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Wisdom from within: Finding modern truths in traditional proverbs

C.J.E. Uys, B Arb (Pret), B Occ Ther Hons (Medunsa), M AAC (Pret), PhD (Pret)
Professor, Center for Augmentative and Alternative Communication, University of Pretoria

ABSTRACT

The South African occupational therapy profession is not immune to professional migration of colleagues to richer countries due to various external pull factors and internal push factors. This paper aims to identify and describe important pull and push factors as experienced by occupational therapists currently working in the country. This information was obtained through a survey and personal interviews. The paper concludes with ten guidelines on how we can collectively work towards motivating occupational therapists to stay and work in South Africa. This is done through the wisdom of Sepedi proverbs and applied to the modern context of South Africa.

Key words: push and pull factors, professional migration

Vona du Toit is the mother of Motivation in Action, a concept close to the hearts of occupational therapists, as we apply it in the assessment, planning and intervention of patients and clients. In the current health care crisis in South Africa, however, it is paramount for *employers* to acknowledge what motivates *employees* in order to arrest further deterioration of health care services and/or migration of health care professionals.

The questions that come to mind are "Why are we training excellent occupational therapists in South Africa, just to lose them to richer countries? What can we do differently in our health care system to motivate our well trained colleagues to remain in South Africa and deliver a service to a population who really needs them?"

I briefly want to sketch the scenario of health care in South Africa, but as this lecture is in memoriam of Vona du Toit, I want to pull a golden motivational thread through the arguments for excellent service delivery to those who depend on our service for a better quality of life.

"South African health care is in crisis". This type of head-line has been seen too often in the past few months on the newspaper stands and on the news readers' prompts. Poor management and misallocation of resources are among the primary reasons cited as to why the healthcare system is in disarray[1]. A survey conducted at 33 Gauteng hospitals acknowledged that the proposed standards of care were only met by 11 of the hospitals and the standards at

other hospitals were declining due to management issues, as well as staff shortages[1]. Research indicates that there is a strong correlation between quality of care, health care outcomes and the availability of health professionals[2]. Literature on human resource management emphasises that successful companies invest heavily in their human resources. Without dedicated, motivated people, a company can not reach its goals, but in order to have a motivated worker, specific issues need to be addressed. Service quality, efficiency and effectiveness are all directly dependent on worker motivation and therefore change should take personnel needs into consideration.

In a multi-faceted country like South Africa, which embraces diverse communities ranging from resource-rich to resource-poor, the management of health care poses serious challenges. Since becoming a democracy in the early 1990s, South Africa has developed a strong constitutional obligation to provide social, educational and health services to children with disabilities[3]. As I am mostly working in early childhood intervention, I want to present a few examples of the resource imbalances pertaining to young children and their families as illustration of our current context.

The South African government has ratified the United Nation Convention on the Rights of the Child[4], the UN Millennium Development Goals, the UN General Assembly resolutions such as "A world fit for children"[5] and the African Charter on the Rights and Welfare of the Child. Having ratified and signed these international instruments, the South African government has agreed to implement them and is bound by the stipulated obligations. These policies and regulations resulted in all children from 0 – 6 receiving free health care. Although this is a progressive policy, the consequences on budgets, staff and consumable materials etc. were not foreseen, causing further management problems and unsatisfied staff due to the unreasonable demands placed on them.

The statistics confirm this impression. According to Statistics South Africa, in 2001 10% of the population in the lowest income group shared R1.1 billion, whereas 10% of the population in the highest income group shared R381 billion. This makes South Africa one of the most unequal societies in the world. In layman's terms it means that the bottom group takes nearly a year to earn what the top group earns in a day. It is therefore no wonder that therapists in hospitals report that they experience frustration as they can not provide effective rehabilitation because patients, for instance, cannot honour follow-up sessions after discharge due to financial constraints.

The incidence of disability amongst children aged 0-9 years in our country, is estimated to be in the region of 5,2 to 6,4%, which means that approximately 1 million children are disabled[6]. Added to this is the incidence of children at risk for developmental delays due to risky environmental conditions such as poverty, violence and diseases such as HIV/AIDS. This continues to drive the numbers of children and families requiring early intervention services on an increasingly upward spiral[7].

The first map in *Figure 1* presents a land area map of the world and the second map indicates the territory size of the proportion of all people aged 15-49 with HIV living in each country[8]. This visual image emphasises the huge challenges that we need to consider in the field of *inter alia* early childhood intervention and as the child does not live in isolation, we also need to consider the family and the community they live in when planning and implementing intervention. Similar to HIV/AIDS causing waves of devastation on the socio-economic sector of our country, other illnesses like malaria and diarrhoea also impact on families at risk. These factors, combined with the policy which mandates that mothers and children under the age of 6 years-of-age receive free medical intervention, increase the burden on health care professionals. Apart from the increase in their case loads, dealing with patients dying due to a variety of explained and unexplained circumstances, places additional stress on health care professionals. As one occupational therapist stated:

"Sometimes I feel that why should I see the patients if they are going to die soon? I therefore tend not to form relationships with my patients or to get too attached to my patients."

Although figures are not specifically available for the 0-6 year population which forms the focus of early childhood intervention in SA, it is estimated that over 10 million children under the age of 18 years in South Africa live in poverty. The fact that the AIDS pandemic was thought to affect approximately 3,4% of children under the age of five in 2005, can only aggravate the circumstances and development of these children[7]. The policies of segregation under the system of Apartheid have also contributed to a racially skewed profile of disabled children with more than 80% of black children with disabilities living in extreme poverty in rural areas[9] where there are less health care services available. McKenzie and Muller[10] described this unequal distribution when they reported that 80% of children with disabilities live in rural areas of South Africa where only 20% of health care services are available, in relation to 20% of children with disabilities that reside in urban areas where 80% of health care services are available.

In 2005, the government made considerable inroads in equalising the provision of health services and introduced the compulsory community service programme for health professionals, including occupational therapists. This endeavour resulted in providing closer access to rehabilitation services for those 80% of the population who live in rural areas of South Africa who did not previously receive such services. It also resulted in the creation of new permanent posts in some progressive thinking provinces, however, the lack of continuity of these rehabilitation services due to the stipulated one year conditions of employment, remains a limitation[11].

Is a compulsory community service programme the answer to a sustainable quest for 'all for health and health for all'? The Public Health Association of South Africa[12] stated that "the proportion of therapists who indicated that they would work in the public sector in the future declined from 50% at the onset of their community service programme to 35% at exit and only 16% were planning to remain at their allocated community service institution. These numbers are indicative of a potential problematic situation that should be investigated and reversed.

It is not only the lack of human resources in the field that affect service delivery, even at a managerial level rehabilitation services experience major constraints. The Department of Health concedes that it is not only difficult to recruit rehabilitation personnel, but also to retain them[11]. The numbers presented in *Figure 2* clearly
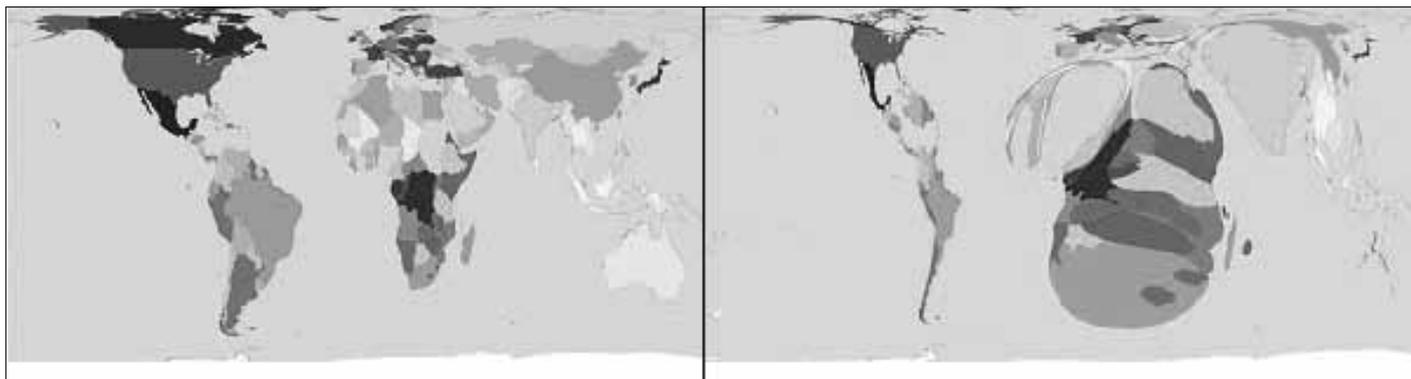

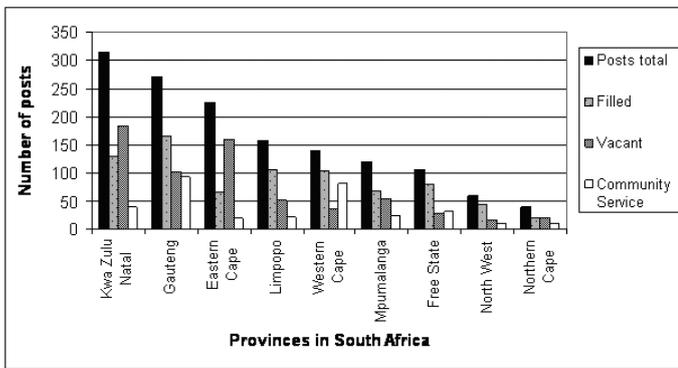*Figure 1: HIV Prevalence according to territory size[8]*

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Figure 2: Occupational therapy posts in public health care[13]

support this acknowledgement as the number of vacant posts across all provinces is glaringly obvious.

It is a known fact that health workers are inequitably distributed throughout the world, with severe imbalances between developed and developing countries. The shortage of health workers is made even worse by imbalances within countries. Sub-Saharan Africa faces the greatest challenges. While it has 11 percent of the world's population and 24 percent of the global burden of disease, it has only 3 percent of the world's health workers. There is a direct relationship between the disparity of health workers to the total population and the survival of woman during childbirth and children in early infancy. As the numbers of health workers decline, survival declines proportionately[14].

We have heard of and have in certain instances experienced the lack of occupational therapists in public health institutions. Is it not time that we look at factors that would motivate therapists to come back and fill those vacant posts? What were the reasons for their departure and what can be done to lure these professionals back to work in the national health care system?

Professional migration of health professionals

Before addressing professional migration, let us consider the graph in *Figure 3* which represents the perceptions of some occupational therapists in South Africa currently working in either the private sector or the public sector.
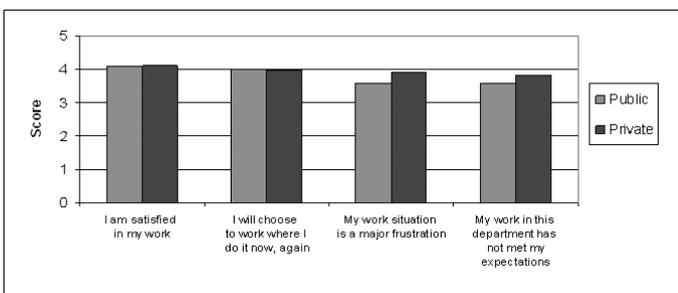

Figure 3: Perceptions of current job

The results of a survey conducted indicated that there was not a significant difference between the therapists in the private sector and those working in the public sector and all experience above-average job satisfaction. However, there was a tendency for professional migration of occupational therapists from South Africa to other countries. Professional migration was seen as the major reason for the continued attrition of trained professionals and the inequitable distribution of health professionals in the health care system in South Africa. Unfortunately, the migration follows a hierarchy of wealth. This means that there is a knowledge and skill loss from the poorer to the richer countries that equates to a reverse subsidy – poor to rich. My first reaction is "How dare we let this happen? How dare other countries lure our well-trained colleagues away from our own needy situation?" However, on immersing myself in literature related to the so-called brain drain, I discovered a myriad of factors that push professionals out of the country and pull them successfully into richer countries. In preparing this lecture, I explored the local OT population's feelings towards job satisfaction by sending a questionnaire to all OTASA members and supported the quantitative findings through interviews with colleagues from the public and private sector. Although the sample was only 140, clear tendencies could be deduced through the analysis.

Researching this field made me realise that we not only need to voice our opinions regarding health care in South Africa to people who will listen, but each of us should also look introspectively at our own ethos of caring as it changes our perceptions and actions of dealing with challenging situations. The following section provides comment to occupational therapists who voiced their perceptions of our health care system.

The most influential internal push factor from the health care system, in deciding to migrate either from public to private sectors or from a poor to a richer country, is remuneration and salary. The occupational therapists say:

I feel that OTs study hard…and this is not reflected in what they are paid. I feel that this is often a great source of concern especially to a graduating OT who often has loans to pay back, is looking to start a life i.e. buy a car or a home. I feel this is the strongest reason why OTs are going overseas.

Even though I am performing the duties of a senior therapist i.e. running the occupational therapy department, they (government) will not give me the senior post.

I want better job promotion prospects in the current health system – one could stay ones whole life at one post level as the OT staff establishment does not permit/allow upwards progression if one stayed at one's choice of workplace.
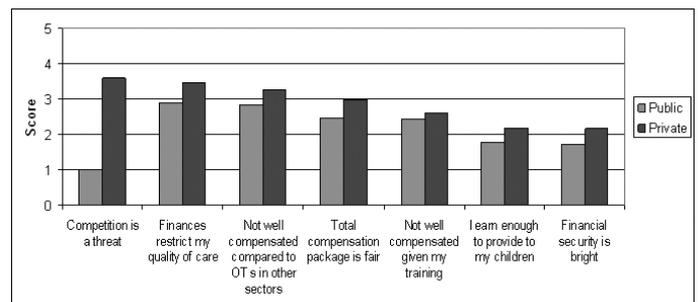

Figure 4: Feelings about payment packages

Figure 4 indicates that although the private sector's score is higher there is also no significant difference between the public and private sector regarding their perceptions about financial compensation for the services they deliver, except for the threat of competition. There is, however, a more negative sentiment about their remuneration. However, similarly to job satisfaction, these results do not seem to be the most important reason for migration.

The second push factor is the fact that professionals feel demotivated due to poor health management and infrastructure. One of the biggest problems in the health care system in South Africa is ascribed to managerial issues[1], and the impact it has on the therapists is recognisable in their comments.

I have worked overseas for 10 years [and] I miss the career development opportunities that exist in the USA for OTs. I feel that we are marginalised based on our degree, not [our] ability or potential. I worked in a large New York city hospital and worked in a hospital management capacity. This would not happen in RSA.

I feel that a lot of OTs leave SA after completion of their community service year as they find the year very challenging both emotionally and intellectually. There is often very little supervision for graduates who have been placed in rural settings or even smaller hospitals and these results in the year not being a positive experience. Even when placed in a bigger hospital, the staff that the hospital is able to retain is often overburdened by little (few) resources and overwhelmed by the demands resulting in the com serve (community service) OT receiving very little supervision and gaining a negative impression of the government system, leading them to look elsewhere to develop their skills and to be appreciated.

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High levels of occupational risk, such as becoming infected with HIV with reportedly poor administration of ARVs is also strongly viewed as a push factor. In addition, HIV/AIDS increases the demands for health services by increasing the number of patients in need of services. Muula[15] also reported that an increase in the attrition of health professionals through death and illness also puts a strain on remaining health professionals.

We live in constant fear of contracting HIV. I have been on antiretrovirals twice. This means a month of being sick – vomiting on a daily basis. Then there is the anxiety and panic for six weeks till you do your HIV test to see that you are negative.

The high death rate of patients sometimes gets me under. It is difficult to form relationships with your patients as you know they are going to die.

The last internal push factor listed is the lack of further education and career development opportunities and from the comments of the therapists they would appreciate more support from their employers.

There are no valuable courses that are affordable. I expected my university to provide more post-graduate courses and workshops for CPD. There are little professional workshops known to the average OT… and the costs involved on top of taking the time off are quite scary!

There are limited opportunities for further education and training, for example I am not always allowed to attend workshops, or conferences and need to take vacation leave to attend. The government should allow for staff to attend CPD activities.

External push factors are factors outside the health care system that push people out of South Africa. According to Padarath[16], 96% of emigrants cited high crime rates as the reason for emigrating. South African emigrants stated that over the past 15 years quality of life has deteriorated, general dissatisfaction with the cost of living, government's affirmative action policy, and the standard of public service as reasons for their decision to emigrate. Some comments from our occupational therapy colleagues are:

Quality of life: Crime, Political insecurity, Safety

I am looking for job opportunities overseas as I have been robbed at gun point and now I am too scared to stay in South Africa.

The minister of health changes after every election and then the health care system changes again.

My family does not feel safe in the city where we live. My husband is job hunting overseas.

War, civil conflict, political repression:

I am concerned about the lack of capacity demonstrated by civil servants, nurses, politicians, many graduates….

I am concerned about SA's state of democracy.

Lack of education opportunities for children:

We would consider moving back to the UK when our daughter requires tertiary education and to retire there for financial reasons.

It is easy to get swept away on a tsunami of negativity and subsequent to this investigation, I realised that we still have ample reason to stay in this country to deliver a quality service to the people who really need it. This can only happen if we listen to the voices of our occupational therapy colleagues and take cognisance of strategies to implement sooner rather than later. Such strategies need to provide direction while remaining sensitive to, and acknowledging, our current context. I want to use Sepdi proverbs to specify the strategies I believe would guide us on a promising road ahead. These proverbs are the rich expressions which older generations have left for younger generations to alert them to the principles of living a just, honourable and productive life in society[17].

1. Mphiri o tee (ntoo) ga o lle *(One bangle does not make any sound: A person cannot succeed without other people)*

Inter-professional training has long been advocated to address the problems of professional collaboration after health professionals graduate. The key element to successful rehabilitation is collaboration between the different professionals as well as the family of the patient so that decision-making, programme planning and the implementation of services can occur in a collaborative fashion. Is it not true that patients are discharged without consulting the rehabilitation team; or that therapists plan intervention just to be informed by the family that it does not comply with their needs? How many of the parents of children we see in our private practices cannot wait to drop the child off at therapy to go and do some shopping or how many parents have to wait in the waiting room until we honour them with five minutes of feedback after the session? Why are all the therapists in schools complaining about uninvolved parents and the fact that professionals have to start all over again with therapy after a school holiday as there is very little carry over to the home context? Do any of these questions ring true? The answer lies in better collaboration between therapists and parents.

Collaboration often remains an elusive goal as it is assumed that it is merely better communication, positive attitudes and creation of inter-sectoral modus operandi. However, we need to fully understand the forces that promote and inhibit collaboration, before more effective partnerships across organisational, sectoral and professional boundaries can be established. The common definition of collaboration means working together. A more formal definition in the human services organisations is the more formal joining of structures. This is part of a spectrum, beginning with cooperation through to coordination, to collaboration and ultimately integration which involves the formation of new organisational structures[18].

There are obvious benefits to coordinated and integrated service delivery models. The improvement in service delivery to the target population as a result of more efficient and effective use of services and its providers is the most important element. In addition, mutual efforts enable parents and service providers to efficiently locate and manage the varied resources, supports and services required by a family[10,19]. Not withstanding these benefits, research suggests that professionals also benefit from collaboration through the process of multi-skilling[20]. Multi-skilling is a form of role diversification and refers to the cross-training of professionals and/or support-level practitioners to perform procedures and functions in two or more disciplines[21, 22]. For this reason it can be seen as a vehicle for promoting cost- effectiveness, efficiency, quality and co-ordination of services, while simultaneously striving to reduce intervention time and fragmented service delivery.

Continuing on the importance of teamwork we need to look at our positive participation in our professional association. We live within a culture that promotes individualism and we do not want to admit that we need others to help make us resilient. However, it is because of the efforts of many of the people around us that we are able to become stronger in the execution of our work. As human beings we need to be bundled together and our bundles protect us best if they are bigger than just the small circle of colleagues who meet on a daily basis. Being part of a professional body gives a person the opportunity to converse with other people in similar situations, thereby decreasing feelings of powerlessness and uselessness. As the association has many members with different strengths, styles and personalities, there is a high probability that social support can be found within the association.

One bangle does not make a sound, but if we put all the bangles together, our voice would become strong.

2. Mahlaku a maswa a ema ka a matala (*Newly cut branches in a kraal lean against the old ones: Young people are best guided by the older generations*)

In our youth, we learn and in our golden years, we understand. The benefits of engaging in a mentor-mentee relationship are well documented and it is well established that the role of the mentor should primarily be that of a role model or counsellor who provides knowledge, experience, guidance and support[23]. The benefits to the mentee include the development of professionalism[23]; instilling greater professional expertise; contributing towards higher job satisfaction[24]; a faster rate of promotion[25] and an increase in research activity[26]. Reflecting on these benefits, I cannot imagine how a profession does not have an established mentoring system in place, when it is evident that younger col-

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leagues can learn from other colleagues who have travelled the same road.

OTASA has a list of mentors and young colleagues are encouraged to utilise this resource, but on inspection it was clear that this list is underutilised. What are the reasons for the underutilisation of this resource and what can be done to promote the use of mentors as a positive resource? Should mentoring be introduced in an undergraduate level to make professionals aware of the benefits of this type of system or should it be introduced as part of a transit programme from being a student to a professional?

Pawl[27] stated in relation to early intervention training of professionals that "how you are is as important as what you do". Personal and professional well-being can only be achieved through a process of reflection which is best explored within a mentoring relationship. Reflective skills are not taught to students and therefore inadequate coping mechanisms are observed. Therapists report that they are emotionally and physically exhausted, however, they still do not access the mentoring resources available. Mentors should also promote their abilities and indicate a willingness to engage in a mentor-mentee relationship. We should overcome the idea that promoting ourselves is self-promotion and rather view it as contributing towards the development of young therapists and the profession as a whole.

3. Ditau ga di adimane meno (*Lions do not lend each other teeth: You should always work with your own tools*)

The theme of "train for Africa not for the World" is not new, however there is a tension in this statement – a tension between Westernised curricula and Africanised curricula. Does it mean that because our training meets the global curricula requirements, professionals can and will emigrate to the "richer" countries[15], or does it mean, according to Joubert[28] that we need to "decolonise our way of thinking and commence [to] reconstruct[ing] an African world view". Muula[15] observed that in Malawi a plant or an animal that is bigger and better than the rest is called *yachi un u* (of European origin) – even though it has nothing to do with Europe. On the other hand, anything that is seen as inferior quality is called *yalo olo* (of local origin). Even if we do not acknowledge it out loud, is our frame of reference that "Western" equals quality and local equals lesser quality? It is not time for us to reflect and develop indigenised curricula that are not inferior to the Western curricula? Curricula that train occupational therapists to "move just as easily within tar roads and white coated clinics as they can within dirt roads and brown earthed communities"[28].

We need to prepare students to deal with the range of diverse cultures in our communities, rather than only espousing Western philosophies of intervention. According to Zondi[29] when talking about training in social work, she states that "it was a huge shock to discover that at this wonderful institution learning skills … had nothing to do with integrating my reality, my back ground, my culture and my experiences into the learning. I was disappointed because I realised that there was nothing that was going to prepare me for working with people from my own culture. The lecturer didn't, the books didn't, and most were written by American authors." As previously mentioned, the importance of publishing South African perspectives of occupational therapy become essential for our professional survival.

Tensions between science, practice, and policy have the potential to make a positive impact if carefully negotiated. We need advocates that can publicise, with a passionate conviction, the multiple success stories of occupational therapy in our country. This should happen at national and international conferences, journal publications, articles in popular magazines and local media. In addition to advocates, we need scientists and researchers who are driven by the excitement of uncertainty and the hunger for evidence. We must think of evaluation research not only as a way to document successes, but also as a tool to find out where and how we fall short in our service delivery. Again, these findings should be published and shared with our local and international population

of health workers, in accredited journals, but also in the popular media. In this way the population, including policy makers, will also learn about the benefits of becoming involved with the occupational therapy profession.

4. Ge o ka bona pholo wa re tuu! wa morago o tla re: "Pholo ya ka!" (*If you see a bull and keep silent, the person behind you will claim: "That bull is mine!": If you hesitate to seize an opportunity, someone else will take advantage of it*)

How often have I heard occupational therapists sounding utterly shocked that other professional groups are taking over our tools of practice? Activities of daily living is not synonymous with occupational therapy any more and various professional groups lay claim to these functional activities in intervention. Opportunities for better, more effective and efficient intervention are never lost; someone else will use the ones that we do not claim as our own. We must be proud of our OT tools, use them to the best of our ability and show the evidence of the success of our interventions. To establish evidence, our profession needs to conscientiously document the status and process of their practice, develop standards of practice and test the outcomes of their actions in practice in order to leave a scientific trail of evidence.

Evidence-based practice is there to assist in the decision making process of planning intervention after all the aspects of health care are considered. Although current research literature needs to be accessed, evaluated and integrated for this process to be successful, some clinicians still viewed professional experience, feedback from colleagues and clients as their primary sources of evidence. They expressed limited knowledge with and experience in critiquing research literature[30]. A lack of time and an excessive workload were other reasons raised for not using the fundamentals of Evidence-based practice in implementing everyday practices. Many occupational therapists also indicated concern at the lack of evidence available for access.

A multi-faceted approach to address Evidence-based practice in occupational therapy therefore appears to be necessary. Educators, clinicians and researchers are challenged to take responsibility not only for the provision of effective and efficient service delivery, but also to measure the effectiveness and efficiency of such treatment programmes; meet the expected standards of assessment and intervention; share data and results with others; facilitate the learning of the importance and the use of outcomes, as well as provide critical reviews of existing outcome measures.

If we do not claim the bull in the background, other professionals will seize the opportunity to declare the bull theirs. Evidence-based practice is but one method to lay claim to our tools of practice.

5. Nonyana phakuphaku e bea lee le ntoo (tee) (*A hurrying bird lays only one egg: A person who tries to do too many things, too quickly, often achieves little*)

The relatively new concept of a community service is commendable as occupational therapy services are extended to where they are needed most. However, some of the community service colleagues feel that they are responsible for more projects than they can and should manage, which has a negative impact on the quality and sustainability of service delivery. As some of these young, inexperienced colleagues work alone and are without the supervision of an experienced colleague, they need to know how to apply ethical theories and clinical reasoning[31]. This implies: "Are my actions good or bad and what is the balance between good over bad? Is quantity better than quality?" Inexperienced colleagues need guidance from more experienced colleagues in making such decisions. How can we ensure that they get the support that they need?

"My senior therapist gave me five community-based projects to manage besides my responsibilities at the hospital. However, I am only allowed to attend these projects once a month. I really do not know how to

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manage it effectively and I feel as if I am drowning. My undergraduate studies did not prepare me for this."

As mentioned previously the reality is that we need more skilled supervisors to support and assist colleagues to reach and maintain success in their endeavours and to facilitate a smooth, but productive transition which will be of benefit to the community they serve. At the same time the training of occupational therapists should be carefully and unambiguously scrutinised so that an independent, creative problem solver, a professional who sees opportunities rather than difficulties is produced. Due to the professional migration and inequitable distribution of manpower, we are currently living the reality of a vicious circle of inadequacy[15] where young, inexperienced OTs serve challenging populations in rural areas during their community service of one year and after that year of diligent work, leave the posts, which are then filled by other young, inexperienced colleagues. We need to structure the community service year so that our young colleagues maintain their whole-hearted enthusiasm in spite of the challenging work circumstances and experiences. This year should make them feel that their lives have meaning, and that they are needed in this world. There are too many ex-community service colleagues who come out of the year disillusioned and with feelings of failure.

Therefore, is quantity better than quality? This question does not only impact on the people we serve, but also on the occupational well-being of therapists.

6. Twhiwana ye sa hweng e leta monono *(An orphan who does not die is awaiting great riches: A person who persists in spite of tragedies and problems is ultimately rewarded by success)*

Health professionals, especially in hospitals, work in the front line, facing life's hardships and even death on a daily basis. They constantly work in a changing environment, continuously dealing with policy changes, budget changes, as well as technological changes. The huge number of vacant posts forces the remaining staff to continue to accomplish the same mission of the organisation with reduced manpower. Often these professionals are placed in situations without appropriate training and preparation for working in an organisational structure. In addition to all this, they need to learn how to be resilient in a situation that requires quick planning to implement positive adaptive change for patients who visit the hospital on an infrequent basis, while enduring psychological stress throughout this situation. In order to cope with this challenging scenario there are six factors which could contribute to the development of resilience:

➢ The goal-directed solution seeking demand for a person to know the vision of the institution with all team members sharing this vision;
➢ The ethical questioning of self, "If I do not have the necessary tools to do the job, should I withdraw from the situation";
➢ Employing clinical reasoning and reflection to enable the person to consider the implications of possible decisions and to access resources when and where needed.
➢ Knowing how to better access and utilise existing resources instead of complaining about the lack thereof and equating resources and money.
➢ Being able to stand in for a missing team member which is necessary when team members have to rely on each other in a time of difficulty (role inter-dependence). This requires training team members to acquire some knowledge and skills of other professions. This is often described in the literature as a transdisciplinary model of intervention[32].
➢ The fifth factor asks of the professional to learn to rely on multiple sources of information which allows for the construction of reality as well as successful sustainability of the intervention.
➢ The last factor demands that professionals have appropriate knowledge to do the job. The importance of training occupa-

tional therapists to do their job in different challenging situations should not be underestimated as it has a bearing on the professionals' psychological well-being and feelings of accomplishment which ultimately influences resilience.

7. Ge mogo o budule (butswitse) o bonwa pele ke bag a tshwene *(When the fig-tree is ripe, it is first seen by the baboon's family: An event is first noticed by those who desire it most)*

According to du Toit and Wilkinson[33] an average of three articles was published in each volume of the South African Journal of Occupational Therapy (SAJOT) between 2000 and 2007. They assumed that this scarcity of publications coexisted with a sparseness of research done in the field of occupational therapy in South Africa and/or that therapists did not put in the necessary effort which is needed in order to publish. This non-availability of occupational therapy research evidence is defined by Muula[15] as the "soft brain drain". This implies a loss of indigenous knowledge. The editor of the SAJOT will acknowledge that it is a constant battle to get publishable articles for the SAJOT. What are the reasons for this lack of professional participation which would generate new knowledge to lay the ground for improved service delivery?

"Write me up, or write me down, but write about me." These are words uttered by famous people. Why? They know that their fans will continue to follow them if their names continue to be in the news. If we are not going to collectively publish success stories based on research evidence in the journal (SAJOT) at some stage in the future we would no longer be considered as internationally competitive counterparts. Vona du Toit is the only South African to have been awarded an Honorary Fellow of the World Federation of Occupational Therapists in 1974. She received this award for the efforts which she made to market and promote the valuable contribution occupational therapy was making in South Africa. We should strive to maintain the high standard which she exemplified. Muula[15] made the following suggestions which regard to improving publication outputs. They include increased funding for running the journal together with acquisition of business skills for editors, training to authors and reviewers, online access, rewards for authors of publications, and mentorship by well known international journal staff.

8. Mogwera wa tshwene o ja se tshwene e se jang *(A baboon's friend eats what the baboon is eating: Do not look down on a friend who comes from a poor/ different background)*

Service providers must explicitly contend with the cultural mismatch which occurs between families' and professionals' expectations of the intervention experience. This requires that interventionists recognise how their own cultural constructs and identity shapes their perceptions. Although on the one hand current professionals require greater knowledge as well as respect for different cultures, on the other hand we also need a more geographically balanced occupational therapy distribution, with particular reference to professionals who can serve their own people in their mother tongue. Language barriers experienced in our health care system increase the likelihood of patients not receiving preventative care, being less satisfied with services and being at greater risk of experiencing intervention errors. Being part of a diverse country, I have to acknowledge that we do need to train more occupational therapists across the different African language groups. This means that we need to market occupational therapy as a viable career for persons who do not want to leave their hearts at home when they go to work, persons who relate to their patients and have a real understanding of issues pertinent to different communities.

Applying the same reasons to training of occupational therapists, we are required to support the training of different levels of occupational therapy, for instance occupational therapy technicians and community health workers, to address the big need for rehabilitation services in the whole of South Africa.

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9. Go diaga ga tshwene ke go gadimela morago

(To look backward delays a baboon: People who keep on delaying, or do not focus on what they are supposed to do, often fail to accomplish a task)

People tend to ask "What do I want from this country?" However, the more important question for the future might be "What does this country want from me?" We should embrace Theodore Roosevelt's philosophy of "Do what you can, with what you have, where you are." Within early intervention services fostering the concept of "try and see" versus "wait and see" is an appropriate application of this proverb in the intervention context. We are so immobilised by our thinking that we do not have resources to do our job successfully. On closer inspection however, therapists report that this is not really the case. Opportunities come in many forms and when you contribute to things that matter and that are meaningful to you, you see yourself no longer as just a victim of negative external forces e.g. poor organisational management, and lack of resources, but you become an active contributor by promoting alternative methods and engaging in problem-solving, implementing a positive sense of self, as well as a positive sense of purpose for the future. In this sense, continued professional development is crucial for the development and improvement in quality of healthcare delivery service. Therefore, in the words of Barack Obama: "Change will not come if we wait for some other person or some other time. We are the ones we've been waiting for. We are the change that we seek."

10. Go bosisa kgosi ga se go e roga *(To question a king is not to scold him/swear at him: Ordinary peoples have the right to question leaders and important people)*

You need to have the strength of mind to confront the brutal facts of your current reality. What are the cold, hard facts of your situation so that you can use them to drive your decision-making processes, aiming for your goals? In essence, you must understand your reality in order to change your reality. Question the status quo not only on matters relating to health care, but also on all the other interrelated systems which might impact on health care. The occupational therapy profession is not functioning in isolation and therefore we need to identify and understand the external forces that have the potential to shape our direction. Have you studied the reasons why our health care system is currently failing the needs of the people? What can and have we done to retain OTs in the country? What mechanisms are in place to lure OTs to fill vacant posts? The answers to these questions need to be sought from government. The government has a responsibility to implement current policies to ensure functional operating work environments, provide strategies for attracting and retaining staff, and to collaborate with the health professionals to improve the health care system for all. Let us not forget that the health professionals' responsibilities are *inter alia* a willingness to engage in professional pluralism that extends to socio-political affairs in your own community and gaining insight and understanding of those current affairs which could have a major impact on your practice.

In conclusion it could be argued that professionals will migrate due to their perceptions regarding the socio-economic-political situation in South Africa, however, as illustrated through the Sepedi proverbs, we can influence the push and pull factors that lure colleagues to migrate to richer countries. We need to find the wisdom within and among ourselves, publicise and proclaim the many successes already achieved to create a wish for belonging and incorporation.

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OTASA gole o be kaaka tlou tshukudu e be mosimane
May OTASA grow to be bigger than an elephant; may a rhinoceros be a mere boy to you
May OTASA be greatly blessed

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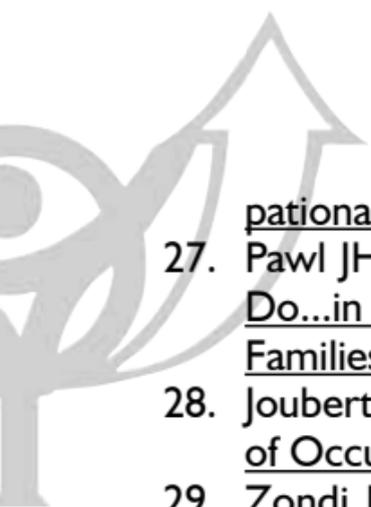
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Author

Professor C.J.E. Uys
Center for Augmentative and Alternative Communication,
University of Pretoria
Lynnwood Street,
Pretoria, 0001
Email: kitty.uys@up.ac.za