such cases, he might abuse his wife in order to punish her for not giving him any attention (Study Schoolnet, Usakos, 2006).

Cases of abuse of women in Namibia have been observed in the north east of Namibia, where many women are exposed to harassment and even abduction on a daily basis.

The National Conference of Men against Abuse on Women has formed a steering committee comprised of volunteers from all regions, in Namibia except for Caprivi. Until now, violence against women in Namibia has been viewed and treated as a women's issue. On 16 July 2001 a young woman of 22 years was attacked with a 'panga', had her throat cut as well as her fingers on the left hand slashed. These injuries were inflicted by a male. Although women can be violent, it is women and children who are most often the victims of domestic violence at the hands of men (Schoolnet, Rehoboth, 2006).

According to the World Scouts Bureau (2007), domestic violence research has been conducted by Namibian Scouts since 2002, and at present they are busy with a program known as the 'Gender Research and Advocacy Project' (GR&AP). In 2004-5, the GR&AP worked with service providers to produce Guidelines on the Implementation of the Combating of Domestic Violence Act for police, social workers and counsellors, the medical profession, prosecutors, and magistrates. The GR&AP also produced an updated version of the Namibia Domestic Violence and Sexual Abuse Service Directory.

In 2005, GR&AP completed educational material on the Combating of Violence Act in English, in the same format as the popular material on rape, which is a detailed Guide to the Combating of Violence Act, aimed at service providers and counsellors, as well as a shorter summary of the Combating of Domestic Violence Act for the general public.

The Scouts in Namibia (2006) report states that, domestic violence is widespread in Namibia. It occurs amongst the rich and poor and in all ethnic groups. Most Namibians do not know the extent of domestic violence and child abuse and when someone is being abused they do now know what action to take. In 2002 the Namibian government declared domestic violence illegal whether it is physical, sexual or economic abuse, intimidation, harassment, emotional, verbal or psychological abuse, including exposure of children to seeing or hearing such abuse. The government's declaration

is aimed at raising the awareness of domestic abuse in the community and giving adults and young people skills to manage conflict without violence.

It was mentioned that the scouts aim to help break the cycle of domestic violence in homes in Namibia. Children growing up in violent families often develop emotional and behavioural problems. These children are more likely to use violence themselves, because they believe that this is the way to solve their problems. Violence increases the unequal relationship between boys and girls and women and men.

Starting 2006, the educational material on domestic violence has been translated into indigenous languages and disseminated widely through government and NGO networks and in workshops (Scouts in Namibia, 2006).

Among the main issues addressed in Namibia's Gender Policy is the balance of power in decision-making. Women in Namibia face high levels of discrimination and policies do not fully address this issue. The inclusion, involvement and participation of women in decision-making, and their election as officials will redress the problem. Women with disabilities should be included in such positions (NGP & NPAG, 1998, pp 17-19).

The issues of inequality between men and women as well as domestic violence have a great impact on the health care and nursing practice. Nurses are taught about these issues because they will be faced with these problems when caring for patients and clients and they themselves may also be personally affected. They must know what type of social challenges to expect and how to act in the face of such situations.

2.5 Development and Health

Development and health are related. The factors that influence the health of communities are the same ones that influence development. This relationship can also be stated differently, that is, for development to take place, the community should be healthy, and the achievement of community health is through the process of developing such health.

Development has led to many outcomes, to mention a few such as rapid population growth, migration and urbanisation. As population grows, the needs for care also increase. The HIV/AIDS pandemic has changed the health care system significantly and placed great burdens on health care facilities (Bezuidenhout, 2004, pp 198 – 203). This is the reason why the issue of social development as related to development in health care needs to be examined.

In order to effectively analyse above-mentioned relationship, an intra-sectoral as well as inter-sectoral collaboration or team approach is needed. The latter type of approach is an integral part of Health Services (The challenge in implementing PHC, 1995, pp 10-12).

Another example of development in health is the Integrated Health Care Delivery: The Challenge of Implementation Programme that was initiated in 1995, under the PHC approach. One of the goals of this programme, is to overhaul all the PHC facilities so that they can deliver a daily comprehensive package of services popularly known as the "supermarket approach" and not individual services on specific days. Nurses are trained as multipurpose health workers. (MoHSS, 1995, p 49). The latter is

an example of how the aspects of health care and development are dealt with in the same sectors and make health and development interdependent and interrelated. Neither of the two can be treated or dealt with in isolation.

The inter-relationship between health care and development can be illustrated in the form of wheel known as the wheel of development equals the wheel of health as shown below.

Figure 2.3 Wheel of development = Wheel of health (MOHSS, 1996, p20)

2.6 SUMMARY

Sociology of development deals with the development of societies. Every society undergoes a certain development at its own pace. This development is described and discussed in Sociology from different points of view, which are known as "perspectives".

For the purpose of this study, only three theories are considered as they are taught to student nurses in Namibia, namely the Modernisation, Underdevelopment or Dependency and Development as a Process of Consciousness theories.

The conceptual framework for this study is based on the above-mentioned theories and the content of the curriculum for sociology of development, which student nurses follow. The emphasis is placed on women and development. Because Sociology of Development is in this case taught to nurses, the relationship between development and health is also considered to be an important aspect to be included in the framework.

The literature reviewed in this study, deals with development in general, theories on social development, how development takes place with regard to women as well as how development is

related to health and vice versa. The empirical investigation will then address these aspects of the conceptual framework in collecting information from the registered nurses in the study sample.

It is evident from the literature and sources consulted, that development brings about change in society, this change can either be progress or regression. In some societies development has caused both improvement and deterioration at the same time. This duality is due to differences in groups within society brought about by the state of inequality, discrimination, exploitation and oppression. Not all the theorists and sociologists, politicians and economists view these issues from the same perspective. Some authors observe society critically while others only see the positive parts of the process. For example, modernization looks into development as a process of progress and mainly from the positive point. They do not mention any exploitation, discrimination and equalities that go together with social development as in dependency theory.

Dependency theory look into development as a process of inequality and exploitation and does not look at the positive impact that development has in many society and the improvement in ways of life for many individuals. Interactionism emphasizes freedom the person has to develop and the issues of discrimination and domination is lost sight of.

Further to the above it is apparent that nursing practice as a process of health care delivery cannot remain untouched by the process of development that takes place in society. Factors that affect the community will obviously affect their health as well as the health care delivery system.

A large part of this study entails research conducted in order to get information concerning the knowledge gained by nurses from their study of Sociology of Development and how they relate

development to health. In the next chapter the methodology and research design are discussed.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapter presented a detailed literature review, and the concepts and relevant statements that guided this study. That chapter gave the researcher direction with regard to what to look into, what type of questions to ask and the topics which need to be covered in the investigation process. It further spelled out which methods are applicable to the study.

This chapter deals with the research methods and strategies employed, the identification of the research population and sampling, the instruments for data collection, the methods of analysing data and the decision attached thereto. The study is divided into three phases.

In order to formulate strategies the situation must be analysed in order to see what is done by the registered nurse with the content of Sociology of Development when practicing nursing and giving health care to patients and clients. This in turn enables the determination of strategies that can be implemented.

PHASE 1: EXPLORATION OF THE POSSIBLE CHALLENGES TO THE APPLICATION OF SOCIOLOGY OF DEVELOPMENT IN NURSING PRACTICE

3.2 RESEARCH DESIGN

The research design of this study is the quantitative explorative, descriptive design. This approach was selected to find out how the content of sociology of development is applied to the practice of nursing in the areas where nurses are allocated.

The study is descriptive as it tries to describe the application of sociology of development to nursing practice, as expressed by the respondents, which in turn serves as a starting point for the formulation of strategies (Bless & Higson-Smith, 1995, pp 42-43).

The study also attempts to describe what is happening in the clinical situation concerning the knowledge acquired in Sociology of Development and to give background information on the issues in question, that is, to describe what the nurses were taught in their training (Sarantakos, 2003, p 6).

It also describes what the registered nurses believed to be the relationship between Sociology and development in the clinical field of their practice. As trained nurses they are expected to be able recognise the knowledge from Sociology that has been most useful and how it relates to what they learnt from other disciplines. A survey was conducted on the registered nurses who have already completed their training at UNAM and who had Sociology of Development as a module. The aim was to determine how they apply the knowledge underlying social development in their practice.

A descriptive study is a factor-searching study, which can be used in the clinical area. It is a type of non-experimental research that focuses on obtaining information regarding the status quo of the situation and it usually conducted through direct questioning of respondents. The purpose is to

observe, describe and document aspects of a situation (Polit & Hungler, 1997, pp 168&456).

The survey was considered to be exploratory, because the researcher also wanted to have enough information about this topic to establish the facts by means of the responses from the respondents. As registered nurses it was used to find out whether the development aspects are due to the study of Sociology of Development. The fact that nurses are taught Sociology of Development, it was then necessary for the researcher to find an answer to the question as to whether Sociology of Development is being applied and what relevance sociology of development has on nursing practice.

The research is said to be contextual, because it was conducted in the context, or clinical environment where nurses practice their administrative, professional and educational functions and have to apply their knowledge of Sociology of Development where it is supposed to be applied. The research was conducted with nurses who were in a clinical situation, where the subject was directly applied and not in a simulated situation or out of context.

3.3 RESEARCH METHOD

A study was conducted using a questionnaire method because this is an efficient way in which data can be collected from a large number of people from the study population (Kirby, Kidd, Koubel *et al*, 1997, p 90). In this case, a number of fifty six (56) registered nurses participated in the study and gave different views, rather than hearing only from a small group which was trained in the subject or course.

The reasons for choosing the questionnaire for this study are:

- It can be sent through the mail;
- It can be completed at the respondent's convenience;
- It offers greater assurance of anonymity (Sarantakos, 1998, p 224). Seeing that the researcher was a lecturer for most of these respondents they could not feel comfortable if their identities were known to her and linked to the responses.
- It reduces the Hawthorne effect which is associated with the presence of the researcher or interviewer.

3.4 HYPOTHESIS

For this study the null hypothesis and the alternative hypothesis were formulated to establish whether there is a relationship between attributes. The null hypothesis stated that there was no relationship while the alternative hypothesis stated that the relationship did exist between different variables or attributes related to the grouping of nurses according to their settings.

3.4.1 The null hypothesis

Ho: There is no significant difference between the groups of registered nurses of different age groups, trained at different times and in different circumstances or regions with regard to the application of Sociology of Development in health care units.

3.4.2 The alternative hypothesis

Ha: There is a significant difference between the groups of registered nurses of different age groups, trained at different times and in different circumstances or regions with regard to the application of Sociology of Development in health care units.

The hypotheses state the significant differences between the independent and dependent variables. A specific null and alternative hypothesis was formulated for every independent variable and dependent variables. As there are seven independent variables, there are seven null and seven alternative hypotheses (as can be seen in chapter 4).

3.5 RESEARCH POPULATION AND SAMPLING

3.5.1 Research population

A population is described by Bless & Higgs- Smith (1997 p 64) to consist of people who are to be studied and from whom the data are to be collected. The unit of analysis in their description is the person, with specific attributes about which the researcher wants to collect data. In this study, the population is described as registered nurses who completed their training at the University of Namibia during the period 1989 until 2001. As part of their studies they should have had successfully completed Sociology of Development, as this is the specific attribute of interest, or more specifically, the principal inclusion criteria. During the delineated time frame a total of 1099 nurses have completed their training, and thus met the ***<u>first</u>*** *inclusion criteria*

*A **second** inclusion criteria stated was that nurses who had met the first criteria should be employed in any of the following hospitals post training, namely:*

- *The Windhoek Central Hospital*
- *The Katutura Hospital (Also inWindhoek)*
- *The Oshakati Hospital in the northern part of Namibia, and*
- *The Onandjokwe Hospital, also in the northern part of Namibia*

The motivation for the second criteria was based on the fact the implementation of all the activities as imbedded in "sociology of development", could only full materialize in these four hospitals, as they are either referral hospitals, or they are serving a diverse and multicultural population. A total number of 280 nurses, now called registered nurses met this second inclusion criterion during the time of the study. These 280 registered nurses are therefore regarded as the final population of the study. Their distribution is detailed in table 3.1

Table 3.1 An outline of the distribution of the target population

Hospital	*Number*	*Percentage distribution*
Windhoek Central Hospital	*60*	*21.4*
Katutura Hospital	*100*	*35.7*
Oshakati Hospital	*70*	*25*

Onandjokwe Hospital	*50*	*17.9*
Total	*280*	*100*

3.5.2 Sampling and sample size

Based on a consultation with the statistician a total sample size of 100 was needed to ensure 95% confidence interval. In this study probability sampling was utilized. Probability sampling is described by Welman, Kruger and Mitchell, (2005, p 56) as being based on the principle of equal inclusion probability, meaning all the units of interest (or registered nurse in this study who had met the two inclusion criteria) are having an equal chance of inclusion

Based on the distribution of the population within four hospitals, the specific sampling method that was utilized, was proportional stratification. In this method units (or more specifically registered nurses in this study), are selected from each stratum in proportion to the size of the stratum (Welman, Kruger and Mitchell, 2005, p 62). In this study a stratum is synonymous with the size of each population in the four different hospitals

The proportional stratification is outlined in table 3.2

Table 3.2 ***Proportional stratification outline***

Hospital	*Number*	*Percentage distribution*	*Sample size required based on proportional distribution*	*Actual number sampled*
Windhoek Central Hospital	*60*	*21.4*	*21*	*20*
Katutura Hospital	*100*	*35.7*	*36*	*30*
Oshakati Hospital	*70*	*25*	*25*	*30*
Onandjokwe Hospital	*50*	*17.9*	*18*	*20*
Total	*280*	*100*	*100*	*100*

Once the sample size had been determined by means of proportional stratification, the required number for each hospital's sample (stratum) was obtained by means of lottery. The names of the registered nurses were alphabetically listed and a beginning point for selection was decided on arbitrarily. From this beginning point every second name on the list was selected. This process continued until the calculated sample size (proportion) had been obtained

Based on the viewpoints of De Vos, Strydom, Fouche and Delport (2005, p 182), the total sample size was deemed adequate as it represented 36% of the total population.

3.6 DEVELOPING THE DATA COLLECTION INSTRUMENT

The quantitative approach was employed where the researcher used a structured questionnaire as a self-employed/self-administered tool for data collection (Annexure A).

The following were the reasons why the researcher opted for a questionnaire:

- It reduces the cost of postage
- There is much less reactivity effect or interview bias linked to the presence of the researcher;
- The responses are not only confidential but also anonymous;
- It creates a greater atmosphere of trust and the answers are truthful;
- It prevents errors in coding of data.

The issue of low rate of response was taken into account when this decision was made to follow the steps mentioned (Gorard, 2003, pp 93-94).

The questionnaire consisted of two parts. Part I: This first part of the questionnaire consisted of personal particulars and demographic data of the respondents which included (See Annexure A):

- The age of the respondent as this may have an important impact on the application of the course content.
- Sex is one of the attributes examined and compared;
- The last course, which the registered nurse completed to determine the programme undergone and the content covered;
- The year in which the last course was completed and at which campus of UNAM, so that the age of knowledge that the course contains is known;
- When Sociology of Development was completed/passed;
- Region where the nurse was practicing at the time of the study to be able to compare practical application according to region;
- The length of time that the person had been practising in the unit where he/she was at time of the study, as the time factor has effects on application of content, knowledge acquisition and the observation of incidents as the development process takes place; and
- The position or capacity he/she fulfils in the unit.

Part II: Specific questions on Sociology of Development and their application to nursing practice by nurses were then formulated consisting of closed-ended and open-ended questions. Open-ended questions took the form of comments on specific issues after the close-ended questions had been asked. The questionnaire covered the following issues: modernisation theory; dependency theory with special reference to capitalism, interactionism with the emphasis on humanistic approaches regarding women and children in development, inequality and abuses as related to health. On modernisation theory questions were set to find out the state of progress, improvement and changes in ability and responsibility of registered nurses. Dependency theory was catered for in the questionnaire by asking about impact of capitalism with regard to acquisition and availability of resources, exploitation and labour relations in practical situation

All these questions were asked to find out how nurses observe the development process in their clinical setups and how they relate clinical issues of development to the content of Sociology of Development covered in their training.

3.6.1 Pilot testing

Pre-testing was performed to determine whether the study could be carried out with the instrument as it is or whether amendments and refinements were necessary. Bless and Higson-Smit (2000, p 155), describe pilot testing as a “small study conducted prior to a larger piece of research to determine whether the method is appropriate”.

For the pilot study, the sample was selected from registered nurses employed at Oshakati hospital. These nurses were from the same population as those for the actual study. A list of all registered nurses in that hospital, who have the characteristics as indicated in the research population, the total number being seventy (70). The desired number for the pilot sample was ten (10). Every seventh name was drawn from the group until ten registered nurses were obtained. These nurses were given the questionnaires to fill in and they returned them to the researcher for analysis.

The pilot study was conducted using the first draft of the questionnaire to test for clarity of wording and whether questions were understandable and answerable (Kirby, Kidd, Koubel *et al,* 1997, p 91). The pilot study indicated that it would be necessary to refine some statements and words, as well as to examine the conditions under which the survey would be conducted (Rea and Parker, 1997, p 13). The registered nurses who participated in the pilot study did so under the same situations as the registered nurses in the actual study sample.

Ten registered nurses, at Oshakati hospital were given questionnaires to fill in. The data obtained were analysed and cross-checked. Any ambiguous, unclear and difficult questions were corrected, reformulated and discussed with the study leader for this study as well as other research experts.

Some questions were deemed unclear for the pilot group, for example the questions concerning the dates when registered nurses passed Sociology of Development and when they completed their final training. The other problem question had to do with the achievements of the registered nurses. After analysis of the pilot study was completed, the questionnaire was finalised. Questions which were unclear or ambiguous were corrected and modified for the initial study. The content of the

questionnaire for the study remained the same as for the pilot test.

The questionnaire was refined and retyped in its final form to be used in actual data collection. The questionnaire was then duplicated so that enough would be available for the size of the sample.

3.6.2 Validity and reliability

To ensure that the research would produce desirable findings the questionnaire was checked for validity and reliability. The generation of true or valid knowledge is dependent on the means with which the process of research is implemented. Each phase of decision-making in the research process may influence the validity of the findings (Rossouw, 2000, p 188).

3.6.2.1 Validity

The concept validity refers to "whether or not a method measures what it sets out to measure" (Burnard *et al*, 1994, p 74), while de Vos, Strydom, Fousche & Delport, (2002, p 83) define validity as "doing what it is intended to do as measuring what it is supposed to measure and as yielding scores whose differences reflect the true difference of the variable being measured rather than random or constant error".

It is also defined as the degree to which an instrument measures what it is supposed to be measuring.

The researcher tried to ensure content validity and external validity in this research. To ensure content validity the researcher did careful planning and the careful execution of a plan (Polit & Hungler, 1997, pp 374 – 375). In this study face validity and content validity were determined.

3.6.2.2 Face validity

Face validity refers to the way in which the instrument appears to respondents (Bless & Higson-Smith, 1997, p 139). Face validity is " concerned with the superficial appearance or face value of the measurement procedure" (de Vos, Strydom, Fousche and Delport, 2005, p 107). In this study the researcher ensured face validity by submitting the instrument to supervisors and by means of peer review. Supervisors agreed that the items appeared to be representative of the purpose of the study. The items included in the instrument were assessed, each question was scrutinised until the researcher was satisfied that it represented an accurate measure of the desired construct, and then modifications were made accordingly.

3.6.2.3 Content validity

Content validity is "concerned with the adequacy of the content area being measured" (Polit *et al*, 1997, p 30). De Vos, *et al* (2005, pp 106,107) states that content validity "is concerned with representatives or sampling adequacy of the content (e.g. topics or items) of an instrument." In this study, content validity was ensured by making sure that the questionnaire adequately covers the topic under study. Furthermore, the opinions of experts were also sought when developing the questionnaire.

External validity was ensured by the representativeness of the sample to the target population to which the findings were generalised. If the population of registered nurses is not well represented in the

sample then the external validity may not be achieved (Mouton, 1998, p 110).

3.6.2.4 Reliability

Reliability is referred to by de Vos, *et al* (2001, p 85) as "the accuracy or precision of an instrument or the degree of consistency or agreement between two independent derived sets of scores; and as the extent to which independent administrations of the same instrument yield the same results under comparable conditions." For this study, stability was tested by means of equivalence.

The equivalence approach is when different observers or rates are using an instrument to measure the same phenomena (Polit and Hungler, 1997, p 248). They afterwards compare the results.

The reliability of the instrument is the degree of consistency with which it measures the attribute it is supposed to be measuring. The questionnaire constructed for this study should produce the same findings each time it is used (Polit & Hungler 1997, p 367; Rossouw, 2000, pp 132 – 133).

Reliability is closely related to validity in that a reliable measure may have a certain degree of validity. As the instrument used captures what it is supposed to capture, it may also be replicable. If the instrument is not valid it may not have the necessary degree of reliability for the study (Viswanathan, 2005, p 62).

A pilot study can be used as a way of ensuring reliability. The pilot study, according to de Vos *et al,* "is the process whereby the research design for a prospected survey is tested" (2001, p 179). The study was conducted by means of a questionnaire with standardised questions that remain the same for each and every respondent.

3.7 ETHICAL CONSIDERATIONS

Ethics in research were ensured in the study concerning the respondents during data collection and handling of data. The respondents were told the true nature of the study in which they were taking part. They were also told about how they were chosen to partake in the research study.

In this study, the researcher refers more respondents than to subjects because the term subjects implies that some procedure is being applied to them and that they have a passive role in research, while the term 'respondents' implies that "something is carried out in conjunction with them" (Walliman, 2005, p 343). It also refers to someone who takes part in the research project and takes an active role (Walliman, 2005, p 436). Respondents are the devoted people who responded to the questions posed to them in the questionnaire.

Permission/informed consent was obtained from the respondents and they participated by their own free will (nobody was forced) (Annexure G). They were told the purpose and the nature of the research (Walliman, 2005, p 434). They were told that they have the right to withdraw from the study without fear of repercussions or force (Burs & Grove, 1993, pp 104, 105).

Their responses were anonymous and the information they gave was treated confidentially. This was done by protecting the subjects by keeping them nameless and the data sources were protected by not exposing them to any person other than those involved in the study, such as the study leaders and the lecturers in Sociology of Development who are responsible for implementing the strategies formulated in this study in the curriculum and teaching of student nurses. The information was always kept under lock and key so that no unauthorised people would have access to it. After data collection no alteration, addition or any form of forging took place.

Permission to do the research was obtained from the Ministry of Health and Social Services, from the permanent secretary's office and from the medical superintendents of hospitals where the study was conducted. See Annexure C – F)

Professional and ethical standards were ensured. The researcher identified herself properly and honestly. Respondents' privacy was also respected and any harm to them was avoided as far as possible. Regarding data gathering, misinterpretation, distortion and omission of data was avoided. The relevant research method was chosen to best suit the topic under investigation and the research context.

Fabrication and falsification of data was considered as unethical and therefore totally avoided. Only the data collected was analysed and then handled in the form it was obtained from the respondents. (Sarantakos, 1998, p 22; Bailey, 1987, pp 409-414; Babbie, 2001, pp 520-528; Mouton, 1996, p 42).

Permission was also requested from nurses-in-charge of hospitals, health centres and clinics where the

study was conducted to allow registered nurses to be given questionnaires to fill in while on duty.

3.8 DATA COLLECTION: DISTRIBUTION OF THE QUESTIONNAIRE

The questionnaires were dropped off at the hospitals. The registered nurses in charge of nursing services were requested to distribute the questionnaires to the registered nurses in the departments and units of each hospital.

Registered nurses were requested to read the questions themselves and fill in the answers as they deemed them to be correct, without the interference from the researcher. This allowed the researcher to collect enough information from a relative large number of respondents, which in turn enabled the researcher to generalise the findings to the entire study population.

The prepared questionnaires were then distributed to the respondents. Those who were easily accessible received their questionnaires from their supervisors at the hospitals. Those who were not easily accessible received their questionnaires from a contact person (supervisors at Windhoek Central and Katutura hospitals) who also collected them after they were completed. At every hospital there was a list of registered nurses who would take part in the research. Every nurse was given an equal chance to be selected in the sample by employing probability sampling.

The researcher gave guidelines to the supervisors on how to distribute the questionnaires to the

respondents. For Oshakati and Onandjokwe, the researcher went to the supervisors at the hospitals and selected the samples with them. Several telephonic discussions were held with supervisors at Katutura and Central hospitals on how to select the samples for their respective hospitals. The researcher ensured that they understood the procedure, by making them explain how they were going to proceed. After the researcher was satisfied the questionnaires were sent to the supervisors for distribution. The actual process was not monitored, but the researcher trusted that they would follow procedures correctly. The questionnaires sent were as follows:

Southern Region: Khomas: Total - **50**

- Central Hospital: 20
- Katutura Hospital: 30

Northern Regions: Oshana and Oshikoto Total: **50**

Oshana: - Oshakati Hospital: 30

Oshikoto: - Onandjokwe Hospital: 20

Total number of questionnaires 100

Table 3.3 Distribution of questionnaires to respondents:

Hospital	*Number*	*Actual number sampled*	*Number of questionnaires distributed*	*Regional divisions*
Windhoek Central Hospital	*60*	*20*	*20*	***Southern region*** *Khomas*
Katutura Hospital	*100*	*30*	*30*	*Khomas*
Oshakati Hospital	*70*	*30*	*30*	***Northern region*** *Oshana*
Onandjokwe Hospital	*50*	*20*	*20*	*Oshikoto*
Total	*280*	*100*	*100*	

A cover letter was attached to each questionnaire in which the respondent was told how he/she came to be selected and also instructed on how to fill in the questionnaire. The respondents were also acknowledged for their assistance in participating in the study as the time they took to fill out the questionnaires. Druckman (2005, p 161) states that the contribution of time should be respected and not wasted. Even if the respondents may have benefited by participating in the research, they contributed a definite and valuable response to it.

After the questionnaires had been filled in, and on the agreed due date, the questionnaires were counted to check for the response rate. As some registered nurses did not adhere to the due date, a second letter was sent in which a second due date was given.

3.9 DATA ANALYSIS

Data were checked for relevance and whether they really address the research questions and the objectives set in the research proposal. The researcher checked whether enough questions were answered in each questionnaire before processing the questionnaires (Rea and Parker, 1997, p 13). Data were reduced so that they could be interpreted (White, 2000, pp 106 – 107).

Data were electronically processed, categorised, coded and analysed by means of the computer by a statistician using the SPSS (Statistical Program for Social Sciences) (Sarantakos, 2003, pp 329, 335-336). The data analysis was done by means of bivariate descriptive statistics (Polit, 1996, pp 69-70) and also hypothesis testing using independent and dependent variables, and the multi-analysis of

variables (MANOVA) t-test for investigating differences between two groups (Siezel, 1956).

Data analysis is about "telling a story from the data" as Hardy (2004, p 1) states. The researcher then performed full analysis by drawing tables, charts and outlining theoretical explanations of what the data entails regarding the topic under investigation. After statistical data analysis was completed, the researcher completed the analysis by using tables and descriptions to determine the p-values for each item and to conclude whether there are any significant statistical differences between the independent and dependent variables. Each independent variable was tested against all dependent variables and for each a null and alternative hypothesis was formulated. This is an example of how data were analysed and presented:

The impact of aspects of development on nursing practice according to age:

- Ho: There is no significant difference between younger and older age group categories, with regard to their application of Sociology of Development as well as with their ratings with regard to whether such knowledge had an impact on their nursing practice.
- Ha: There is significant difference between younger and older age group with regard to application of Sociology of Development as well as with their ratings with regard to whether such knowledge had an impact on their nursing practice.

In addition to the statistically captured data, the researcher also collated the data on the open-ended questions (comments). She combined similar comments given in response to each question. Statements with the same connotations were again combined, summarized and categorised according to items they represented on their *discursive link* to three development theories taught in the course. The researcher related the summary of the comments to the statistical data.

The researcher then linked these aspects with what the respondents have commented on in each of these items and extracted general trends as reflected in the findings.

The summary of these comments is presented in chapter 4, paragraph 4.6 and the summary of the trends regarding the comments in table 4.11.

PHASE 2: CONCEPTUAL FRAMEWORK FOR STRATEGIES FOR THE FACILITATION OF THE APPLICATION

A conceptual framework was developed and described based on the results of phase 1 and the literature review. The framework served as a bridge between the findings from the empirical phase and the development of strategies. The reasoning map used here refers to a structure of concepts and is the one used by Dickoff James and Wiedenbach (1968, p 433). Chinn and Kramer (1995, p 69) define conceptual as "pertaining to concepts." Dickhoff (1968) conceptual framework consists of components such as:

- The agent who performs and facilitates the activity;
- The recipient of the activity performed;
- The procedure (technique) which guides the activity;
- The context or situation in which the activity is performed;
- The dynamics or challenges of the activity;
- The terminus which is the end result of the activity, that is, the outcome.

This framework is described in detail in chapter 5.

PHASE 3: DEVELOPMENT OF THE STRATEGIES

The third phase dealt with the development of strategies to facilitate the application of Sociology of Development in nursing practice. Findings from the data analysis and information from the literature

review were used to build the strategies. Strategies were formulated with objectives and activities on how to achieve the objectives. These strategies are described in chapter 6.

3.10 SUMMARY

This chapter presents the research design and methods used for the study. It gives the reader an opportunity to follow in detail the procedures followed to collect the information contained in the research report for this study. The study followed the positivistic paradigm and a quantitative approach was chosen due to the fact that the respondents are taught and the nature of study is that knowledge is there to be discovered.

The steps followed were highlighted and aspects taken into account during research, such as validity, reliability and ethics were outlined. Informed consent was obtained from relevant individuals whether respondents or those in charge of facilities where research was conducted.

The data collected is analysed in the next chapter, and the interpretation of the findings is performed descriptively, based on the literature reviewed.

CHAPTER 4: ANALYSIS OF DATA AND INTERPRETATION OF THE FINDINGS

4.1 INTRODUCTION

The previous chapter highlighted the ways in which this study has been conducted, now this chapter presents the analysis and interpretation of the data based on the information gathered from the respondents who are registered nurses and who studied Sociology of Development in their diploma course.

After the questionnaires returned they were counted for each hospital. Out of the 100 questionnaires distributed, only 61 were sent back completed, 23 were returned uncompleted and the rest were reported having been misplaced, lost or the registered nurses went on leave without returning them. Of the 61 submitted, 3 were spoiled and 2 were invalid because the respondents did not undergo the training specified for this study. Questionnaires were then sorted to eliminate bad and poor responses from being included in the data analysis and then sent to a statistician for computerisation.

The questionnaire consists of two sections; section one contains biographical data and section two concerns specific questions on the content of Sociology of Development as applicable to nursing practice.

4.2 ANALYSIS OF DATA

The relationship between the variables relates to the different aspect of development as related to independent variables such as age, gender, place of training, practice, institution where practicing, as

well as time of training and length of time in the practical situation after training was completed. Significance of findings was highlighted with analysis of each variable by examining whether $p < 0.05$ (Newton and Rudestam, 1999, p 293).

4.3 THE RESEARCH RESULTS/FINDINGS

The findings are presented as follows:

- A descriptive presentation of the results. The grouping of the results was based on the biographical headings in section A of the questionnaire.
- The integration of the inferential component of the study in the discussion was used. The biographical headings were utilised as the independent variables in the questionnaire under section A, in the inferential component of the study.
- Data on comments levelled at the end of questions and open-ended questions were open coded and analysed. Findings were summarised as presented at the end of this chapter.

4.4 BIOGRAPHICAL INFORMATION

The total number of respondents in this study was fifty-six (N=56). These were the people who responded to the questions relating their backgrounds in section one and general questions on the subject matter under study, that is Sociology of Development.

The information relating to their particulars is analysed below.

4.4.1 Age structure of the respondents

There were 56 (100%) respondents of which 54 (96.4 %) indicated their ages. They are divided into two groups. One group consisted of 31 respondents (55.4%), and the other of 23 respondents. Thirty one of the respondents (55.4%) fall into the interval 26 – 35 years of age and 23 (41.0%) into the interval 36 – 48. The grouping was done on the basis of who is a young adult or an adult. According to the office of the Unitarian Universalist Association (UUA), a "young adult" is anyone between the ages of 18 and 35, inclusive (www.uua.org/members/**youngadults**/index.shtml, accessed on the 02/29/2008). An adult is a person who is over thirty-five years and below sixty years of age.

Table 4.1: Age structure of the respondents

Age of respondents	Age 26-35	Age 36-48	No response	Total
Number of respondents	31	23	2	56
Percent	55.4%	41.0%	3.6%	100%

4.4.2 Gender structure

Both sexes responded to the questionnaire but due to the fact that the intake of student nurses in training has always been more female than male, the presentation of the sample reflects this tendency. Out of the 56 respondents, 49 (87.5%) were females and only six (10.7%) were males.

Table 4.2: Gender structure

Gender group	Females	Males	No response	Total
Number of respondents	49	6	1	56
Percent	87.5	10.7	1.8	100.0

4.4.3 The year when training was completed

Respondents to this questionnaire completed their training between 1989 and 2001. Twenty-seven (48.2%) of the respondents completed during the years 1989 – 1997, while another 27 (48.2%) completed their training during the years 1998- 2001. Two (3.6%) did not indicate the years in which they completed their training.

4.4.4 Campus/region where nurses were trained

Out of fifty-six respondents, 27 (48.2%) completed their training in the southern region (Khomas), and 29 (51.8%) at the northern campuses in the Oshana and Oshikoto regions. The majority of the respondents were trained at the northern campuses.

4.4.5 Year when Sociology of Development was completed/passed

The Sociology of Development course was revised during an extensive curriculum evaluation and

"revamping" in 1995. The implication was that the population under study was exposed to different content and focus points (i.e. the group who trained before 1995 and the group who trained after 1995). It was thus necessary to distinguish between these two groups. Respondents were therefore divided into two groups according to the old and revised curriculum they were taught. The respondents who completed/passed the old curriculum were 30 (53.6%) out of the total of 56, but these responses were 65.2% out of the 46 who responded to the question. Those who studied the revised curriculum were 16 (28.6%) of the total group and 34.8% of those who responded. Ten (17.8%) nurses did not respond. As such the number of nurses who passed under the first curriculum in this group was higher than the number who passed under the revised curriculum. The analysis attempted to ascertain how age might influence the application of Sociology of Development to nursing practice.

4.4.6 Regions where nurses were practicing at the time of the study

The clinical and theoretical exposure of respondents while they were still students occurred in two different contexts. The one context contains considerably more elements of the "first world" while the other contains more elements of the "third world" because one group was trained in the urban (capital) city while another group was trained in a rural environment. A different worldview might have emerged due to this difference in context, thus a distinction was made between the two sub-populations.

Twenty-seven (48.2%) out of the fifty-six (56) nurses were practicing at Khomas region in the capital city of Windhoek. Eight (29.6%) of the twenty seven, were located at the Central Hospital, at the center of the town, the area mostly occupied by whites, while nineteen (70.4%) out of the twenty seven

were located at Katutura Hospital, the area mostly occupied by blacks.

Another twenty-nine of the fifty-six (51.8%) nurses were practicing in Oshana and Oshikoto region. Out of the twenty-nine, twenty-three (79.3%) were at Oshakati Hospital and six at Onandjokwe Hospital. These hospitals are in the most disadvantaged regions in Namibia.

4.4.7 Length of time spent in the present unit

For knowledge, skills and attitudes to be internalised, sufficient time is necessary for consolidation, experimentation and professional growth. The length of time required is not the same for everyone, but if experience is lacking, the effect might be reflected on knowledge, skills and attitudes. This might influence nurses' perspectives and views on the Sociology of Development. Two time spans were used, namely twelve months or less, and more than twelve months.

The group that was allocated for the period of one to twelve months contained 27 nurses (48.2 %) and those who were allocated in their units for more than 12 months (up to 12 years) numbered 27 (48.2 %). Two (3.6%) of the respondents did not indicate their period of time in their current units of practice.

From this data it can be seen that even if both groups are equal in size, the second group had longer exposure in clinical practice than the first one. This could have given them opportunity to explore and experience more in the practical situation than the first group.

4.5 Analysis of specific data on application of Sociology of Development to Nursing Practice

An ordinal 5 point scale was used on these data, where the lowest score was 'not at all' and correlated to point 1 and the highest score was 'too a larger extent' at point 5. Respondents had to respond to these questions according to the points as they felt it was applicable to their own situation and their experience in the practical situation. They had the freedom to respond to items as they judged the situation from their own perspective.

The questions were formulated along the line of what respondents had covered in their training and they were then invited to express for their general perception, which they highlighted under the comments below the questions.

Descriptive statistics as well as inferential statistics were employed in the analysis of this section of scaled items in the questionnaire, where the null hypothesis and the alternative hypotheses are to be tested. The results of the analysis of these items are discussed next.

4.5.1 The impact of aspects of development on nursing practice according to age

With the inclusion of age in this study, the assumption is mainly that older nurses might have a

different perception or experience of the contribution of the knowledge of Sociology of Development on their nursing practice.

Their responses are indicated in table 4.3. In addition the t-test was used to find out if there was any significant difference between the age groups with regard to the application of Sociology of Development, as well as any difference in their ratings about the impact of knowledge of Sociology of Development on their nursing practice. Two hypotheses were stated, the null hypothesis (Ho) and the alternative hypothesis (Ha). These appear below.

Ho: There is no significant difference between younger and older age group categories, with regard to their application of Sociology of Development as well as with their ratings with regard to whether such knowledge has had an impact on their nursing practice.

Ha: There is a significant difference between younger and older age group categories with regard to their application of Sociology of Development as well as with their ratings with regard to whether such knowledge has had impact on their nursing practice.

Table 4.3: Aspects of development and age

Age group VARIABLES	26-35 YEARS			36-48 YEARS			
	N		S	N		S	P
a. Impact/Influence of modernisation on your nursing care	26	3.31	1.09	20	3.00	1.08	0.172
b. Influence of capitalism on your nursing practice concerning availability of resources	25	3.44	1.19	20	3.85	0.81	0.099
c. Sociology of Development led to improvement of your nursing practice	24	3.83	0.87	21	3.67	0.91	0.267
d. After completion of your training to what extent did you upgrade your knowledge?	26	3.50	1.07	21	3.33	1.02	0.295
e. Extent to which the upgrading of your knowledge has influenced your skills	25	3.68	1.07	17	3.76	0.75	0.389
f. Extent to which you are equipped with the necessary skills to eradicate social problems	24	3.33	1.17	18	3.33	0.84	0.500
g. Are you able to disclose information about yourself?	31	3.06	1.48	20	3.45	1.43	0.182
h. Extent of changes that occurred in aspects of health services over the past five years	21	3.33	0.97	20	3.50	0.61	0.258
i. Extent to which you set goals to achieve what you planned in your daily practice	31	3.61	1.15	22	3.59	0.91	0.471
j. Extent to which women are deprived of their rights	27	2.15	0.99	21	2.38	1.28	0.241

k. Extent to which you are involved with empowering women in the community	29	2.41	1.59	22	2.82	1.47	0.179
l. Extent to which you are involved in assisting female patients who are subjected to domestic violence at their homes	30	3.07	1.60	23	3.04	1.61	0.475

As can be seen from table 4.3 no statistically significant difference was found between the two groups with respect to the application of knowledge of the Sociology of Development in their nursing practice in the hospital units where they were allocated ($P > 0.05$). The null hypothesis is therefore supported and the alternative hypothesis is rejected.

In addition, the data was analysed descriptively and central values like the average and standard deviations were calculated. The average score for the two groups was found to be greater than 3 out of a possible maximum of 5 on an ordinal scale for all thirteen items. The descriptive analysis points to a tendency towards the more than average application of Sociology of Development for both age groups as well as a more than average conviction that knowledge of Sociology of Development has had a beneficial impact on their nursing practice. Thus:

- With regard to the item on the influence of modernisation, the tendency for both groups is towards the belief/conviction that modernisation has influenced their nursing practice in the sense that they have experienced more freedom of choice, that it has enhanced personal or professional growth, and improved decision making skills. This influence also includes a belief that increased spiritual growth has occurred with accompanying salvation, and a conviction that their educational needs were met.
- Both groups tend to believe that capitalism has had an indirect influence on what nurses do in their practice, specifically with regard to the structures needed to render services as well as the maintenance and "stocking" of these structures. Capitalism is also deemed to have influenced the availability of human resources, and their optimal therapeutic application.
- From this table it can be seen that they believed that their nursing practice had improved as a result of their study of Sociology of Development. On average, both groups (young group 3.83, older group 3.67) indicated that it helped them in identification of the needs for nursing care, in making nursing diagnosis, in planning and prioritising actions to address those needs, in putting their plans into action, in evaluating the impact of nursing care given and in thinking independently. It also helped them to be able to evaluate themselves and to make decisions

affecting their nursing care.

- Both groups (young group: N = 31, □ =3.50 and older age N = 23, □ = 3.33) indicated that they upgraded their knowledge after completion of their training with regard to nursing process and management of different health services and programs as well as in applying ethics of nursing to their areas of practice. Sociology of Development is about progress or regression. If respondents are upgrading their skills it is an indicator of development and advancement applicable to nursing practice. Emile Durkheim referred to this as specification and specialisation (Allan, 2005, pp 133,137).
- Upgrading of knowledge has influenced the different type of skills of nurses to a greater extent, as the average scores indicate (for young age, N = 31, □ = 3.68, older age group, N = 23, □ = 3.76). They indicated having different skills to communicate, manage, supervise and practice nursing care.
- In the item about disclosing of information about oneself, the young group scored an average of 3.06 and the older age category an average of 3.45. Disclosing of information is a skill that facilitates communication on a health basis. It can be applied for different reasons and in different situations. It is beneficial to know the process of communication or the way to disclose information about issues. It is also necessary to know that in management information needs to be disclosed in order to effectively communicate with subordinates as well as seniors. Therefore, communication helps senders to give the message, somebody receives the message (receiver) through the channel in which it was sent, and they can respond (give feedback) accordingly. This process differs from context to context (Payne, 2001, pp 4, 7, 9-12).
- In table 4.3, the average score of 3.33 obtained by both groups of respondents indicates that they are able to deal with problems of malnutrition, disease, slums, illiteracy, unemployment and social inequality among the people of their community. They stated that they were able to give information and assist clients and patients in minimising these problems.
- Respondents in this study have observed changes in aspects of health care services over the past five years, which indicates that social change is taking place. If change is taking place in the health sector it indicates that there is change in social life, because health is just a component of society. The young age group confirmed these changes with an average score of 3.33 and the older group with 3.50. They indicated the changes that they have observed as infrastructure, accessibility and availability of transport services, human resources and budget allocation. Change in health care, as a social system is an ongoing activity. It takes place in the preventive, promotional, curative and rehabilitative fields as well as in the educational and administrative fields (Searle, et al. 1995, p 446).
- Both age groups set goals for their daily activities, as seen from the table, where the young age did it to the average extent of 3.61 and 3.59 for the older age group. They are able to plan, supervise others, consult with colleagues, give feedback and assist others to improve their performance. They could also observe how exploitation was taking place in the workplace.

- The extent of women being deprived of their rights was observed with the average score of $\bar{x}$ = 2.15 by the young age group and $\bar{x}$ = 2.38 by the older age group both of which are below the average score of 3.00.

The literature consulted indicated these issues as a concern in the world and in Namibia, particularly for rural women. They are always subjected to income inequality and cannot promote their own self-interests. Such conditions have a negative impact on the health status of women (Wallace &Wolf, 1999, pp 418–419). In this study the observation of nurses regarding abuse of women and children in clinical practice is low. It is already known that this is not a true reflection of the problem at hand.

In Chapter 2 under paragraph 2.7, on women in development, Kayongo-Male and Onyango (1994, pp 27-28) state that, in Africa, women are excluded from the power process and structure in their communities. Men are the heads of families and women have to submit to the will of the heads with regard to what is to be done or accomplished. The ownership of properties is also likewise distributed. That is why women in Africa are mostly the poorest of all members of their societies, even poorer than their sons or grandsons.

According to the National Gender Policy and the National Plan of Action on Gender of 1998, rape, domestic violence and abuse of women and children are prevalent and this policy and action is formulated to address these concerns.

Respondents indicated their involvement in the empowerment of women in their communities where they practice, but with low averages ($\bar{x} < 3$). The young age group showed empowerment to a 2.41 average, and the older to an average of 2.82. If less than 3 ($\bar{x} <3$) is used as a criteria for putting focus on an item, then this item needs attention. The contribution sounds positive, because it appears that nurses did not perform well as the criteria set for them.

Assistance to women who are subjected to domestic violence was one of the tasks performed by the respondents. While the older group had an average of 3.04, the younger had a mean of 3.07 to their responses. This confirms what was mentioned in the literature and raised in the National Gender Policy and National Plan of Action on Gender of 1998 (1998, pp 11,13), that violence against women in all sectors, whether sexual, physical or emotional is rife in Namibia and bills to combat such violence have been passed, but need to be enforced. Examples of these bills are the Rape Bill and the Domestic Violence Bill. Women and Child Protection Units have also been placed in all regions of Namibia.

Domestic violence is one of Namibia's most serious human rights problems. Medical personnel interviewed in a recent study indicated that almost half of the women and children that they treat show signs of being victims of domestic violence (LAC, 2005, p 7).

4.5.2 Extent to which development aspects influence/have impacts on nursing practice according to gender

Table 4.4: Impact of development according to gender

Gender / VARIABLE	Male					
	N		S	N		S
a. Impact/Influence of modernisation on your nursing care	6	3.33	1.51	41	3.15	1.01
b. Influence of capitalism on your nursing practice concerning availability of resources	5	3.60	0.55	41	3.66	1.11

c. Sociology of development led to improvement of your nursing practice	6	4.00	0.89	40	3.70	0.88
d. After completion of your training to what extent did you upgrade your knowledge	6	3.00	1.10	42	3.48	1.02
e. Extent to which the upgrading of your knowledge influenced your skills	6	3.33	1.21	37	3.76	0.89
f. Extent to which you are equipped with necessary skills to eradicate social problems	6	3.33	1.03	37	3.30	1.05
g. Are you able to disclose information about yourself	6	3.67	1.51	46	3.17	1.45
h. Extent of changes that occurred in the aspects in health services over the past five years	6	3.83	0.75	36	3.33	0.79
i. Extent to which you set goals to achieve what you planned in your daily practice	6	4.00	0.89	48	3.54	1.05
j. Extent to which women are deprived of their rights	6	2.00	1.10	42	2.29	1.13
k. Extent to which you are involved to empower women in the community	6	1.67	1.21	46	2.70	1.53
l. Extent to which you are involved to assist women patients who are subjected to domestic violence at their homes	6	3.33	1.51	48	3.00	1.60

It was not possible to determine any association between gender and the ratings on the impact of Sociology of Development. No statistically significant differences were found between the gender groups and the twelve dependent variables as they are depicted in table 4.4. This is due to the small number of male respondents.

The p-value for this table, is not significant as the null hypothesis cannot be tested because the number of males is very small compared to the number of females. The average responses are examined even

though they are also from groups that are incomparable in size.

4.5.3 Extent to which development aspects influence/impact nursing practice with regard to the years in which training was completed

Ho: There is no significant difference between the group of nurses trained between 1990 - 1997 and those trained between 1998-2004.

Ha: There is a significant difference between the group of nurses trained between 1990 - 1997 and those trained between 1998-2004.

Table 4.5: Impact/influence of development according to the years in which training was completed

Year completed Variables	1990-1997			1998-2004			
	N		S	N		S	P
a. Impact/Influence of modernisation on your nursing care	25	3.36	1.08	21	2.95	1.07	0.103
b. Influence of capitalism on your nursing practice concerning availability of resources	24	3.83	0.96	21	3.48	1.17	0.134
c. Sociology of development led to improvement in your nursing practice	23	3.74	0.86	22	3.73	0.94	0.483
d. After completion of your training to what extent did you upgrade your knowledge	25	3.36	0.95	22	3.50	1.14	0.325
e. Extent to which the upgrading of your knowledge influenced your skills	22	3.64	0.79	20	3.75	1.12	0.352
f. Extent to which you are equipped with necessary skills to eradicate social problems	22	3.36	1.05	20	3.30	1.03	0.422
g. Are you able to disclose information about yourself	25	3.20	1.47	26	3.19	1.44	0.493
h. Extent of changes that occurred in the aspects in health services over the past five years	22	3.41	0.80	19	3.37	0.83	0.437
i. Extent to which you set goals to achieve what you planned in your daily practice	26	3.65	0.94	27	3.52	1.16	0.321
j. Extent to which women are deprived of their rights	24	2.25	0.99	23	2.30	1.26	0.435

k. Extent to which you are involved to empower women in the community	26	2.62	1.58	25	2.60	1.50	0.486
l. Extent to which you are involved to assist women patients who are subjected to domestic violence at their homes	26	3.08	1.65	27	3.00	1.57	0.431

In table 4.5 the periods in which respondents completed their pre-registration course were compared with the ratings they provided about the impact of Sociology of Development. The motivation for the specific delineation is based on a curriculum review process that occurred during 1997. After 1997 Sociology of Development incorporated a different content as well as different focus.

As seen from table 4.5 no significant statistical differences were found between the periods in which the respondents completed their training and their ratings on the twelve dependent variables. The p value ($p>0.05$) for development issues in their practice therefore indicates no significant difference. The null hypothesis is thus supported by the findings.

In a descriptive analysis of data in table 4.5, it is noted that the average scores for both groups were greater than 3, out of a possible maximum of 5 on an ordinal scale, for ten of the thirteen items (dependent variables). This descriptive analysis points to a tendency towards a more than average application of Sociology of Development by respondents in the two groups as well as the conviction that knowledge of Sociology of Development has had an impact on their nursing practice.

The two items (h) and (k) have average scores of less than 3.00 for both groups.

When the macro curriculum was initially finalised and decided upon, the motivation for inclusion of Sociology of Development was to instil a sense of social responsibility in future registered nurses. This social responsibility included issues of empowerment of women and human rights, which they would now be able to address in their nursing practice.

4.5.4 Extent to which development aspects influence nursing practice according to place/regions where course was completed

Ho: There is no statistically significant difference between the respondents from northern regions and respondents from the southern region, in their application of Sociology of Development as well as with the ratings with regard to whether knowledge of Sociology of Development has had an impact on their nursing practice.

Ha: There is a statistically significant difference between the respondents from northern regions and respondents from the southern region, in their application of Sociology of Development as well as with the ratings with regard to whether knowledge of Sociology of Development has had impact on their nursing practice.

Table 4.6: Influence of development aspects according to place/region where *course was completed*

Region where course completed VARIABLES	Northern Regions			Southern Regions			
	N		S	N		S	P
a. Impact/Influence of modernisation on your nursing care	22	3.41	1.01	24	2.96	1.12	0.080
b. Influence of capitalism on your nursing practice concerning availability of resources	23	3.70	1.02	22	3.64	1.14	0.428
c. Sociology of development led to improvement of your nursing practice	22	4.00	0.76	23	3.48	0.95	**0.024**
d. After completion of your training to what extent did you upgrade your knowledge	24	3.63	0.77	23	3.22	1.24	0.91
e. Extent to which the upgrading of your knowledge influenced your skills	22	3.73	0.77	20	3.65	1.14	0.398
f. Extent to which you are equipped with necessary skills to eradicate social problems	24	3.46	0.72	18	3.17	1.34	0.185
g. Are you able to disclose information about yourself	26	3.15	1.49	25	3.24	1.42	0.417

h. Extent of changes that occurred in the aspects in health services over the past five years	21	3.48	0.60	20	3.30	0.98	0.245
i. Extent to which you set goals to achieve what you planned in your daily practice	27	3.56	0.97	26	3.62	1.13	0.419
j. Extent to which women are deprived of their rights	25	2.52	1.12	22	2.00	1.07	0.056
k. Extent to which you are involved to empower women in the community	24	3.08	1.35	27	2.19	1.57	**0.017**
l. Extent to which you are involved to assist women patients who are subjected to domestic violence at their homes	26	3.42	1.47	27	2.67	1.64	**0.042**

There are no differences in the responses between the two groups. For three items there were statistically significant differences in the ratings of the two groups of respondents, these being items c, k and l. The statistically significant difference was found between respondents who trained in the Northern regions and those trained in the Southern regions ($p < 0.05$). The implication is that respondents from the Northern region are of the opinion that Sociology of Development had led to a greater improvement in their practice of nursing than respondents who trained in the southern region

In the item that dealt with the extent to which respondents were involved in the empowerment of women, the result indicates that responds who completed their training in the Northern region are more inclined to be involved in the empowerment of women **(**$p < 0.05$).

The final item, in which a statistically significant difference was found, was on the respondents' involvement in assisting women who are subjected to domestic violence (item l). The respondents who completed their training in the Northern regions rated themselves more involved than respondents from

the Southern regions, p=0.042 ($p<0.05$).

Therefore, the null hypothesis is rejected by these findings, but for four items of table 4.6, the alternative hypothesis is accepted. For other cases the p value was more than 0.05 and therefore no additional statistical differences emerged.

The clinical and theoretical exposure of the population while students, occurred in two vastly different contexts. The one context contains considerably more elements of the "first world" while the other contains more elements of the third world. Development is low in the Northern regions that were historically disadvantaged in terms of resources and any type of economical development. The northern part of Namibia is always referred to as a previously disadvantaged area. A sense of social responsibility has existed since independence to rectify inequalities (Government of Republic of Namibia, Vision 2030, of 2005, p 19).

4.5.5 Extent to which development aspects influence nursing practice according to the year in which Sociology of Development was completed

Ho: There is no difference between the two groups with regard to the time of completion of their nursing training and their application of Sociology of Development as well as with their ratings with regard to whether knowledge of Sociology of Development has had an impact on their nursing practice.

Ha: There is difference between the two groups with regard to the time of completion of their nursing

training and their application of Sociology of Development as well as with their ratings with regard to whether knowledge of Sociology of Development has had an impact on their nursing practice.

Table 4.7: Extent of influence of Sociology of Development according to the year it was passed/completed

Year Sociology passed VARIABLES	1988-1995			1996-2000			
	N		S	N		S	P
a. Impact/Influence of modernisation on your nursing care	28	3.39	1.08	12	2.83	1.11	0.067
b. Influence of capitalism on your nursing practice concerning availability of resources	27	3.74	0.98	12	3.33	1.15	0.133

c. Sociology of development led to improvement of your nursing practice	26	3.85	0.88	12	3.92	0.90	0.411
d. After completion of your training to what extent did you upgrade your knowledge	26	3.42	0.90	14	3.50	1.34	0.415
e. Extent to which the upgrading of your knowledge influenced your skills	23	3.83	0.78	13	3.69	1.25	0.347
f. Extent to which you are equipped with necessary skills to eradicate social problems	23	3.26	1.05	14	3.43	1.09	0.323
g. Are you able to disclose information about yourself	27	3.22	1.45	16	3.06	1.53	0.367
h. Extent of changes that occurred in the aspects in health services over the past five years	22	3.41	0.80	13	3.38	0.96	0.463
i. Extent to which you set goals to achieve what you planned in your daily practice	29	3.69	1.00	16	3.63	1.15	0.423
j. Extent to which women are deprived of their rights	26	2.54	1.21	15	2.07	0.96	0.104
k. Extent to which you are involved to empower women in the community	28	2.64	1.62	15	2.73	1.53	0.430
l. Extent to which you are involved to assist women patients who are subjected to domestic violence at their homes	29	3.24	1.53	16	3.06	1.61	0.307

In this table two groups are shown according to the time they were trained, 1988 – 1995 and 1996 – 2000. As can be seen from table 4.7 no statistical differences were found between the two groups with regard to their ratings on how they apply Sociology of Development or how it influenced their nursing practice. This can be seen from the p-values which are all greater than 0.05 ($p > 0.05$).

In a descriptive analysis of the data in table 4.7, it is noted that the average scores for both groups were

greater than 3 ((i.e. >3.00), out of a possible maximum of 5 on an ordinal scale, for ten of the twelve dependent variables. This indicates a belief and conviction that, the Sociology of Development has had an impact or influence on nursing practice.

The three items that obtained ratings less than 3 are (j) and (k) for both groups, and (a) for only one group. Items (j) and (k) dealt with women's rights and empowerment of women.

The last item that scored below 3, and only by the group trained during the period 1996- 2000, was item (a). This item dealt with the belief that modernisation has had an influence on there nursing career. This group did not agree with this statement.

As there is also no significant difference on basis of the p-value for this item, the null hypothesis is supported.

4.5.6 Extent to which development aspects influence nursing practice according to area/region where the nurse is currently practicing

Ho: There is no difference between the two groups with regard to region of practice and their application of Sociology of Development as well as with their ratings with regard to whether knowledge of Sociology of Development has had an impact on their nursing practice.

Ha: There is a difference between the two groups with regard to region of practice and their

application of Sociology of Development as well as with their ratings with regard to whether knowledge of Sociology of Development has had an impact on their nursing practice.

Table 4.8: Extent of influence of Sociology of Development according to region where the nurse is practicing

Region where practicing VARIABLES	Northern Regions			Southern Regions			
	N		S	N		S	P
a. Impact/Influence of modernisation on your nursing care	25	3.32	0.95	21	2.95	1.20	0.126
b. Influence of capitalism on your nursing practice concerning availability of resources	26	3.58	1.10	19	3.79	1.03	0.253
c. Sociology of development led to improvement of your nursing practice	26	3.92	0.69	18	3.50	1.10	0.062
d. After completion of your training to what extent did you upgrade your knowledge	27	3.56	0.70	20	3.20	1.36	0.125
e. Extent to which the upgrading of your knowledge influenced your skills	25	3.72	0.68	16	3.63	1.31	0.381
f. Extent to which you are equipped with necessary skills to eradicate social problems	27	3.48	0.80	16	3.00	1.32	0.072
g. Are you able to disclose information about yourself	28	3.29	1.36	22	3.14	1.64	0.363
h. Extent of changes that occurred in the aspects in health services over the past five years	24	3.46	0.59	17	3.29	1.05	0.263
i. Extent to which you set goals to achieve what you planned in your daily practice	29	3.66	0.94	23	3.52	1.20	0.327
j. Extent to which women are deprived of their rights	27	2.33	1.21	19	2.05	1.03	0.207

k. Extent to which you are involved to empower women in the community	28	3.07	1.49	23	2.04	1.40	**0.008**
l. Extent to which you are involved to assist women patients who are subjected to domestic violence at their homes	29	3.31	1.47	24	2.79	1.67	0.117

In analysing table 4.8, it can be seen that for two items (variables) a statistically significant difference was found between the two groups that were compared. In the item on involvement in the empowerment of women (item (k)), it was found that respondents from the Northern region were more involved in the empowerment of women ($p < 0.05$).

The registered nurses in this study were practicing in two different areas in Namibia, south and north, where health facilities differ considerably and where communities have different characteristics, beliefs, cultures and attitudes. The northern regions are more rural than urban, but their responses compare favorably well.

The rest of the items were analysed descriptively in that the averages obtained were considered. The items for which statistically significant differences were found, were excluded. Of the remaining ten items, item (j) is rated below 3 on the ordinal scale out of a possible maximum of 5, by both groups. The Southern region group had an additional two items ((k) and (l)) that were rated below 3. These three items were: the extent to which women were deprived of their rights (item (j)) for both groups; and the item on involvement in empowering women in the community and assisting women patients who were subjected to domestic violence (items (k) and (l)) (see table 4.8).

By implication this means that registered nurses observe very few cases of women deprived of their

rights, which would be a good picture if this was the real situation in Africa in general as Kayongo-Male and Onyango, (1994, pp 27-28) states (refer to discussion of table 4.3 in this regard). This picture is observable in Namibia. Now and then we hear and see cases of such nature in our communities and even in the hospital set-up.

Many of the registered nurses did not indicate their involvement in empowering women in their communities. Empowerment of women is part of the discussion in Sociology of Development as indicated in the literature in chapter 2 and the discussion of table 4.3 in this chapter.

4.5.7 Extent to which development aspects influence nursing practice according to length of time the nurse has been practicing in the current unit

Ho: There is no significant difference between registered nurses who have been practicing in the unit for up to 12 months and those who have practicing for more than one year in the current unit.

Ha: There is a significant difference between registered nurses who have been practicing in the unit for up to 12 months and those who have been practicing for more than one year in the current unit.

Table 4. 9: Extent of influence of Sociology of Development according to the length of time the

nurse has been practicing in the unit

How long in present unit VARIABLES	1– 12 months			More than 1 year			
	N		S	N		S	P
a. Impact/Influence of modernisation on your nursing care	22	3.18	1.01	24	3.17	1.17	0.482
b. Influence of capitalism on your nursing practice concerning availability of resources	23	3.78	1.13	22	3.50	1.01	0.191
c. Sociology of development led to improvement of your nursing practice	21	3.71	0.85	24	3.75	0.94	0.448
d. After completion of your training to what extent did you upgrade your knowledge	23	3.57	1.12	24	3.25	0.94	0.151
e. Extent to which the upgrading of your knowledge influenced your skills	21	3.86	0.85	21	3.52	1.03	0.130
f. Extent to which you are equipped with necessary skills to eradicate social problems	19	3.53	1.02	23	3.13	1.06	0.114
g. Are you able to disclose information about yourself	27	3.44	1.45	25	3.00	1.44	0.137
h. Extent of changes that occurred in the aspects in health services over the past five years	19	3.63	0.50	22	3.18	0.96	0.037
i. Extent to which you set goals to achieve what you planned in your daily practice	27	3.70	0.87	26	3.42	1.17	0.163
j. Extent to which women are deprived of their rights	24	2.29	1.08	23	2.09	1.04	0.251
k. Extent to which you are involved to empower women in the community	25	2.64	1.47	26	2.42	1.55	0.306
l. Extent to which you are involved to assist women patients who are subjected to domestic violence at their homes	26	3.00	1.57	27	3.00	1.59	0.500

In table 4.9, a descriptive analysis of the averages of the two groups was assessed. For ten of the twelve items an average of more than three out of a maximum of five on an ordinal scale was obtained. Both groups therefore tend to apply Sociology of Development (see table 4.9).

In the remaining two items averages of less than three were obtained. These items were:

- On the rights of women, some respondents indicated in the comments leveled under this item, that nowadays women and men are equal, they share the same platforms and the issues of gender equality is promoted by the Government.
- Wallace & Wolf (1999, pp 418–419) state that the role of the women in contemporary society is vast, but that their benefits are very low compared to those of men. They are always subjected to income inequality and cannot promote their own self-interests. Such conditions put the health status of women at great risk. Several approaches are used, these being welfare, equity, anti-poverty efficiency and empowerment of women.

- Empowerment of women by nurses scored less than 3.00, which means that nurses do not readily observe the deprivation therefore they do not help women by empowering them. According to the Namibian National Gender Policy and National Plan of Action on Gender of 1998, the issue of women and development was highlighted. This policy document was also used to address the problem of the disabled. The main issues covered in this document are: Poverty and rural development; Education and training; Reproductive health; Violence against women and children; Economic empowerment; Power and decision-making; Information and communication and the care of the girl-child.

The Department of Women Affairs monitors the progress of women and men under the policy (NGP & NPAG, 1998, pp 1-2). These two issues will be addressed in the strategies to be formulated later in this study.

4.5.8 Summary of the findings that indicated a trend in the responses

In this section a summary is provided of the findings according to the trends they have shown. The results have indicated no statistical significant differences in most of the variables but with general trends on some of the cases like the extent to which registered nurses observe or assess women derived of their rights, empowerment of women in the community and observation of women subjected to domestic violence. The average score between the two groups on the dependent variables have also reflected a trend of being less than 3 (□ < 3.00) on the five point scale. The selection of the findings is therefore based on either the obtainment of statistical significant differences, or findings that are below an average of 3 out of a maximum of five on an ordinal scale. These trends can be illustrated in the table here below (Table 4.10).

Table 4.10: A summary of the trends in the findings based on the statistically significant differences and the average scores of less than 3 out of a maximum of 5 points on an ordinal scale

Dependent variable	Independent variable description	Statistically significant difference found	An average score of less than 3 out of a maximum of 5
Women’s rights	The differences between two age groups (Table 4.3)	None	Yes
Empowerment of	The differences between two age groups (Table 4.3)	None	Yes

women			
Women's rights	The differences between males and females (Table 4.4)	None	Yes
Empowerment of women	The differences between males and females (Table 4.4)	None	Yes
Women's rights	The differences between two time spans of completion of training (Table 4.5)	None	Yes
Empowerment of women	The differences between two time spans of completion of training (Table 4.5)	None	Yes
Sociology of Development leads to improvement of nursing practice	Differences between two groups based on region where training was completed (Table 4.6)	Yes (t-test , p= 0,024)	No
Empowerment of women	Differences between two groups based on region where training was completed (Table 4.6)	Yes (t- test, p= 0,017	Yes, for one group
Assistance to women who are subjected to domestic violence	Differences between two groups based on region where training was completed (Table 4.6)	Yes (t- test p= 0,042	Yes, for one group
Women's rights	Differences between two groups based on region where training was completed (Table 4.6)	No	Yes
Women's rights	Differences between two time spans of completion of Sociology of Development (Table 4.7)	No	Yes

Empowerment of women	The differences between two time spans of completion of Sociology of Development (Table 4.7 item (k))	None	Yes
Empowerment of women	Differences between two groups based on regions where registered nurses practice (Table 4.8 item (k))	Yes (t- test, p= 0,008	Yes, for one group
Assistance to women who are subjected to domestic violence	Differences between two groups based on region where registered nurses practice (Table 4.8 item (l))	Yes (t- test p= 0,017	Yes, for one group
Women's rights	Differences between two groups based on region where registered nurses practice (Table 4.8, j)	No	Yes
Changes occurred in health services over the past five years	Differences between two groups based on length of time practicing in the unit (Table 4.9, item (h))	Yes according to t-test p value is lower than 0.05 (P < 0.05)	No
Women's rights	Differences between two groups based on length of time practicing in the unit (Table 4.9, item (j))	No	Yes
Empowerment of women	Differences between two groups based on length of time practicing in the unit (Table 4.9, item (k))	No	Yes

4.6 Analysis of data on comments (open-ended questions)

This section will examine the specific items of development as responded to by registered nurses with regard to seven variables such as age, gender etc. The comments will include the highlights of the summary of trends as specified in Table 4.10. This data analysis is open-coded and takes the form of a summary of the comments made by the respondents.

4.6.1 The impact of modernisation on nursing care

Respondents indicated that modernisation strengthened interpersonal relationships between nurses and patients, family members and other professionals; that they acquired knowledge and skills to facilitate change from a traditional to a modern way of living; and they mentioned that urbanisation, had an impact, because there is better quality health care in cities than in rural areas.

Furthermore, they mentioned having experienced personal and professional growth in the planning and decision-making processes (Coetzee 1989, pp 4.7).

Nursing practice and modernisation are highly interrelated as nurses seek to meet the needs of their community through high quality evidence-based patient/client care. This is possible in the presence of innovative change and when modernisation of services is continually explored and introduced to achieve and maintain excellent nursing standards. (http://www.gov.je/Health/Hospital+Sites/General+Hospital/Nursing+and+Operations/Naccessed

7/4/2006). [On line]

Modernisation was also found to have negative influences on nursing practice, because it sometimes leads to misunderstanding of human rights by nurses. Some nurses misinterpret freedom of expression and act irresponsibly by doing what they want to even if it is against the nursing ethic. On the other hand, some nurses are not able to practice their professional skills due to the lack of manpower and material that has existed since independence.

4.6.2 Influence of capitalism on nursing care

In Sociology of Development nurses learn to understand the characteristics of huge imbalances and disparities with respect to access to resources and services. By anticipating the dynamics of social change it is possible to identify the influences that such development will have on nursing and the whole care delivery system (UNAM, 1995, p 327).

Some respondents mentioned that there are certain staff members are greedy and who use funds for nursing for their own benefits. The process of supplying equipment as ordered and the repair to damaged equipment is very slow and some personnel do not take proper care of equipment.

Respondents also mentioned shortages of certain medication as well as lack of human resources. With regard to patients, they commented on exorbitant fees payable, expensive medication and services that are unavailable, inaccessible and unaffordable as well as inadequate and inequitable health facilities.

They also mentioned lack of transport and accommodation.

In spite of the above the positive influence of capitalism was also indicated, with specific reference to improvements in health, for example, life expectancy, availability of medication in hospitals. Nurses did, however mention that there is a need for more, ARV (anti-retroviral) drugs.

4.6.3 Improvement in nursing practice caused by Sociology of Development

It was mentioned by respondents that Sociology of Development brought about many improvements in nursing practice, for example, opened-minded, broadened thinking which led to better decision-making ability by nurses. In addition, nurses reported being able to better evaluate hospital management so that nursing care could be improved. They reported that Sociology of Development enables them to assess and process patients' needs in a more holistic manner, that is, to plan and implement that plan according to all the patients' needs. Paul Streeten's Basic Needs Approach (BNA) is similar to the hermeneutic approach, which looks into development as a move to increase humanness, to satisfy human needs and create conditions for the realisation of everyone's personality (Coetzee, 1989, p 153).

4.6.4 Upgrading of knowledge after completion of training

Respondents reported that they upgrade knowledge and skills by means of further study, by acquiring additional qualifications, by attending workshops that enlighten them and equip them with more knowledge and skills. They also reported that they are allocated to areas with more information and experience in higher positions, which entail more responsibility and an expansion of their skills in nursing care.

Some nurses, however, reported that no upgrading of skills has taken place, because they have never been given the chance to study further, due to favoritism, lack of refresher courses and lack of no clear information and direction.

The nurses further stated that they have acquired new knowledge and skills, which they can apply to their daily practice, thus expanding the boundaries of professional practice by way of thinking and reasoning. Advanced training and study is of vital importance to registered nurses, so that they can obtain specialised knowledge and skills, above those acquired in basic training (Rolfe & Fulbrook, 1998, pp 73–75).

4.6.5 The extent to which upgrading of knowledge has influenced nursing skills

Respondents stated that upgrading of knowledge has led to growth in professional practice, whereby they have developed a higher standard of handling and managing cases. They indicated that they can apply improved skills to nursing practice with regard to communication, handling of colleagues and patients, managerial supervisory performance skills and that they have learnt to delegate and allocate

patient care to other staff. Upgrades in knowledge have enabled them to evaluate students and subordinates.

Some respondents also felt that more needs to be done with regard to knowledge upgrades. Sometimes it is not possible for nurses to perform their duties properly, because as subordinates they do not submit to the authority of senior nurses.

They also mentioned that they need to attend more workshops on management, and that they have less opportunity to upgrade their skills because of lack of study leave.

4.6.6 Successful achievement of nurses' professional lives

The achievements that they have mustered are that they have obtained additional qualifications, experience and knowledge on how to manage staff and health problems. They can provide counseling to patients and other nurses and are able to think critically. They have acquired educational and communication skills and are able to evaluate themselves and have developed an ability to take own initiative at departmental level.

The above shows progress in the development process, because as Wilson (1999, pp 9, 12, 13, 26) states, decision-making meetings are a necessary, where group members participate fully and express themselves so as to inform others on their activities in units, where they can share information on a

regular basis and they serve as opportunities to give each other feedback.

Nurses claim that they have succeeded in minimising neonatal death rates, fresh stillbirths and in reducing low Apgar scores in newborn babies. They have also managed to improve the prevention of communicable and non-communicable diseases, but they did not explain how they came to the conclusion that they were responsible for these improvements.

There were also nurses who indicated that they have not achieved anything at all due to financial constrains to further study, having been allocated for too long to one unit and because they have had less exposure to clinical situations.

4.6.7 The ability to minimize social problems

There are several examples of social problems to which registered nurses should respond. These include social, physical and environmental issues such as inequality, disease and slums. The nurses' responses indicate that they have the ability to deal with the social problems of their clients. This implies that most of them are reflecting a picture of being able to help their patients and assisting them in finding solutions to the social problems that they present with when they visit the health facilities. If what they indicated is what they do in the real practical situation, then their patients are being cared for as efficiently as possible.

In order to help minimize somebody's problem, it is not necessary for a nurse to find a solution on her/his own, but rather it is necessary to assist the person to find a solution. It is more effective to guide the patient who has a problem towards problem-solving by him/herself, instead of personalising the problem. A nurse needs to possess problem-solving skills linked to decision-making ability. A nurse needs to assess the situation (to determine the cause of the problem), critically think about what is happening and apply the basic principles of problem-solving strategies, which underlie nursing practice (Beekman, 2000, pp 3,4,28,45; Muller, 2003, pp 155,229).

4.6.8 The ability to effectively disclose information about self

The nurses who commented on this point, indicated that their ability to disclose information about themselves depends on the context/situation they find themselves in, the relationship with the person to whom they have to disclose the information, and on whether the disclosure is work related or not. Disclosure also depends on whether it is for the benefit of the patient, and whether the matter being dealt with is private or secret.

Disclosure is found to be difficult in most cases. People are afraid to disclose information for fear of what others may think of them. Compare the issue of disclosure by HIV-positive clients because of stigma (Rabkin, El-Sadr and Abrams, 2005, pp 45 - 46).

From the literature it is clear that disclosure of personal information is a skill that facilitates communication. Disclosure takes place for different reasons and in different situations. It is necessary to know the process of communication or the way to disclose information. It is also necessary to know

that in management disclosure is imperative for effective communication with subordinates and seniors. Communication helps the sender to give the message, somebody receives the message (receiver) through the channel it is sent, and can respond (feedback) accordingly. This process differs from context to context (Payne, 2001, pp 4, 7, 9-12).

Interpersonal communication is purposeful between nurses of the same and different categories. It can help them to share and provide information, it promotes self-expression, it facilitates disclosure, management and control and it promotes the recovery of patients (Dickson, Hargie and Morrow, 1997, pp 12-14).

In addition nurses have pointed out in their comments to this question that the reason for disclosure should be known and that the person who discloses the information should be sure about what the information is going to be used for. This indicates that disclosure of information is a conditional issue for many nurses. The means of disclosing information and its importance needs to be clearly understood.

Stewart (1999, pp 258-260) states that for a person to be able to disclose information effectively, he or she should make strategic preparation in order to manipulate the context so that the listener's response becomes more predictable. Some people introduce the topic on which they want to make a disclosure by joking or slighting, in order to see what the general reaction of the listener is to the topic. If it is safe then they go ahead with the topic.

In some situations, the act of self-disclosure has an educative purpose, which is exactly the case in the

situation where nurses care for patients). Disclosure can be personal, social and professional. Disclosure is inevitable in every health care set-up and wherever people come together or work together. It can also be said to be irreversible, because once something is said, it cannot be taken back (Dickson, Hargie and Morrow, 1997, pp 41-44).

Disclosure can be used to share broad experience rather than literal and specific content. One respondent said that he/she cannot disclose information about himself/herself.

4.6.9 Items that need to be changed or are not fully covered in Sociology of Development

Nurses pointed out aspects that were not fully covered in Sociology of Development, such as challenges after Namibia's independence, social problems such as the issue of street kids, child abuse, marital problems, unemployment and crime. They felt that HIV/AIDS should be included in the content, although this is already the case. All the problems stated are those dealt with under this section and in the section on social problems.

Respondents indicated that aspects that need to be changed are the revision of Sociology of Development content every third year, revisions to the information on dependency theory and modernisation theory, which they feel needs to be emphasised more than other theories. They feel that the process of modernization needs to be elaborated upon.

Sociology of Development itself needs to be made adaptable to the prevailing environment and to be more practical to the case of Namibia. There were some respondents who felt that there is no need to

change the curriculum and that it should go on as it is now.

4.6.10 Extent to which women are deprived of their rights in the community

Very few nurses commented on the issues of political and marital dominance by men, weaknesses of women to respond to deprivation and abuses against them, the fact that there are fewer opportunities for women to take up positions at high levels and the belief that men are superior to women.

In December 1986, the United Nations General Assembly adopted the principle that every person has the right to development by participating in, contributing to, enjoying economic, social, cultural and political development in which all human rights and fundamentals freedoms can be fully realised. It was further stated that opportunity for development is prerogative both for the nation's and of individuals (Jolly, Emmerij, Ghai and Lapeyre, 2004).

Some nurses responded that women and men nowadays have equal rights, equal opportunities to further their studies and are not deprived of any right. The literature referred to human rights violations and deprivation. That is why we find that advocacy of human rights is being advanced as a responsibility of nurses in practice. Nursing must entail the defense of the human right of those patients and clients who cannot defend themselves. Nurses act as advocates for their patients (clients) to plead on their behalf and make their clients aware of what they are entitled to and what they can claim or expect from health professionals (Creasia & Parker, 1996, pp 265-266).

The issue of the Ministry of Women and Child Affairs which is now known as the Ministry of Gender

and Child Affairs, was mentioned by respondents as an indication of women being well cared for by the Government of Namibia. Even if this Ministry exists, the issue of deprivation of women's right comes up in many reports, referring to police files in this case.

4.6.11 Changes that have taken place in aspects of health services over the past five years

The respondents for this study felt that there is still poor management of infrastructure and that nurses are still overworked and overloaded with work. Some changes have occurred like introduction of information management system, more clinics have been built and more health services are taken to the rural areas at low cost or some are given free of charge. Information on health care is made available by means of different platforms, for example, radio and TV, with more focus on the disadvantaged to improve health care facilities and services. More emphasis is placed on health education to give information on prevention of diseases.

4.6.12 Extent and means of exploitation among nurses

Nurses have admitted to being exploited in the work situation and stated different forms/ways of exploitation. They were threatened, had no forums to air their views or express their sufferings, they were excluded from the decision-making process, and some said that they did not enjoy job satisfaction.

They expressed the grievance that they are paid low wages, but spend long hours on duty in overcrowded health facilities and stated that their overtime rates are very low and that overtime is

sometimes not paid at all. Nurse who are employees of the health authority, have the right to be provided with a job description, a fair salary/wage as agreed upon, remuneration equivalent to others in the same category of health worker, taking into account the classification of functions and responsibilities and overtime duties and unsociable hours where these are not compensated for by additional vacation leave (Searle & Pera, 1995, p 420).

They stated that they are subjected to unfair policies and deprived of their rights and complained of staff shortage and lack of respect shown to them. They complained of being accused and criticised instead of being praised for their good work.

Nurses as employees need their work to be acknowledged. Nurse managers represent employees within their working environment even if they are also employees. They need to understand that their subordinates want to do a good job or a great job, therefore they need to be respected, recognised and trusted. Managers need to acknowledge their performance and thank them for a job well done. Managers need to praise more and criticise less, just as firm owners or managers dealing with their customers (McKean, 2005, pp 43-44, 4, 50, 84-85).

Nurses in management positions should give feedback on what their subordinates have done, in writing or by verbal communication. Praising or constructive criticism is one way of giving feedback on what was done and how it was done (Higgs, Sefton, Street, McAllister & Hay, 2005, pp 247-249).

They claimed that their seniors use power to oppress them as subordinates when they do not agree. Unequal treatment of staff by seniors, favoritism and discrimination against nurses in rural areas are

prominent.

4.6.13 How the respondents empower women in the community

They stated that they educate women on aspects such as how to knit babies' head caps and seat covers, how to start self-help groups in the community, for example, projects and own business, how to cultivate their own vegetable and fruit gardens, how to produce 'mahangu', make traditional baskets and sell 'capana' to earn some money.

Nurses teach young women who are HIV-positive and unemployed, how to sell things, for example, lotion and health products and to join self-help groups in their communities. They encourage them to make their own decisions on reproductive health. They also teach them about the importance of breast-feeding.

Women are encouraged to feel that they have the same rights as men and should work hard for their families and not be dependent, if there are conflicts between them and men.

Respondents indicated that they empower women regarding self-realisation and self-esteem in whatever they do. They help women to establish projects and to rewrite their project proposals. One respondent indicated that he/she has assisted women in leadership decision-making and planning.

Some respondents said that they did not have time to empower fellow women, as they are too busy

washing and cleaning, when they are off-duty.

From their responses it is clear that nurses are doing less for the empowerment of women in the community.

4.6.14 Organisations that are involved in women and child-care development

Many organisations were cited as being responsible for the development of women, amongst others, Women for Action and Development (WAD). See Appendix A.

4.7 Weaknesses identified

For some aspects there was a significant drop in the responses below average for the two groupings of registered nurses of different age groups, trained at different times and in different circumstances or regions with regard to the application of Sociology of Development in health care units. These aspects are highlighted in the table below.

Table 4.11 summary of trends from comments (comments were taken from the majority of the responses)

	Areas identified

Modernisation	Lack of opportunity for further study and in-service education Lack of promotion and recognition
Capitalism	Lack of capital led to lack of medication and equipment Unequal distribution of facilities and equipment to render health care in practical areas Unequal treatment of nurses by their seniors Low and unfair remuneration for nurses and lack of incentives Exploitation of nurses

4.8 Summary

This study investigated how nurses undergo training and how they apply or find Sociology of Development applicable to nursing practice. There were 56 nurses who participated in this study. They were given questionnaires to respond, and the data from these were analysed and interpreted. Interpretation was given for each item, to highlight the meaning of the information at hand. It is necessary for the researcher and readers to react to the information given by respondents, by producing another text as the conclusion to what has been observed or heard. According to Hardy (2004, p 659), it is necessary to ask what the data is saying and to explain why things are happening as they do.

From the research findings, it has become clear that Sociology of Development is being applied in most cases. The results indicate what nurses do with the knowledge they gain from the study of Sociology

and more especially Sociology of Development, which is an issue of concern in this specific investigation. Modernisation theory examines aspects of progress, advancement, forward looking, transformation and change for the better. Nurses stated that modern living is observable in the practical nursing situation. There is also information given by the respondents that indicates that the study of Sociology of Development has positively changed their behaviours. and practice.

Besides the good points they have mentioned, there are also shortcomings of development and bad effects brought about by the modernisation process. Even if modernisation is taking place in nursing practice, not all aspects can be applied due to certain problems and obstacles.

From the statistical analysis, respondents reflected some weaknesses in the application of development in nursing practice and how they relate their practice to social development. The general trends reflected in the data are the significant statistical differences in some aspects and the average responses that are less than 3 on the five points of an ordinal scale. The three major items featuring in this case are the extent to which registered nurses (respondents) observe deprivation of women's rights, empowerment of women in the community and assistance they give to women and children who are subjected to domestic violence. These trends are summarised in table 4.10 in this chapter.

In their comments, respondents indicated the areas where they feel that Sociology of Development is not well articulated in their clinical practice as seen in table 4.11, and mentioned the causes of such failures. Registered nurses have indicated experience of not having equal opportunities and access to services studies. They referred to exploitation in their daily functions and not having equal recognition either as nurses or as health workers within the health care team. These are the features of capitalism.

The respondents were consciously aware that they affect humanity and they indicated that the rights of people are not equally recognized, especially in the case of women and children. They also indicated that there are cases of discrimination, abuse and violation of their rights.

Dealing with development issues is not a one-day process. Some issues can be addressed within a relatively short time, but there are other issues which take time to be resolved, depending on the availability of resources and means as well as the will and preparedness of those involved.

The next chapter will deal with the conceptual framework for strategies to address the challenges highlighted in this chapter.

CHAPTER 5: CONCEPTUAL FRAMEWORK FOR FORMULATION OF STRATEGIES

5.1 INTRODUCTION

The data analysis performed in the previous chapter painted a picture of the situation that exists with regard to the study. It reflects what the respondents think about, believe, experience and observe. The objective of the data that the researcher collected thorough the questionnaires from registered nurses who have done Sociology of Development in the training, was to open up areas in practical

application which need strategies to best utilise the knowledge nurses acquired in nursing practice.

A conceptual framework was described on which the strategies are to be based. The researcher has tried to express the findings in relation to the literature reviewed. This made it possible to examine what different authors have to say with respect to development taking place in societies from three major perspectives, but also to investigate what nurses observe and experience in their health facility settings.

The issue of how, for example, nursing research might be considered in the sociological context is that social structures influence individual actions and those actions in turn maintain or transform social structures. The gap between theory and practice experienced by nurses is generated by a lack of resources, which is a reflection of the social structures of capitalism within which nurses operate.

The aim of this chapter is to conceptualise the empirical findings of phase 1 in order to develop strategies for facilitation of Sociology of Development in nursing practice.

The purpose is therefore, to form a bridge between phase 1 (the empirical phase) and phase 3 (the development of strategies) so that Sociology of Development can be applied to nursing practice.

5.2 THE CONCEPTUAL FRAMEWORK

The reasoning map for this study reflects the components of the framework as listed above (Fig. 5.1).

These components are discussed below.

Agent – The facilitation agent: The nurse educator in Sociology of Development who will facilitate to process for registered nurses so that the identified challenges can be addressed. In this study there is also be a second agent (mobilisation agent) who is the recipient of the facilitation. The registered nurse is the mobilization agent he/she is the professional practitioner who should be able to address the challenges in his/her environment.

Recipient – The person who benefits from the activity, in this case the registered nurse.

Procedure – The facilitating strategies, which are to be formulated.

Context – It refers to nursing practice which is in the clinical units in health care facilities

Dynamics - The dynamics as indicated by the registered nurses who participated in the study are the challenges, which need to be addressed, and these are as follows:

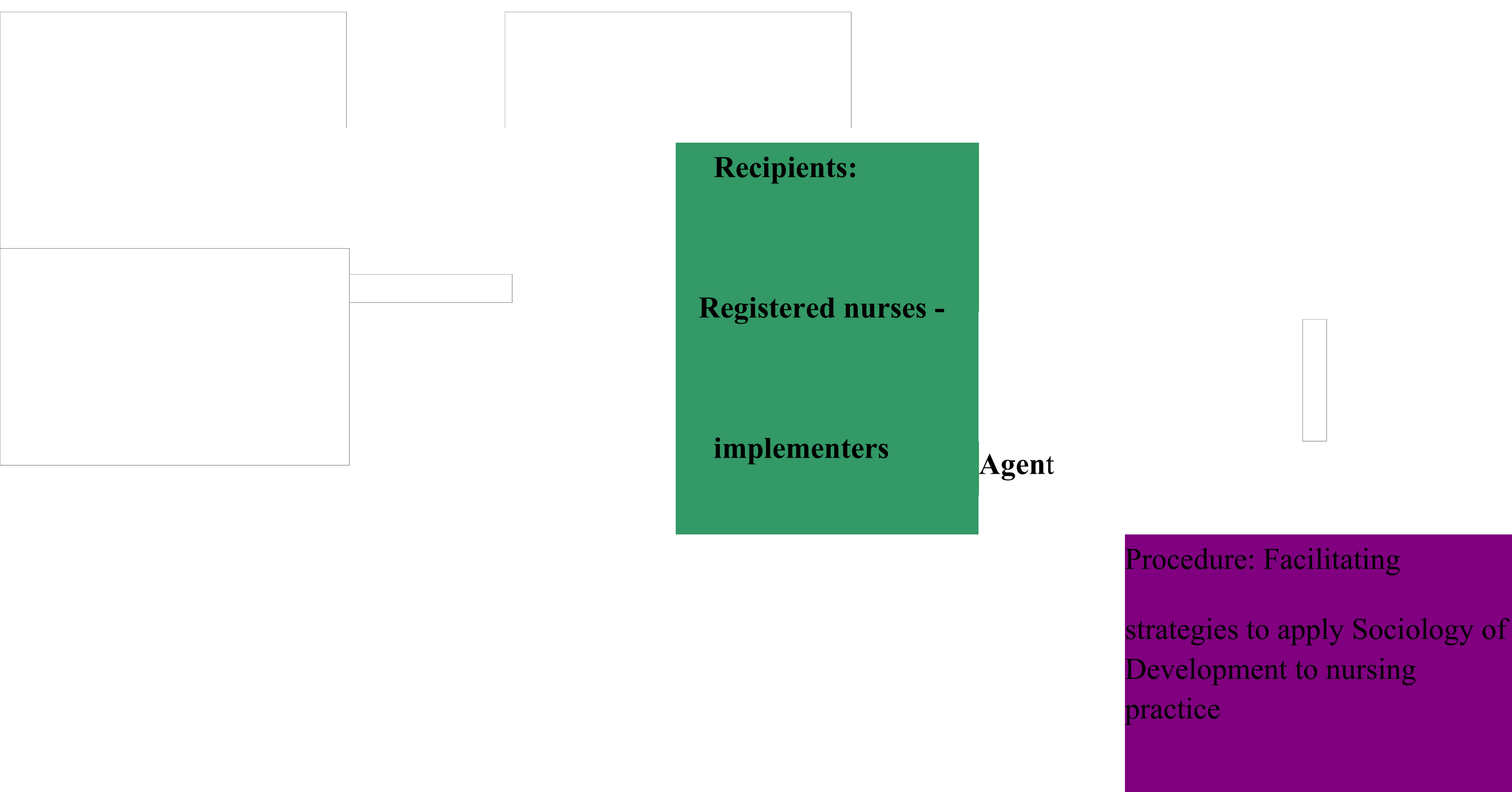
- Nurses lack ability to apply knowledge to practice.
- There is a lack of opportunities for further studies and in-service education.
- There is a lack of capital, which leads to lack of medication and equipment.
- There is unequal distribution of facilities and equipment to render health care in practical areas.
- Nurses' remuneration and incentives are low and unfair.
- Nurses are exploited, they have to work long hours and weekends sometimes without overtime pay, due to shortages of staff and too many patients.
- There are very limited opportunities for promotion and recognition of nursing staff.
- Child abuse in health care facilities is not readily observed.
- Women are deprived of their rights and subjected to domestic violence.

If Sociology of Development is to be applied to clinical practice, strategies and action plans need to be developed to address the needs as reflected in the dynamics above. This application will affect the units and departments where patients and clients are cared, thus affecting people in different categories of gender, race, age and social grouping.

Terminus – This is the outcome from addressing the challenges or dynamics related to the application of Sociology of Development to nursing practice.

For the purpose of this study each of these aspects will be discussed individually.

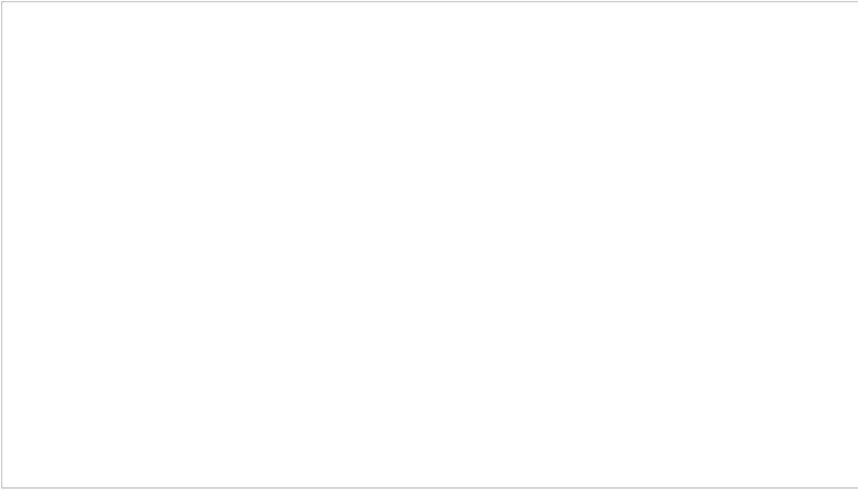
Figure 5.1: The reasoning map



5.2.1 The Agent: Facilitation agent: Nurse educator (researcher)

5.2.1.1 The mobilisation agent: The registered nurse

Figure 5.2: The Agent



Administrative
role

The agent refers to the person/people who is/are empowered to act on behalf of an organisation or other person (Goldblatt and Nelson, 2001, p 7). He or she is also the one who acts and take initiatives in social/community activities. In Sociology of Development application denotes the nurse educator who facilitates addressing the identified challenges and also the registered nurse who mobilises resources to address those challenges (Jarvis, 1999, p 58).

The agent in this study oversees the function of the recipient and acts as a facilitator for Sociology of Development in health care from a holistic point of view, as illustrated by the sky blue circle. The lavender/purple triangle represents the three dimensional roles of the facilitation and mobilisation agent, these being administrative, professional and educational:

- As a professional nurse, the facilitation agent can facilitate nursing care activities within the parameters of applying knowledge to nursing safely and according to practical environment while the mobilisation agent mobilises the facilities and activities in the clinical set-up where she/he is employed.
- Administratively, he/she needs to act as supervisor of the mobilising agent who is a recipient in the endeavor to apply Sociology of Development to nursing care.
- From an education point of view, the agent is a registered nurse /lecturer who is involved in imparting knowledge to registered nurses so that they can apply it and who in turn can mobilises the application to their daily health care delivery.

The facilitation agent has to formulate strategies for the application of Sociology of Development to nursing practice and therefore needs to have knowledge in Sociology of Development, the theories that it encompasses and the aspects applicable to nursing practice. The facilitation agent needs to demonstrate the relationship between social development and nursing as a health care delivery profession, being able to link it to health care issues in a developing society and connect recipients who are registered nurses with social conditions that affect their practice. The agent is the player in the best position to guide registered nurses, showing them the interrelatedness/interrelationship between nursing and social conditions.

Furthermore, both agents need to take a holistic approach when guiding nurses, as illustrated by the circle (sky blue in fig 5.2). This means that they have to view each person as a whole, that is, physically, emotionally, psychologically and socially within the parameters of social development.

It is the final responsibility of the researcher (the facilitation agent), who deals with the responses,

analysis and interpretation of the findings to draw conclusions and develop strategies that direct application of strategies. The most important task that remains is, for the agent who has information at hand, to come up with a path to be followed which suits the problems or challenges that face nurses.

An agent is responsible for making recipients aware of how best they can care for their patients and clients, by considering social conditions and linking them to development as well as the conditions for which the patients need immediate care. It is therefore the agent's duty to come up with strategies that help nurses to apply what they have been theoretically in practical situations.

As a lecturer, the agent is the one who identifies what needs to be applied, how to correlate different needs, how to plan for need satisfaction and how to define modes of application.

The researcher is in a position to act as a coordinator of the intervention process while examining the possible impacts of application and the barriers to the whole process. As a facilitator in this process, the researcher should possess certain characteristics, namely:

- The necessary competency for teaching and guiding the application of theoretical knowledge in practice;
- The ability to establish relationships with nurses based on mutual understanding and trust;
- The ability to guide and support nurses, collaborate with other agents in nursing as well as other lecturers in Sociology and related nursing courses;
- Be able to consult with other lecturers in the Department of Sociology with regard to teaching of Sociology as applicable to nursing care, and then practice and make this part of the curriculum;
  Both, the facilitation and mobilisation agents need to:

- Act as a role model in all spheres of the nursing care environment;
- Have the ability to communicate effectively;
- Accept that she/he is fallible and can make mistakes as well;

- Be able to collaborate with others;
- Be open-minded and have the motivation to act effectively;
- Be able to understand the relationship between the development process, nursing practice and the social evils that can influence development, examples being, social problems and the impact of HIV/AIDS on the country, and be able to guide recipients in new ways of assisting clients, patients and community members in dealing with these issues.

It should be made clear that the agent as a lecturer, also once having been a registered nurse, must realise that certain subjects are taught based on a theory, that sometimes these theories are not applied and that they end up being forgotten and become obsolete and expire unnoticed. Such subjects might be good the bases for curriculum development in new and advanced courses offered at a faculty level. This is the main reason why the topic for this study, linking Sociology of Development and nursing practice has been chosen.

5.2.1.2 Concluding statement

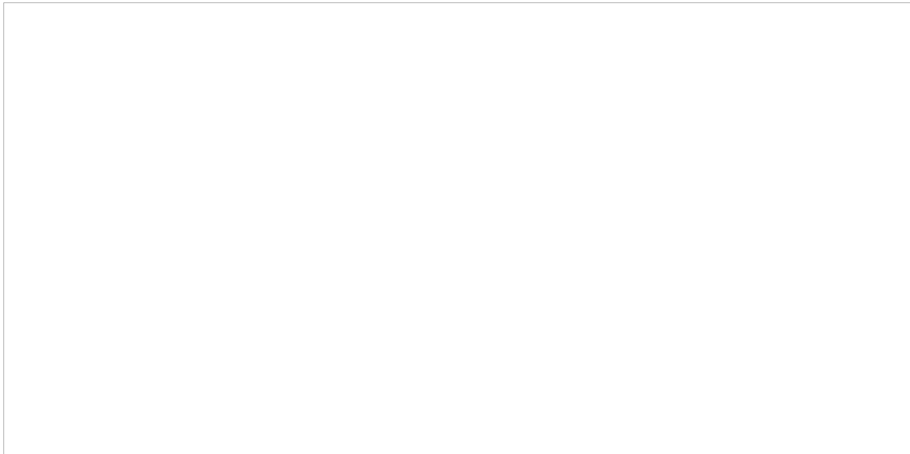
The facilitator (agent) is responsible for creating an environment that is conducive to the application of aspects of Sociology of Development to nursing practice. The agent/facilitator empowers registered nurses to identify problems like abuse of women and children, domestic violence and women who are deprived of their rights, as these patients come to them for care and treatment. The attitude of the agent motivates the recipient to mobilise resources to do more for his/her patients and to see to it that they receive not only the necessary care they need, but that they receive it efficiently and with dignity.

5.2.2 The recipient: The registered nurse

It is the registered nurse who practices nursing and who has to apply the content of Sociology of

Development to nursing practice during daily practice of health care delivery. This nurse has to find the situation where Sociology of Development can be applied. On the other hand he or she should be able to see development as it takes place in clinical practice, as it relates to the social development, which she or he studied as part of the curriculum.

Figure 5.3: The recipient as a mobilizor



Recipient is defined as someone who receives information from another person. In this case he/she is a professional nurse who practices nursing on a daily basis. The other nurses he/she works with, the other health professionals in the health facility where he/she practices, the community that he/she is serving and the patients and clients that he/she deals with, are all members of a developing society.

In figure 5.3, the recipient who is a nurse, always takes a holistic approach whether he/she is working with others or with herself/himself. This principle is represented by the rose circle in the diagram. This view is vital for any professional and responsible nurse. Every person is multidimensional, that is, physical, psychic, social, spiritual and emotional, and for this reason needs to be viewed as such by others. The holistic approach depends on a holistic view. A holistic approach cannot be followed if not people are not viewed as a whole.

The sea green rectangle represents the major functions of the nurse with regard to his duty when implementing and applying Sociology of Development in nursing practice. The functions he/she embarks upon are:

- Professional function where he/she provides nursing care to patients/clients and the community where needed;

- Educational function to patients/clients and other health workers in the unit including student nurses and other categories of workers;

- Managerial function that includes supervising and managing the work of her/his subordinates and other aspects of the nursing unit under her/his jurisdiction;

- Application of the content of Sociology of Development, combining all functions to make up a comprehensive approach or a whole, because these functions are interrelated and interdependent. This function forms part of the professional function but is highlighted for the sake of clarity because it is the one dealt with in this whole study. Nurses cannot fulfill their duties if they perform these functions in isolation. Again in this case the holistic view is prevalent.

Registered nurses are adult learners who put their knowledge into practice. They undergo training that shapes and remoulds. Certain theories such as those formulated by Brunner or Maslow are known to them and help them to build up their potential for application of Sociology of Development (Knowles, Holton and Swanson, 1998, pp 14-15).

The professional registered nurse acquires knowledge from the course facilitated by the agent (lecturer). This is the reason why he/she is expected to internalise and the content of Sociology of Development in practice.

To be able to apply the knowledge content of Sociology of Development in nursing practice nurses need guidance from the agent in the form of the strategies that will be formulated in this study. Recipients in clinical situations fall into different categories. Some (as indicated in their responses in the form of background professional particulars) are first line managers or supervisors, some are nurses in charge of units and some are seniors, or juniors who function under supervisors.

Their responses indicate that some registered nurses are hindered by issues within the system, which are beyond their control. In cases where there are financial constrains, nurses cannot do much on their own, but to accept the constraints and make use of what is available in an economically effective way.

The recipient should possess certain characteristics that enable her/him to practice nursing and apply knowledge to nursing practice as much as possible. These characteristics are discussed next.

Critical thinking: the registered nurse should think and reason critically in order to identify areas of application. Application is not an automatic process, but should be thoroughly thought through and analysed.

Management skills: Every application needs to be managed properly for it to be successful. This includes knowledge management from the content learnt in Sociology of Development.

Responsibility and accountability: This includes responsibility for own acts and omissions as well as the responsibility of teaching others. Not only does a nurse need to teach others, but also has to be responsible for what he/she teaches, so that those learning understand and do what is expected of them, depending on the context.

Drive and motivation: Willingness to serve is an expensive but inevitable characteristic for a professional nurse of any calibre. Where there is a will there is a way. Only dedicated nurses can successfully apply the knowledge acquired from theoretical learning to nursing practice.

Health interpersonal relationship: If a registered nurses does not have this health as an interpersonal process health issues relate to one another in the form of a chain.

Communication skills: Nursing cannot be properly practiced if communication is lacking. For proper care nurses need to communicate with others.

Curiosity: The registered nurse should be someone who is always ready and willing to learn and acquire new knowledge.

Empathy: The registered nurse should view patients not only with sympathy but put her/himself into the shoes of patients who are suffering and in pain, by listening attentively to their complaints and questions, with mutual trust and respect. Trust and respect play an integral part in maintaining empathetic understanding of conditions such as abuse and discrimination.

Self-awareness: In order to apply knowledge successfully, the recipient should be aware of his/her abilities and capabilities, as well as shortcomings and limitations.

Open-mindedness: This is a quality which most people lack. In their answers, respondents indicated being able to disclose their feelings if they know what the consequences will be. This point indicates that whenever a person doubts the results of expressing him/herself then he/she may not communicate with an open mind or may not try to think openly. Open-mindedness is linked to fairness and justice.

5.2.2.1 Concluding statements

The recipient, as a registered nurse, has a very important role to play in this situation. He/she has to know the subject in order to apply and implement knowledge in a meaningful way.

The findings have highlighted some shortcomings in the application of knowledge. This being the case it is necessary to implement strategies that empower and strengthen registered nurses in their endeavors and make it worthwhile to apply knowledge in their everyday functioning as nurses. The weak points indicated in the findings as “dynamics” in this chapter, are derived from their own responses. The fact that these dynamics have been identified is clear evidence that some skills are lacking in the application of Sociology of Development.

As lack of knowledge featured in the responses, nurses should be encouraged to strive to acquire knowledge on what the development process entails in nursing practice, because by acquiring knowledge they develop themselves as well as people that they care for. Coetzee (1989) refers to this as “Development is for People”, and the people are nurses themselves, their clients and the communities they serve.

5.2.3 Procedure: Strategies for application of Sociology of Development

For strategies to be logical and identifiable, process maps need to be compiled. Mapping is one of the relevant ways of finding direction, planning strategies and the means of implementing them. There are different types of mapping which use appropriate structures or forms. Mapping can take the form of a model, a table, a figure or a graphic presentation (Hart, 1998, pp 143-147).

Figure 5.4: Strategic management plan

Strategy Formulation — Strategy Implementation — Strategy Evaluation

This figure outlines the path to be followed when strategies are formulated and implemented. It serves as a guideline and example for strategy formulation in this study. As per the data analysis done in chapter 4, the indication is that strategies for facilitating the application of Sociology of Development in nursing practice need to be formulated to address the aspects identified in the findings. These strategies will be introduced to registered nurses in this study report. The outlined strategies will help them to improve the application of the course knowledge to what they practice in nursing.

For the problems and weaknesses identified, strategies need to be developed to enhance, strengthen, improve or initiate application where it is lacking. For this purpose, the word strategy is defined to guide the direction of formulation.

Strategies are the means by which long-term objectives are achieved. They are also potential actions that require top management decisions and large amounts of resources and can be for as long as 5 years and are future-oriented (David, 2003, p 11).

Strategies are the 'what' of solving the problem at hand. Strategising is the part of the process, where objectives are transformed into broad headings or categories which cover the intended course of action (Hale & Whitlam, 1997, p 32).

Besides that, ideas also need to be synthesised which means that findings need to be organised in such a way that certain information which belongs together is brought together into a comprehensive idea that can assist in drawing conclusions in the form of strategies and ways of putting strategies into action in nursing practice (Hart 1998, pp 110-112).

5.2.3.1 "High catches"

This concept is used by the researcher to denote "the main points of the strategic planning that are useful to the implementation of these strategies in nursing practice." Nurses have different ways of applying their knowledge in clinical areas but they need to be assisted and guided in how they can improve this application, in line with their responses during the data collection process. Each respondent knows what she or he said in answering the questionnaire but does not now what other respondents said.

In effect all the facts are collected and the most prominent ones are synthesized from a higher perspective (challenges and problems identified from the findings). These are then used to find a strategy plan. That is why the term 'high catches' is used to describe this higher perspective.

The reasoning map as indicated above is not used in isolation, but is a clear illustration guiding and planning the path to be followed in this process of strategy formulation and implementation.

This plan does not mean that implementation is always going to be successful but it indicates a practical approach for formulating, implementing, applying and evaluating strategies. It is a dynamic and continuous process. A change in the nursing curriculum will bring about change in the dynamics as well as change in the strategies to be followed. By the same token changes in the health facilities of the Ministry of Health will change nursing practice as well.

Good mapping allows the system to be proactive and reactive in shaping its own future by initiating activities that prevent rather than only to respond (David 2003, pp 13 – 15).

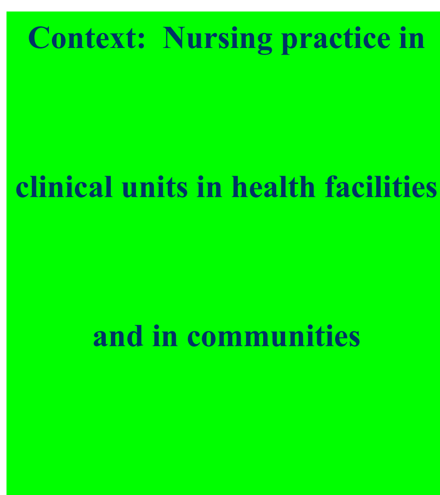
5.2.3.2 Concluding statement

The application of Sociology of Development will ensure that what the respondents have learnt in training is not been left in the classroom, but taken along and used to the best of their ability. Furthermore, it helps them to collate social science courses with nursing science courses. This creates farsighted practitioners who can see their patients and clients not only as biological and physiological

but also as social beings. This reinforces the holistic approach when health care is given. It allows nurses to consider health problems not only from a physical point of view but as also having their origins in the development process within society.

5.2.4 The context: Nursing practice in clinical units, in health facilities and in communities

Figure 5.5: The context: Clinical units, in health facilities and in communities



Context in this regard is nursing practice in clinical units in hospitals where registered nurses are allocated. Within the parameters of their responsibilities they are expected to apply the content

(Fig. 5.5) of the university curriculum of Sociology of Development for nurses. The context here means the environment or background in which application takes place. The environment in this regard includes the University which owns the curriculum and where Sociology is taught and the Ministry of Health and Social Services whose facilities are used by registered nurses for practicing and applying Sociology. In these facilities application is planned according to the health polices. The patient's rights to receive care based on Sociology of Development are contained in the patient charter.

Registered nurses function under the regulations stipulated in the Nursing Act 2004 (Act no 8 of 2004) as contained in the Government Gazette of the Republic of Namibia.

Sociology of Development deals with political, social and economic aspects, all of which influence health development in all spheres. Political development influences decision-making in the health care setting, social development affects cultural beliefs and social interactions in human society, while economic development make things possible and applicable because it the source of materials and means required for the development process to be realised.

In applying Sociology of Development to nursing practice, nurses need to observe the legal and professional framework under which they practice as well as their scope of practice, their responsibilities and accountabilities relating to their qualifications and qualities. Their functions are contained in the Nursing Act (Act no.8 of 2004). They have to take into cognition that development is takes place where there are human beings of different categories, cultural beliefs and backgrounds, and that these factors can enhance or hamper development within and around the health care system.

There are facilitators of development at every level of human life, which can be nurses themselves, other health workers and other community members of different caliber. Registered nurses should remember that their application of Sociology of Development is based on the rights, needs and also acceptance of development issues in the communities they serve and live in. It is their development as well as the development of others that is prevalent.

5.2.4.1 Concluding statement

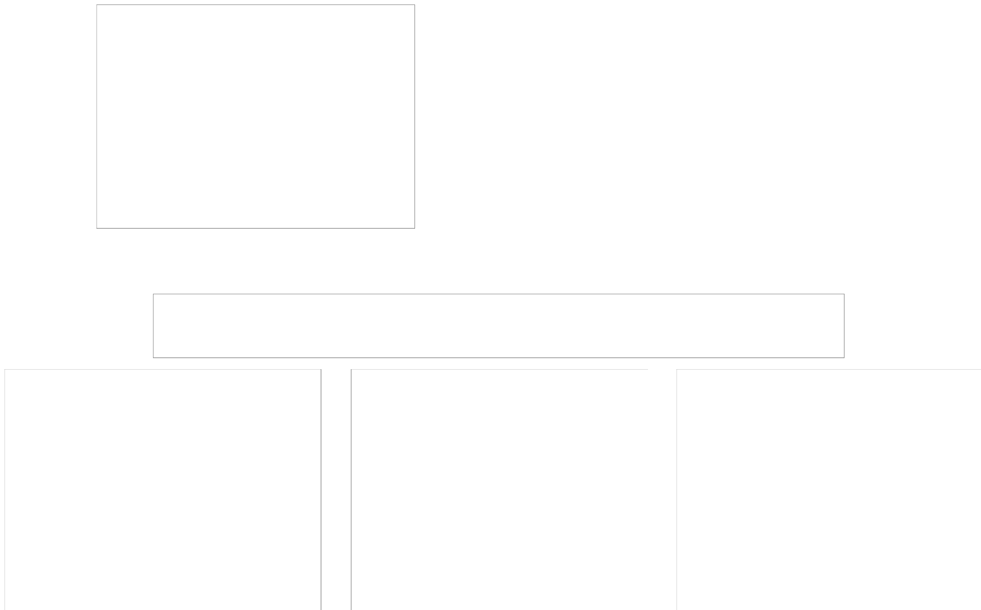
The context implies the environment where the knowledge of Sociology of Development originates, that is, where it is being taught and where it is applied and implemented. This is a vital aspect of nursing care for each and every course of study. The context is the forum where the agent and the recipient meet each other. The recipient takes action, while the agent facilitates action and guides accordingly. This is also the platform where the agent can assess knowledge management by the recipient and assesses her/his own input in nursing practice.

This application/implementation is performed in an integrated manner and not in isolation, which means that the scientific content of other subjects runs parallel.

The strategies that are to be developed in the next chapter will guide registered nurses to take the content of the curriculum and use it in the situation where they practice nursing. The agent or researcher has to act as a facilitator.

5.2.5 The dynamics: Challenges (identified from the findings)

Figure 5.6: The dynamics: Challenges in interactions and how to change them



From the summary on the findings in chapter 4 nurses indicated their experience as stated under the dynamics in this chapter. Dynamics refer to motivating forces, physical or moral, in any field (Miller and Keane, 1987, p 383). The dynamics in the case of application of Sociology of Development to nursing practice are identified in the interactions between registered nurses and their patients or clients, other nurses or other health workers, between nurses and the environment where they function and the challenge of lack of facilities that hinders proper functioning in the health care delivery system (Fig. 5.6).

The challenge observed with respect to the interactions between respondents and/or their patients and clients is the lack of necessary knowledge to observe problems. Nurses act as the ears and eyes of

those who cannot hear or see. If they cannot observe that their patients and clients experiencing problems such as abuse, deprivation of their rights and domestic violence, then they are failing in the work. In the statistical findings it came out that the registered nurses' observation of the abovementioned problems is poor or lacking. This is by implication a lack of knowledge from Sociology of Development, where theories deal with the ability to see and assist in dealing with such problems in communities.

According to the Legal Assistance Centre (LAC, 2005, p 18) medical personnel interviewed in a recent study indicated that almost half of the women and children they treat show signs of being victims of domestic violence. The literature studied indicates that this issue is a world-wide concern and also in Namibia, particularly for rural women.

The mode of interaction and facilitation of the application of knowledge is communication between nurses and their patients/clients and between themselves. Through communication nurses are be able to identify any problems that patients are presenting with, when coming for treatment or consultation. To apply Sociology of Development, registered nurses need to speak or write (verbal communication) about their patients and report on their conditions.
Counselling of patients and clients visiting health facilities is of great necessity. Wyrley-Birch & Wright, (2003, p 93,96) state that, during counselling sessions, nurses and clients make use of verbal and non-verbal communication. Both can act as senders and receivers of messages. In this situation, each gives feedback to the other one. It is therefore necessary for each to be clear on the message he/she sends or the feedback he is giving as a response to the message given. Any problem presented can then be detected.

The second challenge has to do with the practical environment. Registered nurses reported unequal treatment of nurses by other nurses or health workers, exploitation in the form of low remuneration, lack of promotion as well as being deprived of opportunities to study further. Studying further is a feature of development, which can also affect remuneration and promotion. Low remuneration and lack of promotion may hamper proper functioning of registered nurses.

The challenge concerns lack of money or capital, which affects health facilities. This lack leads to shortages of equipment and medication, leading to improper care and treatment of patients.

5.2.5.1 Concluding statement

The challenges faced, as identified in this study, lead to the fact that application of some aspects of the content of Sociology cannot be fully realized, either due to the inability of registered nurses themselves or due to hindrance within the system where they function, but also due to some inequality in society at large.

Whether it is registered nurses who lack the ability to observe social issues in the lives of their patients or the treatment and interactions among health workers themselves that hinder proper and good interpersonal relationships, these issues lead to the failure of the effective application of Sociology of development to nursing practice in one way or another.

From the dynamics/challenges identified, strategies are to be formulated in the next chapter that can help registered nurses to better implement or apply Sociology of Development into nursing practice in Namibian health facilities.

5. 2.6 Outcome/Terminus: Mobilisation of resources to address the two major identified challenges

Figure 5.6: Outcome/Terminus

Outcome/terminus: Application to practice:

Addressing challenges and dynamics

Implementation of strategies to facilitate the application of Sociology of Development to nursing practice

Terminus is the end result of the study and it will give registered nurses the impetus to stand up and do something about what they missed in their practice and if not yet clear about what to do, to revisit the content of Sociology and redefine areas of concern and then do proper planning for implementation (Refer to Fig. 5.7).

The terminus of this study is that, registered nurses should be able to apply Sociology of Development skills to nursing practice in the units where they are allocated. The outcome will help them to address the challenges faced in nursing care in the developmental arena in Namibia.

Registered nurses should also be in a position to address human rights abuses especially against women and children as well as violence which disturbs the peace and stability in the communities they serve and affects the opportunity to develop in their own capacities. These are areas of concern that need to be addressed in the outcomes of this study.

Nurses and those that they are working with need a boost in confidence. They also need to develop a sense of independent and critical thinking and analysis of the situation they find themselves in. It is never the case that they will find a pre-diagnosed or identified situation where they can simply start

applying what they have learnt. Rather, they will need to identify areas of concern on their own and then make a contextual judgment. To be able to do this, nurses need competences and skills. They need to be able to identify goals and set objectives for their own situations rather than generalise, and then find the ways and means to achieve these goals along with the people that they work with.

Professional nurses need to educate others (through in-service education), to manage or administer units in a way that promotes application of nursing skills and they need to perform proper evaluation of all activities, so that responsible feedback and constructive criticism can be given.

5.2.6.1 Concluding statement

Registered nurses functioning in health care facilities need to have the ability to apply and implement what they learn from Sociology of Development. It is therefore necessary for them to identify facets that are working, identify factors that hinder application, and then find solutions to challenges. During this exercise they need motivation, competence and observational skills to identify the need for and areas of application. Application of knowledge from theoretical learning requires well-informed people who can see the relationship between theory and practice, and critically judge what is needed and when.

5.3 Summary

In this chapter the conceptual framework for developing strategies was discussed, according to the

theory of Dickhoff and James (1968, p 433). The role of the agent (nurse educator) and lecturer in Sociology of Development was discussed. The recipient's role in this regard is to observe the strategies that have been formulated, and to implement them appropriately in the clinical setup, where she/he is allocated. The recipient also needs to identify the relevant situation where Sociology is applicable, as situations differ extensively.

The procedure involves developing strategies for the application of Sociology of Development while the context is concerned with the application of said strategies. The dynamics are the challenges of what is to be addressed by the strategies to be formulated. The outcome or terminus is the end result of the process, which is the actual practice of addressing the dynamics as mentioned above.

This chapter is the most crucial one, because it created a framework for the formulation and the implementation of the strategies, which are the goals of this study. The strategies mentioned here will be dealt with in the next chapter.

CHAPTER 6: STRATEGIES FOR THE APPLICATION OF SOCIOLOGY OF DEVELOPMENT

6.1 INTRODUCTION

In the previous chapter the conceptual framework for developing strategies was discussed. The development of strategies will be discussed in this chapter. These strategies are formulated to correspond with the challenges within clinical areas as registered nurses are exposed to them. The strategies have been formulated in response to the aspects covered in the survey, as well as the comments made at the end of the questions in the survey.

From the findings of the survey, weaknesses and strengths of the application of Sociology of Development were derived and these served as guidelines for developing strategies that can enhance and facilitate application. Dynamics were identified to serve as the basis for categorisation and formulation of strategies.

Relationship between the variables were indicated because all the questions in the questionnaire were formulated to indicate the extent to which nurses are influenced, or have observed, or performed their tasks in relation to the content they learned in the subject/course (Polit, 1996, p 71). The relationship was sought with regard to different aspect of development as related to independent variables like age, gender, place of training practice and institution where practicing, as well as time of training and length of time in the practical situation after training was completed. The statistical significance of findings was highlighted by means of analysis of each variable. Thereafter results were discussed and interpreted so that strategies can be identified.

6.2 FORMULATION OF STRATEGIES

Strategies are to be formulated on the basis of the findings for each main area covered in the questionnaire. These strategies will be standardised to fit into the scope of practice of registered nurses and levels of application, for example, whether these strategies are to be utilised in management, professional practice or in a teaching function of the registered nurses to other categories of nurses.

6.2.1 Rationales for the development of the strategies application to nursing practice

The propelling factor and basic reason for the development of strategies is to make Sociology of Development part of the practical reality of registered nurses in their daily practical functioning and during training and education of student nurses.

Nursing as a science needs to be based on evidences that can only be generated from the empirical data collection process. It appears that this has never been done before with regard to the application of Sociology of Development. Nurses can best be assisted in achieving better application of courses like this one, if there is an indication of what they presently or in the past have done with their subject knowledge.

The reason for developing the strategies in this study is to also help nurses in practice to develop a similar attitude, in their clinical practice, towards any other non-nursing subject that does not have a practical session on its own (B-component subjects as they are called).

It is of great benefit to the nursing profession to have strategies for integrating social science course on a practical basis, which are integral parts of nursing as well as any health profession. These strategies

would be a sign of development in nursing practice as a component of the comprehensive health care team within the multi-sectoral collaborative effort of the Ministry of Health.

6.2.2 Development of strategies for application of Sociology of Development in nursing practice

The strategies are the actual skills and activities, which are needed to perform actions. The strategies for this study are formulated to better apply Sociology of Development to nursing practice. Strategies can also be defined as the plans made by top managers and their corporate strategy advisers, and they are the matters of policy that precede actions (Leopold *et al*, 1999, p 23).

The development of strategies will be organised according to the areas identified from the responses (findings) and according to the three theories of social development namely, modernisation, dependency and interactionism. The findings have to be examined in relation to the literature reviewed. As can be seen from the literature, these three theories are concerned with certain main issues, which were in turn reflected in the findings from nurses.

The challenges identified from the data collected were grouped into two main categories, these being resources and human rights abuses/violence. Strategies are to be formulated according to the main categories of challenges concluded from the findings. The strategies will be formulated based on the conceptual framework discussed in chapter 4 and the literature review presented in chapter 2 of this study.

Challenges and dynamics that came out of the comments leveled by registered nurses in response to the open-ended questions were grouped into a summary and the strategy to address these challenges was developed as: Strategy 1: Mobilisation of resources to address identified challenges (such as human, capital and material resources) including the curriculum.

Weaknesses identified from the statistical findings were listed and the strategy to address these was developed as: Strategy 2: Addressing human rights abuses such as child abuse and women being deprived of their rights, domestic violence and the empowerment of women including the curriculum.

The challenges with their corresponding strategies are presented in the table.

Table 6.1: Challenges/dynamics identified and strategies for application of Sociology of Development

Areas identified (dynamics)	Strategies formulated
Lack of opportunities for further studies and in-service education Lack of capital, medication and equipment Unequal distribution of facilities and equipment to render health care in practical areas	

Unequal treatment of nurses by their seniors Low and unfair remuneration for nurses and lack of incentives Exploitation of nurses by letting them working long hours (overtime) weekends, overwork due to shortage of nurses and too many patients and clients Lack of promotion and recognition	**1. Mobilisation of resources to address identified challenges (such as human, capital and material resources) including curriculum**
Nurses lack the knowledge to identify: The abuse of women and children Women deprived of their rights Women who are subjected to domestic violence Nurses lack the means to empower women in the community	**2. Addressing human rights abuses such as child abuse and women being deprived of their rights, domestic violence and the empowerment of women including the curriculum.**

These are the two strategies that have been developed to facilitate the application of Sociology of Development to nursing practice. These strategies are discussed in the next section.

6.3 APPLICATION/IMPLEMENTATION OF THE STRATEGIES

As already stated in the previous section, each of the two strategies will be described and then the underlying objectives will be formulated. For each of the underlying objectives, the specific activities to be performed will be spelled out.

6.3.1 Strategy 1: Mobilisation of resources to address identified challenges/ objectives

The strategy is an attempt to address the challenges posed by lack of resources in the field of nursing care. These resources are human as well as physical. This strategy has to do with the relationship between human beings who care for, people who are cared for and the resources used or needed in this care. It can thus be concluded that this strategy addresses the relationship between physical and human resources.

This strategy examines the aspects that can reinforce proper and effective functioning of nurses when in the clinical situation caring for their patients and clients. Resources in nursing practice, just as in all operational areas, are vital for work with customers, clients and patients.

Resources should be identified accordingly and utilised properly at the right time and in the place. Ways and means of mobilisation of resources to implement this strategy will be guided by the information derived from the policies of the Ministry of Health and Social Services and supported by Namibian curriculum content with regard to nursing. To put this strategy into practice the objectives as

set out below need to be followed.

6.3.1.1 To equip nurses with necessary knowledge and skills by creating platforms for information sharing and peer group teaching

As stated earlier in the background information in chapter 1, knowledge is of no use if it cannot be applied to real life situations. No purpose is served by learning something if it cannot be applied. Nurses need to be trained in such a way that they use the information gained from theoretical sessions when practice nursing. This is the primary reason why Sociology of Development is taught to nurses in Namibia. Social development takes place in all spheres of human life, but at different paces. It takes place in the health sector as well, and health and nursing practice are interwoven and interrelated and cannot be separated.

Change is found to be inevitable in nursing, and advanced-practice nurses must be able to accept the changes that they face and function as change agents who foster change in individuals or groups. Nurses are expected to integrate theories and models of change into their knowledge base, so that they can facilitate changes in their relationships with society and individuals (Sheeby and McCarthy, 1998, p 98).

The correct channels of reporting and communication should be identified in the clinical setting so that colleagues, clients and patients can learn from each other. Communication in this case is very important and should be encouraged. It facilitates interdependence whether it is horizontal or vertical (Bernhard et. al. 1981: 30).

Nurses need to know how to communicate effectively with colleagues, other health professionals and clients/patients. Nurses in management positions should give feedback regarding the actions of subordinates, in writing, or through verbal communications. Praise or constructive criticism is one way of giving feedback regarding performance (Higgs, Sefton, Street, McAllister & Hay, 2005, pp 247-249).

Records and reports are also used as a way of tracking patient procedures (Peplau, 1988, p 274).

A state of dependence can be used to identify needs and ensure communication between colleagues (Peplau, 1988, p 176). In many working environments a group finds itself in phase of dependency, where mutual support is needed, where members get to one another but still view themselves as individuals. Over a time they may overcome tension within the group and develop a sense of independence where they view themselves as a group but are still conscious of their own places within the group.

Later they may develop to a level where members consider the aim and the purpose of the group as more important than individual preferences. They develop a sense of basic trust in one another and can share their satisfactions and frustrations. This phase enables them to embark upon problem solving, and group responsibilities are shared. The environment in this phase becomes more comfortable and free from distractions (Bernhard *et al*, 1995, pp 24-25).

Implementation/Activities: It is the responsibility of the agent and the receivers to see to it that this objective is achieved by doing the following:

- The lecturer should empower and encourage nurses during classes, and reinforce the practical application of information learnt into their field of practice on a daily basis.
- The lecturer should state examples in class that are related to nursing practice with special reference to conditions and situations in which they function.
- The lecturer should use scenarios where a situation is stated and nurses are requested to deal with it by using knowledge derived from Sociology of Development.
- Registered nurses need to understand the decision-making process as a group responsibility (Parks and Sanna, 1999, p 45) where ideas are generated (Parks and Sanna, 1999, p 47) so that they can better function in their practical areas as a process of professional development.
- Student nurses should be encouraged to exercise cross-references between Sociology and nursing subjects and to move/think or reason from the known to the unknown and again from the unknown to the known.
- They should learn to evaluate the practicality of previous work into their clinical department on a weekly or monthly basis.
- Tests should be set that demand practical application and not merely knowledge of the subject.

6.3.1.2 To properly and effectively manage resources at each level in health care facilities

Resources encompass everything that is necessary to do a job, that is the actual work, space, equipment, supplies, budget and people (staff). This point concerns resource allocation, which is the distribution of people, supplies and equipment at every level of functioning in the organisation. Resource management is the process of monitoring the use of resources and making decisions.

The effectiveness of resource management lies in the ability to make satisfactory decisions in the face of difficult resource allocation situations. Health care nowadays is run through a process of decentralization, with proper control of escalating costs of health care while providing quality care to clients (Bernhard *et al*, 1995, p 105). The latter constraints need to be understood by registered nurses

in their capacities as health workers within the Ministry of Health and Social Services in Namibia. Resource management is explained below.

i) Capital

Capital is the source of all development in society in this day and age. Financial management is organised in a decentralized manner to regions, and mechanisms for monitoring expenditures at each level have been put in place, while there is also decentralisation of authority. Supervision by deputy directors of finance and regional directors has also been put into place in health care facilities in Namibia (MoHSS, 1995, January, pp 41-50).

The lecturer should help student nurses to understand the issue of capital while still in training by:

- Explaining the importance of capital management in nursing practice at all levels of functioning and should refer them to nursing administration in their fourth year of training.
- Fostering an understanding of the issue of money or capital as the basis for and origin of every development process, while teaching students how to plan for use and accountability.

ii) Human resources

Human resources play a very important role in health care with regard to getting jobs done. Qualified people should be recruited into specific positions according to their capacities and capabilities. While in the service, nurses should update their practice to the best of their ability in order to meet the demands of the positions they fill.

Level of expertise, education and experience should be considered when staff is recruited (Bernhard *et al*, 1995, p 106).

According to Durkheim, the division of labour has changed from mechanical solidarity in the past to organic solidarity in recent times. In the case of mechanical solidarity, members of society have fewer responsibilities and the greatest part of what they do is similar. In nursing practice this was the case in the past decade, where nurses only attended to patients and implemented doctors' orders. Nowadays, more and more nurses are specialising and they are acquiring higher qualifications. As a result they have the opportunity to be employed in higher positions.

Once personnel are recruited they need to be retained. Retention of staff is enhanced by keeping them abreast of all new developments in the working environment and by cross-training them in order to prepare them for competence in more then one job. Personnel retention is of the utmost importance at present due to the shortage of nurses (Bernhard *et al*, 1995, p 106).

In Namibia the need for training of staff has been identified and different cadres have been considered, for example, nurses for PHC and administrative staff who are followed up by supervisors during annual supervisory and specific supervisory visits (MoHSS, 1995, January, pp 41-50).

Implementation/activities:

- Even if nurses do not recruit other nurses directly, they should be able to motivate the recruitment of nurses by presenting their situation in the clinical environment during meetings, so that they can indicate their need to properly achieve good standard of nursing care.
- Nurses should be given opportunities to further their training and should be exposed to short courses, workshops and any refresher courses in their areas of interests or according to their

allocation.

- They should be encouraged to update their skills regularly, not only attending formal courses. The health sector cannot afford to send all staff for further training, therefore nurses should be made aware of possible distance education courses which are applicable. This training forms part of social development.

iii) Material resources:

Materials like equipment such as supplies, computers and information systems, forms and records can be managed through inventory control. Nurses need to know the procedures for inventory control (Bernhard *et al*, 1995, p 107).

As society changes people's needs and demands also change. Nurses need to understand that social changes affect their nursing practice.

Material resource management is a crucial issue in nursing practice. Nobody can achieve effective and efficient health care delivery without resources. Knowledge and money are wasted if no proper planning is done. If nurses are taught to plan with regard to material resources it would reflect professional development, in turn meaning that they can also participate in the social planning process.

The nurses need the following information from agents regarding material resources:

- Capital is an important aspect when it comes to the interactions between human beings in different aspects of life. Nurses need to address the impact of capitalism in nursing clinical practice and deal with the issues pertaining pertaining to use of capital, according to their own systems and policies.
- Nurses should try to find out all the pros and cons of their duties (ie job descriptions), as well as their responsibilities and remuneration before they assume duties and enter into agreement with their employer.

Agreement made at appointment is binding and cannot be changed any time the nurse feels that he/she wants to change remuneration. Nurses should understand the agreement they are entering into before accepting an appointment. Employers should have clear guidelines on these issues and give it to their employees at assume of duties.

According to Bernhard (1995, p 28), remuneration of personnel needs to be done fairly. Salaries should be fair to both employers and employees and if not, this is what is referred to in sociology, as a state of exploitation of employees (proliteriat/working class) by employers (bourgeoisie).

Implementation/activities:

- Nurses should refrain from making unfair demands which are uncalled for, simply because their own needs have increased and their agreement has not expired yet.
- Accountability and responsibility on duty are more important than demands for fair salary on unfair service delivered.

6.3.1.3 To assist registered nurses to advocate for equal treatment for their subordinates through the right channels and in a fair and acceptable manner

Nobody likes to be treated differently from others when they work under the same working conditions. Nurses as human beings expect to be treated by their supervisors on an equal basis. This in turn enhances a sense of recognition and appreciation. As soon as staff treatment starts to differ nurses may feel like they are being denied their rights as human beings, and this can lead to staff burnout.

In this situation nurses may become alienated from their profession, their jobs as nurses and from fellow nurses. Unequal treatment of nurses can become the bases for unequal treatment of the patients and clients entrusted into the hands of such nurses.

The goal of managing assertively helps to reduce the complaints of sub-ordinates about their supervisors, helps to minimise the failure to appreciate or give credit, increases the ability to see other people's point of view, and addresses the issues of lack of leadership, frankness, sincerity and bias (Burley-Allen, 1995, pp 13-14).

Birchenall and Birchenall (2006, pp 89,90,110), state in their writings that some patients are not treated equally to the others from other groups, but when health workers are asked about this issue, they deny it by responding that all patients are treated equally. This has created a lot of debate on the issue of universalism, which is considered to be an ideal way of treating patients and clients. This state of affairs is an indication of the expectations of human beings for equal treatment whether they are patients/clients or nurses themselves.

Sometimes nurses forget that while they have their expectations of the system/organisation, patients and clients in turn have expectation of them as nurses. Nurses need to examine how their treatments may differ in quality from patient to patient.

Bishop (1996), in her article: “Hoping won’t make it happen…” states that the action of exploitation should be stopped. She urges nurses to stop being victims and try to resolve exploitation through effective ways rather than by trying to follow rules that never help to save their jobs. She suggests that for nurses to stop exploitation they do not need to hope for change but to take action and repeated

action against exploitation. When taking actions it is important to be aware that actions do not have consequences in a day. More people need to work together and there should be people who have the power to implement the action planned.

Nevertheless the actions taken should be relevant to the setup in which the nurse is practicing.

Another writer by the name of Fay Carol Reed (1979), a dean and professor of nursing at Ohio Wesleyan University, cautions that nurses who would like to further their studies should examine their goals and explore the curriculum of several schools before making a commitment to a program of study.

Besides that, they need to understand that seeking to earn baccalaureate degrees, makes them a pool and source of tuition income for institutions to which they apply for study and nursing education programs are a source of program support grants from governmental agencies. Other institutions offering nursing education programs may enroll many nurses and make them pay high fees, while they offer education at the lowest possible cost. In this case nurses may not even be granted salary increases for the extra education that they have undertaken.

Nurses then, should understand that not every course they enroll for can give them credit. Extra credit depends on the quality and content of the course, as well as the need at the health facility where they are employed.

Implementation/activities:

- Nurses need to be assisted in identifying what is exploitation and what is not. They also need to understand and be able to differentiate situations where they should expect equal treatment and where treatment may differ, and compare the treatment they give to their patients/clients.
- Nurses need to closely adhere and conform to the rules and regulations at every level of functioning.
- They should be encouraged to disclose their feelings and air their views with regard to how they are treated in the work environment, using the right channels to address any unfair treatment from seniors.
- Nurses themselves should learn to treat their subordinates, their patients and clients fairly and demonstrate their expectations to them in this regard. It is better to start the process on oneself than to point fingers at others. By doing so nurses might withdraw some of their claims of being treated unfairly, if they realise their own treatment of others.
- Nurses should learn to avoid exploitation by being familiar with the content of job description, remuneration, working hours and conditions of employment whenever they attain a new position. Copies of work conditions and job descriptions need to be requested from employers. These documents should be referred to when inequality or exploitation are identified.

6.3.1.4 Nurses need to observe the promotion policy and recognition system in their working environment/places

In any working situation there is a system of promoting staff members who have performed well or have been loyal to their employers for long periods of time. These promotions are planned and documented in most cases. In the public sector there are policies of how many employees can be promoted, depending on the number of available vacant senior posts. Promotions are made after thorough evaluations are completed.

Where a person has performed well but there are no vacant posts to be filled, recognition is a possible substitute. Both promotion and recognition function as positive reinforcement to employees.

Implementation/activities:

- Nurses should know the promotion policy within their working environment and what they need to achieve or what the requirements/criteria for promotion are.
- They should be aware of the standards set and try to strive to maintain these standards to attain effectiveness and efficiency, all of which form part of the process of development, if assessments of past achievements are reflected upon.
- The process of negotiation applies here, as it is considered to be a part of the development process in each social sphere.

6.3.2 Strategy 2: Addressing human rights and abuse of women and children and the issue of women deprived of their rights

This strategy is meant to address the social evils affecting the groups in the society that are deprived, discriminated against and who have little or no power to deal with their own fate. Here the focus is the interpersonal relationship more especially between men and women, leaders and community members as well as the interpersonal relationship within family set-ups or structures.

Consideration needs to be given to the mechanisms, which policy makers have in place to ensure that individuals in society receive health and social care. Policy effects on social groups need to be investigated and awareness of the implications of social policies in a mixed economy need to be taken into account (Gahetan, 2001, p 20).

Social policies should serve the interest of the people and address the impact of social problems on health, such as domestic violence and child abuse, which cause not only family breakdown but also mental breakdown (Gaëtan, 2001 p 152).

The objectives to be achieved in addressing the issue of abuse and discrimination are discussed below.

6.3.2.1 To conduct proper assessment of children admitted to units for signs of abuse or maltreatment

Proper assessment should be done on children admitted to units for signs of abuse or maltreatment. Signs of neglect, physical injury, non-accidental injury, sexual abuse and emotional abuse should be identified and the concerns then discussed with parents or care providers (Hind, 1997, p 38).

The signs of potential abuse from a caregiver can be the following:

"Has previously abused a child; fails to maintain the child's proper hygiene or care; appears to lack love or concern; has alcohol or drug problems; has emotional problems or mental illness; was abused as a child or has high stress factors, including poverty".

Implementation/activity:

- The nurse should take the histories of all children with signs of abuse or the caregiver who appears to be an abuser. If nurses are unsure of how to go about it, they should consult with colleagues who are experts in this regard.
- Nurses should assess the signs of potential abuse and assess the caregiver.
- A nurse should not ignore any suspicion of child abuse, no matter the appearance or social standing of the parent or caregiver.
- Nurses should use the proper approach and communication methods, in an environment conducive to cooperation.
- Nurses should perform counselling if any abuse is identified.

6.3.2.2 To conduct counselling, early intervention of some type, guidance and support in cases where abuse is identified

Counseling or parenting classes may prevent abuse when the potential is present. In some cases, the child may be temporarily or permanently removed from the home to prevent further danger

(http://wwww.healthline.com/adamcontent/child-abuse-physical/2, accessed 09/03/2007).

During counselling the nurse guides the parent or caregiver in examining his/her problems, conflicts, difficulties and so that he/she can develop awareness and understanding of the issues under consideration. He/she has to work through those aspects and find out what is essential for him/her and the child. It is for this reason that participation of the client should be encouraged so that problems can be correctly identified and specific solutions found (Freshwater, 2003, p 6; WHO, 1988, pp 32,33,90, 91).

The parent or caretaker should also be encouraged to respect individuality. A child is a full or complete human being, although still physically and mentally still undeveloped and therefore cannot be viewed like "a little animal that must be trained". Excessive discipline should be avoided as it produces weak and rebellious character in adulthood (Aguilar and Galbes, 2000, pp 284–285).

Good communication skills are essential and crucial and communication techniques are important in psychosocial assessment. As in all nurse-client communications, rapport is essential. Rapport implies the sense of trust and understanding between the nurse and the client and that both have vested interest in the client's well being. When the rapport is right the client will become more comfortable in revealing personal facts. The client interview may reveal many aspects about lifestyle, behaviour and attitudes if it is conducted with a relaxed attitude and in a non-judgmental, manner without prejudice or bias (Meltzer, *et al*, 1993, pp 152,153; WHO, 1988, p 36).

Barriers to communication can be present and may hamper the process of communication, therefore hindering understanding of the messages sent or feedback given. Barriers can have a negative impact on communication. If barriers are related to attitude, they may be difficult to overcome. Environmental, physiological, psychological/social and semantic barriers differ in intensity, the length of time that they have been present, and they differ across age, gender, religion, education and status.

For all the above reasons effective and attentive listening is an important part of the communication

process, and these skills are born out of good communication skills on the side of the listener (Wyrley-Birch & Wright, 2003, pp 99–101, van Staden, Marx and Erasmus-Kritzinger, 2002, pp 75,87; Tubbs and Moss, 1994, pp 156-157). Good communication is a way of showing respect and paying attention to what a person speaking about (WHO, 1988, p 30).

The nurse needs to take a non-directive approach (act as a catalyst) allowing the patient to choose what he/she finds to be better way of acting. Sometimes use of the directive approach is also necessary for preventative health care when a problem is suspected. The two approaches can be used to compliment each other (Freshwater, 2003, p 7). The client is asked questions that probe him/her to air his/her views and encourage expansion on points already made (Freshwater, 2003, p 41), followed by paraphrasing which may act as a mirror for the client to examine the comment or statement already made (Freshwater, 2003, p 43).

Helping the client to change behaviour by means of the directive approach, helps him/her to dictate his/her decision for the future, thus helping to solve the problem at hand (Freshwater, 2003, p 69).

Intervention/Implementation:

- Ask for consent from the parent/client to enter into a counseling session.
- Establish a rapport with the client and assure him/her on shared confidentiality with regard to the information he/she will give (Rollnick, Mason and Butler, 1999, pp 43-45).
- Choose the most suitable means of counseling to avoid communication barriers. Preferably use the non-directive approach and allow the client to voice the information without leading him/her to do so.
- Allow the person to verbalise feelings or information rather than making use of non-verbal. How people say things matters more than what they say.
- Try not to be judgmental. Always listen emphatically and communicate openly rather than judging others. Critical listening creates distance and resistance in the environment (Burley-Allen, 1995, p 99).
- Give the client the chance to dictate his/her intention of what he/she intends to do and direct her/him where help is required.
- Arrange for watchful guidance and support from the extended family, friends, clergy, or other supportive persons who might prevent abuse, or allow early intervention in cases where abuse has already occurred.
- Child Protection Services, or the local police can be called in if a nurse suspects abuse.

6.3.2.3 To identify the type and extent of violence, abuse and deprivation of women's rights in the communities they serve

Namibia like any other country in Africa or even anywhere in the world is haunted by violence against human beings more especially against women and children. Violence against women and children is linked to deprivation of women's rights. Development in the society should improve the life of every human being. Women in many parts of the world find themselves in the midst of violence and conflict, and women in Namibia are no exception. They are targets of violence in the form of personal and domestic violence and rape. This issue has become a topic of discussion in many public meetings and publications (Iipinge and Le Beau, 1997, p 83).

The modern family is plagued by a host of serious problems like divorce, births outside marriage, violence and inequality of family life were women and children are mostly the victims (Coleman, 1998, p 70). Unequal gender relations influence the spread of HIV/AIDS and women are accused of lacking the ability to control their actions (Iipinge, Hofnie and Friedman, 2004, pp 72-74).

When it comes to violence, feminist groups increasingly exert pressure and focus the public's growing attention to these problems. The dominance of wives by their husbands is one of the many causes of family/domestic violence (Coleman, 1988, p 73).

In Namibia women are subjected to violence under the influence of misconceptions such as:

- Women ask for violence because they fail to do things correctly.
- If what is happening to women is bad, they could leave;
- What happens in the family is private and nobody from outside needs to know or do something about it.
- Alcohol is the cause of battering and if men can stop drinking violence will stop (LAC, 2005,

pp 18-19).

Whatever ideas there might be concerning battering, abuse or violence against women and children, the facts are that domestic violence is widespread, it is against the law, it is harmful to the victim, to the children in the family, to the family as a whole, to the perpetrator, to the community and to society at large (LAC, 2005, 19-20).

A study was conducted in 2001 in Namibia through the WHO multi-country study on Women's Health and Domestic Violence against Women. Fifteen hundred women in Namibia, aged between 15 and 49 years, from all income and ethnic groups, took part. This study exposed types of violence such as: slapping; something being thrown; being pushed or shoved; hit with a fist or anything that could hurt; kicked; dragged or beaten up; choked or burnt; threatened with or had a weapon used (WHO, 2004).

Over one third (36%) of ever-partnered women, have experienced physical or sexual violence at the hand of an intimate partner, 31% experienced physical violence and 17% sexual violence (WHO, 2004).

Cathy Young (2004) says that she has no doubt that women are more likely then men to be injured. One woman is raped every hour in Namibia, but only one in every 20 cases is reported to the police. An example is the case of a mother of 14-year-old twins who had been abused by her husband on several occasions to the extent that her arm was broken. But she still returned to him (Study Schoolnet/Usakos 2006).

Scouts in Namibia are responding to the issue of domestic violence by training leaders and running projects for Scouts. The aim is to help all Scouts understand domestic violence and giving them at least one practical method of dealing with violence in their own lives.

Scouts have tried to implement the Act in two phases. In the first phase, Namibian Scouts are providing a range of training experiences for adult leaders that are undertaken with partner organisations and include skills in advocacy, listening, drama, practical techniques to deal with conflict and sharing ideas on how to develop ‘Gifts for Peace’ projects in their communities. The National Theatre of Namibia has recently trained facilitators to promote drama and art in the community.

In the second phase, leaders will take this learning into their Scout groups and help them to develop ‘Gifts for Peace’ projects in their local communities. Creativity will be encouraged and a small fund will be available to support Scout Groups in developing innovative projects (Scouts in Namibia 2006).

Dianne Hubbard (2002) of the Legal Assistance Center in her article about “The Combating of Domestic Violence Bill- Why We Need it Now” states that a protection order is available that also contains a provision preventing the respondent from committing domestic violence. It suspends firearm licenses and allows for seizure of firearms. If the abused and the abuser live in the same home, arrangement can be made to keep the abuser out or to find suitable accommodation for the victim, where the perpetrator can be held responsible for paying any accommodation fees needed (Hubbard, 2002, p 2).

Intervention/Implementation:

- Allow women to spell out their human rights so that they know them. Help them with formulation of statements.
- Ask them individually to explain what they understand under domestic violence and abuse before going into the detail of whether and how they are abused.
- Assess the type of violence, abuse or deprivation for each individual case and not in general. Make sure the problem really exists and do not just assume anything.
- Assess the causes and contributing factors (involving men who are mostly the perpetrators), of each abuse. Every assessment of violence should be done contextually.

- Determine the extent of the violence/abuse as well as the extent of impact or effects it has on specific woman or women.
- Read reports and or recordings done regarding certain problems which will give you a clue with regard to what to look for when doing such assessments.
- Counsel the affected and effected women and men with regard to the abuse.
- With the permission of the victim, and to avoid future repercussions or threats, report the case to the relevant authority.

6.3.2.4 To assess the needs of women in their communities

Women like any other human beings have their basic needs, which must be met, such as:

- Psychological needs which are the need to eat, drink, be warm, and have shelter and rest;
- Social needs, which are the need to work in groups with other people, to have recognition within the group and environment, the need for self-confidence and self-fulfillment; and
- Ego needs, which have to do with how people acknowledge, for example, their safety and job security (Forsyth, 2006, p 19-20).

Need assessment is a crucial point in dealing with women's problems. If assessment is not properly done, nurses may find themselves occupied with irrelevancies and wrong solutions that do not address the issues at hand. They may start working with wrong assumptions and move from specificity to generality.

Poverty is prevalent in many countries, more especially for women. Poverty should not be tolerated, either by the poor themselves or by those with the power to eradicate it. Poverty has many faces and does not just stem from a lack of income. It can affect health, education, human rights and communication.

More than 90% of people living with HIV/AIDS are in developing countries like Namibia (UNDP, 1997, p 28).

In some countries, women have to air their views and raise their voices regarding poverty. Men are expected to side with women with regard to poverty reduction. If women are poor it affects family life for both women and men. Empowerment of both can help reduce poverty (UNDP, 1998, p 73) by means of social mobilisation, reaching the poorest, expanding opportunities and building human capacities and allowing the poor to take the lead (UNDP, 1998, pp 32-34,38-39).

Gender empowerment measures (GEM) reflect economic participation and decision-making power. They measure women and men's percentage shares of managerial and administrative positions (UNDP 1997, p 124). These are the aspects that need to be considered whenever the needs of women in communities are to be identified. Needs cannot be fully satisfied if the need to eradicate poverty is not part of each endeavour.

Intervention/Implementation:

- Identify the level of development available in the community under examination with specific reference to women's development.
- Identify the means available in the community whereby poverty, as enemy number one to development, can be dealt with or eradicated.
- Give proper guidelines to both women and men on how to assess women's needs for development in communities.
- Assess the needs of women within the nurse's catchment population by using women in that community. Involve men in the assessment process.
- Assess the facilities available to deal with or satisfy these needs.
- Ask women to critically examine their needs and the facilities that best suit them and guide them on how to proceed.

6.3.2.5 To involve nurses in empowering women in communities

Many women are discriminated against when it comes to employment. Men and women are not employed equally, nor are they paid or treated equally at their work places. Women are mostly employed in jobs in the agricultural sector such as fruit and vegetable harvesting, domestic work and laundry services. Historically women are paid less than men (Curram & Renzetti, 1996, pp 173,174).

Women need to be assisted in their endeavors to develop themselves within the community. Education is the core for such empowerment. Education can be formal or informal depending on the goals that need to be achieved. There is a saying "educate a woman, educate the nation", simply because women are the mothers of the nation. Once they are equipped with the necessary skills they in turn uplift the whole community or nation for both women and men. The empowerment of women should be based on the objectives set and the identified needs of women.

For making empowerment effective one needs to consider the following:

- Clear policy/intention;
- Good communication, (lack of clarity hampers it);
- Little interference;
- Self-sufficiency;
- Not taking over or taking all the credit and giving feedback; and
- Attitude to development is motivational (Forsyth, 2006: 121-123).

Women need financial freedom. Financial freedom is the ability to make choices about what preferences in life without the restriction of money pressure. Women with moderate income, single parents and those who do not have higher education can still create long-term financial security. Women should know the principles which underlie a successful future such as: taking responsibility for money; confronting fear; and looking ahead and know what the future holds (Hewitt, 2003, pp 236 –

239).

According to Hewitt (2003, p 245), women should develop healthy habits for earning income, handling money and spending income.

In 2000, for example, President Hosni Mubarak created the National Council of Women to promote ‘development and empowerment of women’ and for the ‘advancement of women’ in Egypt. The first woman was appointed as a judge. Equal rights were given to children born to Egyptian mothers, Family Courts Law was issued and the Family Insurance Fund established.

Despite the above developments, an Egyptian journalist, Dalia Ziada, was adamant that journalists were calling for more freedom, independence, legal protection and amendments to the Press Act. She herself was active in publicising grievous rights violations.

The above story indicates that women need to actively participate in economic and political life to eradicate gender inequality in key areas of economic and political participation and decision-making (UNDP, 1997, p 14).

Human development is the process whereby people's choices are enlarged and their level of well being raised (UNDP, 1997, p 15).

Intervention/Implementation:

- Developmental-targets need to be formulated to help community members (more especially women) to learn new skills, taking more responsibility, improve their performance and increase knowledge and interpersonal skills. These targets should help them to have a vested interest in achieving goals by giving top-down support, which leads to bottom-up development of those assisted (Hale and Whitlam, 1998, p 82).
- The motivation and will of women to participate in the development process in their environments needs to be determined.
- Mutually identify the possible sources of assistance women might have in their community.
- Identify organisations available that can assist women in development. There are many organisations that can attend to women's issues most of which where mentioned by registered nurses in their responses to the study questionnaire. Some of these organisations are governmental and some are non-Governmental (NGOs).
- Find out how these organisations operate and assist women in gaining access to them. Key/contact persons or leaders (especially women) in the organisations should be contacted to give guidance in this regard and serve as entry points.
- Mobilisation of women to participate in development programs and projects for women only and for both women and men in their communities for income generation to help them to become financially independent. Assess their understanding of participation and their acceptance of the programs or projects.
- Mobilisation of men in the community to partake in the empowerment process of women for development. A statement that says: "If you develop a woman you develop the nation" can be used here to serve as a motivational factor.

6.3.2.6 To protect the rights of women and enhance gender equality in communities

The term equality is misunderstood in many cases and should be approached with care. Many men and few women refer to physical equality whenever this issue is being debated. The practicality of

equalising women and men in social, economic, legal, educational, psychological or financial spheres is often counteracted by arguments linked to the physical weakness of women and the strength of men. Sometimes the intellectual abilities of men and women are used as an argument.

Functionalists assume that not everyone in society should be or can be equal. Inequality is necessary for social order. Life-saving workers, like medical surgeons, are not equal to retailers or those selling clothes or groceries. Men are therefore not equal to other men (Leon-Guarerro, 2005, pp 27,29).

Conflict and feminist explanations stated that inequality is generated from a state of having or not having power. Those with power try to maintain their advantages over the system (Leon-Guarerro, 2005, pp 27,30).

Interactionists argue that inequality is created from human interactions and they attach value to these interactions (Leon-Guarerro, 2005, p 30).

If societies delay the process of gaining equality between men and women, not only do they delay the process of social development for women, but they also delay the development of men, because women are believed to be the major agents for development.

On many continents, the rights of women are not fully addressed and protected, as in Arabian countries. International conventions are not yet implemented or guaranteed. "Many of these agreements remains on paper and have not been really implemented", said Dr Zeina Zaatari, at a conference held at Abu Dhabi on March, 19th, 2007. The same can be said of countries in North Africa (Mussallam, 2007, p 1). But to a certain extent the same is applicable in Southern Africa where

Namibia is situated.

Gender development is part of social development, which forms the basis for gender equality. The Heads of State or Governments of the Southern African Development Community (SADC) to which Namibia belongs, have made a declaration to do away with discrimination against anybody in their countries (Iipinge and Le Beau, 1997, p 114).

The heads of the SADC countries noted in 1995 that gender equality is a fundamental human right. Despite that declaration, women in Namibia still form the majority of the poor and disparities between women and men still exist.

During the Fourth World Conference on Women in Beijing, China on the 4th and 5th of September 1995, a declaration was made to reaffirm the implementation of human rights for women and girl children, to empower and advance the rights of women to freedom of thought, conscience, religion and belief because "women's rights are human rights" (Iipinge and Le Beau, 1997, p 114).

For the above reasons, the heads of SADC states were determined to protect and promote the human rights of women and girl children to ensure equal access for women to economic resources including land, credit, science and technology, vocational training, information, communication and markets. This was done to enhance their capacity to enjoy benefits and equal access to these resources (Iipinge and Le Beau, 1997, p 115).

Gender equality must be recognised and asserted by both men and women. Both men and women should share the struggle for gender justice equally. Gender has to become mainstream for all projects and policies.

In South Africa and Zimbabwe, leaders discourage women from campaigning vigorously for succession of the presidency, even though in both cases women hold the vice-presidency. This is to prevent women from full participation in the political process at all levels. A statement was made in this regard that "women should not only be confined to singing and ululating at rallies and political meetings but be able to participate in leadership on broad range issues" (Makuni, 2007).

Intervention/Implementation:

- All women need to understand the aspect of equality between women and men and realise the impact of the inequality that prevails in society.
- Both women and men need to be actively involved in the eradication of all types of social inequality.
- In Sociology of Development where both women and men are trained, this issue should feature clearly and male students should be motivated to be more vocal in the practical situation, for the application of gender equality in working environments and in communities.
- Practical examples stated in class can be applied in clinical practice and have an influence on other health workers, even if they are not part of the classroom situation.
- Platforms can be created for both men and women to share ideas on how and what to address when it comes to equality in different spheres of social life.

6.3.2.7 Identify and observe the policies in place regarding women in Namibia

There are many policies in Namibia that can promote the human rights women, such as the National Gender Policy, the National Plan of Action on Gender and the Family Planning Policy, *et cetera.*

According to the National Gender Policy and the National Plan of Action on Gender (MoHSS, 1998), rape, domestic violence against women and child abuse are prevalent, and it is for this reason that these policies have been formulated and put into action.

Every person has the right to enjoy the highest attainable standard of physical and mental health. Equality in health services for both men and women should be ensured, including reproductive health and family planning (CDC, 1999, p 1).

The Family Planning Policy addresses the issue of making decisions on how to use family planning, what method to choose and when. Women are to be supported by nurses and midwives on how to make such decisions.

Family planning benefits women and their societies. Providers help women with regard to the following aspects:

- Helping them to make informed choices;
- Supporting women's choices, encouraging women to recognise their strengths and to build on them;
- Improve women's skills in communicating with their husbands and with people outside their

families; and
- Creating new images and models of competent women and caring men (CDC, 1999, pp 12-13).

Intervention/Implementation:

- As men and women were responsible for the formulation of most of these policies, the application thereof should also be the responsibility of both.
- Every person in their leadership capacity should be alerted and made to realise which policies affect women and benefit and affect both genders of all ages and at all levels of social interaction, these being gender equality (dealt with in the previous section) and family planning policy.
- Nurses in their practical situation are unavoidably involved with practical procedures where these policies are applicable and they should know what to do in this respect.

6.4 SUMMARY

This chapter forms a crucial part of the study. It is the chapter, which deals with the achievements stated in the objectives of the study.

The strategies that have been formulated serve as the guidelines and basis of the application of development from the sociological point of view to the practice of nursing. Nursing cannot be divorced from social development. Development in turn cannot be left out when nursing care is being delivered to communities or society as a whole.

Coetzee's Sociology of Development book(1989) is called "Development is for people". The people referred to in this case are those who are cared for by nurses, the communities they serve, the nurses

themselves and other health workers.

The strategies formulated here are merely meant to serve as guidelines for nurses and they will mainly be applied to the curriculum of nursing and as in the case of other subjects or courses, the theoretical sessions should highlight what nurses will apply in practice.

After thorough consultation with the lecturers in the Department of Sociology, the Head of the Department of Sociology and the curriculum committees of both the Department of Sociology and Nursing Science, these strategies will be incorporated into the curriculum of "Sociology of Development for Nurses".

CHAPTER 7: CONCLUSION, LIMITATIONS AND RECOMMENDATIONS.

7.1 INTRODUCTION

This chapter serves to round off what has been done throughout the process of research on the topic of 'strategies to application of Sociology of Development in nursing practice.' It provides the overview of major findings, conclusions, limitations and recommendations for improvement of the application of Sociology of Development to nursing practice by registered nurses as well as students in training. Such application touches on aspects of nursing care to patients, education of patients and other health workers, management of units, departments and any other health care facilities.

In the investigation of how nurses apply Sociology of Development to nursing practice, there was an opportunity to see how nurses relate what is happening in nursing practice to what they learnt in Sociology of Development. This investigation needed to be a reflection of what nursing practice does for Sociology of Development and not only what Sociology does for nursing practice. This two-directional relationship impacts scientifically in the form of kinetics and dynamics of social interaction. The strategies developed should serve to make the process of application two sided/directional or bidirectional.

7.2 THE PURPOSE OF THE STUDY

The purpose of this study was to describe strategies to assist registered nurses with ways in which the content of “the Sociology of Development” in Nursing Science is applied to nursing practice. The objectives where stated to guide the purpose of this study as set out below.

7.2.1 Objective no 1

Objective number one was to determine and describe the application of Sociology of Development in nursing science practice by registered nurses who have completed a four-year Diploma at UNAM.

This objective was based on the following questions:

- Is the knowledge acquired in Sociology of Development during training and education being applied to the practice of nursing?
- To what extent is the knowledge acquired, applied in practice?’

This objective has been realised in the study. The researcher embarked upon the study with registered nurses as stated, and has determined the extent of application of this content by registered nurses. The study points to the fact that nurses do apply Sociology of Development to their practice though to differing degrees and extents.

Unfortunately it was observed in this study that the extent to which content is applied is not always satisfactory, because nurses’ observational skills fail to detect social evidence of the applicability of social development among the patients and community members they serve.

7.2.2 Objective no 2

Objective number two was to identify the weaknesses and strengths in the application of such knowledge.

It was concluded that there are areas where application was successful and areas where nurses failed to apply the content as stated under the objective. Strong points of application were detected as reflected in responses and weaknesses also featured, such as lack of ability to observe certain problems of development, such as abuse and deprivations of human rights among patients and clients.

7.2.3 Objective no 3

Objective number three was to develop and describe strategies to facilitate the application of Sociology of Development to nursing practice.

As already stated for the previous objectives, this objective was also realised. Strategies were identified depending on the information about what has or is being done by registered nurse in clinical departments and units.

7.3 Conclusion of the study

The conclusion of the study is based on the objectives that were formulated. The objectives were closely followed and realised. As such, findings were examined to determine what strategies were to be developed. After the strategies had been developed and discussed, recommendations were made on further actions regarding how to use knowledge from Sociology of Development in nursing practice depending on the achievements and failures identified.

7.4 Outcome of the research

7.4.1 Findings of the study

In this study it has become apparent that generally there are no statistically significant differences between the two dichotomies of the study population on application of Sociology Development to nursing practice. Nevertheless, it has come to the light that there are areas of weakness regarding application, which need to be re-enforced, assisted and motivated.

These areas can be identified according to the theories of development, as well as the relationships within social development that are health related, such as development and health, and vulnerable groups like women and children.

The main areas, where application was found to be lacking, are associated with the aspects discussed below.

7.4.1.1 Modernisation and nursing practice

Barriers to full modernisation in the nursing care situation are identified as:

- Lack of opportunity for registered nurses to fully update and improve skills and knowledge through further studies and in-service education;
- Lack of incentives and proper remuneration; and
- Unequal and unfair treatment of staff.

7.4.1.2 Capitalism and nursing practice

Problems related to capitalism with regard to nursing practice are:

- Unequal distribution of facilities and equipment for rendering health care in practical areas which causes improper patient and client care;
- Inadequate funding (lack of capital) for health care services which leads to shortages of equipment, staff and medication;
- Slow and total lack of responsibility for repairing equipment;
- Irresponsible and greedy personnel who run health services;
- Failure of successful achievement due to financial constrains;
- Low and unfair remuneration of nurses and lack of incentives;
- Inequalities among health workers in health facilities with underlying exploitation of nurses by other health workers; and
- Working long hours (overtime) in the week and over weekends, and general overwork due to shortages of nurses.

7.4.1.4 Interactionism

The main observation from the findings related to interactionism is lack of ability to observe and to empower the following in the clinical setups:

- Observation of abuse of women and children abuse in health care facilities;
- Women deprived of their rights;
- Women subjected to domestic violence; and
- Empowerment of women in the community.

7.5 Strategies for application to nursing practice

Strategies formulated from the findings of this study will be implemented or applied based on the nature of the health care facilities where nurses practice. Situations differ and needs differ and these factors will influence the type of strategies to be implemented. Two major strategies have been identified and formulated with their underlying practical objectives.

7.5.1 Strategy One: Mobilisation of resources to address identified challenges

The following are the underlying practical objectives of this strategy:

- To equip nurses with the necessary knowledge and skills, by creating platforms for information sharing and peer group teaching;

- To properly and effectively manage resources at each level in health care facilities; and
- To encourage nurses to observe promotion policy and the recognition system in their working environment/places.

7.5.2 Strategy Two: Addressing human rights issues such as abuse of women and children, domestic violence and women deprived of their rights including curriculum

To achieve this strategy, objectives are necessary for guiding the actor in the right direction. The objectives will serve as sub-strategies of the main stated above. Registered nurses need to base their actions on the following objectives:

- Proper assessment of children admitted to units for signs of abuse or maltreatment;
- Conducting counselling, early intervention, guidance and support in cases where abuse is identified;
- Identifying the type and extent of violence, abuse and deprivation of women's rights in the communities they serve;
- Assessing the needs of the women in their communities;
- Involvement in the process of empowering women in communities;
- Protection of the rights of women and enhancement of gender equality in the communities; and
- Identification and observation of the policies in place regarding women in Namibia.

That concludes discussion of the strategies and objectives for the implementation of development in nursing practice.

7.6 Recommendations

7.6.1 General recommendations

The recommendations made here are related to what was actually envisaged for this study. The results at hand will be placed with the relevant institutions as recommendations, these institutions being UNAM and the Ministry of Health and Social Services, so that they become aware of the issues raised by the registered nurses who were the respondents in this study.

7.6.2 Recommendations on the curriculum

One of the main aims of the study was to identify what knowledge registered nurses acquire and how they use this knowledge in clinical practice, the institutions responsible for their training and the departments in particular where they are trained, should look into the point of how to assist them in this regard.

The curriculum of Sociology of Development should be implemented in such a way that it equips nurses with the necessary skills to apply knowledge in practice. This application depends on the teaching methodology, which should be appropriate and effective. Nurse graduates should leave University competent enough to put their skills into practice, therefore:

- The curriculum content should indicate the practical uses of every section dealt with. This should be indicated in the learning objectives of each section.
- The integration of Sociology of Development into specific nursing subjects such as Community Health Nursing Science, Ethos of Nursing and Nursing Management is vital to this application. Ethos of Nursing should be taken into consideration, given the current situation regarding the current state of social development. Community Health Nursing is

applied to people within a changing and developing society and nurses need to base their practice on new trends as brought about by the development.

- Cross-referencing serves as a tool for bringing content in line with what nurses do. When an aspect of Sociology of Development is the same as the content in another course, students need to be referred to this aspect, rather then to repeat it in full again.

Lecturers should perform the following functions:

- As a registered nurses by profession and being lecturers they should act as facilitators for the implementation of strategies into nursing practice.
- Assist other lecturers responsible for teaching the subject or course, so that they have background knowledge of what nursing is all about, so that they can bring it into context.
- Present the findings to the Ministry, which is the employing body for registered nurses and to managers in health care facilities, so that these institutions and people are able to react to the needs of nurses so that they can use their knowledge in the practical field.
- Assist nurses in accepting strategies as a helping tool to make their learning experience meaningful to them and to their clients.
- Assist registered nurses at their different levels to understand the impacts of their social and professional behaviour and conduct on the social as well as health development in their communities and to develop skills necessary to observe, mobilize and identify women and child abuse.

Registered nurses have the following functions with regard to implementation:

- They need to understand and master the objectives of Sociology of Development

as stated in the curriculum and be ready to take practical action with regard to what they are taught theoretically as per the strategies.

- They must act as agents and recipients together with their lecturers, and should see Sociology of Development as part of their practical skills and not in isolation as only a social science.

7.6.3 Recommendation to Ministry of Health and Social Services

The clinical areas where nurses practice belong to the Ministry. The Ministry serves as a service provider where these registered nurses are employed. The Ministry needs qualified staff members who are competent and capable of functioning to achieve its goals successfully.

The Ministry should therefore:

- Accept responsibility for guiding nurses so that they view social development as comprehensive, where health and nursing development are parts of it.
- Health directors of services where these nurses are allocated should ensure that the services are development-oriented and that nurses act according to the new trends in giving health care.
- Chief-control and principal nurses (as middle and first level managers) in charge of the registered nurses can help to facilitate development aspects to be integrated into nursing care practices. They are planners as well as facilitators of implementation of plans.
- Registered nurses in the clinical situation should consider the changes in their practical situation and in their environment as part of development, which affects them and their

clients.

- The nurses in charge and registered nurses supervising student nurses in clinical areas should identify the needs for application of social development in practical situations and guide them accordingly.
- All nurses need to consider new policies in their set up as a way forward and part of social and health development.
- The Ministry of Health in general and the Directorate of Nursing Practice in particular should have health facilities that are conducive to the application of the knowledge that students gain from theories, not only in Sociology but in other fields as well. This will help students to realise the importance of taking such courses and not seeing them as a waste of time, as some nurses do believe that sociology is a way of punishing students by giving them extra work.
- Health officials within the Ministry's employment should make information available to student nurses and not wait until they complete their training.

7.7 Limitations of the study

There are certain factors that posed as limitations to this study:

- The sample size was adequate but not all nurses in the sample completed the questionnaires.
- Respondents in this research study had their freedom to participate if they wanted to and some of the selected respondents did not fill in their questionnaires. They agreed to participate but had the freedom to withdraw at any time. Therefore, some of the nurses took or accepted the

questionnaires but returned them without having filled them in.

- With regard to design, the researcher observed that there are certain aspects of the questionnaire, which respondents mentioned, which needed more clarification. The questionnaire has limited answers, which mainly depend on the pre-formulated responses. Although there were comments put at the end of each question, unclear responses could not be probed. The accuracy of the answers depended on the attitude of the respondents. No in-depth interview was conducted which could have gone together with observation of non-verbal expressions, but this method was also chosen for its unique advantages. The questionnaire method was chosen to avoid the Hawthorne and placebo effects. The respondents may have chosen to react differently in the presence of the researcher or give answers which are not true by reporting changes which have not taken place or reporting having done certain things which they never did to impress the researcher who to some, is their former lecturer, and to others is known to be a lecturer in this field of study, if the interview method had been used (Mouton, 2001).
- The researcher was not able to be present when the questionnaires were filled in. If this was possible the response rate could have been higher than this.

7.8 Contribution of the study

This study has made its contribution to the body of knowledge in nursing practice as well as to the study of Sociological in the area of development. The contribution has arisen from the following:

- The identified challenges that determined the nature of the strategies to be formulated.
- A conceptual framework was developed regarding the strategies that facilitate the application

of Sociology of Development in nursing practice. This will help nurses to see this section as part of the practical exercise and not merely as a course taken to fulfill the requirements for their diploma or degree. This framework can also be used to identify the relationship of any other course taught to the real practical situation.

- The strategies, which were formulated in this study will help nurses to organise their clinical setups in such a way that they do not only expect things to be done for them, but that they can do this on their own and will be able to make proper observation when ever they are caring for their patients or clients and their family members and the community at large.

7.9 General Conclusion

Sociology of Development is a social phenomenon, which deals with the changes taking place in societies and the responses and reactions brought about by those changes. As a course offered to students of nursing science at university level, it endeavors to bring together what society and nurses as health care providers are experiencing in this changing world, regarding their physical, emotional, economical and social make-ups as well as their health set-ups.

The relationship between social development and the health care system is one of mutual dependence. Factors that affect development in turn affect society, also affecting the health of the members of such a

society. It is therefore evident that nurses are part and parcel of society and that their practice is within and for society. Rain cannot water the plant without wetting the soil.

In order to realise this relationship and to make the connection clear for integration purposes, nurses need to follow certain clear and well spelled-out strategies based on underlying objectives and goals in nursing practice. This is what will make Sociology of Development meaningful, purposeful and the basic foundation of nursing science practice without any claim of encroachment. Sociology will then become a member of the family of health care delivery subjects with legal and necessary bases. Science can be viewed as living and moving (according to the researcher's point of view), that is 'science proven and science in utility'.

The strategies formulated here are not exclusive. There is more room for additional, complementary and supplementary ideas on how best the content can be made practically applicable not only to the nursing field but to other health sciences/professional practices as well.

May the nursing profession survive the era of transformation through transition from better to best. 'Every cow was a calf' and the researcher hopes that nursing science in Namibia is paving its way through thick and thin so that it can emerge as a competitive and a comparable profession with strong pillars based on the 'cement' of empirical evidence.

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ANNEXURE A.

QUESTIONNAIRE

Answer the questions by either ticking in the appropriate box (es) or make statement(s) on the spaces provided.

SECTION 1:

PERSONAL PARTICULARS

1. Age			2. Sex	F	M

3. Year completed………………………..
4. Where………………….……….…………
5. When have you passed/completed Sociology of Development for your diploma course ………
………………………………………………………………………….…..
6. Region where you are currently practicing……………………………...…….
7. For how long are you in the present unit…………………………………………….

SECTION 2.

SPECIFIC QUESTIONS:

Answer the questions below by either ticking in the appropriate box(es) or make statement(s) on the space provided.

See the following example to assist you to complete this questionnaire: To what extent is social development a practical subject in Nursing?

Not at all	1	2	3	4	5	To a large extent
			X			

The cross at 3 indicates that Sociology of Development is practical. If you marked 1 it would mean not at all. If you marked 5 it would mean to a large extent.

1. To what extent do you believe modernization has an impact influence on your nursing care concerning:

	Not at all	1	2	3	4	5	To a large extent
• Freedom of choice							
• Personal & profession growth							
• Satisfaction of education needs							
• Decision making							
• Spiritual & salvation satisfaction							

Comments:

……………………………………………………………………………………..……………………

…………..……………………………………………………………………

2. To what extent do capitalism influence your nursing practice concerning the availability of:

	Not at all	1	2	3	4	5	To a large extent
• Medication							
• Acquisition of equipment							
• Maintenance of equipment							
• Human resources							
• Therapeutic intervention (counseling)							

Comments:

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………

3. To what extent did the content of Sociology of development led to improvement of your nursing practice regarding:

	Not at all	1	2	3	4	5	To a large extent
• Assessing of needs for nursing care							
• Determine a nursing diagnosis							
• Plan nursing care							

• Prioritize nursing activities							
• Implement nursing care							
• Evaluate nursing care							
• Record nursing care							
• Independent thinking							
• Self evaluation							
• Decision making							

Comments:

………………………………………………………………………………………………………
…………………………………………………………………………………………

4. After completion of your training did you upgrade your knowledge with regarded to:

	Yes	**No**
• The nursing process		
• Health care services & management		
• Community Health Nursing		
• Mother and Child Care		
• Ethics of nursing		
• Mental health		

• Nutrition		
• Health education		

Comments:

………

………………………………………………………………………..……

5. To what extent did the upgrading of your knowledge influenced your skills concerning:

	Not at all	1	2	3	4	5	To a large extent
• Communication skills							
• Knowledge							
• Affective skills							
• Psychomotor skills							
• Supervisory skills							
• Managerial skills							
• Delegation skills							
• Critical thinking skills							
• Evaluation skills							

Comments:

………

…………………………………………………………………………

6. What do you consider has been your most successful achievement in your professional life over the last five years.

Comments:

………

…………………………………………………………………………

7. To what extent are you equipped with the necessary skills to eradicate social problems like:

	Not at all	1	2	3	4	5	To a large extent
• Malnutrition							
• Diseases							
• Slums							
• Illiteracy							
• Unemployment							
• Social inequality							

8. Are you able to disclose information about yourself appropriately?

		Not at all	1	2	3	4	5	To a large extent
•								
•								
•								

Comments:………………………………………………………………………………………

…………………………………………………………………………………………………

9. How do you view Sociology of Development in a future curriculum?

• It should continue as it is now	
• Some aspects need to be changed	
• Some information are not relevant and should be removed	
• I have no idea what can be done	
• There are certain aspects not fully covered	

10. Comment on what you have indicated above (example: there are certain aspects not fully covered). If any change is necessary list aspects to be changed.
……………………………………………………………………………………………………
……………………………………………………………………………………………………
………………………………………………………………………………

11. To what extent did changes occurred on the following aspects in the health services over the past five years.

	Not at all	1	2	3	4	5	To a large extent
• Infrastructure of health services							
• Dissemination of health information							
• Accessibility of health services							
• Availability of health services							
• Transport for health services							
• Human resources for health services							

• Budget allocation for different section in health services							

Comments:

……………………………………………………………………………………………………

……………………………………………………………………………………………………

…………………………………………………………………………………….

To what extent:

12. Do you set goals to achieve what you have planned in your daily practice (hospital, clinic, health center).

Not at all	1	2	3	4	5	To a large extent

13. Involve registered nurses in your planning for nursing care activities.

Not at all	1	2	3	4	5	To a large extent

14. Rely on your supervisors for decisions concerning nursing care that must be taken.

Not at all	1	2	3	4	5	To a large extent

15. Consult with your colleagues about their needs concerning job satisfaction.

Not at all	1	2	3	4	5	To a large extent

16. Give feedback on performances of your subordinates concerning the nursing care they have given.

Not at all	1	2	3	4	5	To a large extent

17. Acknowledge any good work they have done.

Not at all	1	2	3	4	5	To a large extent

18. Assist them to correct any weak performances.

Not at all	1	2	3	4	5	To a large extent

19. Observe exploitation of nurses in the workplace.

Not at all	1	2	3	4	5	To a large extent

20. If yes, indicate in which ways does exploitation took place
……
……
………………………………………………………

21. To what extent did you observe women who are deprived of the following rights.

	Not at all	1	2	3	4	5	To a large extent
• Health care							
• Marital							
• Political							
• Economical							
• Education							

Comments:…………………………………………………………………………………………
………
……………………………………………………………………………………………

22. To what extend are you involved to empower women in the community

Not at all	1	2	3	4	5	To a large extent

23. If you are involved, indicate the part that you played
……
……

……………………………………..………………………

24. List the organizations that you know of who are involved in women and childcare and development.

……

……

…………………………..………………………………………………………

25. To what extend are you involved to assist a women patient who is subjected to domestic violence at home.

Not at all	1	2	3	4	5	To a large extent

26. If you are, what do you do?

……

……

………………………………………..………………….

27. Are there any cases of child abuse admitted in your hospital units?

• Always	
• Sometimes	
• Never	

28. If case were admitted how did you deal with the case

……

……

……………………………………………………………………………………

29. How do you give health education to patients that are illiterate

• Verbally	
• Show pictures	
• Don’t give health education	