

UNIVERSITY OF KWAZULU-NATAL

Faculty of Education: Center for Higher Education Studies

and

School of Medicine: Department of Psychiatry

PHD RESEARCH STUDY THESIS

By John Mudenda Student Number 204520130

Supervisors;

Professor Charlotte Mbali

Professor Dan L. Mkize

Durban

June 2007

TITLE OF THE STUDY

PERCEPTIONS AND UNDERSTANDINGS ABOUT MENTAL HEALTH PROBLEMS OF CHILDREN AND ADOLESCENTS IN ZAMBIA: IMPLICATIONS FOR INNOVATIVE CURRICULUM DEVELOPMENT FOR PHC PRACTITIONERS.

Declaration

I, John Mudenda, declare that this thesis “**Perceptions and understandings about mental health problems of children and adolescents in Zambia: Implications for innovative curriculum development for PHC practitioners**”, is my original work. Research Material and contributions by others have been properly acknowledged. The Thesis has been submitted to the Center for Higher Education Studies in collaboration with the School of Medicine, Dept of Psychiatry at the University of Kwa-Zulu Natal, Durban for the PhD degree. It has never been submitted before for any other degree or examination at any other university.

Signed

Date

.....

.....

John Mudenda

.....

.....

Professor Charlotte Mbali

.....

Professor Dan L. Mkize



Dedication

This work is dedicated to my beloved family: My mother, Maritha Chaambwa, My dearest wife Agnes, and My children: Mweetwa and Emelda, Muteka and Edna, Milimo, Mutinta and Buumba, My two grandchildren Luyando and Chipego as well as my niece Josephine and nephews Michelo and Edward. I commit you all; to the Lord for the support and encouragement you gave me while I was away studying.

Philippians 4v13

TABLE OF CONTENTS	PAGE
DEFINITION OF TERMS	i
ABSTRACT	iv
ACKNOWLEDGEMENT	vi
LIST OF FIGURES	vii
LIST OF TABLES	ix

Chapter One: Introduction

1.1 Introduction	1
1.2 Background	5
1.3 Statement of the problem	9
1.4 Purpose of the study	10
1.5. Research questions	11
1.6. Significance of the study	12
1.7. Justification for the study	13
1.8. Limitations	16
1.9. Validity and reliability	17
1.9.1 Validity	17
1.9.2 Reliability	20
1.10. Trustworthiness of data	20
1.10.1 Credibility	20
1.10.2 Consistency	21
1.11. Dissemination of the findings	21
1.12 Ethical consideration	22
1.13. Conceptual/theoretical framework	23
1.13.1 Introduction of the Framework	23
1.13.2 Systems Theory Model for Curriculum Development	26
1.13.3 Ecological theory model	30
1.13.4 Biopsychosocial Model	33
1.13.4.1 Model description and Application in Medicine	34
1.13.4.2 Criticism of the biopsychosocial model	36
1.14 Conclusion of chapter	37

Chapters: Two, Three, Four, and Five: Literature Review

2.0 General Introduction of chapters 2, 3, 4 and 5	40
---	----

Chapter Two: Action Research

2.1	Introduction	42
2.2	Literature Review	46
2.2.1	Concept and Definition	46
2.2.2	Characteristics of Action Research	49
2.2.3	Justification for the choice of use of Action Research Methodology	49
2.2.4	Assumption about Action Research	51
2.2.5	Background to Action Research	52
2.2.6	Historical Development of Action Research in Africa	60
2.3	Action Research Approaches	61
2.3.1	Participatory Action Approach	63
2.3.2	Action Science Approach	63
2.3.3	Soft Systems Methodology Approach	65
2.3.4	Evaluation Approach	66
2.3.4.1	Snyder Evaluation Approach	66
2.4	Application of Action Research to Curriculum Development	67
2.5	Conclusion of Chapter	73

Chapter Three: Curriculum Development

3.1	Introduction	75
3.2	Literature Review	77
3.2.1	Concept and Definition of Curriculum	77
3.2.2	Constructivist's view of curriculum Perspective	79
3.2.3	Historical Background of Innovative Curriculum	82
3.2.4	Curriculum Development Approaches	85
3.2.4.1	Outcome Based Curriculum Approach	86
3.2.4.2.1	Conclusion of Section	90
3.2.4.2	Content Based Curriculum Approach	91
3.2.4.2.1	Conclusion of Section	95
3.2.4.3	Process Based Curriculum Approach	95
3.2.4.3.1	Conclusion of Section	98

3.2.5 Implications of the Approaches for designing Curriculum	98
3.2.6 Innovative Curriculum Models	100
3.2.6.1 SPICES Curriculum Model	101
3.2.6.2 PRISMS Curriculum Model	103
3.2.6.3 SYMBIOTIC Curriculum Model	105
3.2.7 Implications for PHC Practitioner Education	109
3.2.8 Strategies of Facilitation	110
3.2.8.1 Student- Centered Learning	111
3.2.8.2 Problem Based Learning	112
3.2.8.3 Integrated Teaching	113
3.2.8.4 Community Based Education	114
3.2.8.4.1 Implications of this method	115
3.2.8.5 Electives Learning Approach	116
3.2.8.5.1 Implications of this method	117
3.2.8.6 Systematic Learning Approach	117
3.2.8.6.1 Implications of this method	118
3.2.9 Significance of Local and Cross-Continental Studies	118
3.2.10 Conclusion of Chapter	120

Chapter Four: In-service Education and Training (COS)

4.1 Introduction	123
4.2 Literature Review	124
4.2.1 Definition and Concept	124
4.2.2 Education and Training	126
4.2.3 Reality of practice vs. COS model	127
4.2.4 COS and Organizational dilemma	128
4.2.5 Adult learning theory	132
4.2.6 In-service Education and Training (COS)	133
4.2.7 Conclusion of Chapter	142

Chapter Five: Child and adolescent mental health

5.1 Introduction	144
5.2 Literature review	145

5.2.1 Historical perspective	145
5.2.2 Definition and Concept	149
5.2.2.1 Definition	149
5.2.2.2 Concept of Mental Health	149
5.2.3 Perception of Child and Adolescent	152
5.2.4 Epidemiology	155
5.2.4.1 Local National Studies	155
5.2.4.2 Cross-Continental Studies	158
5.2.5 Etiological factors	162
5.2.5.1 Life Stresses	162
5.2.5.1.1 Bereavement in the Family	169
5.2.5.1.2 Poverty as a Life Stressor	172
5.2.5.1.3 Culture and Ethnicity	173
5.2.5.1.4 Substance Use/Abuse as Life Stress Factor	174
5.2.5.1.5 Environmental Factors as life Stressors	176
5.2.6 Biopsychosocial Factors	182
5.2.7 Core Competences of Practitioners	187
5.2.8 Resource Support	188
5.2.9 Significance of Local and continental studies	190
5.2.10 Conclusion of Chapter	192

Chapter Six: Research Design and methodology

6.1 Introduction	194
6.2 Methods of the Study	197
6.3 Data Collection Methods used	198
6.3.1 Pre-Research Core Group	201
6.3.2 The Search Conference	201
6.3.3 Data Collection using Focus Group Method	204
6.3.4 Document Analyses Method	207
6.3.5 Preliminary Analyses of Data in Review Conference	207
6.3.6 Analysis of Data by Core Research Group for Dissemination	208
6.3.7 Presentation of Core Research Group Report to National Stakeholders	209
6.3.8 Functional Analysis Method	210
6.4 Research Design	212

6.4.1 Introduction	212
6.4.2 Critique of the Framework Model	215
6.4.3 Design Interventions of the study	216
6.4.3.1 Creating and Negotiating Entry into the Community	216
6.4.3.2 Core Research Team Formation	217
6.4.3.3 Second Design Intervention of the Study	218
6.4. 4 Research Instruments	219
6. 4. 5 Selection of Research Study Sites and Setting	219
6.4.6 Sample Selection of Participants	221
6.4.7 Data Collection Techniques and triangulation	222
6.4.8 Selection of Participants	223
6.4. 9 Sample Inclusion and Exclusion Criteria	224
6.4.10 Sample for the Second Phase of the Study	225
6.4.11 Sample for the Third Phase of the Study	225
6.4.12 Sample for the Fourth Phase of the Study	226
6.5. Trustworthiness of Qualitative Data	226
6.5.1 Credibility	226
6.6 Reliability and Validity	227
6.6.1 Reliability	227
6.6.2 Validity	227
6.6.2.1 Internal Validity	228
6.6.2.2 External Validity	229
6.6.2.3 Content Validity	229
6.7 Research Ethics and ethical Considerations	230
6.8 Data Analysis	231
6.9 Conclusion of Chapter on Research Design and Methodology	231
6.10 Dissemination of the findings	232

Chapter Seven: Data Analysis

7.1 Introduction	233
7.2 Analysis process of various nodes	233
7.3 Analysis by node	238
7.4 Conclusion of Chapter	240

Chapter Eight: Presentation of results	
8.1. Introduction	242
8.2 Participants Vital data	244
8.3 Focus Group Participants' Tables	249
8.4 Search Conference Results	253
8.4.1 Curriculum Preferences	253
8.4.2 Procedure Used	254
8.5 Search Conference perceptions of CA Mental Health	256
8.5.1 Practitioners' Perceptions in Homogenous Groups	256
8.5.1.1 Nurses' Perceptions	256
8.5.1.2 Clinical Officers' Perceptions	259
8.5.1.3 Clinical Officers and Nurses Merged Perceptions	261
8.6 Phase Three: Perceptions of Individual Focus Groups	264
8.6.1 Method of Categorization	264
8.6.2 Monze Town District Focus Group	268
8.6.2.1 The environment	270
8.6.2.2 Life Stresses	270
8.6.3 Kabwe District Focus Group	273
8.6.3.1 Environment	275
8.6.4 Lusaka District Focus Group	277
8.6.4.1 Child and Adolescent	279
8.6.4.2 Life Stresses	279
8.6.4.3 Environment	280
8.6.4.4 The School	281
8.6.4.5 Biological Factors	282
8.6.5 Ndola District Focus Group	283
8.6.5.1 The results of the findings	285
8.7 Phase Four: Merged Perceptions of specific Free-Node Areas all Groups	288
8.7.1 Perception of a child and adolescent by all groups	289
8.7.2 Perception of Mental Health as a concept by all Groups	291
8.7.3 Perception of life stresses by all focus groups	293
8.7.4 Summary Results of the section	295
8.7.5 Perception of environmental factors by all focus groups	296

8.7.6 Perception of Biophysical factors by all focus groups	298
8.7.7 Perception of biological factors	299
8.7.8 Perception of physical factors	301
8.7.9 Summary of the results of section	303
8.8 Quantitative Data from (Step 2b)	305
8.8.1 Presentation of results	306
8.8.2 Lusaka Chainama Hospital Out Patient Department	306
8.8.3 Ndola General Hospital Out Patient Department	310
8.8.4 Kabwe General Hospital Out Patient Department	312
8.8.5 Monze District Hospital Out Patient Department	314
8.8.6 Conclusion of Results for the section	316
Chapter Nine: Discussion of findings	
9.1. Introduction	319
9.2 General view of perception	322
9.3 Perceptions of Practitioners (Nurses and Clinical Officers)	324
9.3.1 Introduction	324
9.3.2 Nurses Perceptions	325
9.3.3 Clinical Officers Perceptions	325
9.3.4 Merged perceptions for Cos and Nurses	327
9.3.5 Conclusion of Section on Perception of Practitioners	329
9.4 Perception of the Concept Child and Adolescent in the Communities	329
9.5 Perception of Mental by the Community	332
9.6 Perception of Factors Associated with Mental Health Problems	335
9.6.1 Life Stresses	335
9.6.1.1 Poverty as a Life Stressor	336
9.6.1.2 Environmental Factors as life Stressors	338
9.6.1.3 Attitude of the family and the community as life Stressors	340
9.6.1.4 Wife Battering by Husbands as life stressors	342
9.6.1.5 Living Conditions of Parents after Loss as life Stressor	343
9.6.1.6 Infringement of Children’s Human Rights and the Dress-Code	344
9.6.1.6.1 Dress-Code	344
9.6.1.6.2 Human Rights	345
9.6.1.7 School as an Environment Stressor	347

9.6.1.8 Township Planning, Housing, and Location as life stressors	347
9.6.1.9 Culture and Ethnicity as life stressors	348
9.6.2.0 Polygamy and Early Marriages as life stressors	350
9.6.2.1 Cultural Beliefs as life stressors	351
9.7 Biological and Physical Factors	354
9.8 Physical Factors	356
9.9 Resource Support for CA in the community	359
9. 10 Quantitative Data	360
9.10.1 Epilepsy	361
9.10.2 Manic Depressive Disorders	362
9.10.3 Mental Retardation	362
9.10.4 Child Development	363
9.10.5 Diagnosis of Psychosis	364
9.10.6 Conversion Disorder	365
9.10.7 Undiagnosed Cases	365
9.10.8 Conclusion of Section on Quantitative Data	366
9.11 Curriculum Development	367
9.12. Conclusion of the Study	370
9.12.1 Perception of community/Practitioners about Mental Health Problems	371
9.12.2 Preferred Curriculum Model and Content for PHC Practitioners COS	375
9.13. Implications of the Study	376
9.13.1. Safety and good health habits	376
9.13.2. Health information, Education and Communication	377
9.13.3. Child and Adolescent Mental Health Services in PHC:	377
9.13.4. PHC Practitioners' Curriculum	378
9.14. Recommendations	379
9.14.1 Strengthening of Mental Health Services	379
9.14.2 Medical Education	380
9.14.3 Further Research	382
9.14.4 Innovative Curriculum	382
10. Annexures	383
11. References	406

DEFINITION OF TERMS

Nodes

These are the places where ideas and categories are stored using the NVIVO Soft Ware. These areas or places were:

Free-Nodes

The free-nodes represent the general concepts of knowledge category or class areas in a study. These collections of nodes are unstructured. They are used for ideas, which are not yet ready for categorizing.

Tree-nodes: the tree-nodes represent main category or class areas of the knowledge for the study. Tree- nodes are categorized into hierarchies, moving from a general category at the top (parent-nodes) to more specific categories (child-nodes) at the bottom.

Child-Nodes

The child-nodes are used to organize nodes for easy access. The child-nodes are specific critical knowledge areas extracted from the tree-node areas.

*A good example of the concept of **nodes** would be to view it from the disease perspective for instance, affective disorder (this would be the equivalent of free-node concept), while the disease depression, (would be the equivalent of tree-node concept), and flat affect (would be the equivalent of child- node concept). The node operational language is used for convenience in the NVIVO Soft ware. In this analysis of data the nodes are used to mean an orderly classification of knowledge areas and should not be misconstrued for other meanings for which it is not meant.*

Documents: are the data that the researcher analyzed. All NVIVO documents are in the Rich Text Format.

Child

A young person of either sex, especially, one between infancy and youth; hence, one who exhibits the characteristics of a very young person, as innocence, obedience, truthfulness, limited understanding (*Webster's Dictionary 1913*). When I was a child, I spoke as a child, I understood as a child, I thought as a child; but when I became a man, I put away all the childish things...1st Corinthians 12.

Adolescent

The stage in the life cycle, which begins at puberty, ends when the individual reaches maturity, sometimes in some cultures, when the young person is entitled to the vote with age ranges from 12-18 years.

Mental Health

The capacity of the individual or group and the environment to interact with one another in ways which promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality.

Mental Health Problem

A person under the Mental Disorders Act who **uses** Mental Health Services and provisions for treatment and promotion of good mental health.

Primary Health Care

Essential Health Care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost that the community and the country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economical development of the country.

Clinical Officer

Health care provider in Zambia trained for 3 years and registered to practice clinical medicine and Psychiatry by the Medical Council of Zambia and awarded Diploma in Clinical Medical Sciences general/psychiatry.

Primary Health Care Practitioner

A health care provider as defined by this study only, who is either a registered nurse or clinical officer trained for a period of three years and awarded a diploma to practice clinical medicine, primary health care and nursing.

INSET

“All learning experiences, after initial training that help health workers to maintain or learn competences relevant to the provision of health care.” not just refresher courses and lasts from the completion of initial training until retirement.

PRODEC

An acronym used in this research organizational framework model, and stands for; *research problem, research design, empirical evidence, and conclusions.*

Competence

Holistic combination of thinking, doing and attitudes, in performance which can be observed when components are integrated into the whole, i.e., manipulation of tools and the invisible part of performance in which information is interpreted within a particular value orientation through application of particular mental abilities (Christie, 1997, p. 65).

Perception: The term perception though it is construed differently and mean several things to several people, in this study, perception refers to judgment, opinions, views or even discernment of both practitioners and the community about mental health problems of children and adolescents (Flanagan., Leaderman, 2001).

OPD: These are out patients’ facilities available within a hospital sometimes known as clinics which screen all patients before any decision either to admit them as inpatients or treat them as outpatients can be made by the practitioners.

ABSTRACT

An *exploratory study covering phase 1 stages 1, 2 and 3 only* was undertaken in this large hybrid research project to determine perceptions and understandings of the practitioners and the community about mental health problems of children and adolescents in Zambia because so far there is little known about this phenomenon. The aim of this *exploratory study* was to gain new insights into the phenomenon by undertaking a preliminary investigation to *determine priorities for the future post doctoral research* before a more structured study to develop the PHC innovative curriculum.

The process first *'explored' social reality on the ground* to better comprehend the perceptions and understandings of mental health problems of CA and the curricula model preferences as perceived by the practitioners and the community respectively. This was done to appreciate the "reality of practice" on the ground using the Systems, Ecological, and Biopsychosocial theories which underpinned the four field areas of the study which are: *Mental Health, Curriculum Development, INSET and Action Research (AR)*.

The total project is open-ended with three (3) phases and eight (8) stages, from the initial exploration of perceptions (phase 1), through reports to government and stakeholders, curriculum development and piloting with health educators (phase 2) and finally implementing the re-constructed curriculum and integration (phase 3) in such a way as to empower primary health workers to themselves do further research. This thesis, covering the initial explorations of perception, encompasses ONLY the first phase and three stages of this larger qualitative research project because of the Higher Education requirements and funding to try to complete in 4 years. This entails literature review of all 4 field areas because in order to orientate the first phase and three stages of such research and to see the implications of results, it is necessary to have a good grounding in all four.

The research study process commenced with an orientation and introduction of the context and purpose of the study, followed by the search conferences and focus group meetings using Qualitative Research Design and Methodology. Search conferences, focus group discussions, hospital registers and clinic records were the three sources of data collection. Analysis of Qualitative and Quantitative Data used NVIVO and SPSS 13.0 Statistical Data Analysis Software respectively.

The study showed that mental health problems of Children and Adolescents perceived by the community and the practitioners were also referred and recorded in various hospital registers. The analysis of data from hospital records on referred cases further showed that there are serious psychotic mental health disorders in children and adolescents referred for further consultations to hospitals from the community, some of which are: acute psychotic states, with some associated with HIV/Aids. In addition to these psychotic states, epilepsy, drug and alcohol abuse, child defilement, rape cases, mental retardation and conversion disorders particularly in female children/adolescents appeared to be relatively significant mental health concerns and problems in the researched community sites.

The conclusion of the study suggests that there were more environment related factors perceived to cause mental health challenges to children and adolescents. This finding further suggests that there are similarities of cases referred from the community with those seen in clinical practice areas. The significance of these findings in the reality of practice, implies that the preferred PRISMS curriculum model to be developed later as *a post doctoral activity* for 'INSET' of PHC practitioners in Zambia should have deliberate blending of curriculum content with more socio-environment related issues than the current traditional curricula models which are more clinical in structure, process and content.

ACKNOWLEDGMENT

I am indebted to many individuals who have contributed assistance, encouragement, and support throughout my pursuit of this doctoral degree. I would like to praise the Lord Jesus Christ for allowing this to happen. My special thanks to my two Supervisors: Prof. Charlotte Mbali and Prof Dan L. Mkize for their tireless work up to the end of the study, without whom this study would not have been a success. Ruth Searle, Director of the Center for Higher Education Studies, Faculty of Education at the University of Kwazulu-Natal for the encouragement and support during the residential work and all administrative support during the period of my stay in the University and Members of staff

My special thanks to Sheryl Jeenarain, administrator of the Center for Higher Education Studies for her motherly support and continuing encouragement; Kogi Naidoo, Open Learning, for a number motivating academic moments and Jane Schuilder from the Department of Psychiatry, School of Medicine for all the administrative support. My dearest wife, Agnes and children for their encouragement and support including my in-laws Drs Davy and Drina Nyirenda and Auntie Gertrude Banda, Suezen Phiri, my sister in law, for her instrumental support and encouragement to both the family and myself. Sida-Sweden I C and Zambia I C Core group, for sponsoring and funding the programme as well as Dr S.K Miti, Permanent Secretary, Ministry of Health: for clearance and granting me permission to pursue further studies and authorization of research funds for data collection. My special thanks to Mr. John Mayeya, Mental Health Specialist, Ministry of Health, for facilitating acquisition of research funds from the Ministry of Health as well as Dr Velepi Mtonga, Ministry of Health for allowing me to collect data from hospital boards.

The Executive Director of Chainama College Hospital Management Dr. M. M. Zulu is appreciated for the encouragement and support throughout my study. Dr. P.C. Msoni - Consultant Psychiatrist and Director of Clinical Care whose support was invaluable, for technical support throughout the data collection process and chairing all the research meetings and conferences. Mr. Anel Bowa, Ag Registrar, Chainama College of Health Sciences and staff. All PHC practitioners that were part of the study which are: Monze, Kabwe, Lusaka and Ndola research sites and the communities that took part in the focus group discussions. Finally, my special thanks to Thembelihle Patience Khuzwayo for skillful typing as well as Salome Palley of the Department of Surgery, UKZN, School of Medicine and all those institutions and friends that I have not included on this list, they are all appreciated.

LIST OF FIGURES

Figure	Page
0. Whole Project Concept Map	2
1. Map of the Systems Theory Applied in the Study	25
2. Systems theory model for Curriculum planning and development	28
3. An ecological model of child development	31
4. Ecology of Human Development as Applied to the Child	32
5. Biopsychosocial Model of Disease and illness	35
6. Bligh's Concept of Symbiosis of Curriculum	107
7. Framework for Inset Planning, Development and Implementation	130
8. Concept of the Whole Child and Adolescent	153
9. Model of Developmental Transition in Early Adolescence	167
10. Heuristic Model in CA with underlying chronic Adversaries	171
11. Model of change as a function of the environment	179
12. Medical model using the child to mother attachment construct	180
13. Invulnerability Model based on the view of acquired trait /social status	181
14. Bio Psycho Social factors developmental disease model	186
15. Conceptual Map of Action Research Data Collection Process	199
16. Components of the Organization of the Study	214
17. Model Showing Nurses' perception about causes of mental ill health	258
18. Model showing Cos' perception about causes of mental ill health	260
19. Merged Perceptions of Cos and Nurses at search Conference	261
20. Set of Merged Conference Perceptions of PHC practitioners	263
21. Model showing Monze Focus Group Perceptions of mental health problems	269
22. model showing Kabwe Focus Group Perceptions of mental health problems	274
23. Model showing Lusaka Focus Group Perceptions of mental health problems	278
24. Model showing Ndola Focus Group Perceptions of mental health problems	284
25. Model showing Perception of child and adolescent by all F/G participants	290
26. Model showing Perception of mental health by all F/G participants	292
27. General model showing Perception of Life Stresses by all focus groups	294

28.	Concept map of perception about factors causing mental health problems	296
29.	Model showing Perception of environment by all focus groups	297
30.	Biophysical Concept map of perceived precipitating/predisposing factors	298
31.	Model showing Perception of biological factors by all focus groups	300
32.	Perception of physical factors on mental health problems by all focus groups	302
33.	Lusaka-Chainama Hospital identified CA Mental health problems- 2004	308
34.	Ndola Hospital identified CA Mental health problems- 2004	311
35.	Kabwe Hospital identified CA Mental health problems- 2004	313
36.	Monze Hospital identified CA Mental health problems- 2004	315

LIST OF TABLES

Table	Page
1. SPICES curriculum model	102
2. PRISMS Curriculum. Model	105
3. Pre-Research and Search Conference phases of the study	200
4. Overall Process of Data collection for the study	242
5. Details of the Core Research Group	244
6. Search Conference Participants' Vital Data and their experience	245
7. Length of work experience as PHC practitioners	246
8. Current Positions of Search Conference Participants	247
9. Key purpose of the work various PHC Practitioners do	248
10. Demographic Characteristics of Research Site Focus Group Participants	249
10.1. Age ranges of Focus Group participants	249
10.2. Gender of Focus Group participants for all Research Sites	250
10.3 .Social status of Focus Group participants	250
10.4. Demographic Characteristics of Participants in the various F/G Sites	251
11. Institutions responsible for Training of PHC Practitioners in Zambia	252
12. Preferred Curriculum Model by the PHC Practitioners in Zambia	253
13. Reasons for selecting the PRISMS Curriculum Model	255
14. Matrix Table - perceptions of Etiological factors by individual groups	267
15. Perception of Etiological factors of CA mental health problems - Monze	268
16. Perception of Etiological factors of CA mental health problems –Kabwe	273
17. Perception of CA mental health problems and Etiological factors – Lusaka	277
18. Perception of CA mental health problems and Etiological factors -Ndola	283
19. All Focus Groups' Perception of “Child and Adolescent”	289

20.	Perception of Mental Health as a concept by all Groups	291
21.	Perception of Life Stresses by all Focus Groups	293
22.	Focus Groups Perceptions of biological Factors	299
23.	Focus Groups Perceptions of Physical Factors	301
24.	Summary of Coding passage Counts for the six-free nodes areas of the study	304
25.	Lusaka District –Chainama Hospital OPD record of patients 2004	306
26.	Ndola Gen. Hospital in-patients’ record of data by age and diagnosis 2004	310
27.	Kabwe Gen. Hospital in-patient record of data by age and diagnosis 2004	312
28.	Monze District Hospital OPD data by age and Diagnosis 2004	314

CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 INTRODUCTION

The plan of the whole study project was in three stages, to do *only the exploratory phase 1 of the whole project for doctoral purposes (figure 0 below)* and then carry on after doctoral studies to curriculum construction/development and piloting (**phase 2**) and then to re-constructed integrated curriculum (**phase 3**) implemented in the field with service administrators, educators and practitioners.

The purpose of the thesis was *merely phase 1, up to Stage 3, as shown in figure 0 page 2 below, of the total project concept map*. The objective of this *exploratory phase 1* is to summarize the implications of the perceptions and understandings of the practitioners and the community about mental health problems of children and adolescents in their environment in order to start the process of developing an innovative curriculum for INSET of educators of PHC practitioners in *phases 2 and 3* of the whole project respectively.

All developed research questions for the study were intended to address ONLY phase 1: stages 1-3. The results of the data in this phase are critical for the post doctoral part of the whole project as shown on **page 25 figure 1** which illustrates that the study had to *explore the social realities first on the ground, a relatively unknown area to determine the context of the situation for purposes of insight seeking from the communities themselves* in order to draw the required baseline data to start the process of developing the curriculum for Practitioners.

FIGURE 0: WHOLE PROJECT CONCEPT MAP

	Research	Stage	Action	New Knowledge
Phase 1	Doctoral part of the whole project	Stage 1	Reading up literature in the field	Proposal to do a qualitative research incorporating PAR principles and theories in Medical Education
		Stage 2	Discussion with Practitioners and PHC Educators	First search conference merged perceptions and understandings
			Educators responding to Questions about Curriculum Practitioners' discussing their concept of mental health.	Analysis of curricula preferences Reconstructed heterogeneous Concepts of mental health
Stage 3	Four community focus groups facilitated by practitioners	Enhanced reflection on own clinical practice among practitioners and educators		
	Collection of OPD data in the four sites of the study	NVIVO analysis of focus groups data Analysis of the OPD data		
Phase 2	Post doctoral curriculum construction and piloting	Stage 4	Report-back conference to government	Report based on the N VIVO analysis of main emerging issues and themes
		Stage 5	Conference with PHC educators and the community	New curriculum for PHC practitioners
		Stage 6	Piloting the new curriculum	Piloting new curriculum analysis
Phase 3	Post doctoral curriculum reconstruction and integration	Stage 7	Re-constructing the new curriculum	New – reconstructed curriculum
		Stage 8	Integrating the new re-constructed curriculum	Analysis of findings from piloting curriculum

This figure shows the whole project concept map and the logical pathways required to develop an educational innovative curriculum for PHC practitioners in medical practice and further shows that *exploratory phase 1: stages (1, 2, 3) only gathers perceptions and understandings* required to inform phase 2 (stages 4, 5, 6), which further informs final phase 3 (stages 7, 8) of the whole project.

Phase 1 part of the whole project deals only with base-line data required for an

educational research thesis generated by a participatory action research process. Finally, the *concept map in the last column highlights the logical actions* generated for each phase and subsequently resulting into *new knowledge* derived from each phase at the various stages of the project. The concept map further shows that the innovative curriculum implementation is *outside the scope of this doctoral study* even though it is still on plan as a post doctoral undertaking.

The *exploratory study (phase I)* was undertaken using four focus groups which included the *practitioners, educators, and the communities* who represented the children and adolescents on one hand. The actual children and adolescents on the other hand who experience the nature and impact of mental health problems in their daily living *did not form part of the focus groups with their community counterparts, practitioners and educators nor could they be used as research respondents because the ethical committee of the UKZN asserted that it would enlarge the thesis too much and possibly create ethical complication.*

Focus on who are the critical respondents for a given study depends on the purpose and objectives of the study. *This particular study focused on practitioners and educators to explore their perceptions and understandings of mental health problems of children and adolescents with the aim of eventually creating a curriculum to improve professional practice in primary health care as its critical respondents.* Other primary health care studies which use participatory action research (PAR) as a method to *explore information using focus groups*, for instance Marinowitz (2004), stress the inclusion of patients/clients purely for the therapeutic value such patients would *gain* from their inclusion in the focus groups with care givers, family members and other multidisciplinary players. In contrast, the aim of this *exploratory study is for educational purposes, not initially for therapy.*

For this study, four meetings at each research site were held, they were audio-taped at the places which community members themselves negotiated and agreed to meet with each other and later transcribed. The research questions for the study aimed only at *exploring*

perceptions and understandings of practitioners and the community about mental health problems of children and adolescents at each of these meetings using focus groups PAR method and these were: ‘ What are the perceptions of the Practitioners and the community towards mental health and mental health problems of children and adolescents?’ and ‘How does the Zambian community deal with children and adolescents’ mental health well being?’

On the part of the practitioners and the stakeholders, two conferences were held one at the beginning of the study and the other at the end of the research process which are: the search conference and an evaluation conference. The key research questions asked at the search conference and **review conference** meetings respectively, again focused on *exploring* perceptions, were: ‘*What are some of the key issues that affect the introduction of new aspects of mental health into the generic curriculum ?*’; ‘*What Curriculum content would be appropriate for the planned child and adolescents’ Mental Health curriculum for PHC Practitioners in Zambia ?*’; and ‘*Which one of the four curricula models presented by the researcher is the Preferred Model and most appropriate for the ‘INSET’ of PHC practitioners in Child and Adolescent Mental Health in Zambia?*’

The qualitative data was collected during the search conferences and focus groups through an *exploratory participatory action research process*. *The “action” in this does not refer only to a final action of constructing a curriculum but also to the actions in each cycle of participatory research involving reflection on practice as in generic AR theories which are well elaborated in the review of literature in Chapter 2.*

This qualitative research was supplemented with secondary data from the hospital registers and OPD clinic records. Also there is *some quantitative tabulation of the bio-roles of the participants, and also of the curriculum preferences*. *But it must be stressed that the main thrust of this thesis is the qualitative research of phase 1 of stages (1, 2 and 3) focused on exploring perceptions in order to establish knowledge and actions required to inform the process of curriculum development later, after doctoral studies.*

1.2 BACKGROUND

The operational framework of the study was based on two research paradigms which are: *interpretivistic and critical research* paradigms. This framework was meant to empower communities to get to the core of problem solution through collaborative action. In addition, the study anticipated at the same time, to facilitate the process of change, particularly of attitudes and negative perceptions of the community towards the plight of children and adolescents with mental health problems (researcher's opinion). Experience has shown that these communities have not supported well enough the mental and emotional health development of these children and adolescents so that they too could enjoy the most in this diverse environment for purposes of their emancipation as well.

The study comprised four (4) main chapters which set the basis for the understanding and appreciation required to initiate the process of determining the *exploration of perceptions and understandings* with resultant implications for innovative curriculum development. The chapters comprise: *Action Research; Innovative Curriculum Development; In-Service Education and Training; and Child / Adolescent Mental Health*. The setting to the study was also the many mental health problems of children and adolescents in Zambia whose predisposition and precipitation was perceived by the community to be based on: life threatening stressing factors; environmental factors; biophysical factors; and cultural factors. (World Health Organization, 1998)

In respect of the curricula state of art, it is important to note that for several years until the late 1970s, Zambia was using a straight specialization curriculum model to offer training in psychiatry and mental health for clinical officers and nurses who are referred in this study as PHC Practitioners. This curricula paradigm received much criticism in preference for an integrated curriculum into the general generic curricula models from both policy and field staff. A number of reasons why mental health curricula was not given the attention it deserved were based on the notion that mental health was not a priority in addressing the

numerous health care problems the country was faced with (WFMH, 2000) (Robertson, 1996), (WHO/UNHCR, 1996).

In the late 1970s, a study was commissioned by the government to assess the reality of practice on the ground in respect of the *triaxial* (biopsychosocial) performance of mental health practitioners and generalist practitioners at primary care focal point levels throughout the country as a response to the criticisms labeled against the curriculum models. This study was meant to obtain empirical evidence to show that straight specialization curricula models did not meet the WHO operational definition criteria of PHC as:

"PHC is essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a Cost that the community and the country can afford. It forms an integral part both of the country's health system of which it is the nucleus of the overall social and economical development of the country" (WHO/UNICEF, 1978).

Against this background, a situational analysis was conducted by the government with WHO hired consultant in mental health on behalf of the government. The results of the study culminated into abolishing the straight stand alone specialization curricula paradigms in psychiatry and mental health. However, the notion that there was no need for a standalone form of mental health curriculum where the emphasis was on straight specialization after high school in psychiatry and mental health for Primary Health Care Practitioners *did not work*, yet the reality of practice dictated that the practitioner attends to all patients irrespective of the health status they present with at first contact with the practitioner.

Fifteen (15) years down the line, while the integrated curriculum model was in place, it did not produce the required numbers of PHC practitioners in the community in matching with the county's expected human resource requirements in mental health field. The reason for the failure was as a result of a number of mental health problems during the same period, which also increased particularly those associated with HIV/Aids. The generalist trained practitioners, who were thought would be able to handle adequately the mental health

problems as well in their daily practice in an integrated curriculum structure, *was not possible*, they were not able to cope with the magnitude of the mental health related problems in their practice.

Even the few mental health practitioners that were on the ground dealing with mental health work, after its abolition, *were not adequate enough* in terms of numbers available to cope with the scourge of the problem in addition to the natural attrition during the same period. The need to reintroduce the abolished programmes became an *emergency* hence the government's decision to reintroduce the programmes again but with a more integrated approach.

Therefore, this study was based on the understanding that a curriculum based on the perceived needs and demands by the community on one hand, and felt needs of children and adolescents through the community on the other hand, was a better way of coming up with a people driven curriculum for it to succeed. Action Research was the preferred methodology to move the process of the study and involved the stakeholders and the community right from the inception of the process to work together.

In the context of this study, the use of Action Research was based on the assumption that PHC Practitioners and the community knew best what was happening in their practice and were therefore the best people to be involved in the practice of the art of the study. Against this background, the assumption of the design and methodology used in the study assumed that those community members identified to participate in the study knew best what was happening in the field at community level and were the best to support the community-based research.

Another aspect of the study was intended to understand the basis for the evolution of the held perceptions, beliefs, values and understandings of the community about mental health etiologies. Values for instance, are beliefs people have about what they think is right or wrong, good or desirable, they are also expressions of what is of value, or what is thought to be worthwhile, even though some values may be held by people who stand in

opposition to the collective values of their own community. These views were important assumptions around which this study operated.

In most communities and Zambia in particular, girls for instance, more than the boys are traumatized by cultural and traditional practices such as initiation ceremonies, while generally the young have fallen victims of the obsession of community beliefs, restriction of child human rights and effects of loss in a number of contexts such as bereavement in the family, divorce of parents, accident of parent, separation of parents just to mention a few, and if nothing is done to reduce or control these life stresses in the earliest possible time, the country will see an explosion of these un resolved child and adolescent mental health problems.

It must therefore be the concern of all to ensure that good mental health of children and adolescents is an important agenda for all cultures and races; this is true globally for instance, from infancy to young adulthood and beyond. Recognizing and treating serious childhood and adolescent emotional and behavioral disorders must be a priority for all countries if all children and the societies in which they live are to reach their full potential (Franciosi, 2003)

The process of collaborative and participatory research, with opportunities for reflection and discussion, was in itself an empowering experience for those who were brought into closer engagement with child and adolescents in mental distress. As these same people would be the recipients of the curriculum to be designed, this participatory and collaborative process enabled them to gain ownership over the education process. This study addressed this problem and aimed to develop an indigenous medical innovative curriculum in child and adolescent mental health within the context of innovative medical education curricula models (Harden, 1984), (Bligh, 1986).

1.3 STATEMENT OF THE PROBLEM

The notion that integrating psychiatry and mental health in the generic general curricula paradigms in general clinical medicine and general nursing streams would adequately incorporate the care of persons with mental health challenges and needs, including children and adolescents mental health has not worked since the abolition of the *straight specialization curricula paradigms* 16 years ago for psychiatric and mental health training for clinical officers psychiatry and mental health nurses.

The reasons for this failure were among others: very few qualified general clinical officers and nurses opted to specialize in this area as it was not attractive compared to general practice: there were neither career prospects for them or inducements to attract those who opted to do the specializations to stay. Mental health was not a priority programme of the government like TB, STD, HIV/Aids, and Control of Diarrhea Diseases (CDD) and was not considered at the same level with others and even more remote were problems of children and adolescents.

The situation on the ground covering the 1980s and the 1990s as well as the early 2000s, was that caring for the persons with mental health challenges became even more complicated particularly in the advent of HIV/Aids related mental health insults for adults, adolescents and children. The numbers of qualified and specialized practitioners in psychiatry and mental health reduced drastically over the same period mainly due to the decreased annual output of these cadres in the field by the *integrated curriculum model* and complicated by attrition through death, emigration, switching to private personal businesses, or total change of career even for the few that remained.

In addition, there has never been a study done in Zambia to *determine perception and understandings among communities and practitioners in child and adolescent mental health*, neither one applying a comprehensive collaborative action research method using the action research cycles, nor one that establishes knowledge about PHC workers'

existing competencies to enable them manage children and adolescents with mental health problems in primary health care settings. The reality of practice in the field of mental health as well as teaching of psychiatry has shown discrepancies in both the way students learn and the actual reality of practice of mental health in Primary Health Care. Worse still, was the distinct omission of child and adolescent mental health component in the Zambia National Basic Health Care Package Project in 2001, in which the researcher was involved in evaluating a pilot integrated Competence Based In-service Training (ICT) with focus on a reconceptualised curriculum.

This source of concern on one hand was based on the premise that the Basic Health Care Package (BHCP) was a very important national program to omit completely child and adolescent mental health from the total package and on the other hand, the lack of appropriate competences by the PHC practitioners to manage the Basic Health Care Package (BHCP) itself identified by the Ministry of Health in 2000, as well as the lack of competencies in the identification and care of C&A mental health problems at both District and Primary Care levels by PHC Practitioners were the serious omissions that needed to be restored urgently.

1.4 PURPOSE OF THE STUDY

The purpose of the study was to *explore* the perceptions and understandings of practitioners and the community about child and adolescent mental health problems in Zambia through *search conferences and focus group discussions* respectively using *AR methodology* with their full participation and involvement.

The implications of the data collected through practitioners' and communities' perceptions and understandings, would be used to commence the process of developing an INSET innovative curriculum for practitioners on child and adolescent mental health problems by first exploring the social reality of the problem through a collaborative and participatory process with practitioners and the community itself. Doing so would offer a

basis for a critique of social reality with a view to emancipate children and adolescents with the services they need most through services of knowledgeable PHC practitioners by suggesting possible solutions to social problems these children encounter so as to empower and liberate them.

1. 5 RESEARCH QUESTIONS

It should be noted that part of the research questions for this study are highly qualitative which are: (1, 2, and 3) in that they focus on *exploring perceptions embedded in attitudes and understandings*.

For purposes of the doctoral study which is (phase 1 stages 1, 2 and 3) only, all the 5 research questions designed for the study using the exploratory process have been answered going by the context of the study. They were able to measure what they were intended to measure hence the required evidence based baseline data from the community itself (phase 1) to inform the commencement of the process of developing a curriculum after doctoral studies as shown in figure 0 phases 2 and 3 respectively.

The following are the research questions which primarily seek to *explore those perceptions and understandings* by the practitioners and the community required to commence the process of developing a medical education curriculum for PHC educators as shown in *phase 1, figure 0* of the whole project concept map in the introduction of the study:

1. What are the perceptions of the Practitioners and the community towards mental health and mental health problems of children and adolescents'?
2. How does the Zambian community deal with children and adolescents' mental health well being?
3. What are some of the key issues that affect the introduction of new aspects of mental health into the generic curriculum?

4. What content should the planned curriculum for PHC practitioners in Zambia comprise in child and adolescents' Mental Health?
5. What curriculum model would stakeholders consider most appropriate, of the four the researcher introduced for the 'INSET' of PHC practitioners in child and adolescent mental health in Zambia.

1. 6 SIGNIFICANCE OF THE STUDY

This study aims to *explore* perceptions and understandings about mental health problems of children and adolescents in Zambia with a view to increase the child and adolescent knowledge of PHC practitioners as well as develop their skills, critical thinking, attitudes and understanding for specific application in Zambia's mental health practice areas. The study has the potential to contribute to the general improvement of mental health users' status in Zambia through improved care, which will add value and quality to Primary Health care services offered to the communities. Reinforcement of such contextual ideas are found in Fullan's theory of innovation, where those responsible for implementing change need to make sense of what the change is about and the reasoning behind its introduction (Bligh, 1986), (Fullan, 1991).

In his unpublished paper (Mambwe, 1985), in which he was commenting about 'managing an institution in crisis,' stipulated that the conservative estimates of mental health problems are that 70,000 people in Zambia have an incapacitating major functional illness; 700,000 will suffer from a mental health problem sometime in their lifetime, while 20% of all the patients attending general outpatient departments have mental health problems requiring treatment.

There has been no study done in child and adolescent mental health through a comprehensive collaborative action research to determine mental health problems of children and adolescents in Zambia, and further there has been no established knowledge about PHC workers' existing competencies to manage children and adolescents with mental health problems in primary health care settings.

1.7 JUSTIFICATION FOR THE STUDY

The problem of mental health in children and adolescents is a global concern with an overall rough estimate picture of mental health problems accounting for 10-20% worldwide and rated 5 out of the top 10 mental disorders leading causes of disability in the world (Giel, 1981) (Shatkin, 2003).

Impacts studies show that up to 20% of children and adolescents world-wide suffer from a disabling mental illness; with 3-4% requiring treatment, some as a result of influence due to displacement through various life situations (WHR, 2000, 2001 and 2003) (World Health Organization, 2003).

WHO studies have further shown that certain specific areas of mental health problems particularly depressive, disruptive, eating, learning, substance abuse, tourettes and teen suicide disorder have become a source of serious concern and these are but some of the most worrying mental health problems (Weissman, 1999): (Geller, 2001), (World Health Organization, 2003), (Kotler, 2001)

Experience has shown that change imposed from outside of the institutional setting, by people other than those who work in it, is unlikely to succeed. Those undergoing the change must identify the need for change; in this study the researcher facilitated a process where PHC Practitioners themselves and the community came up with their own perceptions and understandings about problems of children and adolescents in their own environment.

Practitioners and the community were assisted in developing appropriate strategies to deal with the process of developing goals or problems, so that they were intimately involved in the process of change from the beginning of working together in the study. For significant reconstruction and development to occur, health care educators and the

community need to own the process of change. The basic assumption is that those undergoing the change must identify the need for change themselves.

Mental health worldwide and Zambia in particular, has continued to receive low priority, it has not yet been elevated at the same level as other programmes particularly at district level, (Ministry of Health, 2000), in spite of the fact that the Global picture of mental health problems show that 10-15% of the burden of diseases is due to neuro-psychiatric disease (Ministry of Health, 2000). This historical lethargy of the community towards mental health dates far back early 1900's when lack of awareness and interest in mental health was reflected by the omission of mental health in the international statistics, classification of diseases, injuries and causes of death (ICD).

This study is addressing the issues of children and adolescents' mental health problems with the aim to develop an indigenous innovative curriculum in child and adolescent mental health using the Process curriculum models (Harden, 1984) which are the modern Medical Education curriculum models. The sampling procedure to get community members that participated in the focus group discussions were identified using the non-probability (convenient sampling) instead of probability (random) samples of respondents (Light, 1990)

The selection of participants to the discussions that was used was '*the purposeful selection*' (Light, 1990), also referred to as *purposeful sampling*, which is basically *criterion-based selection* (LeCompte, 1993b). In this method, the settings, participants and activities were selected deliberately in order to have participants with an opportunity to provide information that could not be gotten from other choices.

In-service education and training (INSET) of PHC practitioners in child and adolescent mental health would probably be the most likely solution to the current problem as a long-term measure for improved health care status of the children and adolescents in Zambia. To do this, a collaborative action research study and analysis of needs as perceived by PHC practitioners and the community would be the most objective way in

the process of curriculum planning and development, in which it is always fundamental to start the process from where the people are with their active participation.

It is expected that once this study has been completed, the curriculum process commenced and completed, there will be definite change in the way and manner children and adolescents with mental health problems will be diagnosed and managed at primary care level in Zambia. The children and adolescents as the mental health users will directly benefit from this study and overall the Zambian community through improved care and quality of services that will be provided by the primary health care trained staff.

The setting and practitioners/ stakeholders and the community selected were appropriate for this study. The provincial Hospitals, districts and training colleges where the study was conducted were typical, and the researcher's relationship with these institutions, Practitioners and the community facilitated the study. The practitioners and stakeholders selected were appropriate and diverse, and adding any additional numbers would not contribute anything significant.

It is against this background that there is a great need to introduce an effective innovative curriculum model in child and adolescent mental health. This type of innovation has motivated the researcher and hopes that this new innovation within PHC context will be successful and fruitful in Zambia too.

1.8 LIMITATIONS

Some of the most important limitations were as follows:

- Colleagues in provincial offices, districts and hospitals, administered the collection of data using instruments that the author developed. This brought about difficulties but due to geographical difficulties of the country, the most dependable way was through other people.
- The expense of telephone calls and fax transmission limited the contact between the researchers based in Lusaka and respondents in provinces/districts.
- Permission from Ministry of Health/Central Board of Health and the ethical committee slowed the pace of data collection process because the research ethics committee only meets on agreed specific times and the researcher had no influence over the schedules.
- Communicating and working through other people required a lot of negotiating time and patience as it carries a number of constraints because its success is usually highly based on the good will of others and their willingness to support the study without any financial implications on the part of the researcher.
- Many people first seek traditional healers for treatment before they consult a health facility in Zambia. This scenario is similar with children and adolescents and most of them may not have called at hospitals and clinic facilities during the year 2004 for their mental health problems because they were still consulting traditional healers.
- The study was not extended to hard-to-reach rural communities, which could probably have held more traditional inclined perceptions about child and adolescent

mental health problems than their colleagues in sub-urban/rural and urban areas because the researcher did not have the financial capacity and transport to reach such distant places with limited time for the study.

- The difficult, the researcher faced for the proposed search and post search conference was the availability of the policy makers, statutory bodies and professional associations all the time at the two conferences as they were in and out of their offices on those dates the conferences were held.

1.9 VALIDITY AND RELIABILITY

1.9.1 Validity

This form of validity was preferred to other forms such as *face validity*, *semantic validity*, because of its appropriateness, meaningfulness and usefulness of the data that was collected from the community and PHC Practitioners about their perceptions in respect of mental health problems of children and adolescents in Zambia. This type of data would be appropriate and realistic in making inferences and predictions about the type and quality of an innovative curriculum which would be developed from the collected baseline data. According to (Babbie, 2001) validity refers to the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration. Content validity is assessed using content procedure.

According to (Golafshani, 2003) states that: "*Validity determines whether the research truly measured that which it was supposed to measure or how truthful the research results were. In other words, did the research instrument allow the researcher to hit the bull's eye of the research object?*" (p.599). Babbie (2002) states that *content validity refers to how much a measure covers the range of meanings included within the concept* while (Smith, 1981) points out that *a content validity procedure is a measure designed to*

determine whether an instrument measures a representative sample of the concept under consideration.

The participants were requested to judge whether the moderator's guide was in fact representative of the research purpose and questions planned to be administered to the community groups through focus groups. In this study there was a general agreement among the core research team about the appropriateness of the guide. This indicated that the guide was measuring the essential issues about the perceptions and understandings of the practitioners and the community about mental health problems of children and adolescents.

Scriven (1997) points out that *validity is linked with the conduct of any study and development of an instrument*. Guba (1981) makes a case for side stepping reliability in favor of validity. The authors state that, "*Since it is impossible to have validity without reliability, a demonstration of validity amounts to a simultaneous demonstration of reliability*".

In relation to the validity of instruments, (Cronbach, 1971) makes the issue much clearer and lists them as those to do with: *the researcher unable to maintain confidentiality of data and finally the researcher unable to preserve the anonymity of subjects etc.* Thorndike (1969) also advises that, "*whatever procedure for collecting data is selected, it should always be examined critically to assess to what extent it is likely to be valid.*"

Smith (1981) described *criterion-related validity* as one evaluated by correlating one's operation with some direct measure of the operation's characteristic, and lists forms of this kind of validity as *concurrent and predictive validity*. Smith explains that using this approach one would compare how people answered new questions to measure a concept. Smith further points out that if respondents' answer on both the new and the established measure were highly correlated then it would be inferred to mean that the new measure is valid. However, there are several types of validity, which are used by researchers and for

the purpose of this study; two types of validity will be used, which are: *internal and external validity*.

This study used *triangulation* as one kind of method used against the threats to data *validity or credibility* (Denzin, 1985) and proposed four types of triangulation, which are: *data sources, methods, investigators and theories*. Triangulations of analysis studies have also been added as the 5th type in recent years *but only two* of these were used in this study, which are:

- **Methodological triangulation**

A method involving a combination of two or more research methods in the same study was applied. This was the commonest form of triangulation. Denzin described the with-in method and across-method triangulation. “*Across-method*” and “*With-in method*” were used as the study used both quantitative and qualitative methods.

- **Data Triangulation**

Information was collected from a variety of sources for the same study. In this study; data was collected from PHC practitioners, Stakeholders and the Community. In his study, (Denzin, 1970) describes how a researcher can use triangulation of data sources across time, space and person. In this study as stated the researcher used the PHC practitioners, Stakeholders and the Community. Data source triangulation maximized the range of data that contributed to a more complete understanding of the mental health problems of children and adolescents being studied (Morse, 1997).

During the data analysis verification techniques were done so that other members checked by paraphrasing the research understanding of some things participants said and requested them to react to them. This also further helped to re-read the transcripts to see where they supported or conflicted with the research findings-this was very evident as the researcher wanted to identify evidence of any discrepancy (Heider, 19972).

Selection of the participants was based on the knowledge of the setting of the study, facility of access and data collection, research relationship with study participants while the problem of '*key informants bias*' in the selection of participants in the study was alleviated by systematic sampling in order to be able to claim that key informants' statement were representative of the group as a whole (Pelto, 1975).

Dimensions of variation in the population to the study were defined and systematic selection of individuals and settings represented the most important possible variations of these dimensions (Strauss, 1987), (Strauss and Corbin, 1990). Participants deemed as critical to the theories of the study developed were examined at the beginning of the study. In the same context (Maxwell, 2002), argues that extreme respondents provide crucial test of theories, and illuminate what goes on in a way that representative respondents may not.

1.9.2 Reliability

Reliability of an instrument is *the degree of consistency with which it measures the attribute it is supposed to have measured*. The focus group moderator's guide, which was developed by the researcher, was able to obtain the planned data of the perceptions and understandings of the practitioners and the community on mental health problems of children and adolescents as well as the curriculum models proposed for adoption after the core research team reaffirmed that *it was clear and objective for the purpose and intentions it was designed for*.

1.10 TRUSTWORTHINESS OF DATA

1.10.1 Credibility

The researcher carried out an inquiry establishing trustworthiness in qualitative data in such a way that the probability that the findings were credible was enhanced, for example participants for the study were nurses and clinical officers who were responsible for training and practice. The findings from the study were presented to all the 25

participants in plenary meetings held aimed at consolidating the data collected from the field.

After a detailed discussion on the interpretations of the findings, *the practitioners participating in the study verified or approved the data collected as a true reflection of what happened in the field and this was used as a starting point in the research proceedings.* The use of triangulation in the methods used in the collection of data also contributed to the credibility of the findings. The participants during the workshops were able to contribute to discussions freely.

They were able to contribute to the discussion because the researcher and participants had worked together and had gained trust and commitment in doing the work. Due to long acquaintance between the researcher and some of the participants in the study in the subsequent meetings the participants freely reflected on the decisions they had taken in the previous meeting before planning for the future.

1.10.2 Consistency

This study can be replicated since procedures that were undertaken in collecting data were recorded in detail. The comment by (Lincoln, 1985) states that: *“There must be something tangible and unchanging out there that can serve as benchmark if the idea of replication can make sense”* (p.299). In this study if the steps which were undertaken were followed and if the practitioners and the community did not become fatigued thus tending to make mistakes, findings would be similar.

1.11 DISSEMINATION OF THE FINDINGS

In response to the obligation that the researcher had in informing the participants about the findings, a summary of the findings will be sent to the hospitals from which the participants were recruited. In addition, the findings will be submitted to the Ministry of Health library and Institutional Collaboration library where the data will be used as

resource material to enhance theory and practice in human resources management and development.

1.12 ETHICAL CONSIDERATION

Authority to collect data was obtained from both the health permanent secretary and the Director General of Central Board of Health, after clearance from the Ethics Committee of UKZN. Informed consent was obtained from the respondents who are PHC Practitioners; Stakeholders within the health industry and the community, as well as the facilitators who conducted the focus discussions on behalf of the researcher. *The children and adolescents did not constitute the respondents' sample during the focus group interviews in the study.* The focal research point persons at the various study sites who knew these areas well and the culture of those environments better than the researcher who could have been regarded as a stranger by those communities negotiated as respondents. *Respondents were assured that the information obtained would be anonymous and confidential.*

Confidentiality was observed, for instance, the search conference workshops discussions and focus group discussions were recorded in a way *that individual responses could not be linked to personality.* The data was kept in strictest confidence. Participants were informed that they were free to withdraw at any time during the period of the study and that no cost would result from their participation. *Respect and courteous treatment applied throughout the research process.*

In health research, respondents are human beings and their rights should be respected and considered before, during and after the research process. Collecting data from the community on the subject of mental illness or mental health problem is highly sensitive because of the held social constructs about the nature of the illness and this makes the issue of ethics particularly critical and useful to this study in such areas as; *value of AR projects; informed consent; protection from harm and honesty (Ulin, 2002)*

In community setting studies the individuals within the community must be protected including the community itself. Cassel (1976) points out that in community “*power is shared between the investigators and subjects, with subjects having a rather more power to frustrate the researcher than the researcher has to compel*”, hence the participants should be willing to participate.

Punch (2001) points out that there are issues that need to be addressed in research such as *consent, deception, privacy and confidentiality which should be dealt with either before, during and even after field work*. Beauchamp (1995) and Durkheim (2002) also cite that within the framework of ethics there are four major principles, namely: *respect for autonomy of individuals, non-maleficence, beneficence and justice* and remind that, ethics in any research is very important; particularly research involving humans and animals.

The researcher has an obligation to make known the results and findings of the study to the scientific community (Babbie, 2001), as well as feedback meetings for both the practitioners and the community about the way forward in addressing the plight and services for children and adolescents’ with mental health problems. This type of feedback will be *a societal benefit as the communities were involved in the conception of the mental health problems of children and adolescents in their communities and locations*.

1.13 CONCEPTUAL/THEORETICAL FRAMEWORK

1.13.1 Introduction of the Framework

The conceptual and theoretical framework of this study was underpinned by the systems theory. Following below is a representation of *the map of the systems theory* used in the study, *it was necessary to verify with the community first*, in the form of *an exploratory participation* about what the community perceived and understood were the mental health problems of children and adolescents in their communities.

Evidence suggests that the use of a conceptual framework for research *provides direction for data collection methods and the recommendations that evolve*, (Grorty, 1993). From the guidelines of the Systems theory concept, the inquiry for these perceptions and understandings were important and were primarily drawn from the areas *colored light Turquoise and numbered 2a, 2b, and 3, in a rectangle as shown in figure 1 below*. The importance of this theory for this kind of study was that it enabled the researcher *to remain focused and collect the required information from parameters set in the systems theory map only on page 25 and figure 0 page 2, phase 1 stages 1, 2 and 3 to inform the next phases and stages of developing an innovative curriculum*.

Using this systems theory and the whole project concept map, it was easy to follow the subsequent areas to draw the data from, which were: *the ecological, biopsychosocial and cultural factors drawn at macro level by the systems theory and at micro level by the ecological and the biopsychosocial and cultural theories as well as phase 1, stages 1, 2, 3 only of figure 0 for PhD programme*. The combination of these, collectively influence the development of the child's mental health wellbeing in a diverse environment and consequently the curriculum endeavors which have to be developed later with changing times in the field with fellow professional colleagues.

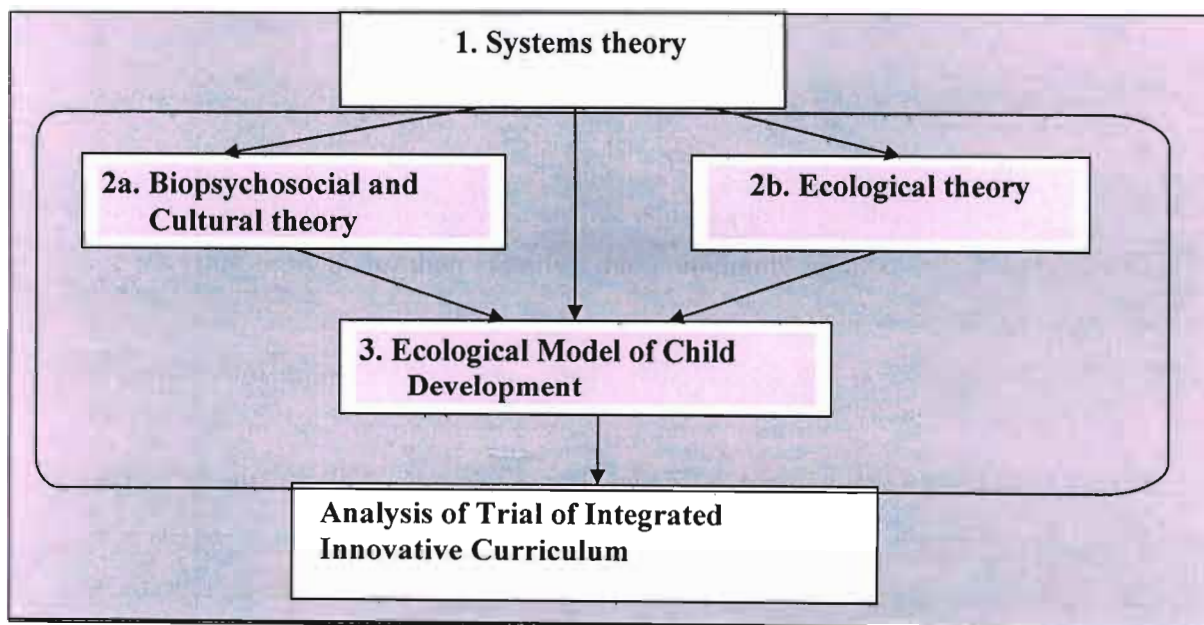
It was also possible to see how the curriculum would be drawn and what data would constitute the type of innovative curriculum envisaged for the PHC Practitioners' educational intervention. Therefore, *the study of the perceptions of the community and the practitioners was the main body of the study for the thesis and the next step in the process will be to work on the innovative curriculum based on the informed data collected from the community*.

The study took its dual nature which was: determining perceptions and understandings of the practitioners and the community about mental health problems of children and adolescents, within the biopsychosocial and cultural contexts, and the subsequent implications for innovative curriculum development, the ecological model was used to illustrate the ecological interactions of the child and the adolescent mental health

development. In the health context, concepts of *micro* (individual), *mezzo* (family), and *macro* (community) level interaction are used to assess how illness affects the individual and other interrelated systems.

According to (Goldon, 1960), crucial assessment of a child occurs at the interface, or transaction between the individual; their systems that are interdependent, and the environment. He further noted that, change and adaptation to illness affects all within the system: the individual, their family, the community and surrounding environment (biopsychosocial and cultural environment). The map of the systems theory as shown below also illustrates that there are factors in the society that if not manipulated are likely to influence the development of the intended curriculum if they are not carefully explored for real locally construed experiences and understandings from the community itself.

Figure 1: Map of Systems Theory Applied in the study



This figure shows the map of the systems theory applied to the study. It further illustrates how the ecological theory thus, the factors around the child, such as the child himself, the

family and the community at large, as shown in figure 3 below, draw from the general systems theory on one hand and on the other hand, it shows how the biological, social, psychological, and cultural factors influence the development and growth of the child.

As can be seen from the figure, the focus of the study was precisely around the areas in *light Turquoise color and numbered 2a, 2b, and 3, in a rectangle*. From this illustration, it can be seen that the study had to *explore the social realities on the ground* from the communities themselves in order to draw the required baseline data from the rectangle blocked factors numbered **2a, 2b, and 3**.

Drawing from this illustration, *it implies that the innovative curriculum still on plan and outside the rectangle will draw the content of the curriculum from the perceptions and understandings of the community* about mental health problems of children and adolescents in their communities and such data stand the test of time and will also stand as evidence of data that is empirical. As it stands at present, *the area of curriculum development will be reactivated later as a post doctoral intervention*.

1.13.2 Systems theory model for curriculum development

The systems theory particularly that of (Bertalanffy, 1968) mooted in the 1940s with focus mainly on Cybernetics, dealt with general systems theory. Bertalanffy's general systems theory was based on his reaction against the principle of reductionism in favor of his agenda to promote the restoration of the harmony of science in which he emphasized that real systems are open to, and interact with, their environments, and that they can acquire qualitatively properties through emergence, resulting into repeated progress as opposed to reducing an entity to the properties of its parts or elements.

The systems theory focuses on the arrangement of and relations between the parts that connect them into a whole within the context concept of holism. Once the organization has been determined using the systems theory, the assertion holds that it is possible to ensure order and discipline, this is the premise that this study is underpinned, and to state

further that, the same concepts and principles of organization underlie the different disciplines, providing a basis for their unification..

Figure 2 below provides a general framework process for curriculum development and elaborates factors and actions required before, during and at the end of the programme of the innovation, all arising from the perceived demands of the community about some evolving problem concerning the people and about the people.

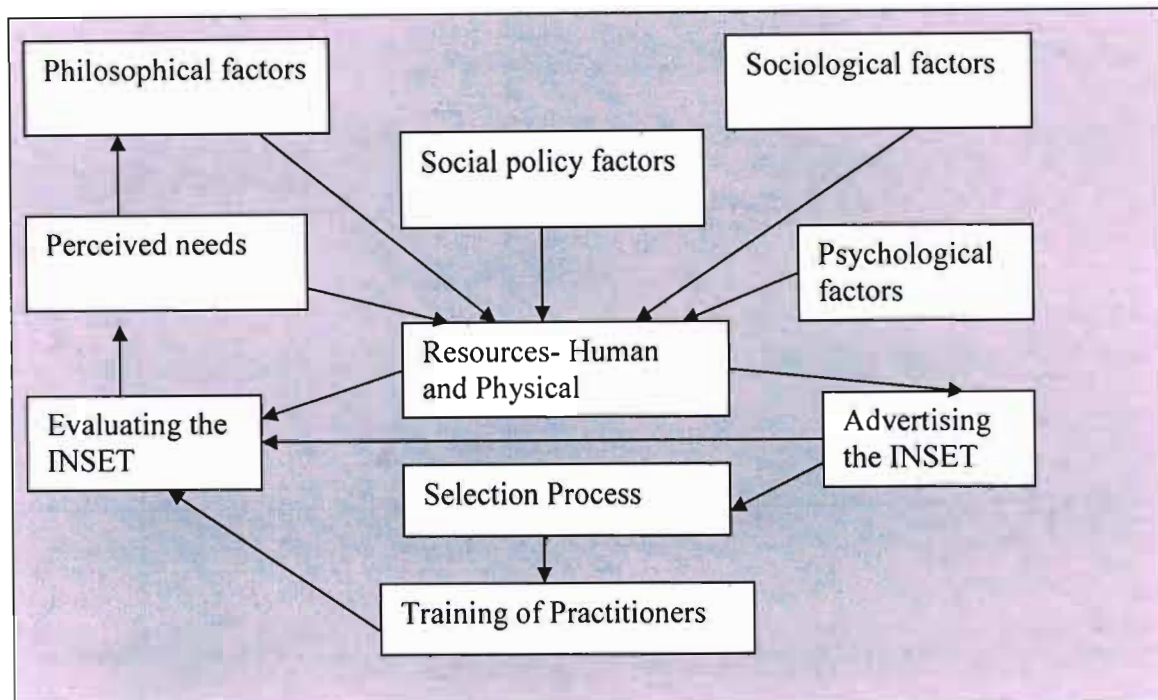
In curriculum development, it has to be acknowledged that, among the factors that underpin the social policy factors. These are in the first order of importance as was the case in this study by exploring the perceptions and understandings of the community about the mental health problems of children and adolescents in the community.

In the second order, are the perceived demands and needs, as well as the psychological aspects? The philosophical and sociological undertones, of any planned curriculum innovation, are essential; they determine the aims and values attributed to curriculum plans and development including the technological changes that could have taken place needing an innovation.

While the perceived needs and psychological factors focus on issues of ethos, motivation, and actual demands, requests and successes in the community, all these draw from the philosophical and sociological development in the community. This theory, establishes lessons that can be learned that: beautiful ideas and plans can be conceptualized but there must be the human factor and material factor to translate the innovation agenda forward.

In figure 2 below, the illustration is about the essentiality of the central factor, the human resource (HR), meaning that in systems theory. HR and materials are key to the success of the system itself with full participation of key, relevant, and appropriate stakeholders involved at the right time from the inception of the plans through to implementation and evaluation of the innovation.

Figure 2: Systems Theory model for curriculum planning and development, Peter Jarvis, 1995, p. 207.



This figure illustrates the systems theory in curriculum development process and shows factors and issues which are critical in the development of curriculum innovation. The top three factors which are: philosophical, social policy and sociological, illustrate that in curriculum planning and development, these factors determine the approach and model of curriculum paradigm to take into consideration.

They will underpin how that curriculum will be shaped and addressed in the form of, what processes, methods, outcomes and assessments and evaluation methods. It should be noted as well that social policy factors are very critical in the process of curriculum development as they have in many cases the financial power, regulatory influence as well as statutory dominant role in any professional discipline and that even when the curriculum has been developed and running they still have a dominant role in its management (Jarvis, 1983) and noted that different conceptions of curriculum models

had immersed which were subjected and influenced by various social systems and factors. Langenbach (1988) examined a number of some of the social systems theories in curriculum planning and development, but were prevalent in the education of adults. He argued that in programme planning there are always several external and internal factors that intervene in the process of planning and development, as shown in the figure above.

The systems theory application demonstrated that the research process, if exposed to the wider social cultural environment and its governing bodies, without proper innovative strategic plans, it could be adversely affected by the philosophy of the planners, interrelationships and functioning of other types of organizations in social systems (Child, 1997), and ultimately could result into the creation of uneasy tensions as a result of the interplay of the forces stemming from philosophical, sociological, social policy and psychological factors (figure 2, above).

The implications of systems theory is that, when undertaking a research study especially one that involves participation of other people, with a diversity of backgrounds, experiences and cultures, it is important to facilitate people to think backwards periodically, meaning that, people cannot know what they think, until they see what they say (Bertalanffy, 1968).

Developing an innovative curriculum in child and adolescent mental health would be based on constructions and reconstructions of perceptions of stake holders and the community. This will not only give the partners a say in the innovative curriculum plan and process but would also promote ownership of the curriculum by the society once it will be developed. This would mean that the community and the practitioners would support it as it will be their product.

1.13.3 Ecological theory model

The ecological theory rests on an evolutionary, adaptive view of human beings in continuous interaction with their environment. In biology, accommodation occurs when an individual actively interacts with their environment to ensure a goodness-of-fit. The result of accommodation is the creation of a "niche." The niche represents the unique place in which one "fits" in the environment; and once established, attains a level of homeostasis.

If the person or environment is changed, the survival of the whole is dependent upon the niche accommodating change in all other parts. The ecological map below shows the interplay of critical factors in the mental health development of the child. It is also important to note that there must be equilibrium in the interplay of the factors for the child to remain at balanced development.

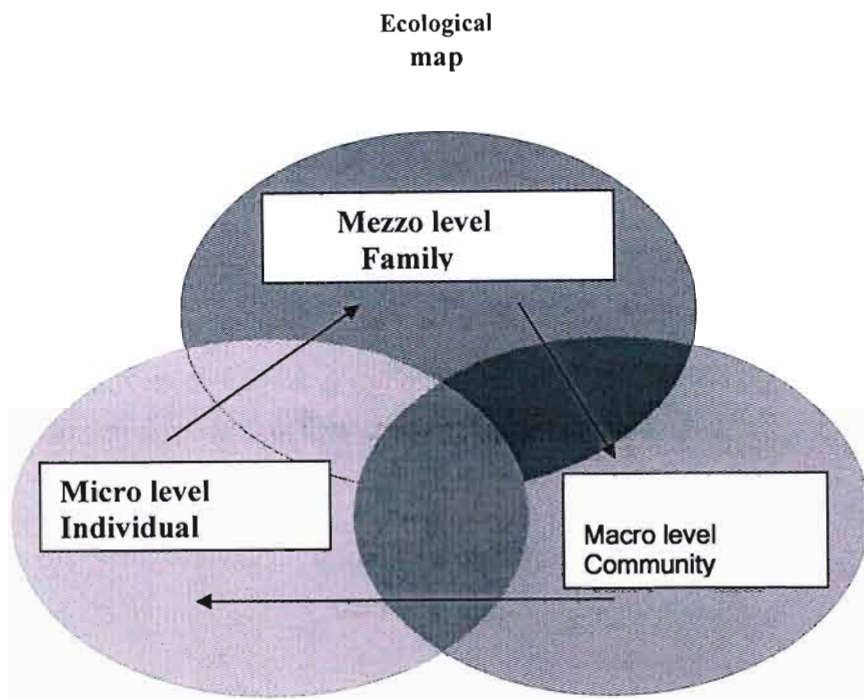
The Ecological theory of Child Development can be likened to an ecosystem with plants in which there is an interacting system of plants, animals and humans and their surrounding physical environment. An ecosystem contains living and non-living organisms that each contribute to a unique service or function.

It is a system of interrelationships, interactions and processes. The flow of energy and the cycling of matter are two important processes in an ecosystem. Green plants capture and process solar energy, and through food webs animals transfer the energy throughout the ecosystem. Plants, animals and chemical processes continually use and recycle organic material and nutrients in an ecosystem.

The studies of ecology assert that everything is related to everything else-or that everything depends on something else for its survival. Because of this interconnection, our actions can create long strings of consequences. In the ecological model, the child is at the center of the model. The model acknowledges that a child affects as well is affected by the settings in which he/she spends time. The most important setting for a young child

is his/her family, because that is where he/she spends the most time and because it has the most emotional influence on him or her as shown below.

Figure 3: An Ecological model of Child Development showing the interplay of critical factors involving an individual, family and the community.

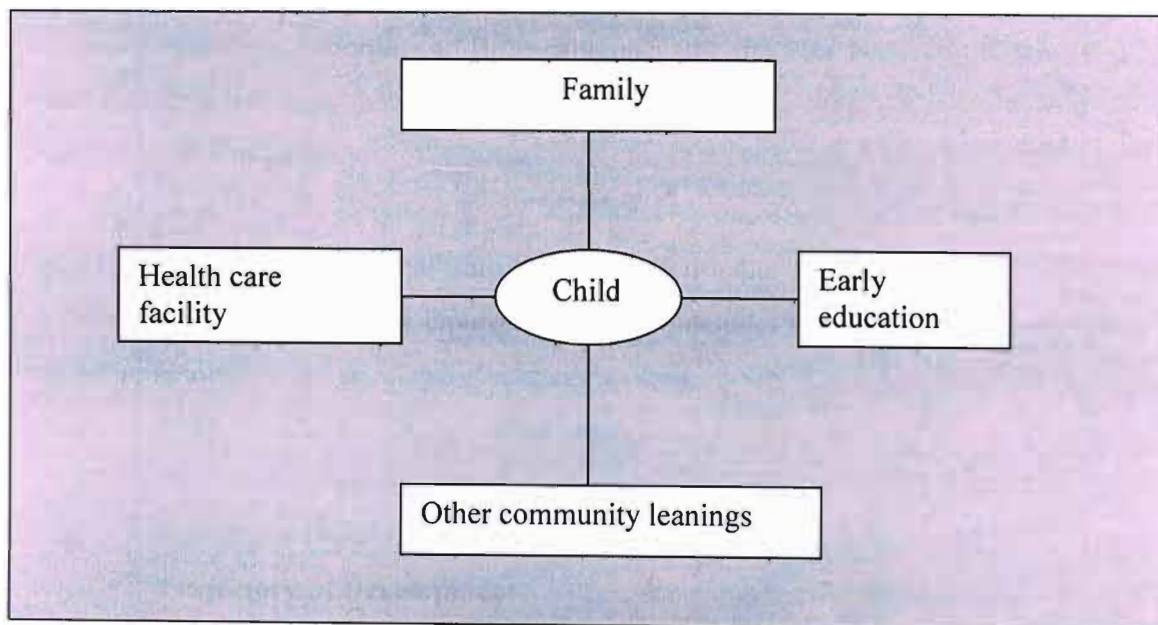


The figure shows some principles of the ecology of child development with the interplay of micro, mezzo and macro level factors in the mental health development of the child, adopted from (Bronfenbrenner, 1998)

Concepts used in this model are boundary definitions and maintenance between systems, interdependence, synergy, environment, and homeostasis. Bronfenbrenner used an illustrative model which characterizes the child and adolescent perspective to explain the development of the child and adolescent as shown below.

Bronfenbrenner's ecological model below further explains and illustrates the centrality of the child in the milieu of the family, school, health and the community for good mental health development. According to Bronfenbrenner, the linkages between the family, the school, other community leanings and health, provide strong mental health development of the child and in situations where these levels all link evenly and coherently, the child's mental health status development will not be affected and such children and adolescents follow and grow along a normal trajectory. The child is put in a central position because of its interdependence with the environment which includes the family itself as shown in the figure below.

Figure 4: Ecology of Human Development as applied to the Child in its Trajectory of Development



This figure illustrates the ecology of human development in general and the child in particular in its trajectory of development, and further illustrates that humans do not grow in isolation, but in relation with their family and home, school, community where various

leanings take place and the exposure to the larger world society. According to this model, the linkages between the family, the school, other community leanings and health, provide strong mental health development of the child. In situations where these levels all link evenly and coherently, the child's mental health status development will not be affected. Each of these ever-changing and multilevel environments, as well as interactions among these environments is key to the mental health development of the child and adolescent.

1.13.4 Biopsychosocial Model ("BPS")

This is a general model that posits that biological, psychological (which entails thoughts, emotions, and behaviors), and social factors all play a significant role in human functioning in the context of disease or illness. This is in contrast to the traditional, reductionist biomedical model of medicine that suggests that every disease process can be reduced down (i.e., explained) by an underlying process, such as an antigen (Engel, 1977).

The biopsychosocial model expands on the ecological theory, viewing disease as interplay between environment, physical, behavioral, psychological, and social factors. The following premise is outlined using the biopsychosocial model to underlie social work's role with health care as:

- Social, cultural, and economic conditions have a significant measurable effect on health status and illness prevention.
- Illness related behaviour, whether perceived or actual, frequently disrupt personal or family equilibrium and coping abilities.
- Medical treatment alone is often incomplete and occasionally impossible to render without accompanying social support(s) and counselling services.
- Problems of fragmentation, access, and appropriate utilization of health services are sufficiently endemic to the health care system as to require concerted community planning as well as institutional innovations.

- Multi-professional health team collaboration on selected individual and community health problems can be an effective approach to solving complex social/medical problems.

The concept is used in fields such as medicine, nursing, health psychology and sociology, and particularly in more specialist fields such as psychiatry, health psychology and clinical psychology. The biopsychosocial paradigm is also a technical term for the popular concept of the mind-body connection, which addresses more philosophical arguments between the biopsychosocial and biomedical models, rather than their empirical exploration and clinical application (Sarno, 1998).

The "model" was theorized by psychiatrist George Engel at the University of Rochester, and putatively discussed in a 1977 article in *Science* (Engel, 1977), where he posited "*the need for a new medical model*"; however no single definitive, irreducible model has been published (McLaren, 2004) However, the general BPS model has guided formulation and testing of models within each professional field

1.13.4.1 Model description and application in medicine

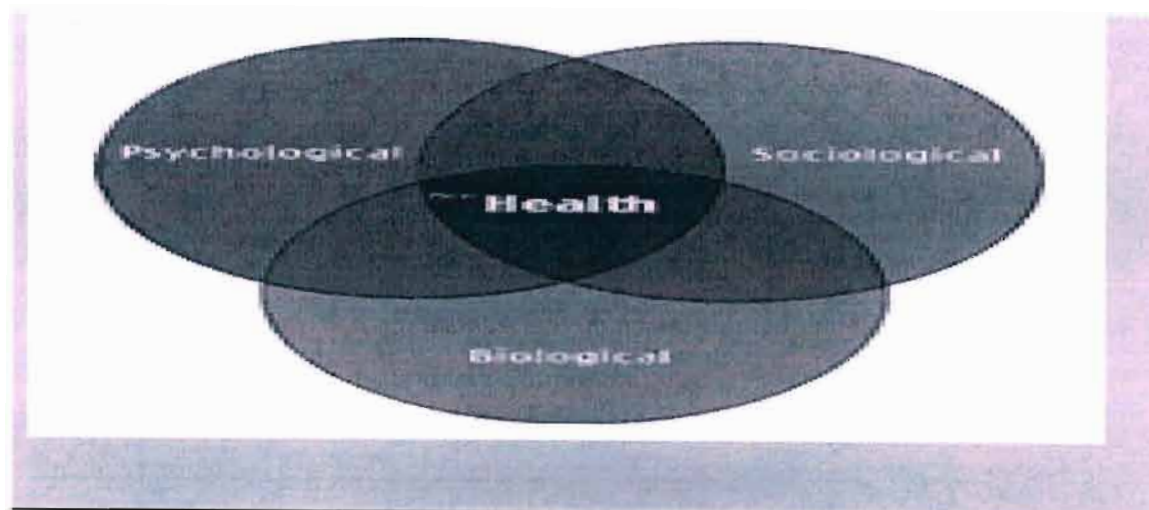
The biopsychosocial model implies treatment of disease processes (e.g., type 2 diabetes, cancer, etc.) requires that the health care team address biological, psychological and social influences upon a patient's functioning. In a philosophical sense, the biopsychosocial model states that the workings of the body can affect the mind and the workings of the mind can affect the body (Halligan, 2006). This means both a direct interaction between mind and body as well as indirect effects through intermediate factors.

The biopsychosocial model presumes that it is important to handle the three together as a growing body of empirical literature suggests that patient perceptions of health and threat of disease, as well as barriers in a patient's social or cultural environment, appears to

influence the likelihood that a patient will engage in health-promoting or treatment behaviors, such as medication taking, proper diet, and engaging in physical activity (DiMatteo, 2007)

Health is traditionally equated to the absence of disease. A lack of a fundamental pathology was thought to define one's health as good, whereas biologically driven pathogens and conditions would render an individual with poor health and the label "*diseased*". However, such a narrow scope on health limited understanding of wellbeing, frustrated treatments efforts, and more importantly, suppressed prevention measures. The figure below illustrates the biopsychosocial model of disease and illness.

Figure 5: the Biopsychosocial model of Disease and Illness



This figure illustrates how the model accounts for biological, psychological, and sociological interconnected spectrums, each as systems of the body. The model accompany a dramatic shift in focus from disease to health, recognizing that psychosocial factors (e.g. beliefs, relationships, stress) greatly impact recovery the progression of and convalescence from illness and disease.

Many institutions and medical doctors have managed to incorporate a holistic view of health in sound medical application, primarily based on the Biopsychosocial (BPS) Model of Health and Illness. The concept of wellness is particularly stressed, where the state of being in good health based on the biopsychosocial model is accompanied by good quality of life and strong relationships. Engel eloquently states:

"To provide a basis for understanding the determinants of disease and arriving at a rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he lives and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the health care system. This requires a biopsychosocial model."

Today, individuals are living with diseases that would have taken their lives in the past. We see health and wellness is a broader forum. Medical practitioners are more frequently adopting the biopsychosocial form in their clinician practice.

1.13.4.2 Criticism of the Biopsychosocial model

Some critics point out this question of distinction and of determination of the roles of illness and disease runs against the growing concept of the patient-doctor partnership or patient empowerment, as "*biopsychosocial*" becomes one more disengenuous euphemism for psychosomatic illness (McLaren, 2004). This may be exploited by medical insurance companies or government welfare departments eager to deny access to medical and social care (Rutherford, 2007: 978).

Some psychiatrists see the BPS model as flawed, in either formulation or application. Epstein et al describes six conflicting interpretations of what the model might be, and proposes that "*...habits of mind may be the missing link between a biopsychosocial intent and clinical reality.*" (Epstein, 2005: 979). Rather than the result of the BPS model, David Pilgrim suggests that *necessitous pragmatism* and a form of "*mutual tolerance*" has forced a co-existence and not "*genuine evidence of theoretical integration as a shared BPS orthodoxy*" (Pilgrim, 2002). Pilgrim goes on to state, "*Despite these*

scientific and ethical virtues," the BPS model "...has not been properly realized. It seems to have been pushed into the shadows by a return to medicine and the re-ascendancy of a biomedical model." Out of all critics of the BPS model, McLaren is perhaps considered to be the most vocal philosophical critic of the BPS model, and writes:

"Since the collapse of the 19th century models (psychoanalysis, biologism and behaviorism), psychiatrists have been in search of a model which integrates the psyche and the soma. So keen has been their search that they embraced the so-called 'biopsychosocial model' without ever bothering to check its details. If, at any time over the last three decades, they had done so, they would have found it had none. This would have forced them into the embarrassing position of having to acknowledge that modern psychiatry is operating in a theoretical vacuum."

The next section that follows below is the general introduction of the four chapters which constitute critical knowledge areas of the study. These chapters are important in that they feed each other and support the innovative curriculum with context and information areas required together with data from the community and the perceptions from the practitioners to inform the development of the curriculum for PHC practitioners.

1.14. Conclusion of Chapter

This chapter has raised a number of critical information about the introduction and background of the study in general. *It has been seen that for phase 1 stages 1, 2, and 3 the study was merely, exploring perceptions and understandings of practitioners and the community* in order to have baseline data which will be used later to commence the process of developing an innovative curriculum after doctoral studies.

It has clearly defined the confinement of this particular study *to only the drawing of perceptions and understandings supplemented by the secondary data from the hospitals and the OPD records and registers*. It has also been made clear that the secondary data

obtained from the hospitals and the OPDs using the qualitative method, was *not the core of the study*. The core of the study was primarily *exploration of qualitative information* and this was important as it helped the researcher to remain focused within the core parameters of the study which is: *phase 1 stage 1, 2 and 3 only*.

The chapter brought on the fore the illustration of how the conceptual framework of the study was able to guide the *first phase of the study and the phase of curriculum development* which comes later as shown in *figure 1 above of the general systems map and the whole concept map of the project figure 0*.

Worth of note was the manner the sub-theories which are: biopsychosocial, ecological and child development are linked to one another and how they linked and drew from the main general systems theory. On the aspect of the curriculum using the theoretical framework, the chapter has provided within the systems theory, how the curriculum to be developed will be informed and what factors influence planning and development of any curricula.

It can also be seen that the systems theory is universal and flexible. It's embedded roots in biology where it was used to describe how living things function helps to illustrate how organizations and institutions operate.

This particular study engaged the systems theory because of its adaptability to a variety of other fields particularly considering that, within these broad fields, there are organizations in the health sector such as the medical and nursing councils of Zambia, the nurses and clinical officers' associations of Zambia, which by their structure and function have a strong hold in the affairs of nurses and clinical officers whom they represent.

On the aspect of the biopsychosocial theory of the general social theory, which states in part that '*development of a child and an adolescent is a sociological construct*', the sociological construct focuses on society and events outside the individual for a satisfactory explanation, the sociological theory holds two key concepts of '*socialization*'

and 'role' to which the adolescents must learn and conform. The choice of a sociological dimension and not the biological dimension to underpin the study is primarily on the premise that the study is collaborative and interactive and heavily draws on other people in the research process using various curricula theories as well as AR.

The next chapter looks at Action Research as a methodology which in the actual execution of data collection process incorporated the principles and theory of PAR to *explore the baseline data required to inform the later curriculum* through a planned process of collecting information through collaborating with stake holders and the community itself.

CHAPTERS: TWO, THREE, FOUR, AND FIVE

LITERATURE REVIEW

2.0 General introduction of the chapters

The review of literature in the four (4) chapters which follow addresses four main field areas of the study, presented in a series as shown below. The four field areas support each other to form the core body of information essential for a sound basis of those aspects needed to inform the development of a socially constructed innovative curriculum for PHC practitioners in child and adolescent mental health.

The Action Research field area is presented as a methodology chapter; therefore it integrates and links the three areas of the study listed below coherently with one another. The mental health component of the study provides the core knowledge *explored from both local and international literature and the community as well as Practitioners.*

This means that the combination of mental health knowledge and action research knowledge exerts a strong bearing to the study as it is used as a method to collect the data required and ultimately integrate the collaborative process of developing the planned curriculum for the practitioners *later as a field activity after the doctoral programme.*

INSET in the context of this study is the expected training programme which will be designed to ensure that the PHC practitioners are trained in the required competences in the field of child and adolescent mental health. This hybrid nature of combining disciplines is complex, and the following are the four specific research areas which are: Chapter two: Action Research, Chapter Three: Curriculum Development, Chapter Four: In-service education and training (INSET), Chapter Five: Child and Adolescent Mental Health

All these interdependent knowledge areas of the study are essential to inform the later innovative curriculum to be developed with its social and community implications in a negotiated social constructed environment. Chapter two which follows below examines AR as a method of carrying out this study to explore the perceptions and understandings of practitioners and the community about mental health problems of children and adolescents.

The chapter illustrates how team work in a study can be enhanced including stake holders and also demonstrates how the researcher within the context of an *exploratory study* was able to learn from the experiences of those with field and practical expertise in the community.

The review of literature starts with Action Research *merely as a core generic field area which is strongly linked to this exploratory study* and illustrates concisely how groups of people and communities can work together and learn from each other on issues that have common social inclinations through to all the other three field areas which are: Curriculum Development; INSET; and Mental Health which are consequently presented below in Chapters 2, 3, 4 and 5 respectively.

CHAPTER TWO

ACTION RESEARCH

2.1 Introduction

This chapter focuses on AR as a field area discipline *but used as a methodology in this exploratory study as stated in the above introduction of the review of literature for the 4 study knowledge field areas of the study, and is applied in this study to generate a research process in a practical, collaborative, emancipatory, interpretative and critical manner*, so that the information explored from the practitioners and the community would be used to inform the later development of an innovative curriculum. Practitioners in the context of this study, refer to those *'health care professionals who provide education and training, while the other group provides health care practice to the community.*

The context and track of the study was the use of active PAR process with stakeholders, practitioners and the community members themselves without the C&A (clients) who could not participate in the study *even though their inclusion in the study (Researcher's Opinion) would have made a difference in that their participation would have had a lot of therapeutic effects onto them hence the improved mental health status for those that would have been selected to be part of the four (4) focus groups in the study (Marincowitz 2004).*

This observation is true for patients or clients whose condition tends to be lifelong and /or threatening as was made clear in the case of a study (**Putting Participation into Practice**) in the *Marincowitz Action Research Article of (2004:46(5):31-36)*. If children and adolescents were included in the focus groups they too would have had a say in what they experienced as real mental health problems affecting them in the communities in which they live to the advantage of the Practitioners and the communities.

Action research as a discipline has been applied in various research situations by different researchers for a substantive number of years who have used it as a method in a variety of research arenas for dealing with issues presented in people's daily activity. The

following authors have used action research in organizational development: (French, 1995) (Whyte, 1989), (Checkland, 1991) while (Argyris, 1991), (Zuber-Skerritt, 1990, 1996), (Eizenberg, 1990), (Kemmis, 1988b), (Kemmis, 1988a) (Carr, 1986) and (Grundy, 1982) and refer to it for educational settings, and lastly (Gamble, 1995), (Turnbull, 1993), (Webber, 1993), (Bawden, 1991) and (Whyte, 1991) refer AR to agricultural settings.

However, of particular note is (Sommer, 1990) who applies action research in local participative community research settings and (Kemmis, 1988b,) who presents a contemporary description of the action research method. These authors attribute their model as having evolved from the work of (Lewin, 1946), which has at present been transformed in a developed form. The authors recognize that action research provides a framework for developing ideals, which make it as a research approach and suggest that it *offers "... a concrete procedure for translating evolving ideals into critically informed action"* involving concrete procedures, ideals, and critically informed actions relate to the social situation of education.

In furthering the above assertion (Kemmis, 1988b) describes the four phases of *planning, acting, observing and reflecting* following the identification of the initial thematic concern or problem. The initial cycle of these four activities leads to a second cycle in which the reflections of the previous cycle inform the plan. Zuber-Skerritt (1990, 1996) suggests the same phases as relevant for professional development while (Dick, 1995) emphasizes that the *"two very important features of action research are its cyclic nature and the use of regular critical reflections."*

In agricultural settings, (Webber, 1993) and (Turnbull, 1993) present the same basic cycle of designing/planning, acting, observing the outcomes that follow and critically reflecting upon them. Each presents the approach as a useful way of operating with a range of farmer groups to achieve change.

French (1995) describe their model for organizational development as" *diagnosis, data gathering, feedback to the client group, data discussion and work by the client group,*

action planning and action" while stating that it is practitioners and not just researchers who use action research. This is supported by the work of (Dick, 1994,1995) and (Susman, 1983). In addition various other authors such as (French, 1995), (Sommer, 1987) and (Grundy, 1982) recognize that many subjects form the focus of action researching.

From the examples of descriptions various authors give it seems that foundationally there are four elements in descriptions of action research. The commonest cycle, has the four elements of planning, acting, observing and reflecting and on examination the other cycles are quite similar. The cyclic nature of the process is referred to as well. Thus, it seems that action research can be located in a tradition of research that pursues improvement through planning, acting, observing and reflecting in connected cycles of this process.

These various descriptive features of action research as stated above appear to suggest that AR is educational in life and further the various features show that, there are agreements and disagreements among authors as to what are Action Research's defining characteristics for instance, (Denscombe, 1998) suggests four such characteristics of AR which are; practical nature, focus on change, involvement of a cyclical process and its concern with participation.

The researcher's experience during the study in respect of these four elements was that they were very important, as practitioners in AR were the crucial people in the research process. Their participation was active; however, some authors reject the view that AR must be participative, or qualitative, or published (Dick, 2000), but, irrespective of the views by others, this study settled for the participative approach in order to draw everyone into the process with full participation

As the name suggests, action research is a methodology which has the dual aims of action and research. The methodology has the potential to bring about change in some community or organization or program. Action research is a term which refers to a practical way of looking at one's own work to check that it is as you would like it to be.

Because action research is done by the practitioner, it is often referred to as practitioner based research; and because it involves the practitioner thinking about and reflecting on their work, it can also be called a form of self-reflective practice

The idea of self reflection is central. In traditional forms of research – empirical research – researchers do research on other people. In action research, researchers do research on themselves. Empirical researchers enquire into other people’s lives. Action researchers enquire into themselves. Action research is an enquiry conducted by the self into the self. The Concept of using Action Research as a methodology to systematic inquiry was illustrated and developed in detail by (Smith, 1957). It was used in this study in the context of the Curriculum paradigm to be developed later for PHC practitioners in child and adolescent mental health.

The format used in the carrying out the study was underpinned by the Systems Theory adequately covered in chapter one, figure 1 of the study. The way the study has been formatted is very much in line with (Lewin, 1948) who notes that, the inquiry of using AR commences in the first step of the process and this approach usually modifies peoples’ perceptions about the nature of the initial problem, which in the case of this study was used as a stimulus to successful completion of the first step which yielded important elements, and led to subsequent actions.

AR was used as a systematic process to explore the perceptions and understandings of the community about mental health problems of children and adolescents. It did not advocate psychological manipulation, of the people in order to achieve the predetermined ends of the situation but that ensured that the most influential participants in the community were involved into the study at the search conference and focus group meetings held at various research sites.

2.2 LITERATURE REVIEW

2.2.1 Concept and definition

Several conceptions and definitions of AR have been proposed and all tended to focus on AR as;

an approach to social research that is based on collaborative problem solving relationship between researcher and client, aims at a problem, generates new knowledge and involves a cyclical process (Lewin, 1946) (Carr, 1986) (Elliot, 1991) (Stringer, 1999), (Levin, 1998), (Winter, 1996).(Burns, 1990); (Oja, 1989) for instance, conceived AR to refer to the application of fact finding to practical problem solving in a social situation with a view to improving the quality of action within it, involving the cooperation and collaboration of researchers, practitioners and laymen, and is characterized by the strong involvement and degree of participation of members of the public in the research process (Whyte, 1991) (Whyte, 1991), and the reconceptualization of educational practice (Carr, 1986) (Pinar, 1976).

It is also referred to as a form of social research that typically involves making changes to resolve a problem that exists in a social context and aims to contribute both to practical concerns of the people in an immediate problematic situation and to the goals of social science by joint collaboration within a mutually acceptable ethical. On the other dimension, it is viewed as educational, and a systematic reflection, inquiry and action carried out by individuals about their own professional practice' after analyzing their own practice in order to improve it (Bassegy, 1998), and combines a substantive act with a research procedure, which is action disciplined by enquiry, a personal attempt at understanding while engaged in a process of improvement and reform.

Another view point, suggests that AR is a flexible spiral process which allows action (change, improvement) and research (understanding, knowledge) to be achieved at the same time usually described as cyclic, with action and critical reflection taking in turn. The reflection is used to review the previous action and plan the next one. Also AR is an approach, which has proved to be practically attractive to educators because of its

practical, problem- solving emphasis' (Bell, 1993). (Denscombe, 1998)), further conceived AR as 'a form of self-reflective inquiry undertaken by participants in social situations in order to improve the rationality and justice of their own practices, their understanding of those practices, and the situations in which those practices are carried out. This conception along with others, are supported by (Burns, 1990) (Oja and Symulyan, 1990) who define Action Research as the application of fact finding to practical problem solving in a social situation as well with a view to improving the quality of action within it, involving the cooperation and collaboration of researchers, practitioners and laymen.

They also viewed it as a form of social research that, typically, involves making changes to resolve a problem that exists in a social context and aims to contribute both to practical concerns of the people in an immediate problematic situation and to the goals of social science by joint collaboration within a mutually acceptable ethical framework.

Action research is open ended. It does not begin with a fixed hypothesis. It begins with an idea that you develop. The research process is the developmental process of following through the idea, seeing how it goes, and continually checking whether it is in line with what you wish to happen. Seen in this way, action research is a form of self evaluation. It is used widely in professional contexts such as appraisal, mentoring and self assessment.

A useful way to think about action research is that it is a strategy to help you live in a way that you feel is a good way. It helps you live out the things you believe in, and it enables you to give good reasons every step of the way. Action research can be seen as related to experimental research, though it is carried out in the real world rather than in the context of a closed experimental system. A basic definition of this type of research is:

" a small scale intervention in the functioning of the real world and a close examination of the effects of such an intervention" (Cohen, 1994)

Its main characteristic is that it is essentially an *"on the spot"* procedure principally to deal with a specific problem evident in a particular situation. No attempt is made to

separate a particular feature of the problem from its context in order to study it in isolation.

Constant monitoring and evaluation are carried out and the conclusions from the findings are applied immediately and further monitored. Action research depends mainly on observations and behavioral data. As a practical form of research, aimed at a specific problem, and situation, and little or no control over independent variables, it can fulfill the scientific requirement for generalizability. In this sense, despite its *exploratory nature*, it is the exact opposite of *experimental research* (Cohen, 1994)

Action research is a broad movement with diversity in purpose, theoretical frameworks, disciplines, professions and industries. Differences of *geography, language and culture* give rise to variety and research participants develop their own way of doing action research specific to particular situations. Various models of action research have been developed for teaching, planning, reflecting and reporting action research. The varieties of models reflect diversity in practices and purposes of action research.

There are in fact action research methods whose main emphasis is on action, with research as a fringe benefit. At the extreme, the "*research*" may take the form of increased understanding on the part of those most directly involved. For this form of action research the outcomes are change, and learning for those who take part. This is the form which the study has used.

In other forms, research is the primary focus. The action is then often a by-product. Such approaches typically seek publication to reach a wider audience of researchers. In these, more attention is often given to the design of the research than to other aspects. In both approaches it is possible for action to inform understanding, and understanding to assist action. For purposes of this study the researcher chose a form where the research is a substantial part of the study

2.2.2 Characteristics of Action Research

Action research is a form of research intended to have both action and research outcomes. Almost all writers appear to regard it as cyclic (or a spiral), either explicitly or implicitly. At the very least, intention or planning precedes action, and critique or review follows. It provides a mix of responsiveness and rigor, thus meeting both the action and research requirements and the following are the features:

1. The spiral nature of action research is an important feature.
2. Action research is primarily qualitative.
3. It can be more responsive to the situation.
4. Participation is a requirement for some writers. Some, in fact, insist on this.
5. Participation can generate greater commitment and hence action.
6. Because change is a desired outcome in AR, it is more easily achieved if people are committed to the change.

There are many conditions under which qualitative data and client participation increase the value of the action research. However, to insist on these seems unnecessary. It seems reasonable that there can be choices between action research and other paradigms, and within action research a choice of approaches. The choice the researcher made depended upon the weighing up of the many advantages and disadvantages.

2.2.3. Justification for the choice to use Action Research methodology

The reasons below are some of the many which motivated the researcher to choose use of action research methodology for the study to *explore the perceptions of the practitioners and the community* about mental health problems of children and adolescents. The reasons are outlined as follows:

- It was the stimulation from the various readings from a number of advocates of AR notably, (Winter, 1989) (Kemmis, 1991), (Elliot, 1991), (McKernan, 1991),

(Lewin, 1948) and (Zuber-Skerritt, 1992a and 1992b), who applied participatory action research methodology in their studies and work based research.

Action research as a methodology can be responsive to the situation in a way that many other research methods cannot be. Another was on grounds of its cyclic qualitative and participative nature and in the interest of rigor, each cycle includes critical reflection. It was the preferred method to drive and integrate all the three key areas of this study which fed and supported one another as they brought together the researcher, practitioners and the community closer to the realities of participatory and socially negotiated community study (Pinar, 1976).

The application of AR was on the assumption that professionals knew best what was happening in their profession, and therefore were the best people to do research of their profession. Using action research, it was assumed that people can learn and create knowledge on the basis of their concrete experience through observing and reflecting on that experience, by forming abstract concepts and generalizations, and testing the implications of those concepts in new situations, which would lead to new concrete experiences and hence to the beginning of a new cycle.

- It was the assumption by the researcher that, Action research lends itself to use in work or community situations. Therefore, practitioners are people who work as agents of change, and can use AR as part of their normal activities because, conventional research in some field situations can be more difficult to use.
- Increasingly, practitioners within academic settings are being pressured to publish more. Those talked to report that the research is a heavy additional load: almost an extra job.
- It was the perception of the researcher that, when practitioners use action research it has the potential to increase the amount they learn consciously from their experience.

- The action research cycle has a learning cycle (Kolb, 1984) the educator, (Schön, 1983) argues strongly that systematic reflection is an effective way for practitioners to learn.
- It is good for a résumé to have done a study which has direct and obvious relevance to practice. If it has generated some worthwhile outcomes for the client, then that is a further additional benefit.
- Action research is usually participative. This implies a partnership between the researcher and the clients. This was seen to be more ethically satisfying and it may also be more professionally relevant.

2.2.4. Assumptions about Action Research

Action research is used in many professional learning contexts, both formally and informally and requires that action enquiries begin with the question, ‘How do I improve my work?’ This perspective is quite different from traditional views of professional education, which often take the form of training.

In traditional forms, the usual procedure is that an acknowledged expert offers advice to professionals (who are then usually positioned as trainees). More enlightened forms of professional learning programmes work on the assumption that professionals already have a good deal of professional knowledge, and are highly capable of learning for themselves.

The question ‘How do I improve my work?’ contains a social intent. The intention is that one person improves their work for their own benefit and the benefit of others. If you can improve what you are doing (at least improve your understanding of what you are doing), there is a good chance you will influence the situation you are working in. Your increased awareness and your readiness to be self critical will probably have an influence on the people you are working with

The methodology of action research means that you have to evaluate what you are doing. You need to check constantly that what you are doing really is working. This awareness of the need for self evaluation shows your willingness to accept responsibility for your own thinking and action. Accountability is part of good professional practice. You are always aware that you have to give good service, to attend to the needs of others in the way that is best for them, and to show that you have responsible attitudes and behavior.

In doing action research you are giving an account of yourself. You are showing that you are a responsible person and can justify what you are doing with good reason. Action research helps to formalize your learning and give a clear and justified account of your work, not on a one-off basis, but as a continuing regular feature of your practice.

2.2.5 Background to Action Research

The concept of Participation of other key player in Action Research (PAR) has many of its roots in social psychology. It builds on the Action research and Group Dynamics models developed by psychologist Kurt Lewin in the early-to-mid 1900s, as well as on the study of oral culture by such scholars as Milman Parry and Walter J. Ong. At its core, PAR revolves around three sets of relationships: relations between individuals within communities and groups, relations between those groups and communities, and relations between people and their physical environment. Management of group dynamics in its many aspects thus plays a central role in PAR processes, and PAR practitioners/facilitators must have a strong foundation in this field.

PAR builds on the critical pedagogy put forward by Paulo Freire as a response to the traditional formal models of education where the “teacher” stands at the front and “imparts” information to the “students” that are passive recipients (Freire, 1990). This was further developed in "*adult education*" models throughout Latin America. Paulo Freire writes:

"The silenced are not just incidental to the curiosity of the researcher but are the masters of inquiry into the underlying causes of the events in their world. In this context research becomes a means of moving them beyond silence into a quest to proclaim the world."

Action research began in the USA during the 1940s through the work of (Freire, 1990), a social scientist. The understanding of AR as a form of research and method was first mooted or conceptualized by Lewin 1952. It was further developed by (Carr, 1986) and from that time it began to attract other researchers in various places as well, but Lewin's work is generally taken as the starting point. It was popular for instance in the USA for a time, but then went into decline because of cultural, political and economic changes.

It emerged in the 1970s in Britain through several influences. One major influence was the work of Lawrence Stenhouse who directed the Humanities Curriculum Project. He believed that the curriculum ought to be organized in schools so that it was meaningful and relevant to students' experience, and they should be encouraged to take on the responsibility of their own learning. He also promoted the idea of 'teacher as researcher'.

Action research was developed mainly by academics in higher education, who saw it as a useful way of working in professional education, particularly teacher education. They began studying and clarifying the steps involved, and also the principles underpinning action research, such as the need for democratic practices, care and respect for the individual, and the need for disciplined enquiry. Action research is today prominent not only in teacher professional education but also in management education and organization studies, social and health care work, and other professional contexts.

Over the years, various models and different interpretations of action research have developed. Some people prioritize technical aspects, believing that it is important to get the method right. Other people are also interested in the values that inform action research, such as a belief that people should be in control of their work and the way they conduct that work, and how the research can lead to a living out of those values. Most people recognize the educational base of action research. These different perspectives generate lively debates.

The action research family includes a wide range of approaches and practices, grounded in different traditions, philosophies and psychological assumptions and pursuing different political commitments (Reason, 2001). Action research is a broad movement with many beginnings. There is not one single coherent history of action research (Reason, 2001). Yoland Wadsworth identified about 40 related streams (Wadsworth, 2002). A few of these are: action research , learning, and science, developmental evaluation, participatory action research and inquiry, reflective practice, learning organizations, process consultation and management, applied anthropology, total systems improvement, and soft systems. The term action inquiry (Tripp, 2003), is used to refer to the broad movement.

People in the various streams use different terms for the same thing, or the same term for different things. This should not cause any alarm when consideration is given that streams that make up the action inquiry movement arose in various languages, professions, and situations for a range of purposes. There are many ways of categorizing the streams of action inquiry. Daniel Selener identified four approaches related to professional fields: community development, Organizational development, education and agriculture (Selener, 1979). Action research in health may be added to this list. There are important overlaps, similarities and differences among action research in these fields.

Elizabeth Hart and Meg Bond arrange types of action research along a political continuum, from experimental action research, with high levels of researcher control, at one end, through organizational and professionalizing action research to empowering action research with bottom up control, at the other end (Hart, 1984).

Several writers (Grundy, 1988); (Holter, 1993, (McCutcheon, 1999:730); (McKernan, 1991) classify action research into three main types. Though their typologies are not completely consistent, there is a general correspondence. Technical action research uses a positivist, scientific frame of reference. Action research is seen as a method of solving problems Projects seem to be instigated and managed by researchers seen as skilled experts. Technical action research promotes efficient and productive practice. It includes

experimental action research (Hart, 1984) leading to the accumulation of predictive knowledge to refine existing theories in an essentially deductive process.

Most action research projects are probably practical action research, which take a pragmatic approach to solving practical problems after arising professional practice. Practical action research may employ an expert action researcher collaborating with asset of people recognized as “owing “the problem or situation to be improved, or may be undertaken by professionals researching their own practice. It enables the practitioners to gain a new understanding of their actions, and fosters the development of autonomous and reflective practice. Over time practitioners gain skills and rely less on specialist researchers.

Collaborative action research often (but not always) uses systems theory. Hart and Bond divide this into two types, Organizational (involving organizational development) and professionalizing (building autonomous reflective practice) (Hart, 1984). The interest by the researcher to apply Action Research methodology for the study links with democratization and organization development in Kurt Lewin’s approach in his research on social change and social conflicts (Lewin, 1948). Emancipative action research often employs a critical perspective to address issues of social change and emancipation. This way of working with and relating to others, promotes liberation and critical consciousness in participating actors, which shows itself in political, as well practical, action to improve the lives of disadvantaged people.

Emancipation action research has twin goals. The research aim is to reduce the gap between the problems experienced by the disadvantaged people in specific settings, and the theory by which they understand and explain their situation. This is a consciousness raising process that builds local theory. The action aim is to build and empower people to take strategic and effective action to improve their lives and liberate them from oppression. Emancipative action research is often informed by critical theory, and is highly participative.

The types of action research do not differ in the research methods used to collect data and analyze data, but in the purposes of research, and the social and power relationships between the actors and the researchers. There is a continuum of participation across the three types, from the differentiated roles and recognition of the researcher as expert in technical research to the highly participative and shared roles of empowering research.

Diversity in action research stems from cultural traditions, national and local situations, intellectual traditions in universities and schools, professional knowledge and practices, and also because action research can be emergent. When participants own the research, they will often develop their own way of doing action research, specific to a particular situation (Coughlan, 2001) or way of knowing.

These local ways are often developments or elaborations of models learned in formal education and through experience? As they are applied in participatory or collaborative practice, models are often transformed or elaborated. This process produces more models reflecting the diversity in practice and purposes of action research, and reflecting the actual local character of many action research projects. Participative action research can be long term emergent inquiry, in which the form of inquiry itself undergoes change.

(Greenwood, 1994) using their cogenerative AR model identified two main groups of actors in the action research process, these are on one hand, the insiders who are the focal point of the AR process. They are the “owners” of the problem, but they are not homogenous, egalitarian, or in any way an ideal group. They simply “own” the problem. On the other hand, outsiders are the professional researchers who seek to facilitate a co learning process aimed at solving the local problems.

In this study, the researcher was both an insider and outsider. Insiders and outsiders in this study were both equal and different. They were different because most insiders have to live directly with the results of any change activity in a project, whereas most outsiders can leave. Another difference is that, insiders have the central influence on what the focus of the research study should be (Greenwood, 1994). This particular study laid primary

emphasis on elaborating the understanding of AR in relation to two closely related approaches; the clinical approach, (Schein, 1987) and participatory AR (Whyte, 1989) The clinical approach is explicitly value-based and involves a professional helping role and this suggests a therapeutic model of the relationship between the researcher and the system.

The researcher knows how to diagnose and treat, and the system is the patient having the illness. This model has certain characterizing hallmarks such as; an early identifiable client whose problems chiefly relate to him or her, voluntariness, neutrality in terms of values and joint objective, namely, to become healthy. The interaction between researcher and system is complex and difficult to handle, and decisive importance is attached to the professional integrity and diagnostic ability of the process consultant. In the participatory AR, the interaction takes a different perspective.

One-way of describing it is to make the explicitly value-based perspective the point of departure. In the researcher's relations to the various systems, he works with and uses two key phrases to describe how he views the process of change and his role in it, namely, that the changes are to be participator based and participator controlled. Participator based means that those who are affected will also take part in defining which problems are to be treated, and participator controlled means that they will be in a position to participate in making decisions about what activities are to be implemented (Whyte, 1989).

This kind of approach obviously implies conference techniques process, such as the search conference and the focus group discussions with their explicit value aspects directed towards a commitment to democratic ways of working and not to specific outcomes. Another point involves the objectives for the changes. What is to be achieved must be decided by the participants. Objectives are formulated by looking at those elements on which demands have been placed (Gustavsen, 1986). Therefore understanding of action research commences with individual research and development, as Altrichter et al, writes:

“action research is about people reflecting upon and improving their practice; by tightly interlinking their reflection and action; and making their experiences public to other people concerned by and interested in the respective practice” (Altrichter, 1991)

In describing Action Research and its cyclical process, (Marrow, 1969) underscores the underpinning theoretical framework under which it evolves and points out that the theory behind AR is particularly that of search of understanding, but the understanding often evolves during the research rather than being detailed systematically in advance as in traditional positivist research. Action research also rejects positivist notions of rationality, objectivity and truth in favor of a dialectical view of rationality.

It employs the interpretive categories of practitioners by using them as the basis for ‘practice frameworks’ which practitioners explore and develop in their own theorizing (Stringer, 1999) and (Bell, 1993) (Bell, 1999), and entails showing how action research provides a means by which distorted self-understandings, may be overcome by practitioners analyzing the way their own practices and understandings are shaped by broader ideological conditions (Schein, 1992,1996a, 1999b: 942) and finally links reflection to action (Mezirow, 1991). (Towell, 1997) argued that AR builds on people’s own motivations to change, gives authority to a program of change, and offers support and resources to those trying to develop new ways of working.

Canavan further argued that there is a great need for clinical care providers capable of managing change to be involved and concluded that such a scenario requires for those care givers to sit at the table where policy is made (Canavan, 1985). Karlsen in (Whyte, 1991) explains dialogue, relationship, knowledge development and intellectual roots of AR, and reminds that dialogue is a cornerstone for experimentation, participation and development of the understanding and solution of problems in AR. Karlsen further points out that in this phenomenon, relationship between practice and theory, and between research and action, is significantly more organic and close than in traditional social science.

Although action research may not necessarily be the optimum choice in all settings, it is particularly *appropriate where problem solving and improvement are on the agenda.*

Action research *provides a sense of ownership, while focusing on values, beliefs and team building among those involved.* However, in the context of nursing (Greenwood, 1994) argued that '*traditional*' positivist research failed to realize its aim of improving practice, because clinical nurses for instance, did not perceive research findings as important since they did not seem to see their relevance to their own practice.

Within the qualitative paradigm in which AR falls, the researcher borrowed and utilized various AR models/paradigms which explained and illustrated the roots of sociology and its focus on how communities as socio-political systems which enact change as well as structural emancipatory issues, e.g. those relating to health (Winter, 1996); (Winter, 2001); (Whyte, 1991).

Recent reports for instance about AR in UK (Winter and Maisch, 1996) noted that service practitioners involved in action research asserted more emancipatory values than merely working together to produce a curriculum product. Participation of the service practitioners in action research therefore, allowed the practitioners to undertake and incorporate their ideas giving the curriculum a more overt, political stand on service issues such as the overcoming of integrity and discrimination.

Action research rejects positivist notions of rationality, objectivity and truth in favor of a dialectical view of rationality. It employs the interpretive categories of practitioners by using them as the basis for 'practice frameworks' which practitioners explore and develop in their own theorizing (Bell, 1993) and entails showing how action research provides a means by which distorted self-understandings, may be overcome by practitioners analyzing the way their own practices and understandings are shaped by broader ideological conditions and links with final reflection to action.

2.2.6 Historical Development of AR in Africa

From the African perspective, action research still has many beginnings (Reason, 2001). After independence, for instance, most African governments adopted political programmes to promote peoples participation in their own developments (Nyerere, 1968). Participatory research was developed in cooperation with university departments but participatory approaches were not promoted either by the university or funding agencies (Swantz, 2001). By the 1990's top-down technical approaches were found not to work, therefore, participatory approaches including participatory rural appraisal were (Appleton, 1992), participatory problem solving (Schmidt, 2001) and participatory action research (Swantz, 2001) were promoted.

In 1999, Tanzania for instance, prioritized action oriented health research (Kitua, 2000). Research, like that of human activity, takes place in political context, what are considered as topics and approaches for research is influenced by domestic and international factors. In South Africa as another example, under the apartheid regime, participative and liberating approaches to research were not funded by government agencies. Some academics worked for social justice and freedom, but their efforts were not published. Particularly action research was not taught or practiced in university department, and South African researchers were relatively isolated from international trends towards participatory development.

From 1994, after the fall of the apartheid regime, South African academics faced a huge task of making for the shortfall in education and finding approaches to research and development appropriate to the new political dispensation. Many came to participatory action research for the first time, made links to research models they knew (Harmse, 2002) and adapted action research to suit the cultural and economic context of South Africa (Coughlan, 2001).

Much of the action research in Central and Northern Africa has been conducted by health professionals in African languages or French and is under-represented in English language scientific journals. Participatory approaches began to be introduced into Francophone West Africa in the mid-1980 through participatory forestry projects. By 1984, several West African governments formally adopted participatory approach to land management (*Gestion des Terroirs*). Burkina Faso was one of few to institutionalize this practice through a national Village Land Management Programme, employing the method of active rural participatory appraisal, (Gueye, 1999), unlike other regions, where universities have played an important role in the development of participatory methods.

Francophone universities in Africa appear to follow intellectual traditions and academic cultures that emphasize research method rather than focusing on interactions among participants (Hussein, 1996), Leadership in participatory development has been provided by other institutions which are closer to practical issues in the field (CFRA, 1999.).

2.3 ACTION RESEARCH APPROACHES

There are many ways and methodologies to do action research. It is a research paradigm which subsumes a variety of research approaches. Within the paradigm there are several established methodologies. Each of these methodologies draws on a number of methods for information collection and interpretation, and as noted above, there are many approaches to action research, depending on the purposes, cultural traditions, professional training and local context and other factors. African action research in health for instance, operates in poverty situations where resources have been declining in real terms, while the AIDS pandemic and other factors increases need. The lack of resources for research and the urgent need for locally relevant knowledge creates demand for innovative, flexible and strategic approaches that quickly produce practical knowledge that can be directly applied in practice.

The key to action research is the realization that action research has two sides, action and research be in a project or study. Using the metaphor to introduce Bob Dickson's model of action research (Dick, 2001), Bob illustrates that the 'key' has two sides. The front of the key is rough, and patterned, representing action to improve health. The back of the key, the part that is often unseen, is smooth, and represent research. If the key is held up, only one side can be seen. To see both sides, one has to change position. This is the metaphor of the need to be flexible in attitude and perspective if effective action can be engaged in research. Action without reflection is one-sided. Without reflection, we do not learn from our experience as researchers or health professionals. Reflection without action does not produce change.

Out of many forms of research, there are paradigms (such as action research), others are methodologies (such as soft systems analysis), and others are general evaluation methods such as those of Checkland's Soft Systems and Patton's and Snyder's personal communication. Whichever method one chooses to apply in a study, following a published approach has its own advantages because it can be simpler to use a process which has already proved to work in other situations and described adequately by authors who have sufficient expertise, explanation and justification in their studies. In the case of this study participatory Action Research Method was preferred to other methods and below are four out of many methodologies applied by the four researchers in their work:

1. *Kemmis' critical AR* (Carr, 1986) which is participatory in nature and to some extent it is in the style of the "*critical action research*" of Kemmis and his colleagues (Carr, 1986), (Kemmis, 1988).
2. *Action science* as developed by Argyris and his colleagues (Argyris, 1985a) (Argyris, Putnam and Smith, 1985).
3. Checkland's *soft systems methodology* (Checkland, 1981).
4. *Evaluation AR* which is itself a large family of methodologies drawn to some extent on the work of (Patton, 1990) and Snyder (personal communication)

These methodologies are summarized below as follows even though this summary may not be exhaustive:

2.3.1. Participatory Action Approach

The action research literature is reasonably large, and growing. It is often characterized by process-oriented, practical descriptions of action research methods. Action research in education, in particular, is common and the following are some of them such as those of (Elliot, 1991),(McKernan, 1991) and (Winter, 1989), in which you find that each one of them is written from a different perspective, others within this group include, (Kemmis, 1991), (Zuber-Skerritt, 1992a and 1992b), these have recently published some useful writings in participatory research tradition. Further works in the same tradition of qualitative research generally are those of (Gummesson, 1991), (Marshall, 1989), or (Strauss and Corbin, 1990). The studies of Marshall and Rossman provide a good starting point in qualitative research while those of (Whyte, 1991) contain a collection of papers mostly illustrating participatory action research with case studies done in a variety of settings.

2.3.2. Action science Approach

Chris Argyris's action science, for some decades now, has been developing a conceptual model and process which is at the one time a theory of social systems and an intervention method. It is particularly appropriate to the researching of self-fulfilling prophecies, system dynamics based on communication flows, and relationships (Argyris, 1985a).

The central idea in this approach is that, despite their espoused values, people follow unstated rules. These rules prevent them behaving as they might consciously wish. The result is interpersonal and system processes in which many problems are concealed. At the same time, taboos prevent the problems or their existence being mentioned. In effect, the unstated rules of the situation, and the unstated assumptions people form about each other, direct their interactions in both group and organizational settings

As Argyris presents the approach it does depend on high quality relationships between researcher and client, and skilled facilitation. However, there are alternatives in the form

of detailed processes which clients can manage for themselves. These processes are directed towards the same improvement in the social systems and the understanding of the actors as in Argyris' own work (Dick, 1990). They have been used rarely in action research, (Anderson, 1993).

The concepts are developed in (Argyris, 1974). Many people find this material hard to read. (Argyris, 1974) is easier to follow. To understand the concept well, it may be useful to read the relevant system dynamics by (Senge, 1990), who describes system functioning in terms of interaction cycles. The research methodology is most clearly described in (Argyris, 1985b). Argyris, too, is evangelical about his approach, and criticizes other research methods. There isn't a simple way to describe the methodology. Essentially it depends upon agreeing on processes which identify and deal with those unstated rules which prevent the honest exchange of information.

The researcher to this point perceived action science as action research. However, note the view expressed by (Argyris, 1989). While acknowledging action science as a form of action research various researchers identify an important difference in focus. In particular, Argyris has argued that normal social research is not capable of producing valid information.

Without valid information the rigor of any action research endeavor is necessarily undermined. Action science is a good choice of methodology if there is strong within-person and between person dynamics, especially if hidden agendas appear to be operating. However, it probably requires better interpersonal skills and willingness to confront than do the other methodologies described here. Soft systems methodology, which follows, is somewhat less demanding in terms of the interpersonal skills it requires.

2.3.3. Soft systems methodology Approach

This is Checkland's soft systems analysis approach; it is a non-numerical systems approach to diagnosis and intervention (Checkland, 1981). However, (Checkland, 1990), (Davies, 1991) and (Patching, 1990). (Jackson, 1991) provided a critique, partly sympathetic, of soft systems methodology. Soft systems methodology first outlines an inquiry process which stresses the notion of dialectic rather more than the descriptions given by the authors cited above, then explains the specific features of soft systems methodology and one form of inquiry process consists of three dialectics. In dialectic, soft systems methodology alternates between two forms of activity, using one to refine the other.

It must be stressed that, it is typical for each cycle in soft systems methodology to take place several times. A better understanding develops through these iterations. If there is a mismatch between the two poles of dialectic, this leads to a more in-depth examination of what is not understood. Continuing uncertainty or ambiguity at any stage may trigger a return to an earlier stage.

Checkland calls them root definitions and further pointed out that, Systems models help to suggest ways in which the different goals of the studied system can be achieved and described this as a seven-step process, which are: the problem unstructured; the problem expressed; root definitions of relevant systems; conceptual models; compare the expressed problem to the conceptual models; feasible and desirable change; and action to improve the problem situation.

In summary, soft systems methodology is well suited to the analysis of information systems and has been used it to evaluate training schemes (Reville, 1989). It seems also to lend itself to the analysis of decision-making systems generally. The next subsection deals with a more generic methodology: '*evaluation*'.

2.3.4 Evaluation Approach

Patton's approach to evaluation is not a single methodology, there is probably far more written on evaluation alone than on all (other) action research methodologies combined (Patton, 1990). The approaches vary from those which are very positivist in their orientation (Suchman, 1967) to those which are explicitly and deliberately anti-positivist (Guba, 1989a). When people have to deal with the complexities of reality, the change in methodology over time has been mostly from positivism to action research and from quantitative to qualitative. .

There is a sense in which the distinction between evaluation and some other processes is artificial. If you are working within an action research framework then appropriate diagnostic methods can be used for evaluation. So can appropriate evaluation methods be used for diagnosis? In both instances the situation is analyzed with a view to bringing about change. Reville used soft systems methodology successfully as an evaluation tool while (Bish, 1992) used a general AR Approach for evaluation of a fourth year university course.

Abundant justifications for use of evaluation were (Patton, 1990) and (Guba, 1990), (Lincoln, 1981); (Lincoln, 1985). Of the two, Guba provided the more detailed description of how evaluation can be done. The approach is also a little more carefully argued, though too polemical to be used carelessly and it is briefly described below as follows using the Snyder evaluation approach:

2.3.4.1. Snyder evaluation Approach

The Snyder "*model*" consists of a *content model based on systems concepts and a number of processes*. The content model has inputs (known as resources), transformations (activities), and three levels of outputs: *immediate effects, targets, and ideals* as follows:

- The process allows the researcher to address three forms of evaluation in sequence. Process evaluation helps the researcher and the clients to understand how resources and activities accomplish immediate effects, targets and ideals.
- Outcome evaluation uses this understanding to develop performance indicators and use them to estimate the effectiveness of the system. Short-cycle evaluation sets up feedback mechanisms to allow the system members to continue to improve the system over time.

If done participative the process component leads to immediate improvement of the system. As the participants develop a better understanding of the system they change their behavior to make use of that understanding. The outcome component can be used to develop performance indicators. The short-cycle component in effect creates a self-improving system by setting up better feedback mechanisms. It can be thought of it as a qualitative alternative to total quality management. The next section discusses the application of AR methodology in the development of the implied innovative curriculum for PHC Practitioners in child and adolescent mental health.

2.4 APPLICATION OF AR TO CURRICULUM DEVELOPMENT

The process so far used to commence the development of the implied innovative curriculum as clearly specified in the title of the study has applied Participatory Action Research methodology. This methodology has effectively enabled the researcher and his team to get to the community and involved them through their active participation and explored their perceptions and understandings about mental health problems of children and adolescents. The drawn information was crucial as baseline data for the commencement of the process to develop the implied curriculum for Practitioners in child and adolescent mental health.

It was decided that the study takes a co-operatively-based action research approach to develop an innovative curriculum for PHC practitioners in child and adolescent mental health based on the perceptions and understandings of the community and PHC

practitioners in their practice areas. We hope to develop a model based upon our experience which will be transferable to other curriculum development initiatives.

It is the view of the researcher that action research in professional education practice is an important source of learning for practitioners. The researcher argues and hopes to show that an action research approach to teaching can be used to improve teaching and learning practice as well.

Action research for instance has been used in many areas of complex social situations and has been sought in order to improve the quality of life. Among these are industrial, health and community work settings. Kurt Lewin, often cited as the originator of action research (McKernan, 1991), used the methodology in his work with people affected by post-war social problems. Action research approaches to educational research were adopted in the late 60s and early 70s by the 'teacher- researcher' movement in the secondary education sector. This sought to bring the practicing classroom teacher into the research process as the most effective person to identify problems and to find solutions.

The researcher has a strong conviction that an action research approach can contribute very positively to activity within the professional sector practice education concerned with teaching quality issues. As "*reflective practitioners*" (Schein, 1985), the researcher believes that a lot can be achieved with greater ownership of the evaluative process by becoming systematically self-assessing, alongside, and feeding into, external assessment processes

Through systematic, controlled action research, professional practice teachers can become more professional, more interested in pedagogical aspects of higher education and more motivated to integrate their research and teaching interests in a holistic way. This, in turn, could lead to greater job satisfaction, better academic programmes, improvement of student learning and practitioner's insights and contributions to the advancement of knowledge in higher education. (Zuber-Skerritt, 1982)

Despite progress in understanding of the way in which people learn and the design of learning environments, teaching practice in professional practice education often remains

unaffected. Traditionally, lecturers have not been encouraged to draw upon theoretical developments as a means of improving curriculum design and delivery. However, more recently, a number of initiatives at national and local levels have been established to create the conditions for innovation in these activities, and teaching/learning is becoming recognized as a more valid area of enquiry for academics across all disciplines, rather than as the unique preserve of specialists.

Action research methodology offers a systematic approach to introducing innovations in teaching and learning. It seeks to do this by putting the teacher in the dual role of producer of educational theory, and user of that theory. This is both a way of producing knowledge about higher education learning and teaching, and a powerful way of improving learning and teaching practice. No separation need be made between the design and delivery of teaching, and the process of researching these activities, thereby bringing theory and practice closer together.

To show that this study needed the application of AR, it is worthy of note that, a variety of forms of action research have evolved (Carr, 1986). All adopt a methodical, iterative approach embracing problem identification, action planning, implementation, evaluation, and reflection. The insights gained from the initial cycle feed into planning of the second cycle, for which the action plan is modified and the research process repeated.

Kolb extended this model to offer a conception of the action research cycle as a learning process, whereby people learn and create knowledge by critically reflecting upon their own actions and experiences, forming abstract concepts, and testing the implications of these concepts in new situations (Kolb, 1984). Practitioners can create their own knowledge and understanding of a situation and act upon it, thereby improving practice and advancing knowledge in the field. According to Zuber-Skerritt, she argues that, action research has a number of further distinctive features (Zuber-Skerritt, 1982), and described these features in Action Research as '*Critical collaborative enquiry*' by reflective practitioners who are:

- Accountable in making the results of their enquiry public

- Self-evaluative in their practice
- Engaged in participative problem-solving
- Continuing professional development.

According to this view, action research is critical in the sense that practitioners not only look for ways to improve their practice within the various constraints of the situation in which they are working, but are also critical change agents of those constraints, and of themselves. It is reflective in that participants analyze and develop concepts and theories about their experiences. Action researchers are accountable in that they aim to make their learning process and its results public, both to each other and to other interested practitioners, using accessible terminology.

Their practice is self-evaluated in that the reflective and analytical insights of the researcher- practitioners themselves form the basis of the developmental process. Action research is participative in that those involved contribute equally to the inquiry, and collaborative in that the researcher is not an expert doing research from an external perspective, but a partner working with and for those affected by the problem and the way in which it is tackled.

Once the proposed curriculum has been designed and developed, It will seek to address two major objectives in both pre-service training and ‘INSET’ education: firstly,

- To enable students to learn child and adolescent mental health in their respective programmes by the application of various innovative facilitative methods; and secondly.
- To facilitate the development of transferable skills. It has long been recognized that traditional teaching techniques often fail to encourage innovative learning of subject content, which goes beyond short-term rote memorization to enable the assimilation of new knowledge in a way which allows re-application to novel situations (Entwhistle, 1988).

Strategies to develop transferable skills in areas such as thinking and learning, self-management, communication, group work and information management, are intended to

prepare the practitioners for work outside of the general clinical work contexts in which they learned initially.

The teaching strategy we have decided upon uses experiential and constructivist learning principles (Duffy, 1992) (Kolb, 1984); For much of the curriculum, practitioners will be engaged in group-based collaborative project activities. A major issue the team as action researchers will be to come to an understanding of the nature and level of support required by students to gain the most from their learning activities.

A number of features were decided of the way the planned curriculum would be developed and this decision marked the approach that will be applied as being action research related, with following features or criterion: The aim in respect of the curriculum to be developed is to apply the curriculum model offered by the action research cycle, which is the PRISMS Curriculum Model (Bligh, 1986). This Model combines the SPICES approaches (Harden, 1984) and the SYMBIOTIC Curriculum model (Bligh, 1986) approaches respectively.

Although the development of the curriculum has not yet commenced, it is coming up later within the context following the action research cycle illustrated earlier. It is hoped that, given already the baseline data from the community about perceptions of the community about mental health problems of the children and adolescents.

The team that will work on developing the curriculum will: identify a number of objectives and form initial working hypotheses about meeting them. The researcher asserts that it will be necessary to encourage maximum student ownership of the learning process. In addition, agree on the planned curriculum model with identified contents and materials as well as the processes to support it.

For instance, a key feature of such a curriculum model will be students' engagement in collaborative group project work. Materials and processes to support it which may include process workbooks and learning diaries for individual work, process workshops to support positive group functioning, and on-line facilitator support.

These decisions and resources will have to be put into practice by running the curriculum. The curriculum will be based upon balanced structure of theory and practice but will be highly interactive on situations and problems. The main form of assessment will be project based work assignment and course work (the group project), supplemented by individually-produced learning diaries.

The facilitators of such an innovative curriculum should be able to put some mechanism to ensure that observations on the facilitators' practice of teaching are evaluated and its effects. Evaluation and self-assessment strategies may include a range of on-going student feedback mechanisms and facilitator debriefings. The facilitators shall be able with training to reflect upon the results of the evaluation, in preparation for modifying their practice for the second implementation of the curriculum.

It was intended right from the start the study that the inquiry be critical in spirit and purpose. The researcher believed that it was useful for our development to perceive ourselves as a "critical community" of practitioners who not only want to improve the quality of teaching and learning in professional education within the constraints and practical considerations imposed upon us, but who also seek to be change agents of those constraints. For instance, assessment by examination is traditionally imposed we anticipate and hope that its outcomes will justify the future elimination of this form of assessment in future implementation.

From a hypothetical perspective, it was agreed during the preparatory stage of the study particularly during the search conference that we would aim to be reflective and self-evaluating throughout the stages of the study and during the curriculum development phase as well.

Insights gained from reflection and analysis of our practice will be fed back into practice. There will be continuous re-assessment of the curriculum and its structure. Built into the curriculum are mechanisms which remind and encourage us to reflect systematically on our activities. For instance, as educators, we keep a collaborative on-line 'tutor diary' in which we share our reflections on teaching performance, content, course structure,

student response, etc., relating them to prior experience and to teaching/learning theory. Individual experience will be made available between colleagues for comment and analysis, and we will attempt to challenge as well as support each other. This semi-public sharing of experience will create a mutually respectful, collaborative approach to our personal professional development.

We intend to make public the results of our evaluation, and the process by which it was achieved, both locally and more widely, as we will be engaged in participative problem-solving such that those doing the research and those doing the teaching will be one and the same. No external evaluators to assess the curriculum will be employed; rather, the team will work together to put the data during its development and implementation which will then be analyzed collectively, taking account of the point of view of each of team member. The reporting of the curriculum development milestones will similarly embrace all points of view, and reports will be jointly written.

2.5 CONCLUSION OF CHAPTER

Many models of action research describe a single process that combines action and research as one process in a single project. These models often require high resource levels, including large amounts of time from skilled participants. The Model applied for this study illustrates a way action and research as separate processes in a single project can be combined. This model of practical action research is especially relevant to situations in which few resources are available to meet high levels of need. In this model, the important point of contact between action and research is the situation analysis, which leads to formulation, or re-examination of action aims and research questions.

The clear distinction between action aims and research questions is borrowed from operations research. This study borrowed and utilized various aspects of AR from the same models/paradigms whose roots are applied in the organizational context as well as other contexts. Action research as is the term is true to label tracks action and research

outcomes. It is most effective when the end result emerges from the data. The conclusions drawn are data-based, preferably drawing the data from multiple sources. The conclusions emerge slowly over the course of the study. At each cycle the researchers challenge the emerging conclusions by strongly pursuing disconfirming evidence.

Many researchers point out the intrinsically political nature of AR and state that participation in AR is empowerment and empowerment in itself is politics. It is also stated that it is very difficult for AR to fully extricate itself from the researcher-community relationship because in itself, affects local power dynamics. Community participation in such a context should be recognized for what it is, as an externally motivated political act (Chambers, 1981).

Summing up the contextual issues about AR it can be concluded that AR is a method for yielding simultaneous action and research outcomes. It is able to do this because it adapts to the situation. To achieve adequate rigor it does this within a reflective spiral. Each turn of the spiral integrates theory and practice, understanding and action, and informs the next turn.

Because it is intervention and research, it draws upon intervention procedures and research procedures. It is usually participative and entry and contracting the community are important. It is a counter-cultural research paradigm. It requires to be justified carefully to the community and other key players in the study particularly before the study itself, for instance, it requires careful explanation of: the need for the study and the actual methods to be used to collect and interpret data.

Therefore, attending to the rigor of the research methods, this can be done by: using a cyclic approach, with each cycle involving data collection, interpretation, and literature search; and as far as possible working at any time with two or more sources of information ("*dialectic*"); as well as testing interpretations strictly by searching out exceptions to the explanations, and explanations of the ambiguities.

CHAPTER: THREE

CURRICULUM DEVELOPMENT

3.1 Introduction

In chapter two, action research was discussed in the application of data collection from Practitioners and the community through their active involvement and collaboration. It was also established that through PAR it was possible to collect data by exploring perceptions and understandings of the PHC practitioners and the community about mental health problems of children and adolescents.

It was noted that a number of researchers have different notions about the concept and definition of action research as well as its characteristics in a diverse environment. The chapter concluded on the aspect of the applicability of AR to curriculum development.

This section discusses curriculum development in general and innovative curricula approaches in education and models of curriculum development in particular as well as teaching and learning strategies. In addition, the chapter also gives brief historical background of curriculum development across continents and Africa in particular. This information is important because there must be records to show that a lot has been happening in the field of curriculum development efforts especially with African governments who changed from colonial system of education to their own underpinned by their own philosophies of governance which had effects on the system of education to date.

The coming of innovative curricula and teaching/learning should be good news us all; we are now seeing remarkable dispensations in the art of facilitating teaching and learning in some educational institutions. Teaching and learning as an example, in this modern era are also quickly replacing the traditional methods which were characterized by straight lectures, large group demonstrations and apprenticeships (Harden, 1984), (Mutema,

1990). It is against this background that the current knowledge revolution requires innovative educational methods in the training of professionals of whatever professional practice that it may be. The current emphasis is to place the learner at the center of the learning process. This emphasis shifts the responsibility of teaching and learning from the teacher to the learner (Harden, 1984), (Bligh, 1986), and. (Abbatt, 1980),

In view of this, it is as well important to reveal that, the growing need for new and effective approaches was recognized by education in the field of basic and secondary education decades ago particularly in the various African governments with histories emanating from the colonial system of education where the decision and control of education was in the hands of the colonial masters who aimed at serving their own interest, destiny and philosophy. These calls were made to change curricula to make them more practical and relevant to the needs of the people of those governments (Mutema, 1990).

The encouraging development at present is the recent recognition by some educators of the need for innovative education in institutions of higher learning particularly in the training of health professionals. The main emphasis of the innovative teaching methods is to place the student at the center of the teaching/learning process and to place the burden and responsibility for learning on the learner (Harden, 1984). The other major emphasis is to avoid rote-learning and to develop problem-solving and life-long learning skills for the learner; in short, teaching the learner how to learn, (Stern, 2002) , but the *hard core* traditional educators who thrived in preparing lesson plans and then lecturing for hours to passive students find it difficult to change. They ask,

“Why do we need new teaching and learning methods now, whereas we seem to have been doing well with lectures, practical demonstrations and apprenticeships for centuries?”

Some traditional educators who are responsible for training health professionals complain louder than all other educators, they ask,

“why do health workers have to contend with the burden of how to learn besides the heavy burden of the immense subject matter of the various courses they to take?” (Mutema, 1990).

These questions and others sum up the problem and the need for innovative education especially for health professionals who are involved in the field of training and development. In view of this, this section which follows, discusses curriculum development in general and innovative curricula approaches and models in particular as well as teaching and learning strategies, but first, the focus on the following section is the review of relevant literature.

3.2 LITERATURE REVIEW

3.2.1 Concept and Definition of Curriculum

The debate and controversy about curriculum began with the views about the definition and the concept of the term curriculum itself. (Tyler, 1949) who is considered as the founding father of the objectives models, conceived and understood curriculum as product, with his four seminal questions which are: purpose of education, educational experiences required, methods and techniques, and assessment. The Tylerian curricula models represent a number of curricula whose conceptual underpinnings are based on objectives, regardless of their heavy criticisms. The roots of these curricula models are in the behavioral psychology and philosophy of education.

A number of authors perceived curriculum as: a concept, product and process, as well as a communication channel (Stenhouse, 1975), as an official course of study, Tomkins in (Goodson, 1993.), as intended outcomes (Griffin, 1983), as social valued knowledge (Bell, 1993), and as an ongoing activity between teachers and learners (Cornbleth, 1990) (Jackson, 1968).

The process of curriculum conception continued with many more other authors such as (Fraser, 1993), who advanced their views and conceptions about curriculum as; a plan (Salfer, 1981); (Stenhouse, 1975): as practice (Stenhouse, 1975): and as hidden (Kelly, 1982); while, (Postman and 1971): considered Curriculum as an ideology (Ashley, 1989)

and (Christie, 1992), (Taba, 1962) and produced a model for the education of professional Practitioners in any practice field areas and pointed out main features of any curriculum, which must include a programme of evaluation of the outcomes (Taba, 1962): & (Bligh, 1995) in which there can be a varied number of curriculum group of actors/players

The conception of curriculum was revisited around three broad views of understanding (Kelly, 1989) and pointed out that: When curriculum is seen primarily as to do with *content*, then education and training are seen primarily as a process of transmission: When curriculum is seen primarily as to do with *process*, then education and training are seen primarily as development: When curriculum is seen primarily as to do with *product*, then education and training are seen primarily as instrumental towards that achievement. He suggested that, it is necessary to distinguish the use of the word curriculum to denote the content of a particular subject or area of study from the use of it to refer to the total programme of an educational institution

(Shirley, 1987) in her important work of curriculum also understood and viewed curriculum in the context of it as product or praxis and described the fundamentals of praxis as action and reflection with propositions which stress that:

“Praxis takes place in the real, not an imaginary or hypothetical world; The reality in which praxis takes place is a world of interaction, social or cultural world; The world of praxis is the constructed not the natural world; and Praxis assumes a process of meaning making, but it is recognized that the meaning is socially constructed, not absolute.”

The views of (Shirley, 1987) were that curriculum was not a concept but a cultural construction. The praxis approach, viewed by (Shirley, 1987), is more appealing and in line with the plans around which this curriculum will be designed including the approach because its development is competence based, stresses on performance, and in many respects resembles action research cycles applied in the study.

Drawing from these views about curriculum conceptions and controversies, this study too viewed and construed curriculum as a social construct and ideology, written as an intended plan and process, derived as a social construct of the community from which it was conceived, based on their choices, and these choices reflected the values and beliefs of key community groups in the society (Young, 1976).

With the aforesaid views, this innovative curriculum to be developed will draw its conceptions from the systems and ecological perspectives that view curriculum from the constructivist view in which the community constructed their views of curriculum from their own perspectives particularly the perceptions and understandings of mental health problems of children and adolescents perceived from their own setting. The following section examines various views of the curriculum from the constructivist perspective and makes connections with the planned innovative curriculum.

3.2.2 Constructivist's view of curriculum perspective

Views about curriculum are diverse and influence the choices and decisions we make about which curriculum paradigm to adopt. Among the choices and decisions are those views based on clear conceptions about education ideologies on which curricula are based. The choices may include those streams from educational philosophy which underpin the choices and decisions from either conservative or progressive and radical view perspectives.

How we conceive of curriculum and making curriculum is important. He believes that our conceptions and ways of reasoning about curriculum reflect and shape how we think, discuss, learn and respond on the education available to learners. Cornbleth further argues that our curriculum conceptions, ways of reasoning and practice cannot be value free or neutral. He sums up by stating that conceptions about curriculum reflect our assumptions about the world, even though such assumptions may not be validated.

Further views about curriculum were advanced by (Young, 1976) these came about as a result of choices that are made which reflect the values and beliefs of key community groups in the society at a particular time. His views are in line with the purpose of this study, which asserts that *knowledge is a social construct*, hence views curriculum from a social construct point of view This view of concept is rooted in the work of Piaget (cognitive constructivist) and Vygotsky, a social constructivist (Gouws, 1998) who believed that *knowledge is made in a social context and is shared with others*, rather than being represented solely in the mind of an individual.

Referring to John Dewey's pragmatic view of knowledge which has been founded on the premise which is subject to constant change and modification, Dewey, believed that to acquire knowledge, children should have the experiences which they can use as a framework to explain and gain control of the environment in which they live (Kelly, 1989). One other ideology additional to the social construct of this study and consequently on PHC practitioners' education is the principle of liberalism, which has its roots in a free society. This principle focuses on the optimal development of independent thought; shift from teacher-centeredness to learner-centeredness ((Harden, 1984); (Bligh, 1986) lays emphasis on open-ended, inquiry-based and interactive education along with development of self-discipline.

Against this background, the view by the researcher is that people who draw curriculum have different understandings or assumptions about the nature of knowledge hence, in this particular study, the involvement of the Practitioners and the Community was critical because it will characterize the kind of curriculum that will emerge. The concept of integration of knowledge as opposed to disciplinary knowledge was the essence of "classification" of knowledge in the study (Bernstein, 1996) to see the emerging knowledge collected from the community and Practitioners.

It was also the assumption of the researcher that, the graduates that will follow this innovative curriculum model will be PHC practitioners with values, characteristics and qualities that will equip them for work. They will be practitioners who will embody a

new set of values appropriate to working with partners and society, proactive enough, creative and critical in thinking but informed by research and endowed with multi-disciplined communication.

Bernstein (1971) on curriculum and social control followed up the link between social/community relationships, the structure of communication, (which include the curriculum) and the awareness and identity of people (community). He understood the curriculum as; how the community selects, classifies, distributes, transmits and evaluates the educational knowledge it considers to be public, reflect both the distribution of power and the key of social control.

Gwele (2005) writing from experience in nursing education, discerns three educational approaches, which are: Content-based, Process-based and Outcomes-based, based on different uses and understandings of knowledge. Gwele notes that, even though the approaches can be classified in that way, how the actual teaching and learning happens is likely to be differently understood in different contexts. The context in which the curriculum is practiced determines which approach dominates.

Gwele (2005) further comments that with regard to the underlying philosophy of the outcomes approach, it is the nature of the outcomes that determines whether the curriculum is techno-behavioral, behavioral and growth-based. Gwele sums up her argument in a table to show that the three curriculum approaches she has described each may have advantages and disadvantages for nursing education.

In this study the implications for designing and developing the PHC practitioners' curriculum is underpinned by the practice that change of the education of PHC practitioners will always be politically and socially driven. Professional regulatory bodies and associations have dominated and will continue dominating the state of art of the professions and the direction of the practitioners' education. The issue of curriculum innovation has always been the responsibility of the various training institutions; however the situation in the Zambian context is different. The inspectorate and nursing secretariat

of the council determines and oversees all nursing curricula in the country. Training institutions work along with the council on all matters of curricula development.

The design and development of the innovative curricula once commenced will be based on the perceptions and understandings of the community and practitioners. This will be in cognizance of various curricula approaches which are: *content driven, process-driven and outcomes-based*. All these three approaches assert to the view that; *content, process and outcome* are key paradigms to curriculum development. While content based curriculum approach is the most widely used approach in curriculum development even in PHC practitioners' education in Zambia, its focus is merely the listing of subject contents to be taught starting from foundational course and upwards.

Zambia like many other countries had adopted the objective (Tylerian) based education system and curriculum planning whether at professional practice level or general educational level, all learning and teaching were designed along the outcomes-based models and to date a lot of the institutions still use the objective curriculum models. The following section, amplifies these models in more details.

3.2.3 Historical Background of Innovative Curriculum

Mutema and colleagues give a historical account of innovative curriculum and state that, in the mid 70's many countries around the world had developed centers in the faculties of health and medical schools with the growing recognition that a body of education and / or science needed to be understood by teachers of medical and allied professions (Mutema, 1990). It was increasingly noted that by training teachers of medical and allied professionals in educational methodology, the overall results were satisfying and rewarding. Specifically it was noted that modern medical education calls for teaching and testing beyond rote memorization of facts and that training should be done for:

- Understanding of knowledge

- Application of knowledge
- Individual performance in realistic situations

As far back as 1951, a World Health Organization (WHO) committee had made mention of the need for medical education. The first medical education to meet the need for trainers familiar with appropriate educational methodologies was launched in the University of Illinois WHO center in 1959. In 1970 WHO began comprehensive coordinated long term programmes for trainers of health professionals. In the same year an agreement was signed and WHO set up some centers for teachers of medical and allied professionals after establishing the Illinois Center, there was a proliferation of centers of educational development for health professionals especially during the period 1971-1973. The following centers were established during this period:

- For English speaking countries – WHO Regional Teacher Training Center (WHO – RTTS) at Makerere University, in Uganda.
- For French Speaking counties –WHO Regional Training Center at the University Center, Younde, Cameroon.
- For Americas – WHO – RTTC in Mexico, and Rio De Janeiro, Brazil.
- For Eastern Mediterranean, at Pahlari University.
- For Western Pacific – University of New South Wales in Sydney, Australia.

Innovative medical education has been developed in response to dissatisfaction of public and health professionals with results of traditional medical education. Innovative strategies were early used by the Greeks-in what were called the dialogue and questioning method (Plato) (Chamberlin, 1889) advocated for “Multiple-making hypothesis, “but (Dewey, 1929) and (Piaget, 1969) had actually demonstrated the ineffectiveness of providing readymade solutions to learners.

(Fraser, 1993) and (Brunner, 1961 1) demonstrated how problems may be used in education. Recently (Cyert, 1990) pointed out that “All professionals are problem solvers and should be taught problem-solving processes”. Brunner is the main proponent of

discovery learning which an important aspect of problem is based learning (PBL). Frazer founded the case study method in which a case contained the facts, opinions and expectations needed to trigger off and feed a process of learning.

In 1961, the application of the problem solving approach to the whole medical curriculum was started by Ham and associates at Case Western University, Cleveland Ohio, USA, in Hematology course. The results of a comparison between students taught in the didactic method and those taught in innovative way (PBL), student directed learning showed the later to be superior in examination scores.

In 1969, Howard Barrows in McMaster University in Ontario, Canada established the first problem solving curriculum. The approach they developed was the PBL approach. This method resembled both discovery learning and the case study method. In 1974, the University of Maastricht became the first European medical school to start an innovative medical education programme, problem-based learning (PBL). The other well known Universities to launch medical education programmes include:

- New Castle Medical School, Australia, 1979.
- Suez Canal University, Faculty of Medicine, Egypt, 1982.

World Health Organization (WHO) has contributed generally to the establishment of innovative medical education programmes. It supported the establishment of a network of community oriented educational institutions for health sciences in 1979. By the early 1990's, it is notable that more than 50 institutions, became members of the network. By mid 1990's, more than 90 countries had signed up as collaborating members in PBL. These countries include those in the African continent as well such as East and Southern Africa.

The notion however, by the SA department of education and science that, at the heart of an educational development process, lie the child, no advances in policy, no acquisition of technology can have the desired effect unless they are in harmony with the nature of the child, and unless they are fundamentally acceptable, is precisely the essence of this

study with focus on perceptions and understandings of the community and practitioners about mental health problems of children and adolescents in Zambia.

Developing an innovative curriculum is therefore, an educational change process; it is a complex phenomenon and involves a chain of events over time leading from policy, to local context and integration of policy, to training before such intervention can hope to have any impact on patient care through trained Practitioners (Hopkins, 1994).

This notion also suggests that the development of a curriculum plan or policy is only the first step in the complex process of innovation in professional educational change (Hopkins, 1994). Innovation, whatever form it may take, tends to show itself in organizations as incremental change (gradual and subtle transition from one state to another) and planned change (seeks to interrupt the status quo and establish a new way of doing things). This point is significant in the context of this study because it is in line with the basis around which the planned innovative curriculum process is underpinned.

3.2.4 Curriculum Development Approaches

There are a number of curriculum approaches in literature, but the most important aspect is to determine whether that approach is SPICES or Traditional. (Mutema, 1990), (Harden, 1986). The SPICES method is basically an approach which represents the innovative curriculum models and is now commonly used in most innovative schools for planning purposes of curricula especially in Medical Education and other health professional educational programmes.

One's approach to educating learners involves much more than selecting the curriculum. It involves deciding on what type of approach to be used to facilitate each course and /or subject. There are varieties of approaches and at times they can be at odds with each other on curriculum development. In this section, approaches relevant to health professional education or medical education are explained to facilitate in deciding which

approach is most appropriate and relevant for a particular institution. The following are the approaches briefly described.

3.2.4.1 Outcomes-Based Curriculum Approach

This Curriculum Approach also referred to as the Product Based Curriculum Approach is a result of several years of reworking of the objectives approach to both curriculum and facilitation of learning. Some of this reworking has been in response to the criticisms of the behavioral objectives which on one hand, focused on competence. It is important to note that competence recognizes that performance is underpinned not only by skill but also by knowledge and understanding.

It involves both the ability to perform in a given context and the ability to transfer knowledge to new tasks and situations. Outcomes on the other hand, are broader than strictly defined behavioral objectives in that they describe non-observable internal changes in the learner as well as observable behavior. Therefore, competency based curriculum approach is closely linked to the objectives curriculum approach.

The Outcomes Based Curriculum Approach is also referred to as Product Based Curriculum Approach. This curriculum model ignores the different conditions and context which exist within each Training Institutional context and adopts a model of central development and planned dissemination with planned top-down strategies in approach and assumes that change is linear and motivated by authority.

The model also assumes that the process of innovation is planned and prepared in fine detail prior to its implementation. The underlying educational philosophy underpinning this approach is Reconstructionism in which methodological processes are underpinned (Gwele, 2005), (Kilgour, 1995), (Welman, 2002), (Tyler, 1949), and (Tanner, 1995). This model operates on critical curriculum theory premise, Henry Giroux in (Slattery, 1995).

The purpose of education is reconstruction of the social order through critical understanding of social, political and economic determinants of, example, health and disease, (Giroux, 1988), (Stern, 2002). The other critical aspect of this model is fostering commitment to collective reflection and action for change (21st Century Schools, 2004), Kinchelle and Pinar in (Slattery, 1995), (Freire, 1972). Achievement of transformative work related outcomes such as competencies for both individual and societal survival marks the characteristic of this approach (Tanner, 1995).

This curricula model belongs to the traditional Tylerian Curriculum models which believe in product as the ultimate for any curriculum programme (Tyler, 1949). These same curricula models are sometimes referred to as the objectives curricula models. However, recently a number of innovative curriculum models have emerged on the scene within the medical field and also within other professional practice disciplines.

The curriculum focuses on social, political and economic issues (Dewey, 1916), Habermas, in (Slattery, 1995), (Beyer, 1986) affecting the community. Social reconstruction is the core of the approach as an educational health promotion strategy. Suffice to say, the nature and the role of the educator is one of a consciousness raiser and a critical mediator of knowledge (Mason, 2000) through creating avenues and opportunities for critical reflection and action, cited in (Slattery, 1995). The nature and role of the learner is one in which he/she views himself or herself as a social and psychological being within the community setup (Freire, 1972).

Their role in the teaching-learning process is questioning the status quo such as questioning and reflection on issues which they find themselves in. The facilitation strategies include issue/problem based learning with emphasis on a preference for socio-cultural approaches to mediated action. Further methods such as debates, Socratic questioning, simulations and conversations are the methodologies of choice.

The formulation of the Tylerian rationale to curriculum development was tightened and placed in a wider social context (Goodlad, 1966) and explicit relationship of curriculum

decisions to sources of knowledge in society (Goodlad, 1966) Lamer and Badenhorst, supported by Hilda Taba., provided a further elaboration of the Tylerian model in an attempt to cope with the complexity and untidiness of curriculum, by specifying Tyler's approach to curriculum and improving it with the four seminal (influential) questions (Lemmer, 1997), (Taba, 1999) .

These four seminal questions which are: purpose of education, educational experiences required, methods and techniques, and assessment have influenced a number of teaching and learning strategies in course design, curriculum design and lesson plans. (Wheeler, 1967) added a further improvement to the Tylerian model with a basic curriculum design model comprising five stages as; goals, intermediate goals, proximate goals and specific goals at classroom level. Wheeler noted that, such an elaboration provided the direction for selection of content, methods and assessment as in the Bloom's taxonomy of cognitive educational objectives as well as in (Kerr, 1968) where traces of Bloom's tradition are seen in a curriculum model which offers objectives, knowledge, learning experiences and evaluation as prominent components.

However, (Kerr, 1968) strong advocate of the objectives model supported content-based curriculum approach with focus on pre-specification of objectives and competencies desired in advance. He did not favor the strict starting with objectives instead, proposed starting with a content-based approach, and reinforced it by adding the Bloom's taxonomy of the educational objectives in order to improve objectives definition, teaching content and assessment. A number of authors argued against pre-specifying objectives. They believed that end products produced by students should not be specified before hand in terms of behavior (Eisner, 1994).

This argument stressed the need in the objectives model to focus attention on the content as a basis for designing and developing the objectives, which would culminate into a situation, in which the starting point would be objectives (Goodlad, 1966). The teacher according to them is the focus of the process and hence developed a technological approach to curriculum development in which emphasis was on the psychomotor skills,

which would be demonstrated with pre-specified ends as well as emphasis on solving practical problems and technologies.

The conventional/Tylerian traditional model of curriculum is based on teacher-centered learning model in which the teacher is the key figure and there is emphasis on activities such as the formal lecture and the formal laboratory. Individual students have little control over what they learn, the order in which they learn things and the method they have to use including the learning itself tend to be more passive than active (Millville, 1982).

This curricula approach forgets one important aspect of education that, what matters is what the students learn, not what the teacher teaches. The approach and its subsequent strategies do not support students to be active learners for their long life education. The planned innovative curriculum model is different from the old one where educational methods of teaching and learning in mental health and general PHC practitioners' training were traditionally, prepared for the old model of healthcare for clinicians/practitioners (Watson, 1999). This type of curriculum delivers theory first, using a didactic approach, with subsequent practical experiences and students were assessed by examinations that relied heavily on memory.

The current Zambia traditional medical curricula in mental health still prepare practitioners for the old model of healthcare (Watson, 1999). This type of curriculum delivers theory first, using a didactic approach, followed by practical experience. This practice, with a rapidly expanding technology in medical education and practice means, it has become unrealistic and even in humane to expect students to assimilate the whole range of medical science (Sadlo, 1994:372).

In addition, the current traditional curricula worldwide is being criticized for being too reductionist, as every situation that confronts the practitioner in their practice is unique and different from one another (Schon, 1983). Thus, a recipe book approach to treating patients does not hold any longer and such an approach has limited effectiveness to

reality of practice hence the preference for innovative strategies such as the PBL method (Sadlo, 1994).

Similarly, the current traditional didactic style of medical education in mental health is still consistent with the transmission metaphor of learning consistent with the Tylerian educational tradition. Control of the teaching-learning process is still with the lecturers, who analyze the propositional knowledge requirements, determine its structure and hierarchy, and then deliver it to the students as theoretical abstractions/concepts.

3.2.4.2.1 Conclusion to the section on Outcomes-Based Curriculum Approach

In the context of this study, this model demonstrates that there is an allowance of flexibility route of learning which ensures that, certain skills levels in participants increase motivation since relevance is immediately observable. It also bridges the gap between vocational and academic education. The curriculum usually allows for different pathways to the outcomes, and this allows for more individualization and contextualization. Learning outcomes are clear and evaluation is potentially more valid and reliable.

The Product-Based curricula according to this study appear to show that, they are authored to meet specific criteria regarding the application of experiential learning methods and usefulness to PHC practitioners. It means that the curricula for the PHC practitioners will be evaluated using a rigorous process which includes a review by the Medical Council and Nursing Council of Zambia.

The Product-Based curricula, demonstrates practical ways experiential learning can be used by the Health Professionals' Institutions to create and initiate innovative programming designs and techniques for professional practice services, using the most Cost effective and least intrusive methods possible. It also links to several other sites that are beneficial in gaining a clearer understanding of how and why experiential learning is

beneficial. Finally, the Product-Based curricula illustrate Kolb's model of experiential learning that is a four element cycle of:

1. Concrete experience
2. Reflective observation
3. Abstract conceptualization
4. Active experimentation

It is also important to state that, John Dewey is a great reference on the history of his life and his impact on experiential learning. However, the use of this approach demands that both teachers and learners learn new ways of working together but if the curriculum is not planned to be coherent, with different modules connected systematically, learning can be fragmented or even over-specialized, with broadening aspects of education neglected.

3.2.4.2 Content - Based Curriculum Approach

This approach to curriculum planning stresses “content” as the first or even the only consideration (Kelly, 1989). The starting point to planning a curriculum with this model is to ask the question “What should learners know?” and how should content be selected? The key point however to note in considering curriculum planning based on content is that those who argue for content differ as to precisely *what* content has to be studied. However, irrespective of the kind of content that is being promoted, the procedure for curriculum planning remains the same: specify the content first, and everything else falls in place

Having set up the argument above, it can be pointed out that the Content Based Curriculum Approach is rooted in the philosophies of essentialism and perennialism but more deeply rooted in the essentialist traditions of the conservative view of education in which idealism and realism feature prominently because of the concern about the importance of body and mind in education (Gaudelli, 2002: 666). It is built upon the

premise of competences required to do a job particularly and more so, in the health sector, it is the most widely used model in curriculum development for professional education including health, and has influenced the manner the health care professionals are trained.

The purpose of education is viewed as transmission of worthwhile bodies of information which contains truths for life (Hearne, 2001: 692), (Ernest, 1991) and (Tanner, 1995), and the curriculum comprises fundamental academic disciplines, such as those cores to PHC practitioners' education. The nature and role of the teacher: is one that is an expert in the discipline and must select, identify, organize and transmit worthwhile facts or knowledge to the learners. The role and nature of the learner is basically passive and willing recipient of information with facilitation process which is: teacher-centered, emphasizing on knowledge acquisition, using methodological approaches, with further emphasis on didactic teaching and demonstrations (Tanner, 1995).

It is still the most widely used approach in curriculum development even in PHC practitioners' education in Zambia. Its approach is based on merely starting the process of developing the curriculum by listing the contents to be taught and focus the building of the curriculum on foundational courses that build in a horizontal and vertical fashion. This model is highly traditional and uses the didactic methods in the presentation of the learning matter to the learners. The learners' role in the learning process is to assimilate the information which they must be examined and assessed at a particular stage in their training.

Competence Based Learning on the other hand, emphasizes performance of the learners in terms of knowledge, skills and attitudes, and is therefore an appropriate method for professional training. The competency-based curricula have been used in designing and developing educational programs in health professions for many years and Kenya, South Africa, Egypt, Sudan are some of the test cases in Africa where innovation in the field of medical education, nursing education and other health professional education have

moved well in the innovations of their training programmes and are in matching with the rest of the world.

This model has been found to be quite appropriate in Problem-Based Learning, students-centered, community-oriented and integrated programs. Against this background, Mutema et al and Harden described ten major steps that are critical in developing a competency-based curriculum particularly in health professions and suggest that the Process of developing Competency-Based Curricula in Health Professions be as follows:

- Step 1 Identification of health problems
- Step 2 Identification of professional roles and functions.
- Step 3 Performing Task Analysis on Professional roles and functions.
- Step 4 Development of educational Aims, Objectives/ Task Analysis.
- Step 5 Identification and selection of Subject matter/ Content to be learnt.
- Step 6 Identification of teaching/ Learning Methods.
- Step 7 Identification/ Selection of Learning resources.
- Step 8 Identification of Assessment Tools to determine learner performance.
- Step 9 Curriculum Implementation
- Step 10 Curriculum Review and Change.

Source: (Harden, 1986) and (Mutema, 1990)

The ASSET curriculum model for instance is a good example of the content-based curriculum model (Winter, 1996), it is specifically designed for professional practice education. It relies heavily on work based experiential learning within a well-defined competence based paradigm, sometimes it is also referred as competency-based education model of curriculum with mastery learning type of education (Krammer 1999), (Mutema, 1990), (Harden, 1986).

This model extends to the future and is based on partnerships with employers and increased involvements in community participation. The Accreditation and Support for

Specified Expertise (ASSET) model of curriculum is an operational conceptual framework that focuses on any professional education practice (Winter, 1996). The features of the ASSET model are;

- Competence statements derived through a process of 'functional analysis' in which groups of practitioners create a detailed description of their tasks/work.
- Portfolios of evidence presented not only in terms of detailed 'task of competences' but also in terms of a set of 'core' assessment criteria that portray in holistic terms the responsibilities and values of the professional role.
- Specific emphasis to the process of interpreting competence statements in individual candidate's varying practice context.
- 'Competence' is presented not simply in terms of practice evidence but also through analytical commentaries upon practice.
- Support for the development of portfolios of practice-derived material provided not simply by relations within the workplace and between candidates and educators but a series of group meetings of candidates.

The Asset model extends the standards and evidence foundation of the qualifications to include the lost vocabulary within higher education. The reflection, judgment, understanding and other higher than mere skills attributes considered missing (Barnett, 1994) are unified within the competence based programme (Winter, 1996), through the module action plan and assessed by a portfolio of evidence.

The action plan is developed by the learner and is informed by the required work place competence standards made from a number of competence elements: Core assessment criteria that express the holistic requirements of the professional role; and accredited prior learning Support from work based and academic tutors, trainers and peers. Here activity

is in context, reflectively supported and provides diverse evidence against previously verified criteria and standards. Autonomy is encouraged within a motivational atmosphere understanding and support.

3.2.4.2.1 Conclusion of Section on Content Based Curriculum Approach

The teacher in this curriculum model has control over what is to be taught as content. The organization of content is easier than in other models but only few competencies might be measured. Independent learning is not fostered since the curriculum is teacher-focused. Teaching becomes irrelevant as there is no direct link with practice and this can lead to over-teaching. Teaching further becomes boring, since it also takes much time and effort to change them.

3.2.4.3 Process Based Curricula Approach

The starting point for planning in this model is a concern with the nature of the learner and the environment in which the learning will take place for purposes of the learners' development, rather than a consideration of what knowledge should be transmitted or a statement of the results to be achieved (Kelly, 1989). The critical question the proponents of this model ask, is "What educational processes are important for the learners so that they can reach their full potential and develop autonomy?"

It can be seen from the outset that the underlying principles of this model are a value position, which places value on the individual's autonomy and this model is a clear departure from the rest of the other two models discussed above. The Process based curricula models therefore, takes cognizance of the environment in which the curriculum is developed as already alluded to and are concerned about developing a capacity for change within the institutional situation, rather than professionals adopting a new approach.

The underlying educational philosophy which underpins this approach is experientialism (Tanner, 1995) in which the purpose of education is based on the understanding of the world of one's professional practice area e.g. medicine and nursing as it relates to the world we live in. This approach attracts democratic participation in the professional policy issues including health policy (Dewey, 1961) and (Hickman, 1998).

The curriculum is based on exploitation of learners' experience of the world of their field practice (Novack, 1975) and (Dewey, 1897, 1961) e.g. Mental Health and such has to be within the context of the perceptions and understandings of that particular society and community as has been the case with this study. The educators' nature and role in the curriculum engineering process is that of mediating knowledge through questioning and facilitating as well as resource provider (Dewey, 1998), while the nature and role of the learner is that of learners viewing themselves as psychological and social beings with a natural need to make connections between their experiences and the world around them (Dewey, 1998). The teaching strategy is experience-based with emphasis on methodologies that promote active learning, problem-solving, cooperative and collaborative learning and experimentation (Dewey, 1998), (Novak, 1975).

The process based curriculum models draw their conceptual theories from the Outcomes Based Education (OBE) concept. It is believed that OBE has its roots in two educational approaches which are: competency-based education and mastery learning type of education (Krammer, 1999). Other authors mention other additional roots for OBE, for instance, clearly stated educational objectives (Tyler, 1949) and criterion-based assessment education (Van de Horst, 1997).

The process model was adopted to underpin the development of the curriculum in this study and was also based on a post-modernistic reconceptualization concept of curriculum (Pinar, 1976); (Kliebard, 1992); (Lytard, 1973); (Giroux, 1983); (Kozol, 1975); (Kincheloe, 1976); (Schubert, 1986), in which the baseline information was designed to inform the development of a new curriculum with focus on society and

events outside the individual for a satisfactory explanation (Elder, 1968), to which the children and adolescents must learn and conform, (Thomas, 1968b); (Brim, 1965).

There are several types of characteristics of innovations, the researcher found (Rogers, 1971) classification of characteristics most useful in the context of planning any innovations, among these characteristics include:

- *relative advantage*, in which the researcher ' examines the extent to which the innovation is seen as better than the idea or practice it is replacing;
- *Compatibility* in which the innovation is examined to what extent the change is compatible with existing values, past experiences and present needs of the practitioners and the community;
- *Trialability*, in which both the policy makers, educator/practitioners are able to try out the innovation on pilot before it is generalized nation-wide; and
- *Observability*, in which the results of the innovation can be motivating for both the practitioners/educators and community, especially if they can see that the results of the innovation are successful (Rogers, 1971).

These characteristics are very important, and in the opinion of the researcher, they appear to be good and appropriate measure when planning an innovation. Nonetheless, at global level perspective, new curricula models have been introduced in a number of innovative medical schools as well as nursing schools and some of these schools among many more are;

Kwazulu Natal Medical and Nursing School with PBL and Community Approach to Nursing Training, Eldoret and Moi Universities with SPICES Curriculum models, University of Zambia, School of Medicine and the PBN School of Nursing with PBL and the Department of Community Medicine with Community Based Education Approach,

Maastricht and McMaster Universities with their PBL Curricula Models, Negev Medical School with the Community Based Curriculum Model; Dundee medical school with the SPICES curriculum model (Harden, 1984), which influenced the inception of the PRISMS Model (Bligh, 2001) and the SYMBIOTIC model (Bligh, 2001), and the East Anglia University with the ASSET model (Winter, 1996), with its focus on enhancing professional practice performance skills.

3.2.4.3.1 Conclusion of Section on Process Based Curricula Approach

Teaching of various competencies using this model is in harmony with the scientific approach of the discipline, for instance, use of PBL, such as Problem-Solving in the Partnership. The difficulty with this approach is that it demands more time to prepare particularly if there is a large population of lecturers and students to manage the various elements of the curriculum.

3.2.5 Implications of the Approaches for Designing Curriculum

The immediate implication of these different approaches to curriculum development appears to suggest that indigenous philosophies governing individual professions have cohered with the overall philosophy of education and hence have influenced the development of curricula generally. It also translates that this study to develop a curriculum must be done under a working philosophy to underpin the study and must match with the planned curriculum innovation for development.

Change or innovation in which ever form it takes is always politically and socially driven and the curriculum that will be developed as a result of this study is not an exception. It will be under the scrutiny of Professional Associations and Regulatory Councils that have the mandate of the various professional groups because they will always have a dominant role and say in the direction of the curricula for their professional practitioners.

In the reality of practice, if any curricula innovation has to be a success story, it must have the mandate of the stake holders and the community as a whole. In addition, it also means that an appropriate and relevant curriculum must have the input of those that it is going to affect, in doing so; the curriculum developer will get the feelings and input of the learners to be.

It is not possible from the perspectives of the various curricula to simply adopt a single model of curriculum, from the lessons depicted from these various curricula models, a mixed or hybrid type of curriculum is the only way forward. It also appears that these innovative curriculum movements have come to stay and this does not mean doing away with the traditional curricula, because not all aspects of curricula development in the traditional model are bad, some are good but the direction should be the deliberate emphasis of any curricula to be people driven and student or learner centered.

Engineering the curriculum innovations has been and will remain the responsibility of training/educational institutions. Planning and developing curricula, whichever approach might take, be viewed on three distinct and conflicting approaches to curriculum development which are; content, process, and outcomes driven. It is important to note that all the three approaches, even though they may vary at philosophical dimension, they all agree to one thing that, viewing the innovation of curricula must be conceptualized from the ends of content, process and outcome which are key to curriculum development.

That be the understanding, it must be appreciated that whatever endeavors it takes towards developing curricula, the selection of planning paradigm may likely evolve around the three approaches which continue to dominate literature in curriculum development.

3.2.6 INNOVATIVE CURRICULUM MODELS

(Health Professional Education)

The focus of this study is on the health professional/medical education curricula models which are: SPICES; PRISMS, SYMBIOTIC, with a characteristic feature of problem based learning (PBL), in them. The feature of PBL and focus on transferable competencies to real life situations in the field makes this group of outcomes based curriculum models more superior to the Tylerian objectives model.

They provide a hybrid problem-orientated style of learning, with realistic case study materials and professionally based real-world problems that satisfy contextual requirements for an innovative curriculum. However, the dependent culture of facilitating training and learning by lecturers, as well as students and staff expectation, can restrict this potential considerably.

The following subsequent sections of the medical/health professional education based curricula models are discussed. Their application and relevance are moving across various medical education cultures across the world, but it is critical to appreciate which one of them has the most diffusing potential to the education agenda of the PHC practitioners in Zambia.

3.2.6.1. SPICES Curriculum Model

This curriculum model was mooted by (Harden, 1984) in which they point out that past decades have seen growing interest in medical education curriculum planning and rethinking of approaches. Harden also pointed out the mounting of pressure for change not only from medical profession but other professions too. The SPICES model of curriculum according to (Harden, 1984) is a representation of six (6) strategies which have both planning and implementation implications. Each letter in the SPICES stands for a strategy as shown in the continuum below.

The SPICES model is a combined curriculum ideology. It is a learning method that does not only discover potentials in a learner, but develops those potentials all the time (Harden, 1984). The SPICES model curriculum integrates six strategic learning approaches and methods and compares these approaches with the traditional / conventional methods. These methods include: student-centered learning, problem-based learning, integrated learning, community-based education, electives and systematic method of teaching and learning (Harden, 1984) and (Zais, 1986).

Since the inception of the SPICES curriculum model, enormous changes over the recent years in the ways medical educators world-over facilitate learning and how students learn have changed, (Harden, 1984), particularly with the introduction and the increased use of problem-based curriculum, integrated teaching and community-based education which all tend to focus on student-centered approach.

The SPICES curriculum model (Harden, 1984) shows and illustrates a continuum of strategies between the preferred and advocated innovative curriculum model strategies and the conventional curriculum model strategies. According to the authors, the SPICES model is said to be more suitable to fulfill the need for the ideal doctor of the 21st century and is more appropriate to the UNESCO's vision of education because the model integrates six strategic learning approaches and methods (Harden, 1984 and {Zais, 1986:

881), and compares them on a continuum with the Tylerian traditional curriculum models and strategies.

According to Harden, the more the curriculum strategies are skewed to the left side on the continuum, the better the curriculum in terms of the way it intersects in meeting the values and assumptions of both trainers, trainees, stakeholders and the service users in that particular community. The skewedness of the continuum to the right denotes that, a particular curriculum is predominantly teacher dominated and based on one direction of communication. Strategies of teaching and facilitation for each model are explained. It is possible to see that in the innovative model, the main character of the process is the student while in the other; the main character is the teacher. Features of this model are illustrated as follows:

Table1: SPICES Curriculum Model

<u>Innovative</u>	<u>Conventional</u>
Student-Centered	Teacher- Centered
Problem-Based	Information Gathering
Integrated	Discipline-Based
Community-Based	Hospital-Based
Electives	Standard
Systematic	Opportunistic

This table shows the facilitation strategies continuum SPICES model with facilitation model in the traditional facilitation according to (Harden, 1984); (Zais, 1986). What this table is also showing is an illustration of two forms of curriculum approaches and the facilitation strategies. It is showing that the more the curriculum is on the left, the more it is innovative and the more it is on the right, the more it is traditional. The current paradigm shift in the educational innovation encourages moving from the right continuum to the left continuum, so that the graduates of the future are responsive and reflective practitioners.

3.2.6.2 PRISMS Curriculum Model

Bligh (2001) notes that the past recent years have seen various reviews and learning of a number of different approaches to medical education as in (Harden, 1984) with the SPICES model in different parts of the world. Bligh (ibid) and associates, point out that the reason for coming up with an additional model to the “SPICES” has been largely due to the growing impact of information technology, the emergency of PBL as a teaching method of choice by new medical schools, particularly the innovative ones. Bligh’s (ibid) focus in the curriculum of tomorrow is the need for greater clinical experience amongst medical and other health personnel students including more protected learning time during postgraduate and post basic training.

Bligh justifies his model, which he calls “curriculum of the future”, (PRISMS) and the contention of such an ideology is based on the premise that the “PRISMS” curriculum, which on one hand has deep roots in the SPICES model and on the other hand has roots in the “SYMBIOTIC” curriculum model This model has strong roots in the SPICES curriculum model and integrates the SYMBIOTIC curriculum model and the PRISMS curriculum model. In practice the two curriculum models have been merged together and form the PRISMS model.

The two merged models of curriculum are the innovative educational strategies in medical education. The emphasis of the SYMBIOTIC model in the PRISMS is mainly on diffusion of the health agenda in its totality in the medical education curriculum strategies, which at the moment is quite weak, and in its infancy. The PRISMS model highlights new educational strategies for medical education (Bligh, 2001). Bligh’s ‘PRISMS’ curriculum model investigates the medical curriculum of the future. He acknowledges the numerous changes over the recent years in medical education, most importantly; ways medical educators teach and learn, especially with the increased use of small group and problem-based learning methods.

There is more teaching in the community with increased shorter and more structured post-graduate training programmes, many of these changes draw heavily on Hardens and Dunn's SPICES model of curriculum planning in which student-centered approaches, problem-based learning, integrated teaching, community-orientation, elective study periods and systematic approaches to curriculum planning have been the building blocks of modern curriculum across the world (Bligh *ibid*). The Prisms medical curriculum model is built on educational principles as shown on the continuum below that are familiar and based on respect of the autonomy of the individual, while recognizing the power of group learning, the importance of critical reflection on practice (Schon, 1987).

The model is Outcomes-focused with emphasis on clinical practice or practice-based.; Relevant both to communities and to students; Interprofessional in character as opposed to nonprofessional character; Shorter, and the numbers involved in the practical sites is smaller as opposed to longer and larger numbers in the traditional curricula; with Multisite locations as opposed to narrow patient mix of teaching hospitals; and Symbiotic – meaning that the curriculum is seen as an organic whole with several constituent elements as opposed to separate and parallel relationships between health training colleges/ medical schools and clinical areas.

The two merged conceptual models of curricula which are: SPICES and PRISMS form the SYMBIOTIC basis of the latest medical conceptual curriculum model and constitute the current movement in educational strategies in innovative medical education across cultures of medical practice and service. They allow flexibility in the context of planning and development of curricula to form worthwhile curricula. The curricula provide for direct relationship between assessment and learning methods and this is a fundamental need to ensure that learning is context-based, relevant and meaningful in the sight of the learners (Harden, 1986) and (Prozesky, 1984) as shown below in a continuum:

Table 2: PRISMS Curriculum Model

<u>Innovative</u>	<u>Traditional</u>
Product focused	Clinical practice or practice-based
Relevant	Non relevant to communities and students
Interprofessional	Nonprofessional character
Shorter and smaller numbers	Longer and larger numbers
Multisite locations	Narrow patient mix of teaching hospitals
Symbiotic	Organic whole

This table shows the specified characteristics and comparisons of the PRISMS with the traditional curriculum paradigm (Bligh, 1986). Its approach as can be seen on the continuum is the integration of the educational training and practice into the community so that the few resources available and the potential available in these training sites selected are used to the maximum, especially the human resource in teaching the learners.

3.2.6.3 SYMBIOTIC Curriculum Model

This curriculum model is the brain child of (Bligh, 2001) and when coming up with this new medical curriculum concept, Bligh was in no way attempting to challenge Harden's "SPICES" model. According to him, having been Harden's closest associate in the SPICES model, borrowed the medical education approaches, principles and processes as those used in the SPICES curriculum model, along with his PRISMS model which he developed soon after the SPICES model except, – the addition of letter's at the end in the PRISMS which creates Bligh's concept of medical education curriculum model (SYMBIOTIC).

Bligh (2001) explains that, the emphasis of the model (SYMBIOTIC) is mainly on '*diffusion*' of the health agenda in its totality in the medical education curriculum strategies, which he describes to be relatively weak at the moment and in its infancy.

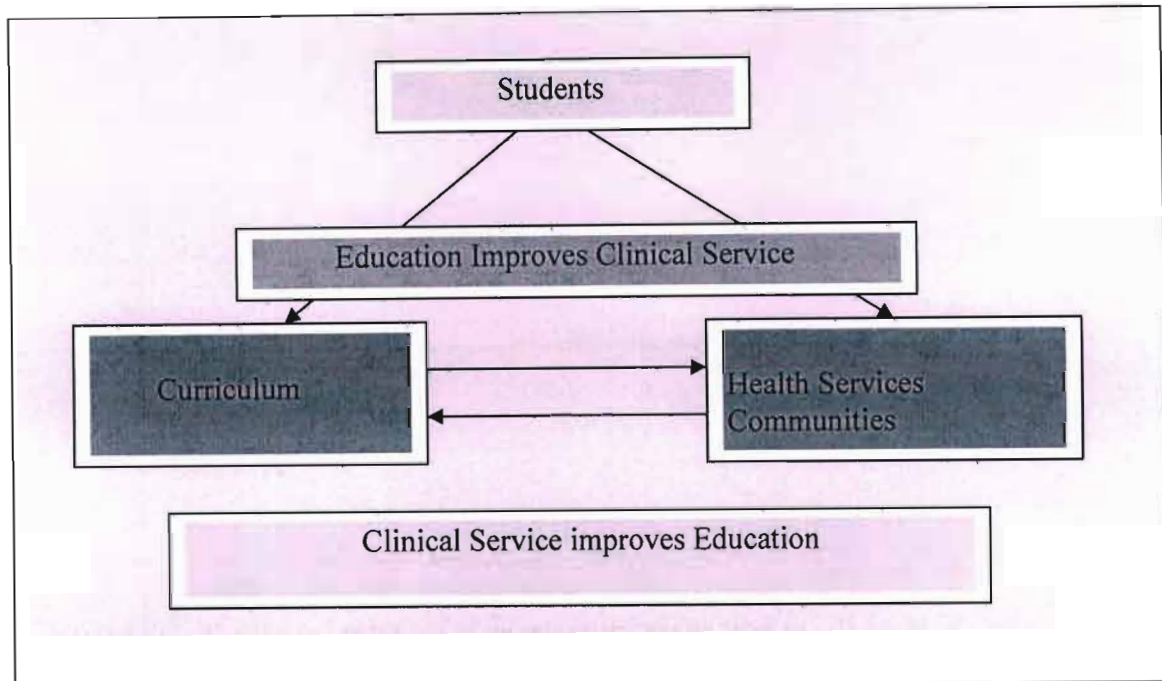
The ideology of the SYMBIOTIC Curriculum Model is based on the importance of partnership between learners, teachers, organizations and the community. SYMBIOTIC curriculum model simply separates and at the same time brings together partnerships of the six elements of the PRISMS model (Bligh, 1997). The six elements as shown on the PRISMS continuum (Table 2) are essential as the health care agenda becomes more diffused, open-ended and contested.

Doctors / health workers contribute one voice to a health care system whose values, needs, and demands are continually changing. Other voices in health care education include those responsible for organizing and managing health care organizations that must achieve the same quality of importance if congruency and accountability is to be achieved, (Cribb, 2000). This model was described in the form of a triangle showing symbiotic relationships of a curriculum of the future with an organic whole comprising several constituent elements as opposed to separate and parallel relationships between health training colleges/medical schools and clinical areas (Prideaux, 2001).

The SYMBIOTIC model is now the later curriculum model of the future and most importantly, an offspring of the PRISMS curriculum model and for medical education strategies to be even more effective, enjoyable and meaningful, clinical education should be the driving force. In contemporary medical education (Bligh, 1986), argued that a curriculum should achieve a SYMBIOSIS with the health services and the communities in which the students will serve.

In contemporary medical education (Bligh, 1986) argued that a curriculum should achieve a “SYMBIOSIS” with the health services and the communities in which the students will serve. The values that underlie the curriculum should enhance health services provision; hence respond to the changing values and expectations in education if it is to remain useful. He cites his concept of SYMBIOSIS of curriculum as illustrated in the figure below:

Figure 6: Concept of symbiosis of curriculum according to (Bligh et al, 1986)



This figure illustrates a triangular relationship that must be fostered between training institutions and clinical areas. In this type of relationship all the SPICES facilitation strategies (table 1) and PRISMS facilitation strategies in (table 2) respectively support this organic whole type of relationship in innovative evidence based educational relationship with service providers in which the student is given the most valuable and challenging learning environment.

The figure further illustrates Cost effective medical education practice and service in that the education of professional health practitioners is the business of all and not just the educational institutions alone. It further shows that health practitioners if not exposed to the socio-economic and cultural environment early in their training, to understand and appreciate the environment in which they will operate after training, they will have difficulties in integrating their potential to the health agenda of the community they will be called to serve and practice.

The values that underlie the curriculum should enhance health services provision; hence respond to the changing values and expectations in education if it is to remain useful. He cites his concept of symbiosis of curriculum in what he termed as triangular relationship in the health agenda and described the relationship in a triangle form showing SYMBIOTIC relationships with the health services and the Communities (see the figure above).

This triangular relationship must be fostered between training institutions and clinical areas if the health agenda can be achieved. In this type of relationship all the SPICES facilitation strategies, (table 1) and PRISMS facilitation strategies in (table 2) reactively support this organic whole type of relationship in innovative evidence-based educational relationship with service providers in which the student is given the most valuable and challenging learning environment.

This also illustrates Cost effective medical education practice and service in that the education of professional health practitioners is the business of all and not just the educational institutions alone. It further shows that health practitioners if not exposed to the socio-economic and cultural environment early in their training, to understand and appreciate the environment in which they will operate after training, they will have difficulties in integrating their potential to the health agenda of the community they will be called to serve and practice.

3.2.7 IMPLICATIONS FOR PHC PRACTITIONERS' EDUCATION

The three medical education curricula models presented are basically concepts and do not cast stones in their translation and practice. What is core in the models discussed is the integrated relationship of the ideologies of medical education practice and the direction it is expected to operate in the context of any health agenda or professional education practice

.Even though these models are guided by their various philosophies underpinning what they believe, the most important core business of these curricula is the student and/or the learner at whatever level, who must be helped to learn how to learn in the most innovative way to enable him or her to deliver most independently and diligently quality professional practice.

The principle behind these curricula models whether in the health industry or other, is the concept of student centered medical education, with a characteristic feature of community partnership in its operation to support the core business of managing a responsive and dynamic people driven educational practice.

Medical education or Health professional education is changing and dynamic, it needs to align itself to graduating health professionals responsive and sensitive to the problems and needs of the people they serve. The curricula in action as demonstrated in these models ensure that with careful planning which takes on board the focal stakeholders and gatekeepers of health practice, the products of such curricula be in health or other, the multiplier effect would impact on improved quality of health of the communities.

The current movement towards effective facilitation and the resultant production of reflective practitioners is the core of the innovative curricula. The facilitation methods that are depicted in the models, if put into practice, have the potential to produce health care Practitioners with a number of multiple abilities to be innovative, evidence based

practice and professional health providers able to relate and work with others in an integrated fashion.

Education of the Health Practitioners as shown in these approaches and models of various curricula conceptions is a clear lesson that needs the attention of all practicing educators of Practitioners that, the traditional tendencies and practices in curricula design and development as well as facilitation of teaching and learning seeks a redress and departure from the traditional conceptual practices which have dominated the educational agenda and practice for decades.

3.2.8 STRATEGIES OF FACILITATION

It is important to clarify two very essential related theories at this point, which have direct roots in philosophies underpinning education, and curriculum development. The concept/theory of teaching has direct influence on "*learning*" (Krammer and 1999). Krammer points out that a teaching strategy indicates the approach that the teacher will use in managing learning activities. In theory Krammer, states that the two related theories can be distinguished between the various approaches but in practice they are normally integrated. Krammer further points out that there are three main strategic choices that educators must make in terms of approaches and each of these decisions lies on a continuum, shown below as follows:

- Direct (teacher-centered)-indirect (learner-centered).
- Independent (individual)-Cooperative (Group learning)
- Reception (rote, memorization)-discovery (meaningful learning.)

The following authors (Harden, 1984), (Branda, 1986), (Zais, 1986), (Millville, 1982), (Bligh, 1986), (Bligh1997) subscribe to this continuum and have used the three strategic choices in developing the medical educational curriculum models as (Harden, 1984) with the "SPICES" model, (Bligh, 1997) with his "PRISMS" model and "SYMBIOTIC" model. This study also includes the "ASSET" model, with (Winter, 1996). The

innovative curriculum models share one common feature, which is of students being in the center of the learning process. Even though various models might use other facilitation approaches, the most important thing is that they will be drawing and applying the SPICES facilitation model strategies as illustrated in Table 1 above.

A number of medical schools have since been associated with this type of facilitation of learning in their institutions, such as the McMaster in Canada and Maastricht in the Netherlands with problem based learning (PBL). The facilitation methods outlined below are for all the innovative schools and can be combined depending on the learning situation at the time. They compare and contrast with the traditional facilitation methods. The following facilitation methods are discussed below:

3.2.8.1 Student-Centered Learning

The role of the teachers is to give advice on the student's needs until they have learned to work completely, independently and retain full responsibilities for certifying evaluation (American Educational Research Association, 1985). 'SPICES' model, with its student-centered approach has potential educational advantages such as emphasis on the student, increasing motivation, preparation for continuing education, and these attributes makes students' learning to become even more effective.

The conventional teacher-centered learning method, the teacher is the center or key figure and there is emphasis on activities such as the formal lecture and on the formal laboratory (Millville, 1982). Individual students have little control over what they learn, the order in which they learn things and the method they use and the learning itself tends to be more passive than active.

3.2.8.2 Problem-Based Learning (PBL)

PBL means learning using a problem as a trigger (Millville, 1982). It is rapidly gaining momentum. One of the reasons for its growing popularity is that it is a more natural method of learning (Sadlo, 1994).

The aim of PBL is to produce students who are able to adapt and participate in change, deal with problems in unfamiliar situations, reason critically and creatively, adopt a more holistic approach, practice empathy with others, collaborative productively in groups or teams, reflect on their own strengths and weaknesses and undertake appropriate self-action (Engel, 1977).

The student tackles patient's problems, health delivery problems, medical science problems or research problems as stimulus for learning in the basic science or clinical medicine ((Millville, 1982). Students in PBL are treated as adults, responsible for their own learning. This is relevant to UNESCO's vision of education that is learning how to learn.

People learn most effectively when they are emotionally engaged in the subject and not simply letting directly related to the profession being studied, acts as a trigger to motivate the students to find out themselves. As there are no set boundaries to the investigation, it allows students to address questions that are on the most vital significance to human existence. .PBL does assist to overcome overcrowded curriculum (Harden, 1984) and can also assist students to overcome tiredness in studying process, it can assist students to be able to create comfortable studying environment.

The outcome of PBL intervention of genuine knowledge can only happen if done by students for themselves, Branda, argues that this can only happen through a process that sometimes can be extremely involving and tiring compared with information gathering method. (Lohead, 1985) points out that PBL is better while findings according to (Paul,

1993) have shown that PBL enhances intrinsic interest in content compared with conventional instruction which in contrast states is more nurturing and enjoyable (Schmidt, 2001).

Albanese and Mitchell rated highly PBL with regard to faculty attitudes, students' mood, class attendance, academic process variables and measures of humanism (Albanese, 1993) hence reported the superiority of PBL students over conventional learning environment such as, practicability, clinical relevance and examinations.

3.2.8.3 Integrated Teaching

Integrated Teaching is the organization of teaching matter to interrelate or unify subjects frequently taught in separate academic courses or departments? It may be horizontal or vertical integration, (Harden, 1984) & (Paul, 1993). Vertical integration is integration between disciplines traditionally taught in different phases of the curriculum so it can occur throughout the curriculum with the medical and clinical sciences starting together in the early years of the curriculum and continuing until the last years. In real practice, integration of courses often has elements of both vertical and horizontal integration, (Paul, 1993). The strengths of this method are that it;

- Reduces the fragmentation of courses offered in a particular programme.
- Motivates the learners and shapes attitudes.
- Improves the educational effectiveness of teaching.
- Meets and achieves higher level objectives of learning and promotes staff communication and collaboration.
- Promotes the rationalization of training resources especially in resource constrained institutions.

The application of integrated teaching has the following advantages;

- Theoretical and clinical subjects are integrated around problem based or system based courses and students are motivated to focus on a holistic perspective of problems of the patient.
- The integrated method of teaching facilitates storage and retention of knowledge learned than knowledge learned in isolation not applied and easily lost. This is common in traditional curriculum in which by the time students start clinical training; they will have already forgotten key points, concepts and principles of the learned subjects.
- The method brings together staff from different disciplines based on common and similar interests in the tasks to be achieved. In this way it rationalizes the usage of training resources such as experts in the faculty in a given field so that the most appropriate members take responsibility for each aspect of teaching.

3.2.8.4 Community-Based Education

In this method of teaching, learners obtain training in a community setting. The objectives of this method varies, depending on the factors especially the level of the student in the programme at which the student enters the community, the amount of time the student has to spend in the community setting and the needs at that particular time.

It is also implied that, besides, students are learning about the social and economic aspects of illness, health services in their community, getting clinical skills as a result of their interaction with patients backed by the approach adopted by the practicing health personnel in dealing with the patients' problems they encounter particularly outside hospital setting.

The application of this method ensures that students are provided with community orientation through their experience of health related problems in their community, and this makes students to appreciate how the community functions, and through working

with practitioners in the community to fully understand their role. The community leaders and other stakeholders are sensitized about the presence of students and the purpose of their presence in the community setting as the community provides useful learning experiences.

Resources that are untapped are made use of particularly health care professionals in the community are used as teachers and this increases the pool of teachers. The use of patients in the community also expands the pool of patients available unlike the hospital setting. This promotes active learning and eliminates “student wise patients”, who have not gone through the boredom of being interviewed by health personnel. However, before this method is introduced in the faculty, a community diagnosis is done to establish which community setting will be best for students’ because it has most learning opportunities and facilities for students.

3.2.8.4.1 Implications of this method

- Students are able to learn about the social and economical aspects of illness, the health services in their community, acquisition of clinical skills as a result of their contacts with patients, learning about the approach adopted by their mentors dealing with the patients problems they encounter (Harden, 1984) and (Prozesky, 1984).
- When such students graduate they are likely to be good doctors/health care practitioners, who can promote health, good communication, and advocates for communities (Schmidt, 2001), the further advantages of this method are that it provides community evaluation and the community itself provides useful learning experience while students make use of untapped resources. It also encourages active learning, which is a useful skill and provides students with the skill to avoid ‘student-wise’ patients, and student is introduced to the health care systems perspectives.

3.2.8.5 Electives Learning Approach

The method of electives gives students the opportunity to select subjects or projects of their choice. This method helps to overcome the overcrowded curriculum; students can tackle what they consider as deficiencies in the curriculum or topics of particular interest, electives are also aimed at providing students with increased responsibility to further their own learning (Blumberg, 1998).

The electives method of teaching may be intercalated years of study in the curriculum during which time students can select one or more subjects to study in depth. There is also a provision that students may select shorter elective periods in which they choose one out of many of available courses on projects or subject areas of their choice.

This approach provides students to choose their own basic medical or nursing and clinical science subjects as a way of coping with an overcrowded curriculum. In this way students are able to tackle what they may consider as deficient areas of the curriculum or topics of particular interest. This area unfortunately is not fully developed in Zambia. Students take pieces of project work or research topics for grading purposes.

There is no system well defined as electives. This method on the other hand can create a room for career progression in areas a student finds interesting and stimulating (Stewart, 1976). This is one where need is required to explore the area in the 'INSET' programme in child and adolescent mental health with a view to spreading it across to other programmes for nurses and clinical officers.

3.2.8.5.1 Implications of this method

This method cannot operate in the PHC programme for child and adolescent mental health because the programme is a highly specialized and the time factor is also a limiting factor. The method is excellent in under graduate programmes where the programme selection to specialize is more.

3.2.8.6 Systematic Learning Approach

The Systematic Learning Approach according to (Albanese, 1993) is described as a systematic approach to the curriculum which results into a systematic delivery of teaching if well planned. In this method a programme is designed for all students so that the experiences necessary for their training are covered.

A comparison of methods is further provided by (Harden, 1984) who points out that, in the traditional curriculum model there is a system of apprenticeship in which students are attached to one teacher or clinical unit or hospital ward for a period. Teaching, in such environment is opportunistic, for instance it is based on unpredictable clinical situations as they arise (Harden, 1984).

Systematic Learning Approach according to (Baik, 1992) as he supplements (Albanese, 1993), points out that systematic approach is reflected in the assessment system where both the breadth and depth of their knowledge is tested and may signify a move towards a more criterion-referenced assessment system. Baik further notes that, this approach can help the students to identify which competencies are necessary, useful but not absolutely necessary. Baik also states that, this method can make students become competent and confident with the least waste of time and resources.

Harden et al in conclusion, point out that, the conventional mode of learning only provides 'the fish' but does not teach how to use 'the hook' and how to catch 'the fish', this pattern of learning does not have any relevancies with modern demands for having creativity and capability to think innovatively and critically.

3.2.8.6.1 Implications of this method

The focus of this method of teaching is designed for all learners so that the knowledge and experiences required for their training are covered and the characteristics of the method is reflected in the assessment system where both the breadth and depth of the knowledge is examined and may signify a swift shift towards a more criterion-referenced assessment system.

The method if applied well helps students to identify which competences are necessary and which ones are useful but not absolutely necessary. Students facilitated using this method of learning, become competent and confident with the least waste of time and resources thus, do not need to see further instances or get additional instruction in areas where they are already competent.

3.2.9 Significance of Local and Cross-Continental Studies

There is no doubt from the readings and map of the literature so far surveyed from the study, that both local and cross-continental studies have influenced the emergence of various innovative efforts to settle on modest curricula that is assertive to the needs and aspirations of a changing and dynamic world society.

The studies have shown that it is because of the long standing and pressured dissatisfaction from various parts of the world about the long dominant Tylerian tradition of both curriculum development and facilitation that the schools of thought began to

question the Tylerian models of curricula and teaching. The argument that has taken centuries has been on the concept and definition of curriculum. This state of unsettled view of curriculum definition obviously implied deleterious effects on the core business and approach to curriculum planning, development and implementation across cultures of the world.

These studies have also struggled to come to terms with the constituents of a curriculum, looking at the diversity of factors that influence the planning and development of any curriculum. What appears to have been settled in these cross-cultural continental studies is the general notion that an ideal curriculum must be country or region specific.

This aspect has been compromised looking at the exodus of various countries of the world, others coming from a Marxist and communist ideologies, others from capitalist based educational ideologies, while, others from the democratic governance ideologies. The other groups of countries are those that are coming from poorly resourced and economically disadvantaged economies, which have fallen prey of the advantaged economies and have forced these countries on their ideologies of education to their cause.

When consideration is given to the essence of education in these continental studies and their perception about education and the to be educated, this diversity of approaches and conceptions, as well as the mix of culture, ethnicity, geography, once sees the importance of what the cross-continental studies have contributed to the unified struggle for curriculum development and improvement.

The movement advocating for innovative curricula such as the SPICES which is basically a model that directs curricula planers, that, at the center of the teaching and learning, is the student, this is a welcome move. This will slow and is already beginning to slow down the traditional Tylerian model of curriculum planning; development implementation. It does not pose any threat to the traditional model as it also has its strength in the education of professionals.

The compromise which appears to be summative from all the studies appear to show that the “SYMBIOSIS’ concept of the curricula for the 21st century is one that holds the health agenda in the context of this study which is: Education Improves Clinical Service and Clinical Service improves Education, this is the climax of any innovation, to integrate students with health services through a well thought curriculum with innovative facilitation strategies.

3.2.10 Conclusion of Curriculum Chapter

In this chapter what has been *explored are approaches* to curriculum theory and practice which are:

- Curriculum as a body of knowledge to be *transmitted*.
- Curriculum as an attempt to achieve certain ends in students - *product*.
- Curriculum as **process**.
- Curriculum as *praxis*.

The debate and controversy about curriculum concept has remained unresolved despite different views and conceptions which have emerged held by various philosophical underpinnings. This study viewed and conceived curriculum development from a social construct, driven by community perceived choices that reflect their values and beliefs (Young, 1976).

The study was developed and undertaken based on the interpretivistic and critical research paradigms so that through the innovative curriculum, able and competent PHC practitioners would be developed who will be able to meet the emotional and mental health well-being of the children and adolescents in the community.

The dilemma of non-agreed definition of curriculum has attributed to a number of implications to curriculum in practice and its eventual effect and impact on practice and quality of services offered.

The present reality of practice particularly among the health care providers, the clinical officers and registered nurses (referred to as the PHC practitioners) in this study and worldwide, has shown that through years, idealistic young health care providers, are molded into rigid practitioners who have lost much of their original ability to sympathize with patients and listen to their problems.

This kind of attitude depicts the kind of curriculum model paradigm they underwent; particularly the effects of the traditional curriculum into the reality of practice (Bligh, 1986). When the fledging practitioners emerge to confront the world of their patients, the very process of becoming a practitioner would have rendered them incapable of dealing with the majority of problems that would face them (Branda, 1986).

The innovative curricula models and strategies should be those which should not only discover the potential in practitioners (Abbatt, 1988), but develop those potentials continuously through INSET for life (Brookfield, 1986) and (Houle, 1967) and to do this a number of strategies/approaches will be applied borrowing from the SPICES, Asset, Prisms and Symbiotic models of curriculum (Harden, 1984); (Bligh, 1986), (Bligh, 2001). The new model of curriculum for Zambia will not only represent a new curriculum shift, but will also require a whole innovative way of teaching and learning in mental health education.

Studies have shown that it is very strenuous to change a curriculum or even implement some form of reform particularly if it has to be at a national level, because of a number of factors which influence whether a curriculum innovation is successful which are: beliefs about the change process (Fullan, 1993); a focus on the educators (Kelly, 1989); training and support (Hopkins, 1996); institutional culture and organization; (May, 1994.) and the nature of innovation (Rogers, 1971).

Like any change process, the researcher right from the inception of the study, did take into consideration that the planned curriculum innovation, would be rooted into two perspectives, the cognitive constructivism and social constructivism. The combination of

the ecological, social systems and biopsychosocial theories in the execution of the study was driven by the Action Research methodology, for purposes of developing an innovative curriculum later which will translate into a training programme.

The writings of (Hopkins, 1999) are useful for this study especially in the event of resistance in the process of executing the innovation. Hopkins et al noted that change takes place over time; and how this curriculum innovation process will be driven is critical to its success and development in the area of child and adolescent mental health and that investment of the change process must be focused on professional human resource for the benefit of the clientele.

The next chapter addresses INSET which will be *dependent on the baseline data or information that will be obtained through the exploration process of the community perceptions in phase 1: stages 1, 2, and 3 of the study*. The chapter will further address issues why INSET is mandatory in professional working career and how it has developed around the world. Since the PHC practitioners are in-service, the case of INSET in areas with obvious discrepancies of knowledge, skills and practices such as attitudes become critical issues which need to be addressed in the working life of professionals.

CHAPTER FOUR

IN-SERVICE EDUCATION AND TRAINING (INSET)

4. 1 Introduction

The main purpose of 'INSET' development according to (Hellriegel, 2002) is:

"To overcome the limitations, current or anticipated, those are causing an employee to perform at less than the desired level" while Training, according to (Gerber, 1995) and (Lankshear, 1995) pointed out that:

"INSET served many purposes. It gave workers direction in their jobs and acquainted them with their working environment, and thereby created the opportunity for employees to become productive quickly".

Rapid changes in society, technology, and values cause new and different areas of learning to emerge and old ones to fade. When this occurs, it is critical to train, educate, and enhance personnel to the meeting of challenges of new areas and provide new learning experiences for staff members. This in turn aids the organization in meeting new demands and helps the professional staff members continue employment. It can be seen therefore that no cadre in the organization was exempted from being developed. (Knowles, 1998) pointed out that:

"one important strategic role for human resource development was to build the organization's strategic capacity, the knowledge and expertise required to figure out the present and to develop rational scenarios of the future and ways to connect them" (p.119).

Knowles (ibid) argued that if human resource development were to be aligned with the goals and strategies of the organization and performance was the primary means by which the goals and strategies of organizations were realized then it followed that:

“human resource development should be first and foremost be concerned with maintaining and/or improving performance at the organizational, process, and individual levels” (p.117).

If human resource development is to be a value added activity of the firm (instead of a line item of Cost to be controlled and minimized) then human resource development practitioners should be concerned about performance and how it enables organizations to achieve their goals. (Peel, 2002) identified several factors influencing which influence training technological development. Most jobs used to be unskilled, or needed only simple skills, such as manual work in factories, in building and on the farm. Currently these have been replaced by the use of machinery. Today in almost all jobs no sooner have staff acquired one set of skills, than technology moves on and new equipment or techniques become available.

If staffs do not learn the new skills these require, they will soon become out of date. Training is no longer something that staff did once for a life-time; it was something that was done continuously throughout one’s life. The increasing pace of change affected those who dropped out of a career with special force. There are few jobs, which it is possible to leave for say, 10 years and then pick up again without retraining. The following are other influencing factors: Changed systems; changes in customers’ needs; new regulations; environmental changes; new materials and products or services” (p.26).

4.2 Literature Review

4.2.1 Definition and Concept

Innovative Curriculum Development is a social reconstructivistic construct (Harden et al 1984, Bligh 1986 and, (Winter, 1996); while ‘INSET’ is:

“all learning experiences not just refresher courses and lasts from the completion of initial training until retirement that help health workers to maintain or learn competences relevant to the provision of health care,”.

To appreciate the human resource development and training as an integral part of strategic planning in institutions there is need to develop a clear understanding of 'INSET' development. *INSET* has been known to be an activity carried out by adults for the benefit of the young (Jarvis, 1983). It has involved pedagogical approaches, and systematic approaches; like those of Herbert, some subject centred approaches, like those of classical humanism, and subject centred approaches like those of Rousseau's; Montessori's; and Neil's and some society oriented approaches such as Dewey's reconstructionism (Jarvis, 1983).

The needs of adults in education have been identified by a number of writers, particularly (Knowles, 1978), who calls the practice of educating adults 'Andragogy' to distinguish it from 'pedagogy' – although, according to Knowles, some student orientated approaches of pedagogy do have things in common with Andragogy. Knowles underpins Andragogy by four premises:

“that adult learning depends on relevance and application; that adults bring to learning a wealth of personal and life experiences which would be used in the learning; that adults' self-perception is conditioned by learning; and that, adults are self-motivated and autonomous learners”.

Knowles (ibid), further points out that, if such principles mean anything, to individual needs, there should be strong methodologies which respect the person and his/her experience, status and should be presented in ways immediately useful to the adults. The work of (Burnard, 1990), makes a good number of comparisons between pedagogy and Andragogy and lists them as follows in line with the Tylerian traditional curriculum model of 1949/1979: Pedagogy focuses on teaching, the teacher is central and knows all, uses Plato's theories of education and his followers such as Hirst and Peters etc. The teacher determines aims and objectives as well as examinations and tests.

Andragogy focuses on learning and the learner, which is much in the innovative curriculum model lines of the proposed curriculum models of this study, which are; SPICES, PRISMS, SYMBIOTIC AND ASSET. The learner is part of the one who

knows and the approach to learning is representative of Knowles, Rogers and Freire theories. Evaluation methods are cooperatively negotiated between teachers and learners (Jarvis, *ibid*).

4.2.2 Education and Training

Education Facilitators (Education Facilitators, 1998) make the following distinction between *education* and *training*. They define education as:” *The development of knowledge, norms and values to prepare a person in life in its widest possible sense.*”

They regard:

“Training as job related and focused on broadening or expanding an individual’s knowledge and skills so that he/ she are in a better position to do his/her work more effectively”.

From the researcher’s perspective, such a distinction is not of high significance because both education and training contribute to human resource development, whether the human resources are developed by means of education or by means of training is not the issue and does not matter.

What matters is that the human resources be developed, be it by means of education or training or both, to be able to attain the institution’s goals and objectives. This study adopted the Process model curriculum paradigm from which (Knowles, 1978) draws his andragogy education and training model, in line with the curriculum model concepts approaches of (Harden, 1984) and (Bligh, 1986) respectively which were proposed for implementation in Zambia.

The basic assumption of ‘INSET’ however is that, it must increase the subjects’ self-reliance, without displaying the negative impact of running their experience. This is necessary for every individual and in every profession. ‘INSET’ therefore, should reveal and make stable everything that is positive and stimulate consideration of what is insufficiently known and not very often discussed. Some form of continuing education by means of local medical societies goes much further back at least 150 years.

To date, it has become clear that 'INSET' indeed is an activity of adults and these adults for instance, in a profession like medicine/health; professionals need to keep abreast with their profession through exposure to 'INSET' courses, materials and new innovations such as the one for this particular study. It has become obvious from the struggle so far recorded in literature that, recognition and making 'INSET' mandatory or an important function of a professional person has not been easy task.

The story of 'INSET' through continuing education appears to be a success story because many governments, both developed and developing including Zambia, financially support it. The challenge is therefore, with those entrusted to develop it even further through 'INSET' centers and to demonstrate its value by its effect on patients care.

4.2.3 Reality of Practice vs. INSET Model

The present reality of practice particularly among the health care providers, the clinical officers and registered nurses (referred to as the PHC practitioners) has shown through years that *without INSET*, idealistic young health care providers, are molded into rigid practitioners who have lost much of their original ability to sympathize with patients and listen to their problems (Millville, 1982).

This kind of picture depicts the kind of *INSET model* they had undergone, particularly the effects of the *traditional curriculum* into the reality of practice (Bligh, 1986). When the fledging practitioners emerge to confront the world of their patients, in the absence of renewed competences and practices, the very process of becoming a practitioner would have rendered them incapable of dealing with the majority of problems that would face them (Branda, 1986).

The process adopted to underpin the development of an *INSET programme* in this study was also based on a post-modernistic reconceptualization concept of *INSET curriculum*

(Pinar, 1976); (Kliebard, 1992); (Lytard, 1973); (Giroux, 1983); (Kozol, 1975); (Kincheloe, 1976) and (Roty, 1985); (Schubert, 1986) in which the baseline information was designed to inform the development of a *new innovative INSET* with focus on society and events outside the individual for a satisfactory explanation (Elder, 1968), to which the practitioners must learn and conform to families and communities which they are responsible for, (Thomas, 1968a) and (Benedict, 1938); (Brim, 1965) and (Baumrind, 1975).

4.2.4 INSET and Organizational Dilemma

These planned innovative curricula will be offered in large colleges where there are a lot of bureaucratic procedures and tendencies and it is important for the researcher to understand how it is going to feature with the rest of the programmes and the environment with its culture within the existing financial framework and administration of these institutions.

Figure 7 below illustrates that the innovative curriculum will be offered in a broad environmental context which comprise the global, country specific and institutional environments. This illustration, in the context of this study, signifies that when planning any innovation, that innovation must take into account the existing organizational structures, otherwise, it is bound to fail because it will have no support of the stakeholders.

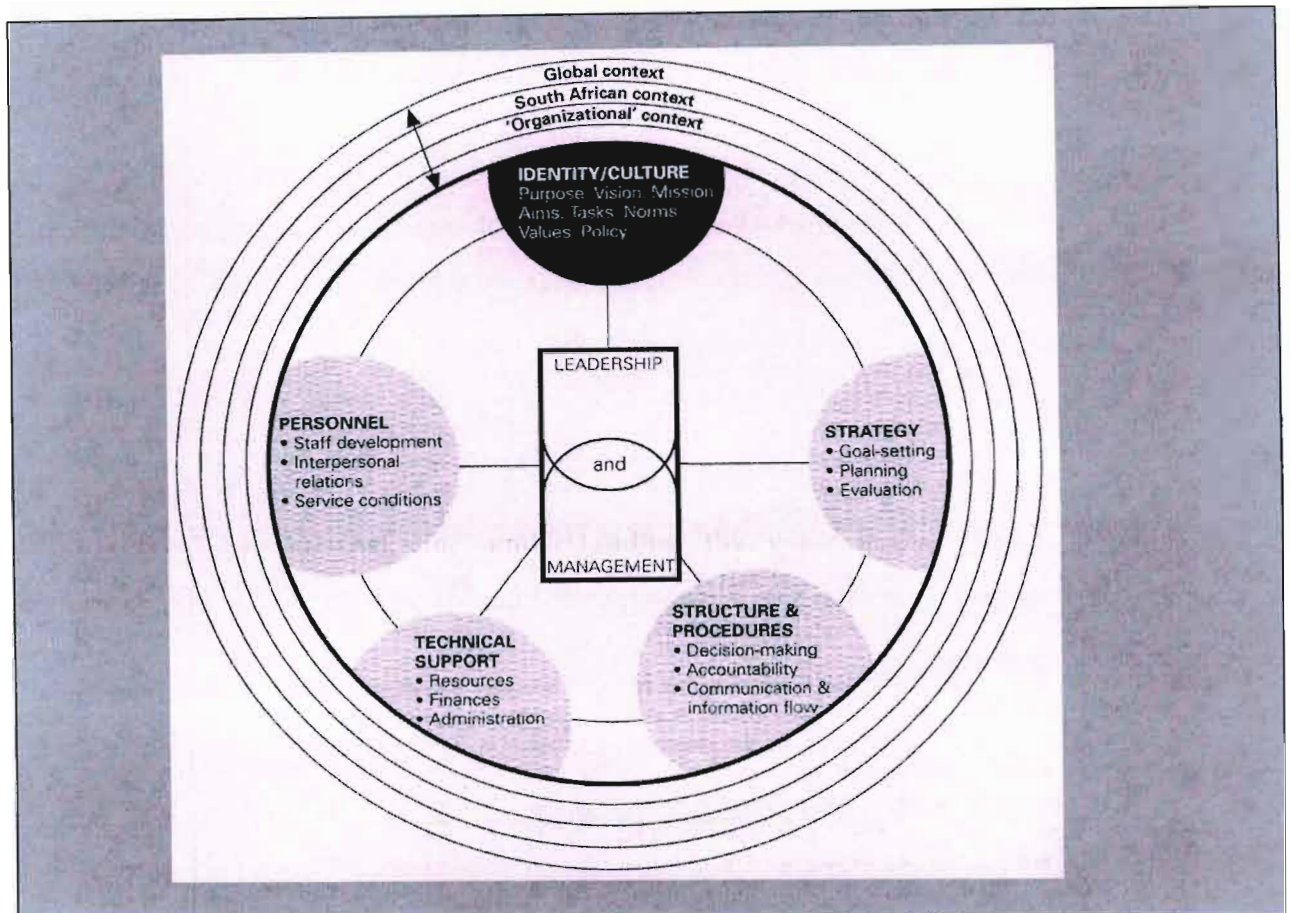
Studies have shown that it is very strenuous to change or even implement some form of *INSET* reform particularly if it has to be at a national level, because of a number of factors which influence whether the *INSET innovation* is successful which are: beliefs about the change process (Fullan, 1993); a focus on the educators (Kelly, 1989); training and support (Hopkins, 1996); institutional culture and organization; (May, 1994.) and the character and nature of the innovation (Rogers, 1971).

Internal or organizational structures where there are fully developed cultures with own politics are critical sub environments which right at the onset of the innovation must be consulted and involved. The key to any innovation are the aspects of leadership and management of that innovation. There must be deliberate recognition of institutional leadership and management consultation and involvement if any process of change can take effect. The positive interaction between leadership and management environments ensures success of other structures within the institution and all other environments internal and external.

The positive interaction between leadership and management environments ensures success of other structures within the institution and all other environments internal and external. This framework prepared to suit the South African situation, is applicable in Zambia as well, and it underlines the systematic nature of organizational life, and highlights the interdependence of the various elements of an organization as illustrated below in figure 7.

The figure shown below was adopted and '*inferred*' for application in the Zambian scenario from Juta Academic Press, in Sue Davidoff (South Africa), Institutional Organizational Development in a changing Political Environment, Section 2: 9 p.100, International Action Research: A casebook for Educational Reform (Hollingsworth, 1997).

Figure 7: Framework for understanding the context for INSET planning, development and implementation from a societal and community perspective.



It can be seen from the illustration in this figure that the element of structures and procedures takes into account aspects of accountability, decision-making, and information flow. Without appropriate structures and procedures to support it, the most inspiring vision will remain stuck-up and unrealized. Similarly, structures and procedures reflect a particular culture-for example a top down decision-making structure and procedure will not enable all the relevant stakeholders to participate meaningfully in shaping the life of the discipline and playing an active part of that movement.

Technical support is an element, which is frequently overlooked or not taken seriously enough. Here the researcher is referring to the physical resources the institution has at its disposal. Also relevant here is who has access to these resources. Part of the technical support at an institution is the financial management. Another aspect is the institution administration: is there adequate administrative support, are there people responsible for ensuring that information flow is active, and that teachers can get on with their important task of teaching rather than having to spend disproportionate amounts of time doing administrative work?

Looking at the community element in an organization, there are personnel, where concerns such as interpersonal relationships, human resource (or staff) development and conditions of service are relevant. There concern in such incidences is with providing an environment at these institutions where life-long learning becomes part of the culture of the institution. This means, among other things, that the developmental needs of the staff, in terms of the vision of the institution as a whole and the individual needs of staff need to be taken into account.

In the center, holding it all together is the leadership and management of the institution: the way in which all these interweaving elements are held together at the center. Here leadership and management capacity is important- the ability for those in leadership positions (and potentially that means that every teacher and other stakeholders in the, institution including parents, students and community leaders) in the institution to be active and responsible leaders.

Thus a healthy organization is one in which leadership capacity is being developed in all staff members (and other constituencies) through ongoing personal development processes, designed to build the capacity of those people involved in the life of the organization to participate meaningfully in the change processes. Leadership and management means directing and investment, pushing forward while maintaining a secure foundation, inspirational and sustaining, listening, paying attention, connecting premise with practice.

Another aspect of understanding colleges as organizational institutions, which is often under-emphasized, is the contextual reality of the institution. No organization exists in a void, outside of its immediate and broader community. The micro-context of the institution is understood as the location of that institution within its immediate community, and the education and training system, while the macro-context refers to the institution as seen within a broader culture.

Presenting issues at the institution must be analyzed and understood within the context of societal dynamics, including issues around power relations: group, gender and other areas of potential exploitation and oppression. If an understanding of and response to institution issues does not take these dynamics into account, they are unlikely to be addressed in any kind of acceptable way. The shift from self-understanding to significant reflections needs to be mediated through and seen against the background of broader community concerns.

4.2.5 Adult learning theory

Adult learning theory has been an issue of great concern for several decades. Notable writers such as Paulo Freire; Robert Gagne; Malcolm Knowles, Jack Mezirow and Carl have examined different aspects of adult learning (Jarvis, 1988). These writers discuss the theory of learning in which the individual adult is located within a socio-cultural milieu.

They see the adult as a human being with a developing selfish physical body in a gradual process of decline. When the adult's experience of the wider world is in harmony with the understanding of it, then the experience merely reinforces that comprehension. In a rapidly changing culture and a developing self, this equilibrium is unlikely to be maintained for long and hence, the adults realizes the need to learn.

This realization is based on the premise that, adults learn best when study is perceived as relevant to their personal interests, when they are active in formulating and following up their questions, when they have an early opportunity to check how well they have learned. The adult person's perception of his world, however, must differ generally from that of the younger person because the adult's past experiences are often represented by the totality of his past and present perceptions will be of a different quality from those of the younger person.

Other authors remind us that the adult's previous experiences tend to influence the way in which they engage in learning and that the most important single factor influencing new adult learning is what they have already learned and organized in some conceptual structure (Lovell, 1984). Lovell further suggests that adult participants in a course tend to underestimate their abilities and often experience difficulties with tasks requiring the interpretation of complex instructions.

Lovell considers perceptions of threat from the outside world, as having particular relevance for an understanding of the educational problems of adult learners. However, when such teacher-centred approaches were used in adult or professional education it led to student resentment. Knowles, further points out that, if such principles mean anything, to individual needs, they should be strong methodologies which respect the person and his/her experience and status and should be presented in ways immediately useful to the adults (Lovell, 1984); (Jarvis, 1988).

4.2.6 In-service Education and Training (INSET)

Coombs and Ahmed seek to distinguish formal education from informal and non-formal education. They define it as; 'the highly institutionalised chronologically graded and hierarchically structured "education system" spanning lower primary school and upper reaches of the university' (Coombs, 1974).

The intention of the authors was to distinguish this formal system from other forms of lifelong or in-service education, which take place in many parts of the developing countries. INSET is a concept and an ideal, which remains rather meaningless unless it is implemented. This point of view points out that INSET has occurred in different forms in various places and each different approach contains within it its own philosophy. This has given the rise of three distinct perspectives, which are; continuing education, recurrent education and community education.

In-service Education and Training 'INSET' has long been a popular idea among some people concerned with education of adults. It has gone under a variety of names in different countries; education Permanente, lifelong education, recurrent education (ACACE, 1979a). A number of professional practices are using the term *INSET* today and for the purposes of this study, the term 'INSET' will be used instead, following (Abbatt, 1988), a leading Physicist and Medical Educationist for Health Workers who with his colleague Mejia describe '*INSET*' as:

"All experiences, after initial training that help health workers to maintain or learn competences relevant to the provision of health care, not just refresher courses and lasts until retirement."

The duos also add that '*INSET*' is concerned with a wide range of competences, not just knowledge, that are directly relevant to the provision of health care. The researcher also holds similar views that '*INSET*' should reflect the health needs of the community, in this way it will leave improvements in the quality of health care and ultimately to improved health status of that community. It is as well true that '*INSET*' embodies the whole range of learning experiences that lead to improved performance in the delivery of health care and the application of a diversity of teaching methods not only makes learning more interesting but makes it even more responsive to the needs of different health workers and to the different ways in which they learn (Abbatt, 1988).

In addition, various methods are needed to meet different types of educational needs and learning, in the context of '*INSET*,' studies have shown that learning is more effective when it is perceived to be relevant to the interests of the health workers; particularly,

where opportunities to play an active role in the learning process is made available; where health workers are confronted by a relevant problem, encouraged to tackle that problem, helped to identify what they must learn in order to solve the problem and given an opportunity to apply their knowledge, skills and attitudes (KSA) to the problem.

'INSET' of health workers should be seen as a continuation from initial professional training, builds up to post graduate Training to continuing education because of its Cost-effectiveness and feasibility for in-service workers (Abbatt, 1988). The recognition of the importance of 'INSET', particularly in the medical circles dates as far back as 1900, during Osler's address to the medical graduates' college when he posed a challenge to the audience and stated:

" if the licence to practice meant the completion of his education, how sad it would be for the practitioner, how distressing to his patients; more clearly than any other the physician should illustrate the truth of Plato's saying that, 'education is a lifelong process". He further went on to explain that," training of the medical school simply gives a man his direction, points him the way and furnishes a chart, fairly incomplete, for the voyage, but nothing more."

(Kneller, 1974) describes education as a discipline that cuts across various professional practice fields and is underpinned by philosophy which seeks to characterize/comprehend it in its entirety, interpreting it by means of general concepts that guide the choice of educational ends and policies.

Through childhood a person learns the knowledge and skills necessary for survival. Van Scotter et al point out that human as a species have self-consciousness and are capable of learning. They point out that survival is not only physical/biological but also psychosocial and cultural. This element, combined together, impels societies towards the need for education. These authors argue on the importance of historical perspectives on curriculum as a field study as is the case in this study (Van Scotter, 1979).

The beginning of the late 1960s, were the start of the modern drive toward organized 'INSET' and refers to this period as the second era of 'INSET', following the first which

was part of the formal establishment of professions (Osler, 1900). What makes Osler's address historical was the emphasis placed on 'INSET'? With the rapid growth and extension of medicine, 'INSET' has come in for a large share of attention, to act as an antidote against premature senility in a profession. Traditional methods of learning, such as lectures, were vitalized; new societies and associations were formed; new theories of teaching, programme planning and methods of testing were devised and a great deal of money began to be spent on 'INSET' programmes.

The 1970s, especially in the USA and Canada and lately in all parts the world; saw the development of mandatory 'INSET' systems as a result of actions by state legislatures and professional organizations (Young, 1984). By the end of the 1970s mandatory 'INSET' was firmly established for many professions, including health and health related professions. Zambia in the health sector the *INSET* systems started in the late 70s and became fully developed in the 80s with full government funding.

The history of each profession which has managed to get itself established shows that formal means of 'INSET' were created early in its life, hence 'INSET' is thus an essential focal point for causality. In another perspective, (Goodlad, 1984) quoting Houle, stated that,

"The founders of the complex modern professions either took for granted or were careful to include formal methods of such learning in their original plans for professionalization.

From about 1920-1960, (Goodlad, 1984) points out that 'INSET' flourished at an astounding rate (at least in the USA) and in 1963 the fall issue of the Intellectual Journal 'Deadalus' began with the ringing declaration: *"Everywhere in American life the professions are triumphant."* It was then, only 13 years later that Harold Enarson said in a statement unconsciously paralleling that of Deadalus;

"Everywhere the professions are on the defensive, all at once are caught in a rising tide of distrust, hostility and litigiousness."

These attacks came from without and within the professions and those individual encounters, cumulatively experienced and occasionally culminating in spectacular

examples of wrongdoing, led to action by courts, legislative bodies and regulatory agencies. Houle points out that,

“Leading physicians have not been silent on the deficiencies of the health professions, including their own but dissident groups have been formed in some professions to attack the alleged weakness of their colleagues.” (Houle, 1967).

The pressure therefore, included by all these attacks led to the proposal of many remedies, including the idea of CE which appeared to offer a solution that was sure to help the situation. Houle further argues that:

“Professionals are not born with specialized knowledge, skills and values, but learn them, therefore, to the extent that deficiency exists, it can best be remedied by further study, that is, ‘INSET’.”

As Young and Willie make clear and pointed out that:” *Mandatory ‘INSET’ was cautiously viewed as a step in the right direction because it moved requirements for practice beyond initial licensure.”*

The opponent of mandatory ‘INSET’ (Adelson R, 1974) argued that ‘INSET’ was not designed to serve the public as a competency assurance method but rather to serve the profession. In addition, Adelson further pointed out that the higher operational Costs of a mandatory ‘INSET’ system would not be viable to most countries. This is true for Zambia, especially at this time, when the country is facing a serious economic recession.

It is sad to mention that most health programmes, including Chainama College are currently facing tremendous financial difficulties in maintaining the present basic and undergraduate programmes. In support of Adelson, (Seldén, 1989) added that:

“The quality of ‘INSET’ activities and the possibility that professionals are passing on to the consumer (patient) the Costs associated with participation, such as the loss of income while away from practice and increased licensure Costs, would mislead the public and professionals by implying that those who devote time to their education are competent and those who do not are incompetent.”

This view was also noted by the (RN B/Colu, 1974 and 2000), while the question of whether those who engage in ‘INSET’, practice with improved skills or continued

unchanged has not often been rigorously researched, the results of the research that has been undertaken have been inconsistent (Young, 1984).

Journal of American Medical Association (JAMA, 1977) records the implementation and development of 'INSET' in the USA and its present state and notes that 'INSET' is today America's policy statement. JAMA continues to reveal that:

"The policy emphasizes the need for 'INSET' of all health personnel, because it provides strong support for re-licensure or re-certification and it was developed to emphasize that 'INSET' should be voluntary and required by employing institutions on the strength that it is competency based and objective."

In a much gentler stance (Knowles, 1980) also argued that, in our present sense, 'INSET' should never be 'didactic'. It should instead be an exchange between equals. Referring to mandatory 'INSET', Knowles suggested that the system is evidently more appropriate in the USA, where most of the doctors are independent specialists in private practice, often isolated from their colleagues; unlike Britain, where almost all consultants are members of a fairly tightly knit hospital group, always open to criticism by the colleagues. The author accuses the American 'INSET' of placing too much emphasis on scientific facts and too little on practice, and advises that:

"An effective 'INSET' programme should have a major concern with a regular review of the outcome of patient care and its comparison with results elsewhere. In this way, results will show up areas of ignorance or inefficiency and will teach a much better lesson than a formal lecture." (Knowles, 1980).

William further reports that, the British pattern of 'INSET' is today, generally accepted throughout the western world and the pattern has also been taken up widely in commonwealth countries, for instance in developing countries such as Zambia. (Haworth, 1972) introduced the 'INSET' pattern for updating and teaching medical/nursing students modern practices of psychiatry on a weekly basis, in the form of case presentations.

Later, (Kapusa, 1978) introduced an 'INSET' programme for clinical and nursing staff at the hospital. This move was aimed at updating their knowledge, it was further revitalized

by (Mambwe, 1982) who introduced a Saturday Journal Club where scientific papers were discussed as a way of keeping Doctors and other staff abreast of their professional practice as well as more staff in-service programmes.

In Kenya, (Mutema, 1986) introduced both the British and Canadian pattern of 'INSET' for middle level health workers, while (Terri, 1984) in Tanzania introduced a Centre for Education Development in Health, to provide 'INSET' to all categories of health personnel. Sibley and his co-workers (Sibley, 1982) report that 'INSET' in Canada as in the United States, is a major industry. Huge sums of money are spent on 'INSET' annually by doctors, hospitals, medical schools etc., and argue that:

" It is nonsense to pretend that 'INSET' usually occurs in isolation of that it must fit a formal programme; in actuality the structure of 'INSET' is more fragmentary than formal programmes and more practical in orientation." He further argues that, " having expensive 'INSET' courses is no longer necessary, but some practitioners throng to these courses because of personal reasons and objectives. "

In the USA, many special schools have been organized and perhaps more systematic attention has been paid to 'INSET' than anywhere else. As a way of improving Continuing Education, (Jarvis, 1983 525) and (Houle, 1967 #66) proposed that:

"Continuing Education should bear objectives that will help professionals to master theoretical knowledge, which in turn will assist them to increase problem solving capacities".

These ideas of continuing professional education prompted an interesting debate for instance, (Knox, 1985 #1053) argue that, views of 'INSET' were just an 'empty ideal' and pointed out that many of the characteristics of the professionalization identified were:

"Control mechanisms but what is missing from those views of 'INSET' is:" an articulation of the vision, the principles, the content of the ideal in the name of which control is to be exercised." Since 'INSET' is not always voluntary, many authors, such as (Miller, 1967) have criticized and condemned mandatory 'INSET' and described it as: "a repulsive idea, that is, antithetical to the ideals that the early adult education movement cherished."

Miller, in particular, feels that mandatory 'INSET' e.g. in the USA, turns adult education into an agent of social control, limits individual freedom and places efficiency above ethical considerations, while on the other hand, (Brookfield, 1986) warns professionals to be aware of the potential danger for client abuse that is present in their refusal to undertake further 'INSET' after initial entry in their particular professional body.

The World Health Organization (World Health Organization, 1998)) makes comments on the concerns of the Health Reforms problems generally and states that:

“Among the many resources to be mobilized to this end, human resources constitute the most precious resource but it has not always received the attention deserved, hence the persisting significant gaps between the ongoing reforms in the health sector and management of human resources for health” (p.1).

The World Health Organization further indicated that it was crucial that the changes which were taking place in the organization, functioning and financing of health care systems needed to be accompanied by appropriate measures for developing human resources both for health and supporting institutions (World Health Organization, 1998). It was at this point that (W H O, 2002) listed the following as factors affecting the development of human resources for health:

The departments responsible for human resources for health was hardly ever structured or given the tools with which to carry out the principal functions of modern day human resources management, namely,

- planning (qualitative and quantitative determination of staffing needs)
- identification projection (determining the type of staff and numbers required and programming of those needs),
- production (training related to needs and job profile),
- Management (routine, forward looking and performance evaluation).

The activities of departments which deal with staff planning, training and management are currently limited essentially to routine personnel management.

According to (W H O, 2002), they state that, initial and specialist training in the health sciences in most countries in Africa, Zambia inclusive, is still focused on hospitals, despite the recognized reform needs of integration of community involvement or the reorientation of medical training and practice such that their curriculum addressed community service.

INSET or Continuing training, virtually is nonexistent in the private sector, and if provided was carried out almost exclusively within specific disease control programmes (vertical) or for the purpose of promoting specific drugs. Combined meetings of private sector and public health sector, as an example, are held to build capacity in prescribing anti malaria drugs, similarly for ant tuberculosis drugs. These training efforts ideally meant to bring about organizational change of the health system in order to score success in the care of patients.

Conversely, isolated reforms without changes in the knowledge base of the practitioners will stand little chance of success. For example in Zambia health centers provide 24 hour first level service to the public while complicated cases are referred to the hospital. If practitioners are not able to diagnose conditions of patients at the PHC level that could have been treated at those health centers they would refer those to another level of care within the context PHC as outlined by the ALMA ATA Declaration (WHO ALMA ATA, 1978).

The human technical report series of (W H O, 2002) states that training in human resources management in Africa seemed rarely to have received privileged treatment. The expertise needed for such training especially for training permanent trainers proficient in human resources management, was often lacking, there was no inventory or needs assessment and partnerships between the authorities in the training institutions concerned were also practically non-existent.

According to the report series of (W H O, 2002) the tools to use to influence behavior of staff or to motivate them in most African countries were generally few or non-existent, and not adapted to the sector or to ongoing reforms, be they in the area of legislation or

existing regulations, including the legislation applicable to professionals' practices, living conditions, incentives or to the professional environment.

Integration between human resources development and development of the health sector was lacking. There was a mismatch between training on one hand and needs and job profile on the other. The health team appropriate to each health care delivery level was not identified.

The report series (W H O, 2002) indicates that investments in training at national level and within disease control programmes in most African countries have rarely produced the expected results, probably due to compartmentalized, isolated and uncoordinated approaches to implementation in all aspects of the development for human resources for health. Baird conducted a study in the U.K on what being a Practice Nurse really means, was commissioned to review the 40 practice nurses in Sheffield South West Primary Care Trust (PCT). There were 22 practices and 40 practice nurses, covering a population of 120,000. An in-depth questionnaire was developed and piloted on three nurses in the PCT. A number of changes as a result were made to the questionnaire.

- A database was set up to help with the analysis of the data.
- All the 40 nurses covering a population of 120,000 were interviewed face to face.
- The findings showed a workforce that was on the whole highly skilled and committed but received little support with (*INSET*) professional development.
- In many cases regarding their salaries there was no relationship between the nurse's skill and the grade she was on.
- This lack of relationship between the nurse's skill and the grade she was on demotivated the nurses (Baird, 2003).

4.2.7 Conclusion of Chapter

'INSET' is crucial, especially in the speed of change in an age of technology; where it should be seen as an enzyme for change as such merits closet attention in times of accelerating change (Harden, 1996); (Marinker, 1990). Supporting other authors who

focus on change through 'INSET', Peckham warns that, "*ignorance could be dangerous and without 'INSET' doctors and other health professionals would soon become out-of-date*". On the other hand, adult learning theory has been an issue of great concern for several decades. Notable writers such as Paulo Freire; Robert Gagne; Malcolm Knowles, Jack Mezirow and Carl have examined different aspects of adult learning (Jarvis, 1988).

These writers discussed the theory of learning in which the individual adult is located within a socio-cultural milieu. They saw the adult as a human being with a developing self- not a physical body in a gradual process of decline. When the adult's experience of the wider world is in harmony with the understanding of it, then the experience merely reinforces that comprehension.

In a rapidly changing culture and a developing self, this equilibrium is unlikely to be maintained for long and hence, the adult realizes the need to learn. This realization is based on the premise that, adults learn best when study is perceived as relevant to their personal interests, when they are active in formulating and following up their questions, when they have an early opportunity to check how well they have learned.

The adult person's perception of his world, however, must differ generally from that of the younger person because the adult's past experiences are often represented by the totality of his past, and present perceptions will be of a different quality from those of the younger person. Lovell further suggests that adult participants in a course tend to underestimate their abilities and often experience difficulties with tasks requiring the interpretation of complex instructions (Lovell, 1984).

The chapter that follows discusses mental health problems of children and adolescents as viewed from the review of literature globally and locally. The perceptions and understandings of the community and the practitioners about mental health problems of children and adolescents are discerned in the context of other studies to appreciate the global context of the problem as it is seen in the *Zambian perspective*.

CHAPTER FIVE

CHILD AND ADOLESCENT MENTAL HEALTH

5.1 Introduction

In the previous chapter it was stated that the core of the study was to determine perceptions and understandings of practitioners and the community about mental health problems of children and adolescents in their community in order to use the implications of these perceptions for innovative curriculum development for PHC practitioners in Zambia. The purpose of these community driven perceptions and understandings was to support the commencement of the process of developing an appropriate innovative curriculum for PHC Practitioners' INSET programme in Zambia.

The severe emotional and behavioral difficulties that can accompany mental disorders in children may interfere with many aspects of a child's life such as family, school, ability to learn, friendships and may lead to difficulties that persist throughout the lifespan. Early intervention efforts are believed to be instrumental in reducing the difficulties associated with many childhood psychiatric disorders. Therefore, early diagnosis and treatment is extremely important. In this chapter, the *concept and definition* of mental health is examined as well. Some highlights of epidemiology and background setting about child and adolescent mental health are outlined, along with relevant cross-continental studies as well as aetiological factors considered by various authors to be contributing to the mental health problems of children and adolescents.

Special of note, are the *perceived factors* by practitioners and the community considered to be associated with the development of mental health disorders of children and adolescents which are: environmental factors, life stresses, and the biophysical factors which collectively constitute the core context areas of this study. Issues of how the children and adolescents are dealt with by the community in terms of social and community support are included as well as *competence capacity* issues of practitioners to deal with mental health problems of children and adolescents.

A review of *core competences* of practitioners in child and adolescent mental health practice across continents are highlighted. These support the cause for this study. The chapter summarises the significance of both the local and continental studies as well as the new knowledge learned.

5.2 Literature review

5.2.1 Historical perspective

Child psychiatry and mental health, a comparative newcomer among medical specialties worldwide, has its roots in several disciplines, the chief being pediatrics, adult psychiatry, psychology and education. It developed as the result of the recognition that the child's psychological development merited attention, as well as physical and it was hoped that early intervention might improve some of the problems of adult mental disorders associated with social adjustment.

Saraceno noted that, worldwide, in the history of the WHO mental health programme attention dedicated to the children and adolescents in mental health care and support has not been commensurate with that dedicated to adults and elderly (Saraceno, 2003), there is therefore, need to put this on the agenda and get it into the curriculum.

Mental health is a component of the overall PHC programme as promulgated by the WHO Declaration of Health for all by the year 2000 and beyond (Freire, 1998). Following this promulgation, the Zambian Government in matching with the world trend adopted Primary Health Care in 1981 even though mental health in the PHC package was not strongly emphasized. Similarly, all generic curricula generally did not have child and adolescent mental health component. In 1991, following the adoption of PHC, the Government reaffirmed its focus on Primary Health Care (PHC) as the main strategy for integrating health, political and economic concerns within the overall policy (Ministry of Health, 1991).

The World Health Assembly in the year 1978 Declared PHC at a small town in the former USSR as the way of providing health to the people of the world and most importantly those communities poorly resourced (UNICEF, 1998). A major goal of the policy Declaration was to achieve “*Health for all by the year 2000 and beyond*” (WHO ALMA ATA, 1978). Primary Health Care was conceptualized as a health care system as well as a strategy for health care development in which child and adolescent mental health was an integral component though it had not featured as conceptualized by the World Health Organization, and consequently defined as:

“Essential Health Care, made universally accessible, to individuals and families in the community, by means acceptable to them, through their full participation and at a Cost that the community and the country can afford. It forms an integral part both of the country’s health system, which is the nucleus and the overall social and economical development of the country” (WHO/UNICEF, 1978).

It is implied in this definition that the concept of mental health is embodied in an ideal situation and setup for the world but unfortunately, the situation of mental health has not been as integrated as it could have been. Many improvements are still required in most health care to ensure access to all who seek health care, including mental health, as well as optimal protection against avoidable causes of suffering as is the case among children and adolescents in Zambia.

Support and Care implications of children and adolescents by the family, community and society are the ideal practices of a well established PHC programme. Studies however, have shown that, both in Zambia and world over, until recently, little attention was paid to childhood as a period when lifelong patterns of behavior were laid down.

When children could live without constant attention of mother or nurse, they were regarded as small adults and were expected to assume responsibly in the adult world; (Ariès, 1960, 1982.). The discovery of childhood on one hand came in the nineteenth century as a result of a growing interest in childhood and recognition of its importance as a period of preparation for adult life.

Kammer (1935) pointed out that the *first decade* of the twentieth century saw the advancement of ideas relating to the mental health of children and services intended to promote it. The *second decade* was marked by serious efforts to identify with childhood problems and, through community measures, to help those showing deviant behavior, the *third decade*; activity was directed toward doing things for the children in the family and school.

Efforts were also made to help children with 'everyday' problems with a view to preventing serious disturbance later on. In the *fourth decade*, methods of working with problem children were developed, attention was paid to understanding the individual child, the meaning that child attached to the life events, why certain symptoms developed, introduction of facilities for the children and introduction of reading materials in child psychiatry (Kammer, 1935)

International classification of disease (ICD), argues that mental illness, particularly psychosis is similar across cultures irrespective of cultural or political boundaries, serious emotional and behavioural disorders plague up to 20% of children worldwide today (World Health Organization, 2001).

The WHO report of 2001, makes it clear that children's early environments, and the traumas they face, such as war, famine and displacement have a serious impact on their mental health (World Health Organization, 2001). The cultural view of a child and adolescent who is malformed socially from the Zambian perspective is described as "*alipena or wakasondoka*"; meaning, *madness* e.g. a child who eats from the dustbins, talking to self and generally, a child or adolescent whose behavior is abnormal and autistic etc.

These are treated traditionally either by *allopathic* (system of therapeutics in which diseases are treated by producing a condition incompatible with or antagonistic to the conditions to be cured or alleviated, also known as heteropathy or homeopathy) or *ethnopathic* (system of treating disease by an ethnic race by applying a physical infliction

on the client to relieve a feeling or disease) methods. The two classificatory systems of treating mental illness however are not in competition (World Health Organization, 2001).

The Concern, about treatment plight of children and adolescents in Zambia was sounded by government as far back in the 1980s particularly over the increase in application of allopathic practice and ethnopathic practice on children and adolescents with mental illness in rural communities of Zambia.

These forms of treatment deny C&A treatment in hospitals, for instance, some mentally ill were buried up to the chest as a way of restricting them so that the treatment process could be carried out (Patel, 1995). This method of administering the treatment has had adverse effects on the individual receiving such kind of treating on the understanding that the treatment was most effective when administered that way (World Health Organization, 2001), (Patel, 1995).

What is still a fact following the historical trend is that the precise causes (etiology) of most mental disorders are not known. But the key word in this statement is *precise*. The *precise* causes of most mental disorders-or, indeed, of mental health-may not be known, but the broad forces that shape them *are* known: these are biological, psychological, and social/cultural factors.

What is most important to reiterate is that the causes of health and disease are generally viewed as a product of the *interplay* or *interaction* between biological, psychological, and sociocultural factors. This is true for all health and illness, including mental health and mental illness. For instance, diabetes and schizophrenia alike are viewed as the result of interactions between *biological, psychological, and sociocultural influences*.

With these disorders, a biological predisposition is necessary but not sufficient to explain their occurrence (Barondes, 1993). For other disorders, a psychological or sociocultural cause may be necessary, but again not sufficient.

These issues are important and must be taken into account when exploring perceptions and understandings to inform an innovative curriculum for training and development as is the case in this study.

5.2.2 Definition and Concept

5.2.2.1 Definition

Robertson defined child and adolescent mental health as; *'The degree of age-appropriate biopsychosocial development achieved using available resource s'*. (Robertson, 1996), whereas, the Health and Welfare Canada, defined mental health as;

'the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and attainment and preservation of conditions of fundamental equality'.

This broader understanding of the definition of the concept of mental health is implicit in the findings of the World Mental Health Report: Problems and Responses in Low-Income Countries, which state that;

"The overwhelming conclusion of this report, however, is that formally defined neuropsychiatric disorders are responsible for only a portion of the overall burden of social and psychological morbidity".

5.2.2.2 Concept of Mental Health

Good mental health in the early years is built on the premise of strong attachments infants make with parents or other primary care givers, this is essential to children's health and development. Children's early experiences, including their environments and the relationships they establish with those around them, play a large role in their development {National Research Council, 2000: 1025. It can be postulated therefore that, for any nation of the world to develop, focus on the total child and viewing the child from a holistic perspective cannot be concessional.

Improving the relationships and communications between parents and other adults in the home promotes children and adolescents' health and reduce risk behavior. Unfortunately, the community has not yet been prioritized as a site for children and adolescent health interventions (Robertson, 1997: 365). Effective parenting and family are an important positive force in the well being of children and adolescents. They provide basic care and material resources and serve as positive behavioral role models; they promote a culturally sensitive, safe and supportive environment (World Health Organization, 1999).

Child and adolescent mental health as an evolving process, is characterized by continuous progress of a child in all areas of development and adaptation as children become adults whereby development must be fully developed and balanced within the 'biopsychosocial' context as an interactive concept, referring to the interaction of biological or physical factors (such as innate intellectual potential), psychosocial factors, (such as acquired coping mechanisms), social influences, (such as family, school and community environments), (Robertson, 1997). The (WFMH, 2000) put their statement about the child as follows:

“Children and adolescents, just like adults, can have mental health problems that are real and painful. These problems interfere with the way they think, feel, and act. Mental health problems can lead to school failure, family conflicts, substance abuse, violence or suicide. Environmental factors for instance violence, abuse, neglect and poverty can place children more at risk for mental health problems. In addition, Biological causes such as genetics, chemical imbalances and damage to the central nervous system are of crucial importance too over the children's mental health, and should be considered when planning mental health activities.”

Providing better primary mental health care for children and adolescents is complex and requires active participation of many stake holders as the task encompasses more than just the identification and treatment of psychiatric disorders and preventive interventions (Robertson, 1996). In order for this to happen it is suggested that a vivid definition and concept of child and adolescent mental health or of the 'normal' child be understood well and sufficiently in concrete and practical terms for it to be useful in the primary care context (World Health Organization, 1977).

The concept of child and adolescent mental health was made clear by the World Health Organization (World Health Organization, 1977), in order to demystify the held views and understandings of the concept of child and adolescent mental health, These two organizations stressed the need for provision of better promotive/preventive PHC activities for the sick children and adolescents rather than emphasis on medicalization

This notion received support through applications such as those of (Coleman, 1979) who attributed cognitive, affective and relational dimensions to interplay and cause a complex phase of development as fundamental dimensions were required in the understanding of the concept of C&A mental health

Child and adolescent mental health is therefore; evolving processes, characterized by continuous progress in all areas of development and adaptation, as children become adults. '*Biopsychosocial Development*' in this context is an interactive concept, referring to the interaction of biological or physical factors, psychological factors and social influences.

The view of a child and adolescent who has a mental health problem on one hand, and the view of madness (as often expressed at cultural levels) in Zambia (Patel, 1995), on the other hand, has both similarities and differences with the Western approach and even taught in schools of medicine.

Adolescence, is a transitional stage between childhood and adult life, it has rather indefinite boundaries, but ending as the individual achieves sufficient maturity to deal with realities of life by him or her and to be responsible for him/her actions. These stages are also popularly equated with emotional upheaval and rebellion including sudden changes of mood, shifting ideologies and clashes with authority are universal.

Foucault's view of '*madness*' referring to mental health problem stated that 'there is no objective knowledge of madness, but formulation of a certain experience based on cultural construction'. He defined madness and civilization not as a view of the history of

madness from a psychiatrist's point of view. He argued that madness was not a constant, negative objective fact but that madness was seen from the view of 'scientific' reason (Foucault, 1965).

In terms of definition of madness or mental illness, this is defined and explained as "*ubulwele bwa mutima*" (disease of the heart). There is a general belief that the brain and the heart are connected. The disease of the heart is actually mental illness with vivid neurotic or psychotic orders (Patel, 1995).

This definition and description of the view of child and adolescent who has a mental health problem and the view of madness (as often expressed at cultural levels) in Zambia (Patel, 1995) may have similarities and differences with the Western approach and taught in schools of medicine.

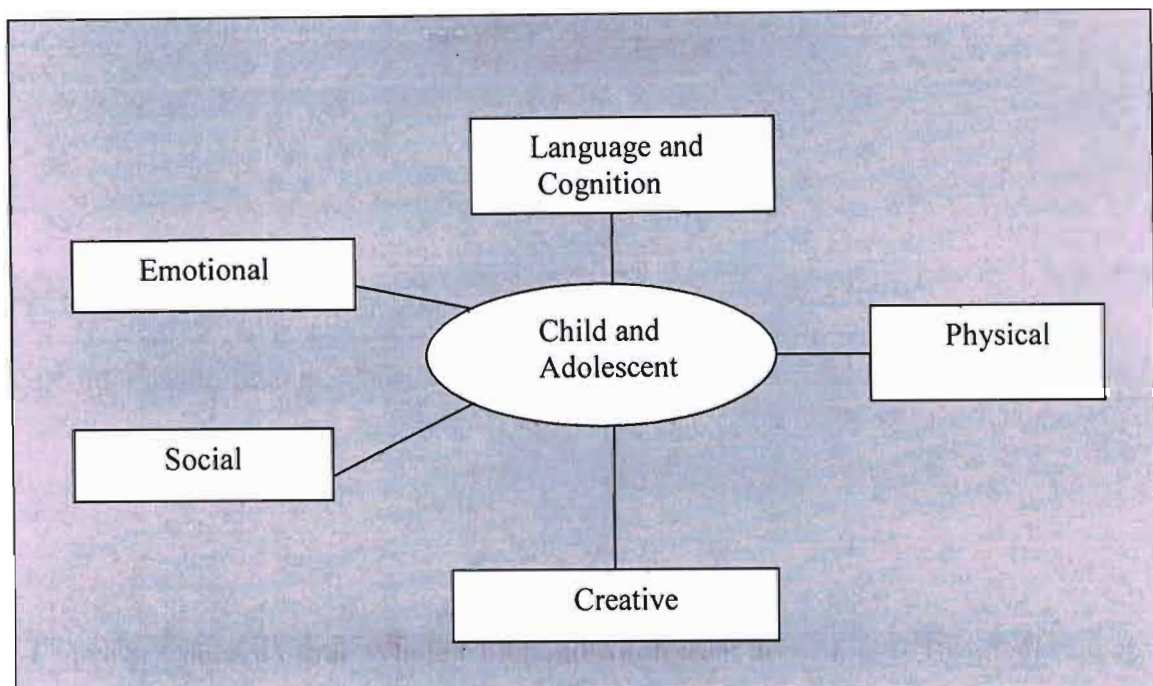
The concept of psychiatric disorders in children was described in a rather different way from the usual notion of disease (O' keeffe, 1987). O'Keefe stated; "children with psychiatric/psychological disorder are quantitatively rather than qualitatively different from the norm". She outlined categories of children as those that are more anxious; miserable; less able to control temper tantrums; slow to establish Sphincter Muscle Control; more active (hyperactive) and less active than their counterparts.

5.2.3 Perception of Child and Adolescent

The psychoanalytic construct of adolescence takes as its point of departure the upsurge of instincts, which are said to occur as a result of puberty. The individual awakens sexually for love objects and consequently, the vulnerability of the personality resulting into coping psychological defenses (Freud, 1937). Adolescence according to Freud is a '*second individuation process*' first having being completed at the end of 3yrs of life (Blos, 1962, 1967).

In order to illustrate the construct of childhood and adolescence, Bronfenbrenner used a model to illustrate the perception of child and adolescent perspective; it is presented below as follows:

Figure 8: Concept of the Whole Child and Adolescent according to Bronfenbrenner.



This figure illustrates the concept of the whole child in the context of the ecology of human development, and shows that humans do not grow in isolation, but in relation with their family and home, school, community and the larger society.

Blos (Blos, 1962, 1967); (Root, 1957) describe both childhood and adolescent periods to have certain things in common, and these include; urgent need for psychological changes which help the individual adapt to maturation; and in increased vulnerability of personality and both periods are followed by specific psychopathology should the individual run into difficulties (such as childhood and adolescent emotional turmoil, regressive behavior, ambivalence, disengagement and rebellion).

Three particular ideas can be drawn from this theory, that adolescence is a period during which there is a marked vulnerability of personality; emphasis is laid on the likely hood of maladaptive behavior and the process of disengagement is given special prominence. The stress placed on identity formation and the possibility of identity crises as elaborated by Erickson (Erickson, 1963) whose theoretical approach in this aspect is most closely associated with Anna Freud (Anna Freud, 1937) and (Blos, 1962, 1967) and all three represent a view of adolescence which might be expected to result from experience in a clinic or hospital.

Psychotic illness in childhood is very rare and further made clear that as a general rule the term 'disease' suggests a pathological process that is with a recognisable cause, effect and treatment leading to cure. She emphasized that this concept of disease is helpful in child psychiatry and stressed that the understanding of the two concepts is key in the practice of Childhood and Adolescent Psychiatry. In her paper at the 1987 CA Seminar she described an adolescent as a process in which a young star is difficult and perhaps goes through turbulent time in which aspects of fear, anxiety, exasperation and most importantly incomprehension (O' keeffe, 1987).

On the issue of modern adolescent sub-culture and parental control, (Konayuma, 1987) noted that, most parents and adults nowadays; admit that children and adolescents have become very difficult to control. They argue that an attempt to solve this scourge must be tackled from a sociological and psychological point of view. There is need to accept the understanding that childhood and adolescence are very critical stages in the development of an individual and that these stages are vulnerable. Konayuma lamented on noting that:

'Youngsters will get involved in distasteful activities such as selling cigarettes, dagga smoking; murder; theft; assault; rape; threatening violence etc' (Konayuma, 1987).

The author explained that children who are deprived emotional warmth and highly personal relationships from the family circle to which they have been used and find themselves interacting a great deal with strangers; the youngster then begins to stand on

his/her own feet and play limited impersonal roles as an adult often in competition with others.

In a study conducted between 1982 – 1985, analysis of data was done and results of the findings were Classified under; trends in Juvenile Delinquency and anti-social behaviour in the age category of 8 to 18 years, then further reported that 895 children and youths were reported for cases of cannabis/dagga out of these 821 were arrested, 741 convicted, and 100 acquitted (Konayuma, 1987).

The view of a child and adolescent who has a mental health problem, and the view of madness (as often expressed at cultural levels) in Zambia (Patel, 1995); has both similarities and differences with the western approach. Adolescence, is a transitional stage between childhood and adult life, it has rather indefinite boundaries, but ending as the individual achieves sufficient maturity to deal with realities of life by him or her and to be responsible for him/her actions. These stages are also popularly equated with emotional upheaval and rebellion including sudden changes of mood, shifting ideologies and clashes with authority are universal.

The cultural view of a child and adolescent who is malformed socially from the Zambian perspective is described as “*alipena or wakasondoka*”; meaning, madness e.g. a child who eats from the dustbins, talking to self and generally, a child or adolescent whose behavior is abnormal and autistic etc.

5.2.4 Epidemiology

5.2.4.1 Local national Studies

This particular sub-section isolates what the paediatrician does in Zambia within the context of child primary care in the general clinic and ward. The problem remains, who does the same at the primary care level outside the clinics and hospitals where the paediatrician is not there? The first group that was studied were the hyperactive children.

According to Chintu, the role of a paediatrician in the practice of child and adolescent mental health in Zambia was to anticipate problems of childhood and adolescents and if possible prevent them, if they cannot be prevented then should try to manage them with the help of other health workers, relatives and friends, these efforts are meant towards making children, adolescents and other persons enjoy a full life and contribute meaningfully to their own welfare and to that of the community in which they live (Chintu, 1987).

The author described children as those who are hyperactive, a subjective sign, which the observer, most likely teachers and parents, observe in children and then raise it as a concern, hence the referral to the hospital for attention. Chintu compared the incidences of *hyperactivity* in children between 5-10 years and found that, although these children have high frequency behaviour problems, they did not form one group. They were in fact heterogeneous group of which hyperactivity was merely a symptom; therefore correct diagnosis was essential in order to manage such children meaningfully and effectively (Chintu, 1987).

The second group were the *argumentative* children: these are children who do not listen to any thing when people in authority ask them to do something, but instead want to be in authority while those with organic disease such as encephalitis, brain damage, cerebral malaria, mental retardation and mental poisoning, showed signs of hyperactivity only.

'Uncompresis': (constipation associated with soiling of pants), was common in families where the father was away most of the time or the father was so domineering, to a point where only his word counted, and this sometimes resulted in open family quarrels. The author concludes by revealing that hysteria (conversion disorders) were common in paediatrics practice especially in girls than boys even though both sexes are affected (Chintu, 1987).

In a study done by Haworth on the most commonly used drugs in Zambia, he found that ; alcohol, tobacco and cannabis were the most abused substances but made it clear that even though others tend to say that alcohol is not a drug, his studies do show that alcohol itself is a pure drug (Haworth, 1987) He further found that in many kinds of beverages such as Tobacco and Cannabis, they are both plants, but contain many drugs, and these differ in their proportion from plant to plant and latter on discussed what a drug is and its uses (Haworth, 1987). This information was also put on mass media for public information. Haworth also publicised in the Sunday report on smoking habits of two samples of youths from school and household and found that there were more male adolescents smoking at school and home than females.

In another study, Haworth discussed the Mother and Child Health Programme (MCH) including Mental Health. He described the role of the mother during the developmental phases of the child and cited the need for good health of the mother and outlined most important problems of children in the first five (5) years of life and possible prevention measures ((Haworth, 1987) and supplementing Haworth, Osborne discussed the role of modern practices of child rearing as opposed to traditional ones. She stated that Zambia has a high urbanization rate according to Osborne's GRZ/UNICEF report of 1986, which state that such a situation has given rise to a number of health problems to the children and the adolescents later on in life (Osborne, 1987). Osborne postulated that such a development has resulted in immense cultural diversities in respect of child rearing practices among indigenous Zambians.

Osborne clarified the effects of traditional child rearing in Zambia; modern rearing practices and generation gap. She cited some of the common causes of childhood and adolescent mental health problems that specifically relate to rearing patterns and proposed possible solutions to the causes (Osborne, 1987).

In some sectors of the community there are even parents who encourage their children to bring home valuables picked up in that way, and the underlying motive of trying to please their parents. The more serious forms of mental disorder in childhood, such as mental

subnormality, Autism (withdrawal from external reality) and childhood psychoses are relatively rare (WHO, 1977), (Osborne, 1987) Serpell and Nabuzoka also provided a description of mental sub-normality and the slow learner, with a preface on terminology, description of children with severe intellectual disabilities including community-based approaches and education approaches for children with special needs (Serpell, 1987).

Convulsive disorders in children were reported by Raghu; he estimated that in his practice of paediatrics at the University Teaching Hospital (UTH) in Lusaka that these were common and made an estimate of 100 infants/100,000/year based on the western trend which is far much less. He estimated roughly that 3-10% of children aged below 5 years will have had a seizure associated with fever and further stated that the incidence of epilepsy is roughly about 5-6/1000 among school aged children and nearly 5-7% of all admissions to the children's ward in the UTH, Lusaka are due to convulsions.

5.2.4.2 Cross-continental studies

A review of international experience suggests that effective child, adolescence and youth health interventions for instance, places emphasis on whole lifestyles and the building of positive capacities and competencies rather than on negative prohibitions and disconnected aspects of behavior. It is a consistent finding from studies in several parts of the world that child, youth and adolescent problems tend to cluster during this period in their life and are characterized by substantial physical, social and psychological changes (World Health Organization, 1999).

Risk taking and other personal attributes of children particularly adolescents and youths that relate to health do not exist in a vacuum, for these young people interact with a social environment which has several interrelated components that shape their thoughts and behavior (World Health Organization, 1998). There are also sub-groups of young people that have specific needs through adverse circumstances, disadvantage, or disability.

They face the same challenges as their peers and in addition to this have to deal with their specific problems (World Health Organization, 1998). The overwhelming majority of visible homeless children and adolescents are male. Some have left their homes on permanent basis and live on the streets; others operate in the cities raising money by begging or odd jobs by day and returning to their homes at night, or on some nights.

Cross-continental studies conducted in; Columbia, India, Sudan and Philippines (Giel, 1981); (Shatkin, 2003) have shown an increased trend (12-29%) of children, ages 5-15 yrs have mental health problems with growing age and these problems have been consistently missed out at the primary health care level among the communities studied. The overall rough estimate picture of mental health problems among children and adolescents accounted for 10-20% worldwide and rated 5 out of the top 10 mental disorders leading causes of disability in the world.

Further studies done in the USA (21%), India (7-20%), China (7%), Korea (19%), Japan (12%), Gaza Strip (21%), have also shown that there are similarities and variations of varying degree of children and adolescents with mental health problems. This picture demonstrates that the problem exists across continents and also affects school-age children who have been reported with anxiety (21%) in the USA studies with diagnosable addictive disorders due to alcohol and drug dependence and other substance dependencies such as the inhalants (glue sniffing, petrol, thinners).

Results of the European studies show that there are clear variations of mental disorders in children and adolescents, for instance, Finland records 15% of ages 8-9yrs, Sweden, 17% of ages 11-13yrs and Greece, 39% ages 12-15 yrs, again giving an overall picture of 10-20% of children and adolescents worldwide. This review of local and international literature shows that, mental health problems of children are real.

Mental health problems among children and adolescents have been found to be common and various studies to prove that the problem of mental health in children is real and exists have been conducted and among these was, a study done in Ethiopia, where it was

found that the prevalence rates of mental disorders were 3% to 4% among children under 9 years and 6% - 10% among those of 10 to 19 years. In Sudan, a community-based survey study involving 1716 children aged 3 to 15 years was also conducted.

The results showed that 63% appeared to look mentally healthy, while about 37% presented features ranging between 8% for mild mental health symptoms, 20% for moderate mental health symptoms and 8% for clearly defined and developed symptoms (Giel, 1981).

In his extended series of investigation (Giel, 1981), further reported on studies conducted on childhood mental health problems particularly in primary health care in four countries; Columbia, India, Sudan and Philippines. The results showed that, the prevalence rates of mental health problems increased with age but notably it was found that 5% was among children of 3 to 6 years of age and 10 % among 7 to 15 years of age, while 80% to 90% of childhood mental health problems were *“consistently missed out at the primary health care level in those communities studied”*.

Given the many problems that face many African nations, mental health is not yet high on the agenda, there is growing evidence in literature to show that childhood and adolescent mental health problems worldwide have been neglected and subsequently little or no attention to the needs of these children and adolescents has been provided (WFMH, 2000): (World Health Organization, 2003); (Robertson, 1996).

The Global picture of mental health problems shows that 10-15% of the burden of diseases is due to neuro-psychiatric disease (Ministry of Health, 2000), while, 80-90% of psychosocial and psychosomatic mental health disorders are missed in the identification and diagnosis by PHC workers (Giel, 1981). This problem was also consistent with other reports of findings by (World Health Organization, 1977), (The World Health Organization, 2003b), (The World Health Report, 2001) and (National Research Council, 2000).

Epidemiological studies of disturbance in adolescence in Australia showed that about 15% have significant psychiatric symptoms. The adolescence is a time of rapid social change when considerable demands are made upon the youth, some show signs of emotional difficulties; this could probably be a reflection on the flexibility of human personality that many withstand the storm so well (Stoller, 1972).

Indicators of such problems may include mood disorder such as depression, anxiety disorder such as attention deficit hyperactivity disorder (ADHP) (Dawes, 1997). Zambia has no national studies at present that provide estimates of the proportion of children and adolescents with such mental disorders.

The international studies indicate that it is on the order of 15% with an estimate of 8.1% for developing countries alone with global burden of disease (GBD), a measure of all forms of loss caused by disease when international self inflicted disease are added, the total global burden of disease is 15.1% for women and 16.1% for men (Collins 1999)

Impact studies (WHR, 2000, 2001 and 2003); (The World Health Organization, 2003a)WHO also showed that up to 20% of children and adolescents world-wide suffer from a disabling mental illness; with 3-4 % requiring treatment of some kind as a result of influence due to displacement through various life situations.

Prevalence and incidence studies also have further shown that the problem is evident with similarities of results in various parts of the world (Giel, 1981). A study of 1,716 children and adolescents in Sudan and Ethiopia (Giel, 1981) and South Africa (Robertson, 1997) confirm the magnitude of the problem with similarities of findings also.

At a global level, the extent and picture of mental health problems of children and adolescents has been expressed in ways and burden that the world community is alerted of the dangers of unmet needs and problems of children and adolescents (Weissman, 1999); (Geller, 2001); (World Health Organization, 2003); (WHR, 2000, 2001 and 2003).

Indicators of such problems may include mood disorder such as depression, anxiety disorder such as attention deficit hyperactivity disorder (Dawes, 1997). Zambia has no national studies at the moment that provide estimates of the proportion of children and adolescents with such mental disorders.

The international studies indicate that it is on the order of 15% with an estimate of 8.1% for developing countries alone with global burden of disease (GBD), a measure of all forms of loss caused by disease when international self inflicted disease are added, the total global burden of disease is 15.1% for women and 16.1% for men (Collins 1999).

As the definition implies, it is appropriate to contextualize mental health in terms of development, specific risk and protective factors which vary according to the development stage of the child and adolescent and intervention measures which fail to recognize the development phase of the child and adolescent are likely to produce poor results (Collins 1999).

5.2.5 Etiological factors

The factors under review in this section include: life stresses; environmental factors; and biophysical factors including the effect of resources to support the child's development.

5.2.5.1 Life stresses

Children and adolescents like adults, once neglected, do experience mental health problems that are real and painful (World Health Organization, 1977) Studies show estimates of the proportion of the children and mental disorders, in the order of 15% with an estimate of 8.1% for developing countries alone (Collins 1999). The Global Border of Disease (GBD) shows that 15.1% of the GBD are women and 16.1% are men, (Collins 1991). Because mental health has roots in several disciplines, it is also correct to state that the mental health problems seen later in adult life are linked with social adaptation.

Where there is absence/lack of parental or caregivers' attachment by the young in the early years has been cited by a number of authors and institutions to contribute significantly to the child's mental health well being later in life (National Research Council, 2000).

In Africa, children have suffered much mainly, as a result of life stresses (psychological factors), such as the enormity of problems especially in health; poor resources, lack of infrastructure, HIV/AIDS, poverty, war, racism, and underdevelopment. It is not prioritized and no comparable advances have been made, in the treatment and prevention of mental health problems (Dawes, 1997).

Studies by (Dawes, 1997) have shown that a number of factors, such as risk and protective factors can affect the child's mental health well being. The former refers to factors that increase the probability of mental health difficulties, while the later refers to factors that mediate the effects of risk of exposure as contained in the term 'bio-psycho-social' in the definition, this suggests, that these risk and protective factors can exist in the biological, psychological and social perspectives (Flisher, 1997).

Through experimental and clinical studies, (Cannon, 1914) laid the ground work for psychophysical research by demonstrating that external stimuli associated with emotional arousal caused changes in basic physiological processes. Mayer argued that life stresses need not be catastrophic or particularly unusual to be pathogenic. He advocated the value of life events to bring out temporal links between such happenings as change at habitat, school entrance, graduation, marriage, divorce and bereavement and the onset of mental health disorder (Mayer, 1957).

This proposition was further developed in the 1960s by (Holmes, 1967) in which the assumption was that it was the extent of life change that was stressful and not necessarily the unpleasant nature of the life experiences. As a result of growing interest in this area, the 1970s saw a reappraisal of psychosocial stress research (Paykel, 1974 and 1978), who noted the importance of undesirable and desirable life changes.

Early literature on life events seemed to carry the implicit assumption that most life stresses arose by chance but most longitudinal studies have shown the huge impact of a person's own behavior in childhood was associated with a lot of increase in negative experiences many years later, such as multiple divorce, unemployment frequent job changes, lack of friends and lack of social support.

Champion and Colleagues, after their 20 years follow-up study of school children showed that mental health disorders (psychopathology) at age 10 years was associated with a more than double in the risk of both acute and chronic life experiences in adult life that caused psychological threat and many of these events and experiences carried psychological risk involving social interactions (Rutter, 2000a) and it was expected that these would have been influenced by the persons own behavior.

Research with adolescents found similar pattern, with poverty depicting school behavior problems, poor achievement and both emotional difficulties and disruptive behavior problems (Conger, 1993); (Hanson, 1997), Although some recent studies have found that poverty during children's preschool years is the most damaging (Duncan, 1998). These findings demonstrate that low socio-economic status is linked to behavioral, emotional and cognitive problems for children and adolescents.

Studies on the *resilience* of children (Rutter, 1985) noted that resistance to stress, is relative, not absolute; the basis of resistance are both environmental and constitutional and the degree of resistance is not a fixed entity, but varies over time and according to circumstance. Rutter gives example of genetic factors, such as temperament or cognitive level; he notes that these have their impact through their role in influencing individual differences in susceptibility to environmental risk, as do children's prior experiences (Rutter, 1999).

Another model, that was applied and found most useful to understand the genesis of child and adolescent mental health problems is one which depicts the establishment of an

aetiological link with the stressor, and then examines the thinking between the presumed stressor and the onset of the adjustment disorder which is stated at the maximum of three months (Kovacs, 1975), (Goodyer, 2000a).

The model proposes coping strategies or satisfactory adjustment with a stressor for normal coping and normal responses to the stress which mostly depend on culture-bound; (Friedenberg, 1995). The model proposes coping strategies or satisfactory adjustment with a stressor for normal coping and normal responses to the stress which mostly depend on culture-bound (Friedenberg, 1995).

Harrington and Harrison state that, although bereavement enhances the risk of mental health disorder, other studies have shown that the majority of the bereaved children do not develop mental health disorders either in childhood or adult life (Harrington, 1999).

Further epidemiological studies indicate that childhood bereavement in itself is not a major risk factor for later mental health disorder. This finding harmonizes the unproven assumptions about the impact of bereavement on children and of the perception that loss of a beloved one causes mental health disorder, even though it is capable of precipitating or even predisposing the genesis of mental health problem depending on its intensity and other related factors.

One of the most important theoretical models used in the recent times has been most clearly described by (Engel, 1977) who believes that many diseases begin as a response to the real, or threatened, assumed, or imagined loss of a significant person in the family or clan. This loss according to Engel creates a sense of extreme insecurity and results into what Engel calls “*giving up/ given up*” state, one of helplessness and hopelessness.

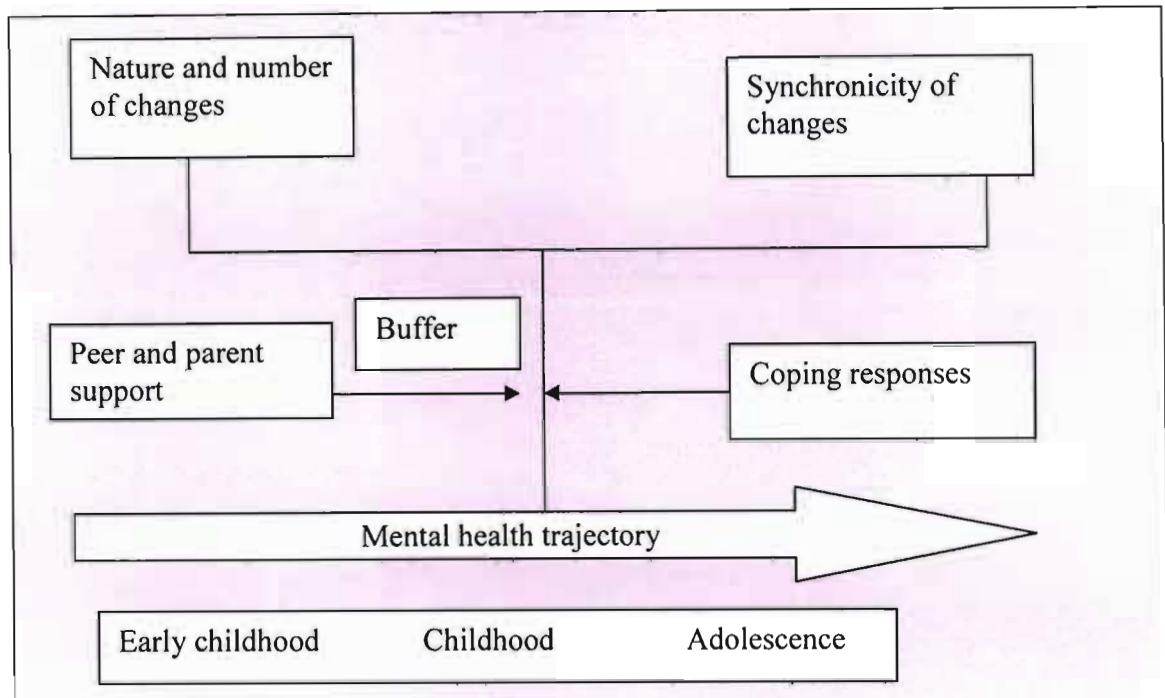
Engel explains that, loss resulting in the “giving up/given up” complex is associated with disease onset in 70 to 80 % of all patients, not just those with the classical mental health problems and diseases. He further notes that, real or threatened, loss has been described as a predisposing event to many diseases and not just mental diseases including cancer

(Bahnon, 1969), (LeShan, 1966). As a consequence of loss, dependence has been reported on the part of the affected with classical manifested mental health problems in particular the psychosomatic conditions that , but caution has been cited that not everyone reacts to the loss the same way. Prior life experiences as well as personality types will determine the nature of the individual's reaction. Many other clinical and epidemiological studies have further shown associations between life events of a severely negative kind and mental health disorder in children and adolescents (Goodyer, 2000a); (Goodyer, 1990).

A model of developmental transition in early childhood and adolescence was used by Riese et al, in (Coleman, 1979); to illustrate the developmental transition. The model has a *trajectory* which is a continuum from childhood to adolescence and beyond as shown in the figure below. Rice and colleagues in their model examined nature and number of changes and the synchronicity of those changes in the life of the child and adolescent.

After examination of these two changes (nature and number of changes plus synchronicity of changes), they suggested a buffer process where the child and adolescent required the support of the peers and parents on one hand and the coping responses on the other hand. The advantage of this interplay of peer and family support and the subsequent coping suggests a smooth mental health trajectory or route/path as illustrated in the figure below.

Figure 9. Model of developmental transition in early adolescence.



This figure illustrates that in order for the child to go through a normal developmental milestone and in this case the mental health trajectory which commences from childhood to adolescence, there must be a buffer system which must be influenced and supported by the parents and the peers in the community, the school as well as the community at large.

The support mechanism at this stage is critical as the child continues to face the challenges of life during this mental health trajectory with various natures and number of changes as well as the synchronicity of these changes. What is very important are the coping responses together with peer and parent support which must mitigate the child's environment as the child keeps developing.

The controversy as to whether children are provided with or without resources while at school, the community reported that whether children are given money or in some cases

are not given the money, this aspect does not make any difference as to whether to concentrate in school or not, they cited particularly in instances where there is virtually no food security at home for them to carry some of it to school. This, in most cases has led many girl children into sexual options with bus drivers and any other people who could support them financially and at times materially just to eat and occasionally to dress just for them to appear like the rest of the other children at the school.

The lack of adequate food for children and the family was said to have direct relationship with *retrenchments* of parents from employment, leading to economic problems in the homes and sometimes has tempted many parents to begin giving unfulfilled promises to children, leading to mistrust of parents. In some situations, it is not just the food aspect while at school, but the dressing itself, the type of dress and the version or fashion on the market matters. These children and adolescents find themselves while in these schools in a competitive world between the children coming from the well to do families and the lower income groups.

It is at this point that such kind of problems and inadequacies in the children begin to manifest and if no correctional support is timely intercepted the girl child simply drifts away into the open world for support particularly that they are left alone for long periods because parents are out to their business places.

As some of the parents are not good models to their own children and families, the common thing that children do behind the scene is to begin to imitate bad behaviors and practices of the caretakers for those families with caretakers as well as neighbors. Inevitably, some children find their way out to public places anytime as there are no guiding restrictions of age in a number of places like bars, hotels, restaurants and clubs. Girls in these places subsequently get involved into prostitution and other risk behaviors, and regrettably the families are not affected by the fate of their children as they become a relief from the pressures of socio-economic burden.

5.2.5.1.1 Bereavement in the family as Loss

Perception and understandings about loss in the broadest sense against other competing cultures have attracted a lot of controversy about it in families and communities that have encountered loss of their loved ones. The model figure below assists to illustrate the processes underlying the impact of chronic life stresses in children and adolescents, with foregoing implications if the family and community do not intervene to provide a correctional support and/or therapy.

In subsequent years, it has been generally recognized that stressful life experiences may have an adverse effect on the well being of children and predispose them to physical and mental disorder (Riese, 1969);(Garmezy, 1985). Studies by various psychologists tend to focus on the relationship between bodily changes and life experiences containing an emotional component but the studies done by (Ruth, 2004) clarified chronic adversaries/life stresses of children and adolescents and included *loss* of a loved member of the family, Ruth used a *heuristic model (figure 10 below)* to explain the process underlying the impact of chronic adversaries or life stresses in children and adolescents' mental health well-being. Her model outlines examples of chronic adversaries and their key characteristics on intrapersonal processes such as attachment, emotional, security and emotional regulation, internal representations and physiological systems.

On inherent predispositions, Ruth's model outlines gender, genetic, physical health and temperament as the key characteristics of life stresses, she highlights: low sensitive response, low stimulation, punitiveness, sense of danger and unpredictability, as some of the many key characteristics of life stresses, which may precipitate the arousal of intrapersonal processes and inherent predisposition.

In summarizing her model, she suggests that there must be a balance of the chronic adversaries between the *intrapersonal processes and the inherent predisposition processes* in the child's/adolescent's life-world, failure to which the child's life may

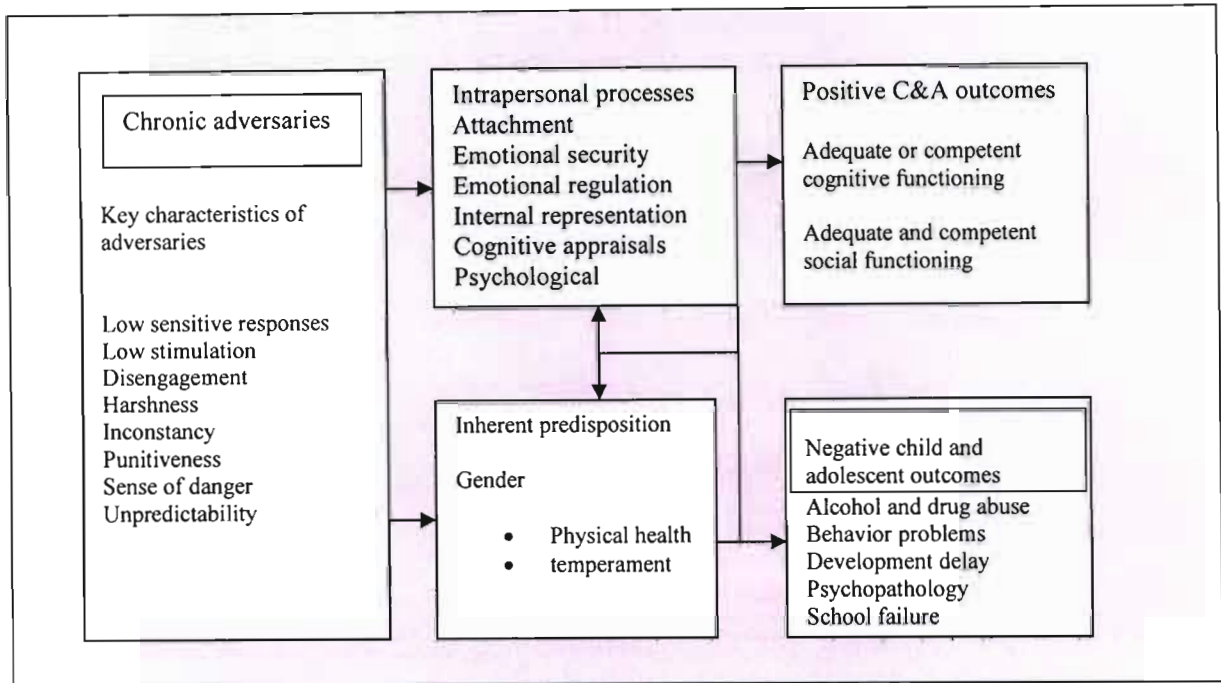
manifest positive child/adolescent outcomes in which the child and the adolescent will function adequately and consistently in cognition as well as function adequately or competently socially (Ruth, 2004)

The opposite is what the child and adolescent will manifest for instance, negative child and adolescent outcomes such as: alcohol and drug abuse, behavior problems, developmental delay, mental health problem, school failure and teenage pregnancy in some instances. What seems to be coming out of Ruth's model is a model which uses a process oriented approach to thinking about the meaning of chronic adversaries as well as more process approach to investigating the impact of chronic adversaries on children, adolescents and families.

In respect of chronic adversaries (Cannon, 1914) also in his studies on the historical basis of life stresses laid the ground work through experimental and clinical studies for psychophysical research by demonstrating that external stimuli associated with emotional arousal caused changes in basic physiological processes. However, (Mayer, 1957) argued that life stresses needed not be catastrophic or particularly unusual to be pathogenic. He advocated the value of life events to bring out temporal links between such happenings as change at habitat, school entrance, graduation, marriage, divorce and bereavement and the onset of mental disorder.

Early literature on life events also seemed to suggest the implicit assumption that most life stresses arose by chance but most longitudinal studies have shown that huge impact of a person's own behavior in childhood was associated with a lot of increase in negative experiences many years later, such as multiple divorce, unemployment, frequent job changes, lack of friends and lack of social support. The figure below illustrates the heuristic model for processes underlying the impact of chronic adversaries in a child and adolescent.

Fig. 10: Heuristic Model for processes underlying the impact of chronic adversaries in a child and adolescent: Ruth et al (2004)



This figure illustrates a child or adolescent growing in an environment with chronic adversaries on one hand with intrapersonal processes and on the other hand with inherent predisposition endowments such as gender.

What is important about this figure is that in situations where the Intrapersonal processes are well nurtured and supported by the environment that child grows up Positive C&A outcomes and in the event where the inherent predisposition is not supported by the environment, then the CA experiences negative child and adolescent outcomes such as indulgence in alcohol and drug abuse, behavior problems, development delay, psychopathology and school failure.

5.2.5.1.2 Poverty as a life stress factor

The issue of poverty is a real problem worldwide. Studies conducted by Duncan and Rodgers in 1977 under the US government found that, 19% of children in the US lived in families with income below the poverty line of (\$16,400 for a family of four).

Poverty description in the US is an official measure of economic standing, and is defined by the US government as the '*income necessary for the basic support of food, clothing and shelter*'. The poverty line is a monetary threshold and those falling just below the poverty line are usually not meaningfully better off than those falling just below it. In another study, it was found that 50% of all US children at some point during childhood live in families whose income is near the poverty line, and almost one third of children in the US live below the poverty line (Duncan, 1998).

It has as well been reported that poverty is related to poorer physical, cognitive and social outcomes for children and adolescents (Duncan, 1997) and low birth weight and other health problems, such as asthma, have been reported to have a higher prevalence rate in low-income populations .

Family poverty is linked to more behavior problems and poorer cognitive functioning during early and middle childhood (Dodge, 1994); (Duncan, 1994). Neighborhood poverty is related to cognitive delay, antisocial behavior and emotional disturbance concurrently and over time controlling for age, gender and race (Dubow, 1994).

Research with adolescents found similar pattern, with poverty depicting school behavior problems, poor achievement and both emotional difficulties and disruptive behavior problems (Conger, 1993); (Hanson, 1997), Although some recent studies finds that poverty during children's preschool years is the most damaging (Duncan, 1998). These findings demonstrate that low socio-economic status is linked to behavioral, emotional and cognitive problems for children and adolescents.

5.2.5.1.3 Culture and Ethnicity

Super and Harkness, in trying to describe culture as the major determinant of the developmental position of young humans said that the physical and social settings, the customs of child care and rearing, and the psychology of caretaking, these together define what kind of behavior will be experienced as stressful to the child's family, what will be problematic is the child's development (Super, 1960A). They structure the adaptations that a family and community can make to a poor fit of individual and environment. The sequences of adjustments are the ingredients for learning, for the development of self, and for acquisition of conflict and coping.

At the same time, the growing child is following his or her own parameters of change, against this background, Super and Harkness concluded that, the process of adaptation is a mutual one (Super, 1960A), and at each step of the way cultural meaning and local logistics shapes the progression. Some kinds of problems are more likely to occur in a particular context, and some kinds of responses are more likely to be given. The effect of culture and tradition, were the norms and code of conduct required and exerted on children and adolescents as a criterion for upbringing within a cultural context, has a lot of influence on children and adolescents as it is exerted by the community or area influences in respect of values, or shared goals (Sampson, 1994).

Osborne drawing experience from her profession as Pediatrician stated that Zambia has a high urbanization rate (GRZ/UNICEF, 1986) and such a situation has given rise to a number of health problems to the children and the adolescents' later on in life. This has resulted in immense cultural diversities in respect of child rearing practices among indigenous Zambians. She clarified the effects of traditional child rearing in Zambia; modern rearing practices and generation gap.

She cited some of the common causes of childhood and adolescent mental health problems that specifically relate to rearing patterns and proposed possible solutions to the

causes (Osborne, 1987). Some parents encourage their children to bring home stolen valuables and the underlying motive of trying to please their parents.

In the Zambian scenario, these again varied to some extent from province to province and tribe to tribe. Culture/ethnicity as sometimes called; involve group characteristics that define values and styles of life (Shweder, 1990). The crucial element of culture as has been identified in the study, has been seen to partially lie in living conditions such as: poverty, overcrowding, absence of resources that derive from discriminatory value system or from a lack of educational or employment opportunities, or from housing or other policies (Greenfield, 1994).

5.2.5.1.4 Substance Use/Abuse as Life Stress Factor

Substance use/abuse in its broadest sense has been attributed to the mental health problems of children and adolescents. Substance abuse concerns which include *inhalants* has been reported and shows a marked rise during adolescence due to its use and abuse particularly alcohol and other drugs (Weinberg, 1998). The cause of the rise in the teen years is not obvious. The authors consider that part of the explanation may lie in age-related psychological responses to the physical substance.

Some other studies suggest that early *menarche* is associated with an increase in smoking and drinking of alcohol in girls (Shatkin, 2003), as well as the already established in the socially disapproved behavior. A Finish twin study (Dick, 2000) found that the effect was confined to girls in urban rather than rural) settings. The study also found that the effect was not caused by any shared genetic liability between early puberty and drinking/ smoking.

Concerning *inhalant* abuse, (Cambor, 1990) reported that inhalants are legally obtainable volatile substances (glue, thinners, aerosols and petrol). These inhalants are easily obtainable by the economically disadvantaged children because they are cheap and easily

accessible, and present in most households. The substances are found mostly among street children, but they may be abused among children of all social strata.

Their use may begin as early age as 8 or 9 and typically occurs in groups and is more common among boys. A study done in South Africa revealed that more high-school students had used inhalants than cannabis (Flisher, 1997), but that inhalant use typically decreased after adolescence. Inhalant abuse according to Flisher on one hand is associated with school problems, family problems, conflict/ dysfunction and anti-social behavior while on the other hand; the use of these inhalants is short-lived and is gradually replaced by alcohol and cannabis though in some cases it occasionally progresses to dependence.

It is not possible to generalize about the etiology of substance abuse related disorders because individual variation in etiological factors is marked. In addition different etiological factors are likely to be involved in the use opposed to the abuse of the substances, as well as abuse as opposed to dependence, and the use of '*softer*' as opposed to '*harder*' drugs. There is however consensus in literature that the etiology is multi factorial, with an interaction between biopsychosocial factors (Zeitlin, 1991).

Adolescence is a time to practice new roles, after the age of 10; the pre- adolescence begins experimenting with a range of behaviors. The likelihood of substance use at this stage appears to be influenced by both parents', peers' and the community's pattern of and /or attitude to substance use, some sources even attribute its portrayal in the media, as well as accessibility of substances (Friedman, 1989). Recent studies have even attributed some theories of behavior as being the basis in some children and adolescents for the use and abuse of the substances (Ajzen, 1990), (Jessor, 1991).

5.2.5.1.5 Environmental factors

Constitutional and tribal cultural backgrounds modify the symptom constellation-group or gathering (Paterson, 1975), (Patel, 1995). In a Zambia study Gynnerty (1994) pointed out that causes of mental illness are socially constructed, often attributed to witchcraft, breaking certain taboos and the influence of the spirits of the dead on the living (Patel, 1995).

Further studies cited that the majority of children, going to school spend longer periods of time in schooling institutions throughout their childhood and adolescence than the time they spend at home with their parents/guardians. Therefore, School-based mental health programmes in situations such as these can exert a major contribution in promoting the mental health state of the children and adolescents (Pender, 1996).

Because the extent of health problems in general, within the community and schools in particular among children world-over is a real practical problem, this led to an international collaboration network established to reduce the mortality and morbidity among this age group.

Other studies which tried to explain the genesis of mental health problems of children and adolescents used models of developmental psychopathology to explain the origins of pathology in a child or adolescent with subsequent application in the form of environmental models', which explain the role of exogenous factors.

Models of development were used to represent worldviews about human nature and environments that create a human life course (Lewis, 1984); (Riegel, 1976) Models of abnormal development also reflect these views, and the data from normal and abnormal lives inform our theories of development; for instance, the *trait notion* of personality (Block, 1980) and the *invulnerable child* (Anthony, 1970);(Garmezy, 1985); (Rutter,

1981) both share the view that some fixed pattern of behavior may be unaffected by environmental factors.

The models developed by (Reese, 1970) and further by (Riegel, 1976), showed an appropriate scheme for considering models that involve the child and the environment. Riegel's model of development which has been used to illustrate child's development shows that each of the elements can be active or passive agents.

The model for instance, with active agents gives an environmental control view, because in this situation the environment actively controls, by reward and punishment of the child's behavior. The characteristics of this environment may differ as may the nature of the different reinforces, but its environment determines the child's behavior. This type of environment is similar to that of Operant conditioning (Skinner, 1953).

The advantage of this model is that it is applied in various medical therapies as well as other diverse areas such as behavior modification therapy to modify maladaptive behavior and in theories that explain normal sex role learning by parental or peer reinforcement (Bem, 1987); (Fagot, 1969).

The trait/status model as is often called is characterized by its simplicity and holds to the view that a trait of the child at one point in time is likely to predict a trait at a later point in time. It is stated that a trait model is not interactive and does not provide for the effects of the environment.

A model of this nature however, has a number of problems, , even though it is widely acknowledged that the mother-child relationship in the first year of life can affect the child's subsequent social-emotional life as well as impact on its mental health (Lamb, 1985); (Lewis, 1984).

This model was also useful when considering traits that are not genetically or biologically based. The attachment model proposed by (Bowlby, 1969) and (Ainsworth, 1973.) holds

that the child's early relationship with the mother, in the first year of its life, will determine the child's adjustment throughout life. The security of attachment that the child shows in the end of the first year of life is the result of the interaction between the mother and the child. Once the attachment has been established, it acts as a trait affecting the child's subsequent behavior.

Other various types of models have been used by other authors to explain the environment and its impact on child and adolescent mental health development: Such types of models are like those of the *prototypic environmental* model which hold that exogenous factors influence development the most. Behavior, normal or maladaptive is primarily a function of the environmental forces acting on the child/ adolescent at any point in time.

In such a model, a child does behaviors **X** but not behavior **Y**, because this behavior is positively rewarded by the parents and **Y** is punished. In this model the environmental forces act continuously on the child and the behavior emitted is a direct function of the action.

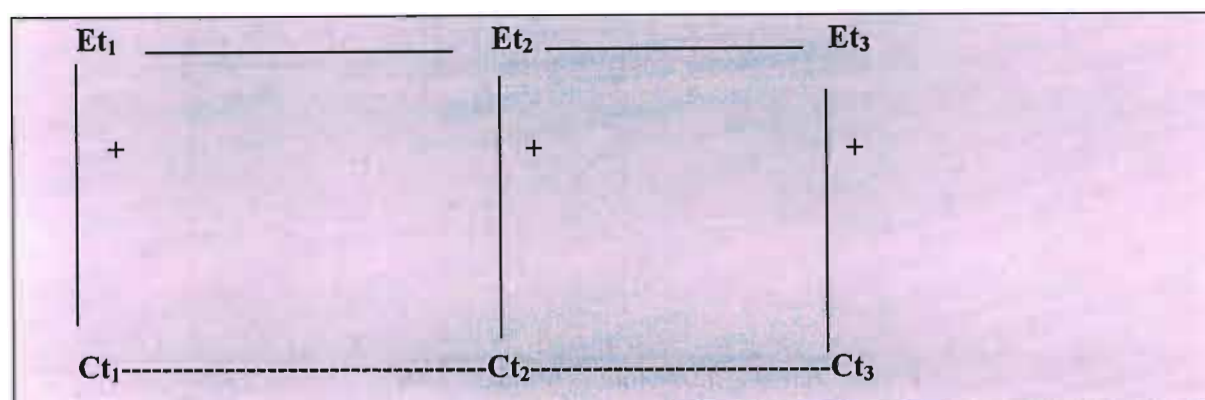
Although this model may apply for some behavior, it is more likely the case that environmental forces act on the child/ adolescent, directly at that point in time and indirectly at later points in time. In this case the child may do behavior **X**, not because of the immediate reward value, but because the child remembers that **X** is a rewarded behavior and much of the child/adolescent behavior is controlled by his indirect forms of environmental pressure. Several examples can be given to illustrate this point e.g.

'A mother who scolds the older child for sleeping out or coming home late and the young one, though not directly punished, does learn that sleeping out or coming home late is not an action to be performed'.

These indirect forms of learning received attention among communities/ families (Lewis, 1984). A general environmental model suggests that children's/adolescents' behavior is a function of the environment in which the behavior occurs. As long as the environment appears consistent, the child/adolescent behavior will be consistent too. If the

environment changes, so will the child's/adolescent's behavior change too. The figure below illustrates what (Lewis, 1989) called model of change as a function of the environment and illustrates it as follows:

Fig 11: Model of change as a function of the environment, adopted from (Lewis, 1989).

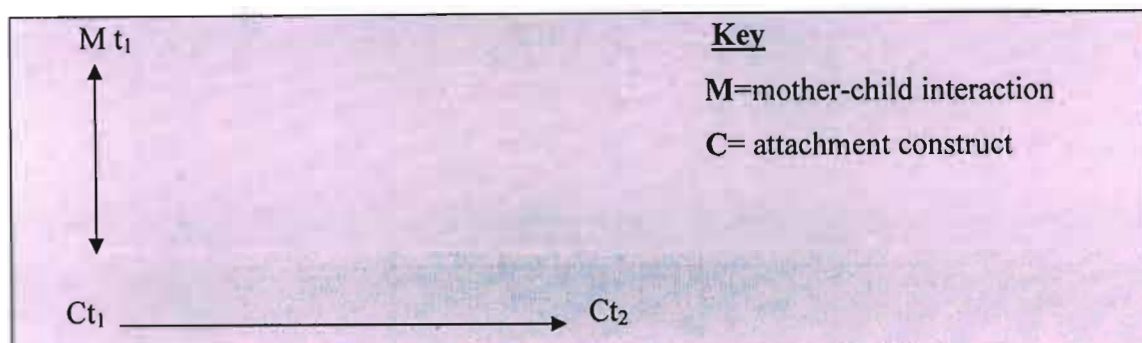


In this figure Lewis and Fering, shows that the environments at t_1 , t_2 and t_3 all impact on the child's behavior at each point in time. The child's behavior at Ct_1 , Ct_2 and Ct_3 appears consistent, and it is as long as E remains constant, in other words, the continuity in C is an epiphenomenon of the continuity of E across time, in the same way, the lack of consistency in C reflects the lack of consistency in the environment.

The child's/adolescents' behavior change over t_1 to t_3 as the environment produces change. Even though it appears that C is consistent, it is because E is consistent. Therefore, consistency and change in C are supported by exogenous rather than by endogenous factors.

The figure below illustrates the interaction of the mother and child at T_1 which subsequently produces intra-organism trait Ct_1 which might be a secure or insecure attachment for the child and Bowlby and Ainsworth illustrate this point of view in the figure below as follows:

Fig 12: Medical model using the attachment construct of the child to the mother, (Bowlby, 1969) and (Ainsworth, 1973.).



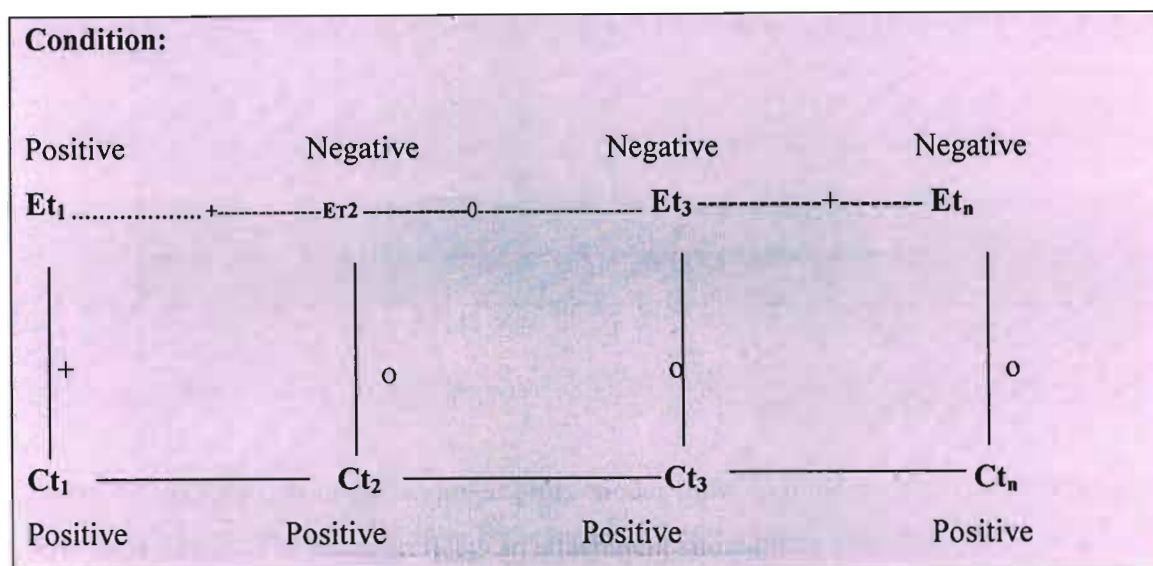
This figure illustrates the interaction of the mother and the child at T₁ which produces the intra-organism trait Ct₁ in this case, a secure or insecure attachment. Although attachment is the consequence of an interaction, once established, it is the trait (Ct₁) residing in the child that leads to Ct₂. In a situation like this one, there is no need to posit a role of the environment (M t₁ _____ Ct₂), except, it initially produces the attachment of the mother as shown in a medical model using the attachment construct of the child to the mother.

Lewis describes that attachment of the child and the mother may also play a special role as it may serve as a buffer against stress (Lewis, 1984), he further found that securely attached infants were unaffected by subsequent stress while insecurely attached infants who experienced negative environmental factors were more likely to develop psychopathology than were insecurely attached children who did not experience these factors.

The concept of *invulnerability* model shown below is similar to a trait/status model in that; there are attributes of children, which appear to protect them from subsequent environmental stress; these attributes serve to make the child stress-resistant. This mechanism is important to explain why not all at-risk children develop mental health problems (Garmezzy, 1985, {Rutter, 1979 #371). and further in the next figure (fig.13.)

illustrate this view using the invulnerability model from the point of view of an acquired trait/social status. The model reflects an attachment situation of a child.

Fig.13. Invulnerability model based on the view of an acquired trait/social status.



This figure shows that at t_1 the environment is positive so the child acquires a positive attribute. At t_2 the environment becomes negative (stress appears). However the attribute acquired at t_1 protects the child (the child remains positive) at each additional point in time, ($t_3, t_4 \dots t_n$) the environment may change; but it has little effect on the child because the intra-organism trait is maintained.

Making the point more clear, about the invulnerability model based on the view of an acquired trait/social status, Rutter further clarifies and states that:

“Alongside the life world of the child, a protective factor can act to increase the child’s threshold before a stress can affect the child. Stress may have an effect but will only do so only after a certain level is passed. The threshold concept applies not only for intensity but also for duration; that is, invariability may present the ability to sustain one or two stress events, but not prolonging stress or alternatively it may protect the child against long term stresses”

Culture/ethnicity as is sometimes called; involves group characteristics that define values and styles of life (Shweder, 1990). The crucial element of culture as has been identified in the study, has been seen to partially lie in living conditions such as: poverty, overcrowding, absence of resources that derive from discriminatory value system or from a lack of educational or employment opportunities, or from housing or other policies.

5.2.6 Biophysical Factors

The studies for instance, about the *Perceptions of the physical factors*, carried out by the Commission on classification and Terminology on epilepsy (KAE) described epilepsy disorder in terms of syndrome and within the general framework of classification of the epilepsies.

The classification distinguishes generalized epilepsy, in which seizures apparently arise in both hemispheres, and partial epilepsies in which seizure onset is in a circumscribed cortical area. The commission also makes clear the division between symptomatic epilepsy with evidence of structural brain disease, cryptogenic epilepsy in which the pathology is thought but unproven, and idiopathic epilepsies arising in an intact brain clarified by the electroencephalogram (EEG) which shows these criteria clearly according to the (KAE).

In another study, the neuropsychiatric component of the classical Isle of Wright epidemiological study showed that the brain disorders are powerful risk factors for brain disorders: the rate of psychiatric disorders recorded were 44% among children with structural brain disorders and 7% among children free from physical disorders (Rutter, 1979).

The finding that cerebral disorders carry a much higher psychiatric risk than direct brain-behavior was linked in addition to the risk attendant on any chronic or stigmatizing disorder. This conclusion was supported by a companion study that compared children

with cerebral disorders with a matched group of children disabled by other disorders, mainly musculoskeletal.

One of the most important theoretical models used in the recent times has been most clearly described by (Engel, 1977) who believes that many diseases begin as a response to the real, or threatened, assumed, or imagined loss of a significant person in the family or clan. This loss according to Engel creates a sense of extreme insecurity and results into what Engel calls “*giving up/ given up*” state, one of helplessness and hopelessness.

Engel explains that, loss resulting in the “giving up/given up” complex is associated with disease onset in 70 to 80 % of all patients, not just those with the classical mental health problems and diseases. He further notes that, real or threatened, loss has been described as a predisposing event to many diseases and not just mental diseases including cancer (Bahnsen, 1969), (LeShan, 1966).

As a consequence of loss, dependence has been reported on the part of the affected with classical manifested mental health problems in particular the psychosomatic conditions that , but caution has been cited that not everyone reacts to the loss the same way. Prior life experiences as well as personality types will determine the nature of the individual’s reaction.

Many other clinical and epidemiological studies have further shown associations between life events of a severely negative kind and mental health disorder in children and adolescents (Goodyer, 2000a); (Goodyer, 1990).

In subsequent years later, it has been generally recognized that stressful life experiences may have an adverse effect on well being and predispose to physical and mental disorder (Riese, 1969) ; (Garmezy, 1985). Studies by psychologists focus on the relationship between bodily changes and life experiences containing an emotional component.

A number of other studies have been carried out with empirical evidence which clarify the role of the physical factors in child and adolescent mental health challenge and have demystified the notion of the belief and misconception in respect of the causes of mental disorders of children and adolescents. The studies for instance, about the *Perceptions of the physical factors*, carried out by the Commission on classification and Terminology on Epilepsy described epilepsy disorder in terms of syndrome and within the general framework of classification of the epilepsies.

The classification distinguished generalized epilepsy, in which seizures apparently arose in both hemispheres, and partial epilepsies in which seizure onset was in a circumscribed cortical area. The commission also made clear the division between symptomatic epilepsy with evidence of structural brain disease, cryptogenic epilepsy in which the pathology was thought but unproven, and idiopathic epilepsies arising in an intact brain clarified by the electroencephalogram (EEG) which showed these criteria clearly.

In another study, the neuropsychiatric component of the classical Isle of Wright epidemiological study showed that the brain disorders are powerful risk factors for brain disorders: the rate of psychiatric disorders recorded were 44% among children with structural brain disorders and 7% among children free from physical disorders (Rutter, 1979).

It was found that brain disorders increased the risk of most mental disorders (Rutter, 1979) while the neurological factors component did influence the type of psychiatric disorder, other reports found and underpinned particular associations between particular brain disorders and specific psychiatric disorders including pervasive developmental disorders between Sydnham's Chorea and Obsessive-Compulsive Disorders and between developmental abnormalities of the Temporal Lobe and Schizophrenia (Taylor, 1975) and between Hemiplegic's, Cerebral Palsy and Hyperkinesis (Ingram, 1985).

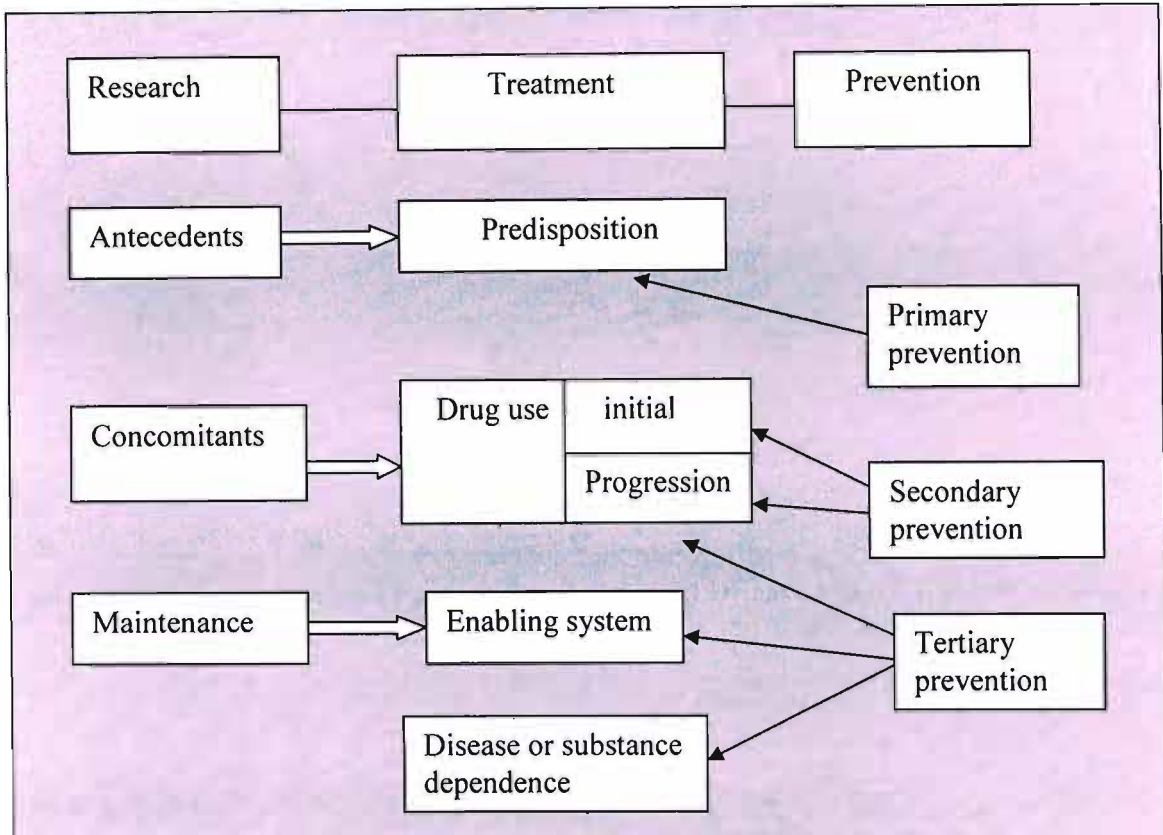
Within these milieus, (Chatlos, 1996) also did a study using the Biopsychosocial Factors Developmental Disease Model and called the *antecedents* which predispose the child to

mental disorders as genetic, constitutional, psychological and socio-cultural factors. In his study he further elaborated that *concomitants* such as (drug use and other events) are enforced onto the antecedents which give rise to predisposition of some form of child and adolescent mental health disorder once initiated and if no intervention it progresses.

It was generally pointed out that certain diseases and conditions, which run in families e.g. Down's syndrome and epilepsy, were cited as some of those which the community related to life styles of the communities as well as conditions of living in some households.

Even though the connotation this statement gives is like the community causes Downs Syndrome and epilepsy, this is not the point, but what is being referred to here by the community is, where the community uses herbs, toxic enough to cause secondary epilepsy and/or the household eat insufficiently cooked pork which may be infested with *taenia solium* (tape worm) segments which are both '*hermaphrodite*' which in the long term has the capacity to cause epilepsy, therefore their perception about the etiology of the two forms of conditions is not too far from reality even though they are not in a position to provide scientific basis of what they perceived and said. The figure below gives an illustration of biopsychosocial factors developmental disease model, where prevention at all levels of disease progression is essential as described in the figure below:

Figure 14: Biopsychosocial Factors Developmental Disease Model, Chatlos (1996)



This figure illustrates a model using a *maintenance plan* in a situation where the child and adolescent's condition is established for instance, the child and adolescent enabling system has the disease/illness or substance dependence. In this model, it is proposed that the application of *primary prevention* will counteract the predisposition and *initiation process* of the illness and substance dependence in the initial phase to prevent it from progressing where it will require *secondary prevention*

In his further illustration of the maintenance plan, Chatlos proposed use of an *enabling system* to support the child and adolescent with progressing disease or substance abuse, by application of *tertiary prevention* support which starts at *secondary prevention*, enabling systems level and illness dependence levels as illustrated (fig 14) above.

5.2.7 Core Competences of Practitioners

Human Resource Development and Training of Primary Health Care Practitioners and Nurse Practitioners in Zambia are regulated under the statutory instruments of the ((Medical Council of Zambia, 1977) ; (General Nursing Council of Zambia, 1997); {National Health Strategic Plan, 2000 #1060).

Research findings worldwide on competencies have shown that generalist PHC practitioners consistently miss out the identification and diagnosis of psychosocial and psychosomatic mental health disorders at primary care level in 80-90% of the cases seen {Giel, 1981: 396}, due to lack of appropriate competencies to identify and manage mental health problems of children and adolescents in their practice.

Such findings, as (Kastrup, 1976), puts it, calls for the need to build the capacity of staff, which was evidently the view of both the American Board of Paediatrics' statement of training requirements for Pediatricians in Growth Development, and (Starfield, 1980) psychosocial and psychosomatic diagnosis of mental health problems of Children and Adolescents in the Primary care settings supported.

The discrepancy with practitioners is the culture of not exhausting all possible avenues before labelling a child hyperactive, and advised parents to know conditions of their children in order to correlate the evidence with that of the Practitioners. On the issue of enuresis (bed wetting) - in children above 4 years of age, this was a problem, even though it is argued that after this age a child must have already developed good toilet training The only difficult with such children is the public ridicule that they face as a result of bed-wetting (Chintu, 1987).

Chintu further observed that children referred to the clinics by the schools, were referred because of learning failure or possible dyslexia because of restlessness and over activity in their behaviour. This problem was particularly marked in children from broken homes

or where there are family disturbances causing stress. Their behaviour was attention for help rather than an inherent mental disorder.

Children referred by the general doctors for disorders such as not sleeping, bed-wetting or soiling their clothes were common reasons for referral, but behavioural disorders could vary widely in the underlying casual factors. Those of the children who were caught stealing by shoplifting the underlying motive could have been simply greed but some children take things they do not really want and their behaviour may then be a reaction to the challenge of doing what is forbidden.

Practitioners are often not trained with competencies to identify and manage mental health problems resulting in missing and misdiagnosing C&A with mental health problems. There is need to put this right by way of training practitioners on the Zambia agenda to manage C&A with mental health problems and this must be factored into the curriculum to address the development of an innovative indigenous Zambian curriculum.

5.2.8 Resource Support

In Zambia like any other part of the world as noted by (Saraceno, 2003) the situation worldwide, in the history of the WHO mental health programme, attention dedicated to the children and adolescents in mental health care and support has not been commensurate with that dedicated to adults and elderly. There is therefore, need to put this on the agenda and get it into the curriculum.

Attention and care of childhood and adolescent mental health problems in Zambia National Mental Health Resource Centre (NMHRC, 1987); and worldwide (WFMH, 1997; (WHO/UNHCR, 19); (Robertson, 1996) has been neglected and subsequently little or no priority to the needs and problems of these children and adolescents has been placed.

In the African context, with a number of overwhelming factors such as poverty, wars, racism, and the enormity of problems especially in health with prominent poor resources, lack of infrastructure, HIV/ Aids: are not yet highly prioritized, these have facilitated increase to the many mental health problems of children and adolescents, and this is a growing concern (WFMH, 2000); (The World Health Organization, 2003a); (Robertson, 1996).

Zambian Government in matching with the world trend adopted Primary Health Care in 1981 even though mental health in the PHC package was not strongly emphasized. Similarly, all generic curricula generally did not have child and adolescent mental health component.

Treatment of children and adolescents historically, though it is dying down these days, at traditional level, meant treating the child either by *allopathic* method (system of therapeutics in which diseases are treated by producing a condition incompatible with or antagonistic to the conditions to be cured or alleviated, also known as heteropathy or homeopathy) or *ethnopathic* method (system of treating disease by an ethnic race by applying a physical infliction on the client to relieve a feeling or disease) methods. The two classificatory systems of treating mental illness however were not in competition, each model could be right when used in its proper context but only differed in precision and discrimination.

The Concern, about treatment plight of children and adolescents in Zambia was sounded by government as far back in the 1980s (Chanshi, 1987) particularly over the increase in application of allopathic practice and ethnopathic practice on children and adolescents with mental illness in rural communities of Zambia.

These forms of treatment deny C&A treatment in hospitals (The World Health Report, 2001). For instance, some mentally ill were buried up to the chest as a way of restricting them so that the treatment process could be carried out. This had adverse effects on the individual (The World Health Report, 2001). These issues are important and this study

addressed them taking into account the curriculum intervention to be addressed. Unfortunately, the community has not yet been prioritized as a site for children and adolescent health interventions (Robertson, 1997, 365).

5.2.9 Significance of Local and Continental Studies

Studies in South Africa showed that 36% of the population (1991 population survey), are children whose age range is between 0-4 years, while those under 18 years is roughly 46% {ANC, 1994: 1032}. Like other parts of the world, it has been reported that, *depression and anxiety* among adolescents were the common mental health problems in South Africa; this finding was consistent with similar studies done in other countries.

In an American study done by Yates, he found that 95% of the 55 million children for instance, “those just attending school,” were between the ages of 5 and 18 years (Yates, 1994) and showed a similar trend as that in South Africa.

This finding is highly significant because it supports the concern of the researcher for the current problem in Zambia, which requires a thorough study to assist children and adolescents. Mental health of children and adolescents is influenced by several factors and among these, some of them are sociological constructions which are: displacement through war and catastrophe, stresses on families, economic adversity, limitations on child rights affording access to education and health, and by the women in the society who must raise these children whose futures are faced with uncertainty (The World Health Organization, 2003a).

Carter pointed out that emotional and behavioural disorders of children and adolescents contributed to the building of the 2002 ‘*Theme*’ of the WFMHD which focussed on the effects of trauma and violence on the mental and emotional well-being of young people (Carter, 2003) and in her World Mental Health Day message for the Global Mental health

Education programme of the World Federation of Mental Health Declaration (WFMHD) stated;

“Little attention and resources are currently allocated to understanding and effectively treating emotional and behavioural problems experienced by children and adolescents.”

Carter (ibid) further made it clear that the 2003 WMHD global mental health education campaign focused on provision of adequate information, resources and suggested actions to address emotional and behavioral disorders of children and adolescents in a variety of settings in local communities and nationwide. (Franciosi, 2003) and the (USDHHS, 1999) further put it:

“Across the Globe, Good Mental Health of children and adolescents is important; this includes all cultures and races, from infancy to young adulthood and beyond. Recognizing and treating serious childhood and adolescent emotional and behavioural disorders must be a priority for all countries in which they live, if they are to reach their full potential. The hope for all children across the Globe is for good physical and mental health. ”

The description of the extent of the problem of children and adolescents by the World Health Organization, signals a dangerous situation laying a head, hence alerted nations of the negative impact this would cause of unmet needs and problems that would emanate out of children and adolescents (Weissman, 1999); (Geller, 2001); (The World Health Organization, 2003b).

The development of a series of activities designed to identify treatment gap, promote training, encourage rational treatment, and disseminate model policy was as a result of the timely warning by WHO of the magnitude of the burden of child and adolescent mental disorders which could ameliorate the situation such as; barriers to treatment; and funds for the care of children and adolescents with mental disorders (The World Health Organization, 2003b).

Such findings as these are very useful, they assist innovative programmes justification and also can be used to infer the general pattern of things or status quo for the rest of the developing countries and even developed ones to facilitate innovative PHC interventions

against mental health situation (Pender, 1996). Despite this recognition and efforts to support children and adolescents, comparable advances have however not been made in the treatment and prevention of mental health problems in most developing countries (Dawes, 1997). This signifies that a lot more requires to be done across continents to improve the mental health of children and adolescents.

5.2.10 Conclusion of Chapter on CA Mental Health

The concept of child and adolescent mental health has been viewed from three dimensions of the biopsychosocial perspectives (Robertson, 1996). In this research, the focus of the concept of the biopsychosocial view of mental health problems of children and adolescents was looked at more of the *sociological dimension* (Elder, 1968); (Thomas, 1968a); (Benedict, 1938) taking into consideration the triaxial concept as in (Freud, 1937); (Blos, 1962, 1967); (Root, 1957); (Erickson, 1963) and Anna Freud (Anna Freud, 1937).

The reason behind undertaking the process of determining practitioners' and the community's perceptions and understandings of mental health problems of children and adolescents before commencing developing the innovative curriculum using the sociological route was based on the conceptual and theoretical frameworks which underpinned the integration of the ecological theory of child and adolescent development, systems theory and the biopsychosocial theory.

It was for this aspect that it bears strong features of a socially negotiated and construed undertaking for it to earn its trustworthiness, credibility, consistency and not only these aspects but for purposes of the validity of the key purpose of its development and the key research questions. It is hoped that in this way it will be reliable and stand out as a justified document which had the participation and input of the community and the practitioners.

The view in Zambia that mental illness is largely incurable and nothing can be done about it, is something that must not remain with us forever, it is a problem that by taking suitable measures, can be reasonably remedied, with hopes for further progress in the future (Paterson, 1975), (Patel, 1995) and advancement in diagnosing the different types of mental disorders in providing for the management and treatment of the mentally ill.

It can be argued that, quite often, those not directly involved in the care of the mentally ill do not always appreciate the extent of the problem of mental illness. A good example is surveys in the UK, which have shown that one family in five is affected by mental illness of one kind or another. One man in nine and one woman in five will require psychiatric treatment at some time in their lives, and more than 30 million working days are lost through mental disorders each year (Arena, 1977)

The role of a paediatrician in the practice of child and adolescent mental health in Zambia is to anticipate problems of childhood and adolescents and if possible prevent them, if they cannot be prevented then should try to manage them with the help of other health workers, relatives and friends, these efforts are meant towards making children, adolescents and other persons enjoy a full life and contribute meaningfully to their own welfare and to that of the community in which they live (Chintu, 1987).

As resources are not equally available to all children, the maximum level of mental health that can be expected will vary accordingly. Similarly, the provision of resources will vary according to levels and the extent to which children and adolescents use the resources available to them (Dawes, 1994). It should be noted that children are individuals as well with agency and not merely objects passively influenced by external forces.

CHAPTER SIX

RESEARCH DESIGN AND METHODOLOGY

6.1 Introduction

The main purpose of chapter five (survey of literature) was to provide the ground for the mental health knowledge required to contextualize this study, by *exploring* through the relevant literature, emergent trends, developments and current knowledge in the field of child and adolescent mental health. This study used two forms of research designs which are:

1. Qualitative research methods were used in the three stages:

- search conference
- 4 focus groups
- Evaluation Conference

To collect the data from both practitioners and the community through an *exploration process of perceptions of the practitioners and the community* about mental health problems of children and adolescents.

2. Quantitative research design which applied document analysis method to extract information from the hospital and OPD registers and records.

The quantitative research aspect of the study was applied as a systematic scientific investigation of quantitative properties and phenomena and their relationships, widely used in both the natural and social sciences. It is also used as a way to research different aspects of education.

The general objective of quantitative research studies is basically to develop and employ mathematical models, theories and hypotheses pertaining to natural phenomena and the process of measurement is central to quantitative research studies because it provides the

fundamental connection between empirical observation and mathematical expression of quantitative relationships (Johnson, 2007).

It uses quantitative methods which are research methods dealing with numbers and anything that is measurable. They are therefore to be distinguished from qualitative methods. Counting and measuring are common forms of quantitative methods. The result of the research is a number, or a series of numbers. These are often presented in tables, graphs or other forms of statistics. In most physical and biological sciences, the use of either quantitative or qualitative methods is uncontroversial, and each is used when appropriate (Osborne, 2007).

Advocates of quantitative methods *argue that only by using such methods can the social sciences become truly scientific*; advocates of qualitative methods *argue that quantitative methods tend to obscure the reality of the social phenomena under study because they underestimate or neglect the non-measurable factors, which may be the most important* (Clifford, 2007). The modern tendency is to use eclectic approaches; qualitative methods might be used to understand the meaning of the numbers produced by quantitative methods. Using quantitative methods, it is possible to give precise and testable expression to qualitative ideas.

The reason for using the two designs was based on the assumption that the perceptions and understandings of the community and the PHC practitioners about mental health problems of children and adolescents would also be reported at hospitals and OPD records and that such evidence would be to the advantage of the study. It was therefore important that the two parallel designs were carried side by side so that the required baseline data to inform the planned innovative *curriculum to be done later after doctoral studies would be validated at two end points which are: qualitative end and quantitative end respectively.*

The other reason for using the two research design methods was that quite often *qualitative information does represent the feelings and opinions of people and these may have their own strengths and weaknesses, such information without any backup*

empirical evidence would be difficult to contextualize as is known that opinions and feelings are subjective. Therefore, the combination of objective based data and the perceptions of the people made a rich mix to contextualize the study. Hard core data from clinics and hospitals was necessary to demonstrate that *what the community perceived and understood about the mental health problems of children and adolescents was actually real and evident in the face of reality of practice.* These aspects were core to this study. The qualitative and quantitative research nature of the study implied that the process would broadly apply both *participatory interpretive and critical action research paradigms* (Greenwood, 1994), (Jarvis, 1999), (McNiff, 2000), (Cohen, 2000) in order for the researcher to draw the maximum trust, intimacy and reciprocity from the participants and the community being studied.

Action Research as a paradigm for research has been discussed in Chapter 2, but here it is important to note the actual methods used in the Zambian context. Various researchers have used action research methodology in their studies and projects and among these were (Dick, 1994,1995) who states that the most effective research methodology is one that generates data and interpretations appropriate to a given context. In a similar situation (Graziano, 1993) makes similar suggestion when referring to situations where the control of variables is impractical or unethical.

Action research according to (Dick, 1995) and (Graziano, 1993), is very critical and states that AR is useful in ‘real’ concrete situations where practical action is required. The authors argue that AR is useful where change and understanding is sought and in situations where it is usually too difficult to control variables because the situation is concrete, complex and on-going. *They postulate that Action provides change, and research provides understanding, (as illustrated on page 199, figure 15 below phase 1, stages 1, 2, and 3 only).* Dick (1995), Susman (1983) and (Altrichter, 1990) further refer to the use of action research by practitioners, as opposed to researchers, to develop responses in complex situations that are uncontrollable in any conventional research sense. *In a large and complex study such as this one with 3 phases and 8 stages it was important to focus on phase 1 stage 1, 2, and 3 only for purposes of doctoral studies.*

To support and consolidate the theory behind action research design methods, it is important to appreciate how other researchers have viewed the methodologies and the following sub section below high lights the actual design methods and approaches which were used in this study. *The researcher is aware that methods such as the search conference are not commonly applied as means of collecting data but in this study the search conference method was critical because it availed the opportunity for practitioners to contextualize issues and experiences face to face with fellow practitioners.* The most important of them all was the *imperative* to compare experiences of competences in their practice and their *views about the curricula* they went through during training in view of how much mental health was covered and child and adolescent mental health in particular.

6.2 Methods of the Study

PAR methods were used to collect the data for *phase one of the exploratory study, which are: search conference, focus groups and evaluative conference.* To collect data from hospitals and clinics, document analysis method was used, thus, the study applied both qualitative and quantitative methods. The purpose of these two approaches was to first contextualize the problems of children and adolescents from socio-economic and cultural perspectives which for decades have been sidelined in the PHC Practitioners' curricula context. It is against this groundwork that this study **ONLY** covers *one phase of the three phases for the doctoral programme* using the two methodologies which are: PAR and Document Analysis. *It must be clear from the outset that the data explored at phase one of the study are prerequisite for the process of developing a curriculum driven by the perceptions of the community and practitioners for which the curriculum is intended.*

Four focus group meetings at each research site were held they were audio-taped at the places which community members themselves negotiated and agreed to meet with each other. The questions at each of these meetings were " *1, what are the perceptions of the*

Practitioners and the community towards mental health and mental health problems of children and adolescents'? and 2, How does the Zambian community deal with children and adolescents' mental health well being?''

On the part of the Practitioners and the stakeholders, two conferences were held one at the beginning of the study and the other at the end of the research process which are: the search conference and an Evaluation Conference were held and the key questions asked at the search conference and evaluation conference meetings respectively were: 1, *“What are some of the key issues that affect the introduction of new aspects of mental health into the generic curriculum; 2, What Curriculum content would be appropriate for the planned child and adolescents' Mental Health curriculum for PHC Practitioners in Zambia; and 3, Which one of the four curricula models presented by the researcher is the Preferred Model and most appropriate for the 'INSET' of PHC practitioners in Child and Adolescent Mental Health in Zambia.”*

6.3 Data Collection Methods Used

This section addresses the process and the steps that were followed to obtain data *in phase 1 of the study only* to determine perceptions and understandings of practitioners and the community. The main focus at this point was about what they perceived were the mental health problems of children and adolescents in the community on one hand and on the other to appreciate the context in which the generic curricula were in and to what extent they had content that if passed on to the students in training, were adequate enough to apply the competences required in the practice of child and adolescent care in PHC setting (see figure 15 below).

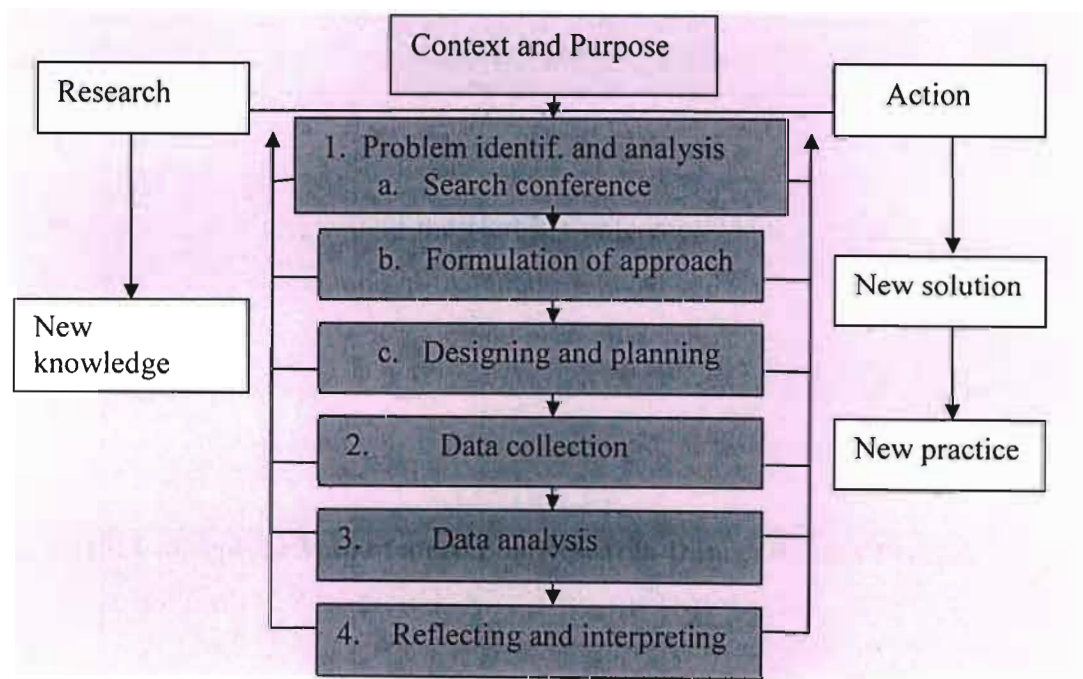
The process also enabled the researcher to draw information from hospital and OPD registers and records. The following are the methods which incorporated the Theory and Principles of PAR applied to collect the required data both from the Community, the Practitioners and the Hospital/OPD as shown in figure 15 below. The importance of the figure below is that it illustrates clearly the steps combining the Lewinian Action

Research Cycles and the Herbst Conference Model Design. The figure below further shows how research and action are inter-related in an inquiry such as in this study. Further details about the figure are given below so that it is clear why the data collection was done in the manner it was done.

The figure that is shown below provides a working framework around which the rest of the component steps of the study are linked. As a conceptual framework of the study, the figure is a map of action research data collection methods used and as stated, it combines the Action Research Cycles and the Herbst Conference Model Design as shown in the figure below. The Combination of two modes of data collection methods particularly the Herbst Model made the collection of data even more motivating as the practitioners were involved in rigorous episodes of action, reflection and action with high levels of interaction and collaboration between themselves and the stake holders.

Figure 15: Conceptual Map of an Action Research Data collection Process.

Jan Irgens Karlsen (in Whyte 1991, Vol. 123) and Herbst (Dual Tract Search Process, 1980).



This figure shows that the purpose of the study was to undertake an *exploratory research study* side by side with action at every stage to *collect the perceptions and understandings required for the first phase of the study comprising only stages 1, 2, 3. The Action, new solutions and new practice will only be done later.* The figure further shows a four-step AR cyclic process phase (*shown in Lavender color*), and also further shows how the integrated and combined qualitative and quantitative methods which are: PAR and Herbist Dual Tract Search Process as reflected in the title of the figure were used to collect the perceptions by the researcher. The figure further shows how through research it is possible to come up with new knowledge about a phenomenon through *an exploration process.* The context and purpose of the study (*shown in yellow*) was not part of the cyclic process. These two aspects were merely orientation information to the participants.

Table 3: Showing the pre-research and search conference phases of the study

These phases were for 1) purposes of consultation with 6 research assistants to plan the process and research instruments at 2 below and 2) to carry out the research process in line with (figure 15 above) which shows the Conceptual Map of Action Research Data collection Process for the study.

<u>S/N</u>	<u>Activity</u>	<u>Method</u>	<u>Participants</u>	<u>Chair/Facilitator</u>	<u>Researcher's role</u>
	Context and purpose	Presentation	Practitioners	Consultant psychiatrist chairs	Selected the core group members
1	Problem identification	Search conference	Practitioners	C/psychiatrist explains conference methods	Chose the consultant psychiatrist. Did not influence discussions
2	Data Collection	a. focus groups in 4 sites b. Document collection	Practitioners and community	4 senior lecturers moderate the focus groups	Chose the core group members. Did not participate
3	Data Analysis of feedback from 4 sites	Review conference	practitioners	Consultant Psychiatrist moderates the discussions	Present but did not influence the discussions
4	Core group presentation of report	Textual report	Core research group	Consultant Psychiatrist	Member of the group
5	Report to national stakeholders	Oral with flip charts	Core group member	Executive Director	Participant and gave a vote of thanks to all
6.	Data only from 1-3 analyzed for PhD				

This table shows that the expected end result in line with the concept map figure 15 above was to develop new knowledge which would inform the development of the curriculum as a result of the intervention in the community, through which the perceptions and understandings of the community about mental health problems of the children and adolescents would be conceived. The newly identified knowledge would be applied to solve the current mental health problems of children and adolescents', hence the new practice by the PHC practitioners to manage CA in the field once given the competencies required based on the baseline data to build the innovative curriculum.

6.3.1 Pre- Research Core Group

The researcher identified 6 people (inclusive of the researcher) to form a core research group prior to the commencement of the study. The group studied the research study proposal, understood the context of the study and methodology which was to be used in the study. This was a form of training for the group facilitated by the researcher and lasted a week before the actual study started the following week. The group comprised the researcher, consultant psychiatrist and 4 senior lecturers from Chainama College of Health Sciences. At the end of the one week training, the group had worked out the programme for the search conferences and data collection from the 4 research sites. This Core group decided that the agenda for the Search Conference should include: some discussion about participants' own definition of mental health; some discussion about participants; definition of who is a *child* and who is an *adolescent*? *What they perceived* as causes of mental ill-health and some preliminary discussion of curriculum.

6.3.2 The Search conference: (Step 1 of Table 3)

The meeting was chaired by the consultant psychiatrist with the following agenda: Explanation of purpose and Context of the study (by the Researcher), Discussion by the participations of: 2.1, What is mental health? What is a child and What is an adolescent? First thoughts on what is an appropriate curriculum? (following a presentation by the

Researcher) and brief accounts of work-place experiences by the participants followed by the adoption of the Action Research Schedule, Discussion in homogenous groups of perceptions of mental health, Discussion in plenary to merge these perceptions on flip-charts and finally discussion on competencies in light of **6** above.

In addition, further thoughts on curriculum, the context and purpose of the study were highlighted by the researcher himself. NB: It should be noted that the context and purpose of the study were outside the research plan (see figure **15** above in the box colored yellow). This was for information purposes only which participants needed in order to build understanding of the study as conceived by the researcher.

The next session was designed to get some common understanding of these questions among the participants as they were to go out in the field and facilitate the same questions, **2.1** and **2.2.**, with the participants in the **4** Focus Groups. This next **session, 3**, was also intended to break the ice since the practitioners were going to be working most of the time in groups, it was therefore important for them to know each other through sharing of opportunities and experiences. The next session assisted the participants to understand that they were involved in an Action Research project (see the paradigm explained in Chapter **2**).

For the next **session, 5** (see above), the participants were divided into two homogenous groups to share further their experiences from the work-place and perceptions of CA mental health. Each group had a facilitator to keep the group on track and encouraged all to participate actively. The group set some ground rules and note takers were chosen by the group. Among the rules was an agreement to use English as the medium of both joint and group plenum discussions.

It was also agreed that since participants though were all practitioners, the cardinal point was that at the time they were coming to the research study conference, they were coming with different experiences and backgrounds, hence, the need for mutual respect and fairness during the study and deliberations. Even though it is said that the approach is

subjective, it was a good new method of handling missing data and validating data collected from the field to check that what the participants in the community said was actually correct and correctly recorded. The approach places emphasis on contextualizing data, it was most useful as the data collection process evolved over several stages of the study.

At Session 6 (see above), chaired by the facilitator (consultant psychiatrist):

- The perceptions from the homogenous groups were reported back and put on flip charts. At this stage, the merged perceptions of these two groups were classified into (4) a etiological categories which are:
 - ❖ Life stressors (psychological)
 - ❖ Biological
 - ❖ Physical
 - ❖ Environmental (socio-economic) and there were also further perceptions on what is a '*Child and Adolescent*' and on what is '*mental ill-health*'

- At the end of this report-back, there was some time spent (as 7 in above agenda) when participants reflected upon their own practice competences to manage children and adolescents with mental health problems and the educators, their capacity to teach child and adolescent mental health in order for them to operate in their primary care settings with the noted content gaps in the generic curricula during the basic training (a flip-chart summary on Resources)

- Finally, (at stage 8 on the above agenda) proposed curricula models were explained again so that participants had adequate time to reflect and discuss among themselves the implications of the models before the more detailed discussions could be held after participants came back from the field. Further analysis of curricula models was done at **Step 3**; this was the review conference (see table 3 above).

- The existing curricula for nurses and clinical officers showed that there were gaps in the curricula on C&A Mental health in the two generic programmes and this meant that some intervention was required on how C&A mental health could be understood, hence covered in their pre-service and in-service training.

6.3.3 Data collection using Focus Group Discussion Method [Step 2a (of Table 3)]

The second phase of the action research project involved the initiation and continuation of a social change and meaning construction process (Gustavsen, 1986) This phase was for data collection through focus group discussions to explore community perceptions about mental health problems of children and adolescents in the 4 research sites. A summary of data collection in the 4 community research sites: Monze, Lusaka, Ndola and Kabwe were done respectively as follows:

- Teams of 3 facilitators to a team, chosen from among the practitioners invited at the search conference went to each research sites and conducted the focus groups.
- A maximum of 25 focus group members constituted the groups who were selected by the facilitators in consultation with the local hospitals at each site.
- Perceptions and understandings of the community members were discussed using the planned focus group guide (Annexure 5) composed by the pre-Research Group.
- Discussions at each site were moderated by a facilitator from the original pre-research group, assisted by two from the search conference practitioner group, one tape recorded and another made notes.

According to (Greene, 1991), the focus group interview strategy is the most popular method of applying social and behavioral science to practice. Asbury described a focus group interview as a 'data collection technique that capitalizes on interaction within a group to elicit rich experiential data' (Asbury, 1995). Another description is that they are semi-structured group sessions directed by a group leader who moderates the group while collecting data on a selected topic in an informal manner_(Carey, 1995). The subjective,

experiential data collected emanate from the people's perceptions, opinions, beliefs and attitudes, abbreviated as (POBAS) according to (Henderson, 1995).

Asbury suggests that the participants should belong to the same culture not only in terms of ethnic grouping but preferably be of the same age, gender, socio-economic status and other characteristics (Asbury, 1995). In support of a range of authors on the subject of focus group interviews, (Smith, 1995) pointed out that focus group interviews have become a popular method in research and are useful in assessing communities' needs and experiences.

Krueger writing in Morgan (Kruger, 1995) however, had a different opinion, suggesting that participants may not necessarily know one another before the focus group session, but that it does not become an obstacle if they do (Kruger, 1995). In this study participants were heterogeneous and did not know one another before the focus group discussion sessions. The critical thing was how the organizers of the focus group sessions managed and coordinated the sessions as well as how they managed to attract the attention and motivation of the participants to the end.

Other authors such as (Michelle, 1999) strongly suggest combining focus groups with interviews following the argument that as much as focus groups are effective, individual interviews allow more in-depth exploration of issues and their possible causes. Ending with focus groups only would have its own demerits as other members of society may not be outgoing to volunteer information because of peer and fear of victimization for divulging communal information hence the essence for individual interviews of household members (Michelle, 1999). This will not be possible in this study as it is not part of the methodology planned.

The purpose of focus groups is that they play a significant role in a variety of settings in social sciences research. Straw and Smith give a summary of purpose of focus groups, particularly in needs assessment, outcome assessments, meaning of results, programme policy development, and message testing (Smith, 1995). This study will use focus groups

in needs assessment. Asbury (ibid) supports the above uses while (Yach, 1992) also believes that the information obtained from focus group interviews is useful in providing insight about the needs of the people and health planning that follows. Focus groups are also recommended and have been found to be useful in preventive and promotive studies recently (Glik, 1990).

It was suggested that Participation at the Focus Group Interviews be around 6-12 members. Homogeneity within focus groups was an essential feature. In terms of the number of groups, Calder as cited in Morgan, (Morgan and 1997), indicates that it usually takes 3-4 groups to gather information until the moderator ceases to obtain new information and can even anticipate the information that the participants will give next.

At this stage adequate information will have been obtained. Preparations for interviews according to Polit and Hungler describe semi-structured interviews as focused interviews (Polit, 1983). It is in this connection that good prior arrangements had to be made well in advance such as; Appointments with relevant research sites, accommodation, Permission from interviewees, and permission to tape the discussion from the interviewees to be secured as well as refreshments if necessary or other tokens.

As stated above, this study involved examination of real situations with a view to providing a solution to the situation by the practitioners themselves. It is in this context that the study was exploratory, explanatory and highly collaborative in nature (Kemmis, 1991). Four teams of (4) research groups (16) altogether from among the participants of the search conference traveled to the four research sites for focus group interview discussions with 20 members of the community for each focus group discussion at the four sites in order to collect the data from the those communities and documents, such as the hospital registers and OPD records from hospitals and clinics covering the 2004 period only.

One core team member of the research group, headed each research team at the four various sites. Another core team member of the research group was a note taker while

one member from the sites was a timekeeper and at the same time did the audio tape recording of the discussions with the community members. The sampling procedure to get community members that participated in the focus group discussions were identified using the non-probability (convenient sampling) instead of probability (random) samples of respondents (Light, 1990).

6.3.4 Document Analyses Method: [Step 2 (b) of Table (3)]

This data collection technique enabled the researcher to obtain mental health records from hospitals, and Out Patient Departments in 4 research sites. At the hospitals and health centers, the OPD registers and records were checked to determine the nature of mental health problems of children and adolescents (diagnosis) seen during 2004 and the condition that they were seen for according to different age groups in the same period, January to December 2004.

The limitations of this approach in this study might be that some children and adolescents may not have called at these facilities for their mental health problems. It is common in Zambia (researcher's experience) that at times people first seek traditional healers before they consult a health facility. In a situation such as this, recorded data by the PHC practitioners was depended on, even though the researcher had a certain degree of doubt regarding quality, reliability, and dependability of the data collected. However, the use of available data added advantages in that there were no Cost implications in obtaining the required information/data, as the data was obtained on record time by the researcher's team with full approval and permission from the Health Ministry.

6.3.5 Preliminary Analyses of Data in Review conference [Step 3 of Table (3): Focus Groups and Documents Data]

The Review conference was convened after the Focus Group data collection. The same participants were invited as were present in the Search conference, and it was chaired by

the same consultant psychiatrist. At the conclusion of this Review Conference, some representatives of the professional councils and associations were present to listen to the preliminary findings of the study. The review method process went on as follows:

A report from each Focus group site was read out

- This was intended to provide the participants with a new picture of the existing mental health problems of C&A on the ground which they could not have been aware of before.
- The analysis of the data was intended to show on the emerging classes and categories of experiences, knowledge and practices of the community in respect of how they perceived, understood and cared for C&A with mental health problems and to bring to surface what the health professionals educators felt about the generic curricula on which they were trained in respect of how much child and adolescent mental health was covered.

The generic curricula were once again revisited in the light of the re-orientation given by the researcher on qualities and models of curricula used in the innovative health professional education schools through homogenous group discussions. A questionnaire was issued so that participants could state their preferences for a type of curriculum for Zambia (see annexure 15).

6.3.6 Analysis of data by Core Research Group for dissemination (Step 4 of Table 3):

A technical meeting for only core research group members was held to listen to the report and discuss the provisional draft report prepared by the secretariat of the conference, thereafter, validate the technical report for presentation to policy makers, regulatory bodies and professional associations at the joint consultative meeting. The technical meeting comprised the researcher, consultant, mental health specialist from the MoH and the assistant researchers only. This technical report was prepared to address mainly key

political and policy issues which came out as a result of the study findings in the field and needed the attention of the stakeholders for immediate action.

6.3.7 Presentation of Core Research Group Report to National Stakeholders

(Step 5 of Table (3): Post Search Conference Method)

This was the last and most critical cycle of the spiral of AR process for purposes of this study. During this phase, a consultative conference at which the final feedback in the form of a technical report comprising all the four steps (table 3) was presented to the stake holders for debate and technical/policy guideline and direction on child and adolescent mental health in Zambia. The contents of this phase were the two conferences (the search and review events) which took place at Chainama College of Health Sciences in Lusaka together a summary of the data which was collected from the four community study sites in the country which are: Ndola in the north; Kabwe in the central; Monze in the south; and Lusaka itself in the capital City. All the institutions invited attended and participated in the final deliberations of the study report and feedback from the research team about the study with focus on the way forward.

This was a perfect time for all the research team groups to learn and reflect on realities of understandings and perceptions of people about mental health problems of children and adolescents. The only difficult however, as earlier predicted, about the policy and administrative staff who were not able to be completely availability at these two conferences at the time of the study, even though they were able to attend most critical times of the workshop and contributed significantly. Against this background, commencement of training for the same research team on the categorized C&A mental health problems was recommended and to subject the same team to practicum, then set up tentative practice first at those research sites, while measures would be underway to develop the curriculum based on the reconstructed perceptions and understandings of both the practitioners and the communities.

6.3.8: Functional Analysis Method (Note):

This method encourages a large number of practitioners to register details of their experience, compared to nominal group technique where emphasis is, from quite an early stage, on the gradual elimination of some contributions in order to seek a consensus among group members.

Data collection using this method about practitioners' competences to identify and manage children and adolescents with mental health problems *was not done*; it will only be done after the reconstructed perceptions of mental health problems have been explored from the community and then analyzed.

As has been noted on the map of the systems theory applied in the study (see fig. 1 in chapter one), the focus of the study was not on functional analysis, but on exploring data from the community as shown in the Systems Theory Map figure 1, numbered 2a, 2b, and 3 respectively, after that, the process of developing the curriculum will commence but first it will require that, the functional analysis of the practitioners be done by the groups of practitioners themselves led by the facilitators themselves. The analyzed data will then be matched with the explored data to note down the discrepancies of performance in the practitioners and then the curriculum preparation will cover these gaps accordingly.

This method also focuses on practitioners actually inquiring into their own practice by finding out among themselves what happens in their professional practice when performing a particular task by means of a sequence of questions directed to themselves by themselves. This minimizes the need for the researcher to impose an interpretive framework (Winter, 1996). When the curriculum development process starts, functional analysis method will be used to reflect and document reality of practice in which a sequence of questions will be asked to the group to draw accurate functional analysis of competences of practitioners.

At the end of each session, the group will be asked to give feedback on how they felt about the session. Once this process has been done, it will assist the curriculum developers to compare the mental health problems of children and adolescents in the 4 selected districts in Zambia with identified competence discrepancies of PHC practitioners in the area of child and adolescent mental health practice. Using a sequence of questions starting from practitioners' perceptions of the 'key purpose' of their role, the practitioners own ordering of their responses will be to some degree 'built in' from the outset.

In a situation where there is an existing curriculum in child and adolescent mental health, the initial plan, would have been to begin the curriculum development process with a functional analysis, a technique that would be absolutely crucial to collect data from PHC practitioners' views about their own competencies in child and adolescent mental health management. In the current situation in which this study has found itself, the functional analysis will be done after the reconstructed perceptions have been collected, grouped and classified into categories, themes and new knowledge which would be used to inform the development of the innovative curriculum being anticipated in child and adolescent mental health.

This process will be conducted at the end of the study and will not be included in this phase of this study. It is planned that service practitioners at a later date be called as a group to consider ways of improving their performance on the identification and case management of children and adolescents with mental health problems against the reconstructed perceptions (*as primary data*) and the emerging classes and categories of new knowledge themes and theories in child and adolescent mental health.

6.4 Research Design

6.4.1 Introduction

Qualitative research design was used to collect data from a large number of the community and the PHC practitioners. Principles and theory of PAR was used in the collection of data as the PhD research is part of the participatory action research to develop a new PHC curriculum.

The research design is useful in studies that have groups of people working together to resolve a problem that concerns them. This is equivalent to what Babbie and Mouton call units of analysis (Babbie, 2001). The importance of the method selected is that it enabled the researcher to *explore* original data for describing the characteristics of a population too large to collect information from.

The design was based on the “*PRODEC*”, framework (**research problem, research design, empirical evidence, and conclusions**). This framework requires that a research problem is identified first, followed by an appropriate design, planned with all its necessary inputs for desired outcomes; the framework emphasizes on the evidence of surrounding issues and controversies about the problem to be researched; and based on thoroughness of the study findings, be able to make sound and workable conclusions out of which action can be based to improve service and practice.

In order to obtain reliable and credible data resulting in reliable findings, (Baugh, 1990) advises that the attributes and character of the researcher before, during and after the study are very critical to the success of the research in the community. It was against this background that the researcher focused on the focal agenda of the research and interacted with the respondents in a simple and friendly manner. The reasons for choosing the action research method were based on the theory readings that the researcher did following the works of the four researchers among many others who did several studies in the area of action research and these were:

- Patton's Action Research Approach to Evaluation (Patton, 1990),
- Checkland's Action Research Approach to Soft Systems Analysis (Checkland, 1981),
- Argyris' Action Research Approach to Action Science, (Argyris, 1985a) and
- Kemmis' Critical Action Research (Carr, 1986), these are briefly described in chapter two (2.3) under approaches of action research respectively.

Among the listed types of action research, *Kemmis' critical action research* stands out to be more similar to the action research methodology selected for this study.

- Action Research as one form of qualitative research which has different descriptions. It reveals both complexity and the truth, which has a strong impact on the readers.
- The researcher is able to obtain a good insight into the nature of reality.
- The phenomenon is easily understood.
- The focus is on participants' perceptions and experiences
- It focuses on the occurrence of events, products or outcomes.
- In the research process, ordinary events in natural settings portray real life.
- It assists in the identification of suitable life skills and career success.
- It emphasizes description, induction and grounded theory.

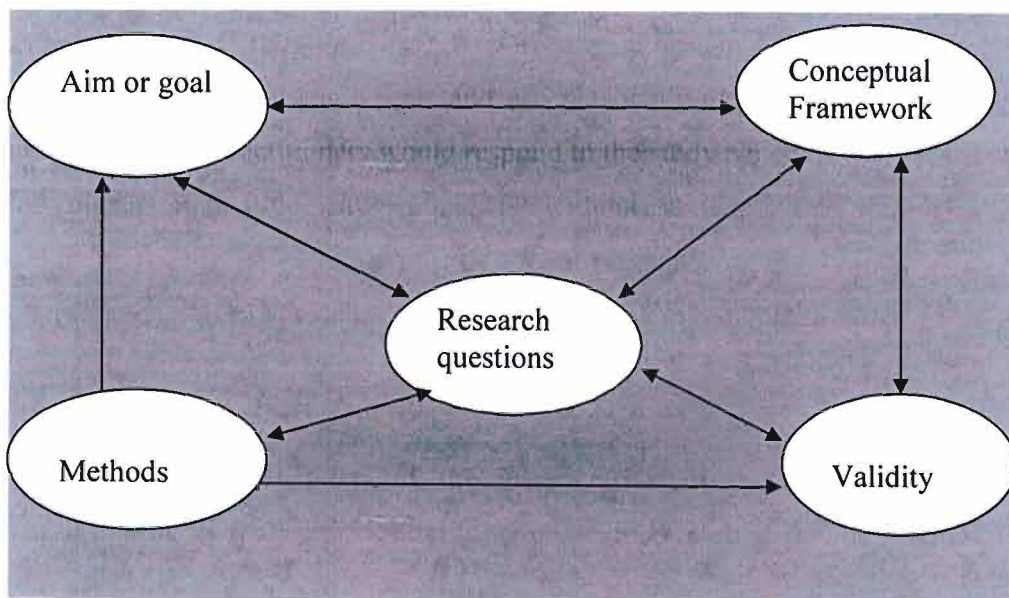
This research study was limited to PHC Practitioners, be in education practice or health care practice either practicing nursing or clinical medicine and the community specified under sample selection. The study was further designed on an organizational model framework, such as that of (Marxwell, 1995), (figure 16 below) Qualitative Research Organizational Framework Model. This model is broad based, and is not in variance with other models, instead it encompasses a number of other AR models, such as: the eminent Lewinian model (Lewin, 1946) and the cogenerative AR model (Greenwood, 1994).

The fixed qualitative research design model was used for this study because this method employed a relatively structured approach, which resembled the quantitative model. The steps were the same as those in the quantitative research, for instance the direction of the

research process, which is a one way-path, from the choice of the topic to the conclusions.

The reason for the choice of this design approach was that the researcher had a clear idea about the nature of the research topic and was personally interested to establish how the community and the practitioners would respond to the study hence the reason for creating at the outset methodological parameters without knowing the responses of the participants. The figure below shows the organizational conceptual framework around which this study was planned and guided in its implementation processes.

Figure 16: Component parts of the organization of the study, illustrating an interactive research design model approach in systems theory (Maxwell and Loomis, 2002).



This figure illustrates that for any planned research study to be successful, the central focus of the study are the research questions and/or the objectives as is in some studies that emphasize on objectives together with research questions for the study. As can be

seen in the figure all the components of the figure are interdependent but on the center of the design framework are the research questions.

If the study had to make any inferences, those inferences would have to originate from the research questions. The figure further shores a fixed sequence of the study as in the action research cycle steps of (Lewin, 1948) Karlsen in (Whyte, 1991). As can be seen in the frame, the figure comprises interconnections and interactions among the different design components (Maxwell, 2002). The various components of the design are interrelated with each component closely tied to several others. Furthermore, this figure demonstrates the most important relationships among the five components in respect of their interconnectedness and flexibility.

The upper triangle of this model is a closely integrated unit. The research questions have a clear relationship to the goals of the study, and are informed about what is already known about the phenomena being studied and the theoretical concepts and models that can be applied to the phenomena. In addition, the goals of the study are informed by current theory and knowledge. The bottom triangle of the model is also closely integrated.

6.4.2 Critique of the framework model

The assumption that can be drawn from this model used in the study is that, when the title of the study has been identified, it is very critical to define its purpose or intentions very clearly. It is from this point of view that it is easy to draw the objectives of the study which can be easily measured or even the research questions which can be easily demonstrated with solution at the end of the study. In some studies, objectives are used and answered at the end of the study, but in the case of this study, the research questions have been used as a measure for exploring the perceptions of the practitioners in the study.

The design of this study is based on an interactive research design approach within the systems theory as shown in the organizational design model shown in figure 16 above. The organization of this study illustrates the focus and worthiness of the study, it lays emphasis on issues that need to be clarified, practices and policies that need to be influenced by the study and why it is necessary to carry out the study. In terms of the conceptual framework of the study, the model illustrates that as you are undertaking a study, it is important to be aware of what is going on in the field or community, as a researcher, you must ensure that you address what is going on in that community or field practice area that you are going to undertake the study.

Worthy of note are particular indicators such as looming issues, settings, and events that have deleterious effects on the wellbeing of the community envisaged to be studied. In addition, various theories, beliefs and prior search findings guided or informed the study, and the kind of literature, preliminary studies, and the personal experiences the researcher would draw from the people or issues being studied.

All the time when undertaking some piece of work to investigate, the questions surrounding the study must be addressed and remain focussed within the set questions. In addition, what questions the study would attempt to answer and the relationship of these questions to each other? The validity of this framework design for this study further shows how it fits in the systems theory which guided the study and consequently, how AR with explicit research questions addressed the phenomena being studied within the overall systems theory which edifies the subordinate theories which are: the ecological theory, bio psychosocial and cultural theories of the study. The other important feature of the research design for this study is that it was an open design and enabled to accommodate the participants' opinions at every stage of the study {De Vos, 1998 #991.

6.4.3 Design interventions of the Study

6.4.3.1 Creating and negotiating entry into the community

The first step in the design of the study was creating and negotiating research relationships with participants from the selected research sites before the search conference (first line intervention). The subsequent steps of the research process were all dependant on the success of the first step, particularly in systems where there are gatekeepers. One thing about gatekeepers is that they can either facilitate or interfere with the study (Bosk, 1979: 89); (Hamersley and Atkinson, 1995).

This research design strategy was the researcher's point of entry because these relationships with the community were very important and crucial prior to the commencement of the study. The gatekeepers made it easier with their support for the researcher and the research team to gain access to the research setting (Borgdan and Bilken, 2003); and (Marshall, 1989). In the same connection, relationship without effective rapport is baseless and cannot achieve what is expected, (Maxwell, 1986), (Bosk, 1979). As soon as this aspect was done, the search conference arrangements were underway and preparations advanced up to the time it was critical to map how the problem of the study was going to be formulated and tackled.

6.4.3.2 Core Research Team Formation

The researcher formed a core research team of 6 people who underwent one-week training in AR methodology before they were joined by 12 other participants in their capacity as practitioners drawn from identified research sites in the country. The mental health users (children and adolescents with mental health problems) were **not** part of the researched due to the nature of the study, in situations such as this one, (Morse, 1997), recommends the inclusion of the clients because according to him, such a decision would have enabled the users also to have a voice in the research study.

Deatrick and Faux in (Morse, 1991, 2003), have argued that many research studies that involve studying children “are not based upon the children and adolescents’ account of

the phenomenon being studied, instead an adult's view (usually the mother's) of the child's world is often substituted," yet the children and mothers' view may be different.

Morse continued his argument and pointed out those children and adolescents as individuals may be unable to understand and thus describe their world due to immaturity and lack of poor socialization (Morse, 1991, 2003), while to the contrary some researchers perceive children/adolescents as experts in interpreting their own world. If it were not for issues of user privacy and the time it takes to seek clearance from the community structures against the time the researcher had for the study, their views would have added very valuable impetus to the study.

This is one area, which future studies should consider to endeavor. The study looked at the children and adolescents' world as perceived and understood by the community as carers, educators, PHC practitioners and community members, representing the adults' view. Critical Factors such as the philosophical, ethical and political issues prior to, during and after the study were seriously considered as these could have affected the study negatively if they were not planned for and accommodated appropriately (Miller, 2001).

6.4.3.3 Second design intervention of the study

Following below was the practical process employed prior to, carrying out the study in line with the conceptual framework map of the study, figure 1 and outlined as follows; A list of critical resources required for field work was drawn such as audio tapes and recorders, note books and complimentary reinforcers for participating with the research core group. Working procedures that would encourage each site team were identified; these ensured that the communities taking part in the study were identified by the community itself and permission for their participation from appropriate authorities sought well ahead including logistics needed. Division of roles at this stage was critical to avoid confusion in the field. A well-planned design of data collection method was

crucial; and a substantial amount of time had to be devoted in planning for the design of data analysis (Caffey, 1996).

The aspect of planning the data analysis has been mentioned here because of the tendency to conceptually separate it from design. The researcher and the participants reviewed and studied the focus group interview guide, which the researcher developed, comments were made and necessary modifications were also made where possible? The instrument used to collect the data at Hospitals and OPD Clinics and Centers was also discussed and modified accordingly so that it was clearly understood by all participants.

6.4.4 Research Instruments

All (focus group) discussions were audio/video taped, translated and transcribed. Questions in the focus groups were open-ended and were carefully pre-determined. The questions selected were phrased and ordered in a way that they were easy to comprehend to the participants/respondents (Krueger, 2000). The dialogue or communication during all the focus group interventions was absolutely critical to create and maintain an informal atmosphere.

The skill and style of questions constituted a sequenced simple beginning then improved from the general premise to more precise and specific scenarios while in keeping with good time management to keep the interest of the individuals and groups. The piloting of the questions was done with research team members. This followed expert opinion by (Krueger, 1988) who advocated that such, is good research practice. The study also borrowed from (Morgan and 1997) who recommends distributing questions in advance and (Greeff, 2002) whose advice is useful when conducting interviews.

A good aspect about the conducted interviews was that it was still possible for the interviewer to follow up certain aspects of the interview later if something inevitable emerged and the participants would still be able to give a detailed account, despite

already set pre-determined questions. This did not create any problem as the interview schedules were guided by, rather than dictated by it.

6.4.5 Selection of research study sites and the Setting

The setting of the study was health institutions in the Lusaka District, Ndola District, Kabwe District and Monze District. These Districts were selected as they had various types of health institutions, which provided a variety of responses from the participants. In the case of Lusaka District, it has a specialized hospital, which offers mental health care. The hospital is a teaching hospital for paramedical officers and mental health nurses. It has a bed capacity of 500 adult and 8 cot beds. It functions as a referral hospital for mental health care in the country.

The district also has a central hospital that is a referral and teaching hospital for medical doctors, nurses and paramedics. It has a bed capacity of 1,655 and 250 cot beds. The hospital offers specialized care in various areas such as pediatric surgery, physical handicap care, and neurosurgery and HIV laboratory services. Participation of staff from these institutions should provide in-depth information for team learning.

Identification of study sites, in quantitative research, is normally the sampling process. In this study, the communities under study were from the following four areas: Monze district, in Southern province, 300km South of Lusaka-Kabwe district, in central province, 150 km North of Lusaka-Ndola district, in Copper belt province, 500km North of Lusaka district, in Lusaka province itself. The four selected areas where PHC practitioners were drawn from were also sites for data collection from the community, the hospitals and clinics. The advantage of these sites was that they are along the line of rail and are easy to reach by both road and rail transport in a country where the system of transport communication is still not good enough. The four sites where the PHC practitioners were drawn from were also part of the core team members of the research study.

These were also designated as focal point persons at those sites even after the research has ended for practical application of the project, which fortunately have training colleges for nurses and other health-related programmes. The selected community sites have a number of health centers and hospitals. The further rationale for selecting these community sites was that: They have diverse polyvalent populations and PHC practitioners were easily drawn from these areas for the study with very little Cost implications to the researcher, and on the aspect of carrying out the curriculum the same research sites have practitioners' health training colleges which can easily implement the proposed curriculum model.

The areas are geographically accessible with adequate road and rail transport network. The researcher was able to communicate in both English and Vernacular Languages spoken in those areas. Town councils, municipal councils and city councils run the sites administratively, which made it easy for the researcher to gain access

6.4.6 Sample Selection of participants

The total targeted sample selected was 101 participants who included 80 community members and 21 PHC practitioners' participants inclusive. This figure was about the number the researcher wanted to make generalizations. The sample precise breakdown of participants for the study comprised: 2 policy and technical representatives, 5 research team members, 4 educators, 5 PHC practitioners, 80 community members, 3 representatives from the regulatory bodies which were: medical and nursing councils including examinations council of Health Sciences: 2 professional associations for nurses and clinical officers. Educators and practitioners were selected on the basis of their willingness to participate in the study with the researcher after those respective authorities were approached to allow them to participate in the study after initial negotiations were done between the researcher and the educators.

The remaining three were drawn from the Central Board of Health/Ministry of Health; Clinical Officers' Association (COAZ) and the Zambia Nurses Association (ZNA). These groups were critical to the study because they both police and regulate all the trainings and monitor standards and ethical practices among their members.

6.4.7 Data Collection Techniques and Triangulation

The sample for the study and the participants were appropriately selected to overcome issues of validity threats (Miles, 1994); (Light, 1990). The Data collection aspects were adequately communicated to the research core team to enable them understand the critical ingredients of successful data collection. Against this background, the data to be collected needed to bear direct and strong relationship between the research questions and the data collection methods and more importantly issues of triangulation of different methods were given a fair deal of consideration (Borgdan and Bilken, 2003). Triangulation, one of the different modes of data collection which was applied in the study and according to (Babbie, 2001) triangulation is defined as the use of multiple methodologies, methods and investigators in the same study.

In this study triangulation of research designs complemented each other and made a stronger research design with more potentially valid and reliable findings. Thakhathi defines triangulation as the process of substantiating the field observed (To ensure the validity and reliability of data collected, the field observations should be confirmed (Thakhathi, 2001). The advantage of triangulation was that it reduced the risk of the researcher's conclusions, which at times reflect the systematic biases, or limitations of a specific method or source (Fielding, 1986).

Using this method assisted the researcher chance to gain broader and secure undertaking of the issues being studied for both innovative curriculum and child and adolescent mental health or the investigated and ultimately assisted in dealing with validity threats (Weiss, 1994); (Miles, 1994); (Light, 1990). Participants that the researcher deemed as

critical to the paradigms of the study e.g. (the biopsychosocial and cultural theories) which the researcher stated and developed were examined at the beginning of the study (Strauss, 1987); (Strauss, 1990) (Maxwell, 2002), argued that extreme respondents provide crucial test of theories, and illuminate what goes on in a way that representative respondents may not.

6.4.8 Selection of participants

Selection of the subjects for the sample was relatively a complex activity to start with as cited by (Morse, 1991, 2003), because it carried a significant effect on the quality of research to be undertaken. Researchers state that qualitative methods tend to lack clear guidelines on the principles of sampling. However (Lincoln, 1985) points out that the emphasis with qualitative studies is on the adequacy and appropriateness of the study sample itself. In this situation, 'adequacy' means that the sample should be relevant, complete and that necessary information should be obtained until saturation is reached, whereas appropriateness refers to the effect that the researcher should select subjects who possess the required characteristics and are capable of giving the required information.

On the issue of appropriateness, (Morse, 1991, 2003) further states that if the research wants to ensure that the sample meets appropriateness and adequacy in qualitative studies, "the researcher should have control over the composition of the sample". The best method to attain control according to Morse is through the use primary selection. Morse (ibid) also points out that primary selection is attained when the researcher chooses the respondents who are known to have the necessary knowledge, as required by the researcher for that particular study and are willing to take part. In primary selection, Morse, further points out that the sample size must be small and this will promote efficiency because the response rate will be high. All the participants in the study as earlier stipulated should have preferably the necessary knowledge and understanding of the needs and problems of the subjects under study.

The selection method of participants to the focus group discussions, which was used, was “*the purposeful selection*” (Light, 1990) also referred to it as purposeful sampling (Patton, 1990), basically a criterion-based selection (LeCompte, 1993a). In this method, the settings, participants and activities were selected deliberately in order to have participants with an opportunity to provide information that could not be gotten from other choices. The researcher’s argument for the use of this method meant to engage community members who were uniquely able to be informative because they were privileged witnesses of the plight of children and adolescents with mental health problems (LeCompte, 1994) in those communities, as they would provide the information required for the study in order to answer the research questions stated, was the most important consideration, the researcher was concerned with in the selection decision.

This method achieved the opposite of what random sampling would adequately capture the heterogeneity in the population and conclusions of the study, would adequately represent the whole range of variations rather than only the typical members or some “average” subset of this range referred also to as “maximum variation” sampling (Guba, 1989a). In the context of this study, selection of the participants was based mainly on the knowledge of the setting of the study, facility of access and data collection, research relationship with study participants, validity concerns and ethics.

The problem of ‘key informants bias’ in the selection of participants in the study (Pelto, 1975), was alleviated by systematic sampling in order to be able to claim that key informants’ statements were representative of the group as a whole (Heider, 1997) with the understanding that, cultural groups that characterized the focus group discussions incorporated substantial diversity of participation and that homogeneity could not be assumed (Hannerz, 1984); (Marxwell, 1995).

6.4.9 Sample Inclusion and Exclusion Criteria

The inclusion criterion for participating in the first phase of the study, one had to be either a clinical officer or registered nurse at specialist level in mental health services,

teaching in mental health and a medical doctor with specialized competences in psychiatry and mental health to form the core group of the study and motivate the whole study process as a technical team which would have received some preliminary training in the study before the search conference. The inclusion criterion for participating in the second, third and fourth phases of the study was same as above but without participation of psychiatrists and for the PHC practitioners' inclusion, one was either a clinical officer or nurse and non-specialist in their fields.

6.4.10 Sample for the Second Phase of the Study

The selection of participants for the second phase of the study was being a registered nurse or clinical officer either teaching in a training institution, doing administration in hospital or statutory institution or working in the general hospital, specialized hospital or at a health center in the selected institutions. The selection of participants to the study was purposive, and was based on recommendations to participate in the study by the hospital or the district management who were responsible for staff development in the respective institutions.

The participants were selected because they were responsible for staff development and service delivery in their centers or institutions. In addition their characteristics were similar to the population of clinical officers and registered nurses that were not selected for the study in the health institutions in Zambia. The total number (20) of the participants selected was made up of 15 PHC Practitioners drawn from the 4 district study sites, professional associations and regulatory bodies.

6.4.11 Sample for the Third Phase of the Study

The sample for the third phase of the study comprised 80 community members. The list of these community members was recommended by the community leaderships in their respective districts with guidance of the focal point persons from each district focus

group site. Purposeful sampling was used to select the participants. Babbie (2001) state that:

“Studies of organizations, if a random sample is selected from a membership list, the data collected from that sample may be taken as representative of all members, if all members are included on the list” (p.184).

6.4.12 Sample for the Fourth Phase of the Study

The sample for the fourth phase of the study comprised **40** participants including those in management positions from the participating institutions (as analyzed in Chapter 7). This sample, large as it may, was necessary. All the preliminary data and the pattern of the data collected would be communicated to policy makers and administrators for discussion and further action.

6.5 Trustworthiness in Qualitative Data

For any study to be scientific readers must regard it as credible, reliable, believable and trustworthy by readers. To attain this, data must be carefully measured by means of reliability and validity instruments (Searle, 1995). According to Lancy, reliability and validity deal with the confidence and belief about the outcomes of the study and she calls this phenomenon as trustworthiness. It has been claimed by (Lancy, 1993) that reliability and validity are the “key concepts” in the trustworthiness of data finding. It is consequently important to elaborate what reliability and validity are in the study.

6.5.1 Credibility

The researcher carried out the inquiry in such a way that the probability that the findings were credible was enhanced, for example participants for the study were PHC practitioners who were responsible for education and training of health care professionals at the same time providing health care services to the community, they are critical in commencing in initiatives in their institutions. The findings from the study were presented to an audience of 30 participants recommended from their various places of

work. After a detailed discussion on the interpretations of the findings the MoH official representing the Ministry and the rest of the participants participating in the study verified or approved the report and recommended that they be used as a starting point in the research process.

6.6 Reliability and Validity

6.6.1 Reliability

Reliability is understood as *the degree of consistency in which instances are assigned to the same category by different observers*. In this measurement, the particular method of data collection is replicable. That is, the same results are obtained each time the researcher utilizes several techniques for measuring the collected data (Silverman, 2000):(Fink, 1995).

Reliability is further regarded, as the fit between what is recorded data and what has actually occurred in the setting being studied after the collected data has been analyzed and interpreted in a uniform manner. There might be errors in this researcher's set of collected data; therefore reliability is used with the purpose of obtaining a more accurate reflection of the truth. Clear and relevant focus group interview questions were formulated with the aim of getting reliable data that was free from measurement errors (Fink, 1995).

6.6.2 Validity

Validity is the degree to which findings of a research study present a true and accurate picture of what is claimed to be described (Silverman, 2000); (Searle, 1995). Thakhathi defines validity as *the correspondence between the research and real and world (Thakhathi, 2001)*. Fink (1995) outlines it as *the degree to which a survey instrument assesses what it purports to measure*.

According to Babbie and Mouton validity refers to the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration (Babbie, 2002). Validity is utilized to ensure that the data includes everything it should and that it does not include anything it should not include. Thakhathi claims that, to achieve validity, the researcher has to use standards such as the fit- between the research question, data collection, data analysis, effective data application and analysis techniques to guide him or her in making valid arguments, findings and reports (Thakhathi, 2001).

This research has attempted to ensure validity by implementing the standard guidance Identified by (Thakhathi, 2001) and (Denzin, 1994). These standards claim that the way an interview acts questions and responds in the interviewing process shapes the relationship and the participants' accounts of their experiences. To adopt this strategy, the researcher has to pay more attention to the respondents – talking little and listening a lot to the accounts of the informants, allowing them the freedom to talk to the researcher.

Time, purpose, approach, language, styles and loyalties were incorporated. The researcher made sure that the recording was accurate. Feedback was checked in order to ensure correctness, completeness and whether reporting was overblown or underdeveloped. This was done by cross-checking responses recorded from the discussions of focus groups as well as the entries from the OPD and Hospital records where the researcher reviewed records to ascertain the accuracy of data obtained from both focus and document analysis.

6.6.2.1 Internal validity

Internal validity *relates to the instrument significance for the study situation* (Sarantakos, 1993, 1998, 2005, 1984, 2005). Based on this view, the researcher was getting the reality from the practitioners and the community through focus group discussions and search conference. With regard to this statement, the reliability and objectivity of this research depended on the participants' agreement with the research results at the review

conference which fed into the Core Research report for presentation to the national stakeholders.

This suggests that the data analysis “closed” at this report back stage, but in fact the data had NOT yet been analysed in detail by the researcher. The report-back was by the participants and was an important strategy *to get political buy-in for improved mental health provision in Zambia*. In terms of grounded theory, in the flexible model approach (Bouma, 2000); (Miles, 1994) data analysis is continuous, but in this case *a two step process was political effective because the voices of the “owners” of the data were heard first*, and then the data was taken by the researcher to analyse in greater detail for *Step 6*, which is this Ph.D. thesis.

6.6.2.2 External validity

In both instruments used to collect the data from the community and the hospital/clinics, the researcher depended on *the responses of the Practitioners and the community from whom data was collected*. The data gathered was accepted irrespective of whether the Practitioners had different views negative or positive in the process or not (Creswell, 2002). From these responses, the researcher had generated a relative level of confidence to claim that the study and the findings had reached the aim of striving for rigor in this qualitative research process (Sarantakos, 1993, 1998, 2005, 1984).

6.6.2.3 Content Validity

Content validity was assessed using content procedure. According to (Golafshani, 2003) states that:

“Validity determines whether the research truly measured that which it was supposed to measure or how truthful the research results were. In other words, did the research instrument allow the researcher to hit the bull’s eye of the research object.” (p.599).

Babbie (2002) further state that *content validity refers to how much a measure covers the range of meanings included within the concept*. In this study, content validity was assessed using content procedure. Smith points out that content validity procedure is a measure designed to determine whether an instrument measures a representative sample of the concept under consideration (Smith, 1981).

The researcher designed a focus group guide which measured a representative sample of community focus group instrument content. Five of the college lecturers, teaching at Chainama College of Health Sciences, and a consultant psychiatrist, were requested a week before the search conference and two weeks before data collection in the districts to judge whether the content of the instrument was representative of what the research questions were focused on and whether what was contained in the instrument or guide was focused on reality on the ground.

The researcher then compared the decision by the team in the form of judgment to determine the extent of inter subjective agreement. In this study there was total agreement among the core practitioners and educators. This indicated that the instrument or guide was measuring the essential qualitative data which was required for the study outcomes.

6.7 Research Ethics and Ethical Consideration

Ethics deal with questions of values and morality. It is focused on what is right and correct and what is wrong. Ethical standard such as the rights of the community, confidentiality, mutual respect and anonymity are imperative in action research like any other forms of inquiry in the same family of qualitative research (Altrichter, 1994: 888); (Denzin, 1994).

Ethical approval was obtained from the University of KwaZulu-Natal Ethics committee and Permission to conduct the study was also obtained from the Permanent Secretary, Ministry of Health as well the Director General of the defunct Central Board of Health,

Lusaka as well as informed consents was obtained from focus group facilitators who conducted the discussions on behalf of the researcher. (Polit, 1983) state that informed consent

“Is a written agreement signed by a study participant and the researcher concerning the terms and conditions of a participant’s voluntary participation in a study” (p.459).

Confidentiality was observed. In addition group workshops discussions were recorded in a way that individual responses could not be linked with practitioner or community member participants. The data was kept in strictest confidence. Participants were informed that they were free to withdraw at any time during the period of the study and that no Cost would result from their participation. Respect and courteous treatment applied throughout the research process.

6.8 Data Analysis

To analyze the data the researcher focused on data reduction, data display and conclusion drawing and verification, (Miles, 1994). Data reduction involved selecting, focusing, simplifying, abstracting and transforming the data that appeared in written-up field notes and transcriptions. The data was collected according to the theoretical framework and the research questions. The data reduction process was not a separate activity from analysis; it was part of the analysis. The reduced data involved organizing and sorting it into codes or categories and then looked for patterns or relationships between the categories of data. This was done with the help of the NVIVO 2.0 Qualitative Data Statistical Package Soft Ware. The limitation with the use of the NVIVO Soft Ware was that it was a brand new programme which the researcher had at the same time to learn and consequently apply in the analysis of the data.

6.9 Conclusion of Chapter on Research Design and Methodology

In this chapter, the researcher outlined how the research was conducted (methods). The rationale for the choice of the participatory action research methodology as a type of

qualitative research method for this study was described. The search conference method of data collection was used because the process was appropriate and relevant for the type of study carried.

The use of focus group method and document analyses of OPD registers and records was most useful in *exploring baseline information* which when combined together would present formidable empirical data which consequently would be used to develop an innovative curriculum for PHC practitioners in child and adolescent mental health in Zambia. The procedure of data analysis was also clarified. In the next chapter, the data generated by using the action research methodology which was thoroughly described and outlined in terms of its use and application will be presented and discussed.

The use of triangulation in the methods used in the collection of data also contributed to the credibility of the findings. The participants during the conferences were able to contribute to discussions freely. They were able to contribute to the discussion because the researcher and participants had worked together for a long time and had gained trust and commitment in doing the work. Due to long acquaintance between the researcher and the participants, the participants were able to freely reflect on the decisions they had taken in the previous search conference before planning for the future.

6.10 Dissemination of the Findings

In response to the obligation that the researcher had in informing the participants about the findings, a summary of the findings will be sent to the hospitals and health training institutions from which the participants were recruited. In addition the findings will be submitted to the Central Board of Health library and Institutional Collaboration library where the data will be used as resource material to enhance theory and practice in colleges and hospitals whose role excellence and service.

CHAPTER SEVEN

DATA ANALYSIS

7.1 Introduction

In this chapter, the analysis of data comprises qualitative data of practitioners' unreconstructed and reconstructed perceptions; perceptions of the community focus groups about mental health problems of children and adolescents as well as quantitative data collected from hospitals and out patients clinic records and registers. The chapter has also a total of twenty-three (**23**) documents comprising *qualitative and quantitative data*. They are listed as follows:

- 1 from nurses
- 1 from COS
- 1 of merged perceptions
- 1 of definition of mental health
- 1 **definition** of CA
- 1 about Resources, particularly human resources
- 1 of questionnaire preferences on curriculum

- 4 documents from the 4 focus groups
- 4 sets of statistics of hospital data from the 4 sites

- 1 document merged the 4 focus groups documents during this Review conference
- 7 transcripts of flip-charts discussed at Review conference

7.2 Analysis Process of various nodes

The concept of *node* was developed from the NVIVO 2.0 Qualitative Data Statistical Package Soft Ware to mean knowledge area classifications of the study from which the key nodes were developed which were: *free-nodes; tree-nodes and child-nodes*. The nodes were developed from the data which was collected from the four focus group sites represented as *documents* of the study. The focus group site documents were named after the *research site towns* of the study. They contained all the information obtained from

each focus group area site based on the interview guide which comprised 10 Questions items in line with the research questions and purpose of the study.

It must be pointed out that even though knowledge areas were identified, there were a lot of inter- relationships of nodes especially at *child-node* level. It was common to find that *tree-nodes* and *child-nodes* in one free-node concept area included *tree-nodes* and *child-nodes* in other free-node concept areas as well. This was expected as these node-areas complemented one another depending on the class and /or knowledge area required.

The analysis of the nodes was based on the developed concept maps, which the researcher developed. Concept maps were very useful in line with node concept principles particularly in the logical and chronological analysis of concept/ theory areas. The concept maps developed by the researcher resembled the '*task-analysis method*,' in which a serial analysis of a task is done from the main task areas to *sub-task areas*, such as analysis of performance into *knowledge, skills and attitudes* required to do a job. The analysis of the *free-nodes* was based on the *bio psychosocial theory* of children and adolescents' mental health.

Data from the search conference and focus group discussions were analyzed using the fixed qualitative analysis method (Maxwell, 2002). This method of analysis was employed mainly because the study followed a fixed qualitative research design model. A systematic analysis of Participants' perceptions for each focus group against the six-node areas in the four sites was done.

All focus groups perceptions were further analyzed against the six-node areas. This was important because it allowed possibility of understanding how individual groups perceived mental health problems of children and adolescents against perceptions of other groups on the same six-node areas. *The reason for individual site focus group perceptions was to establish what each research site perceived were the possible causes of mental health problems of children and adolescents in the defined six-(6) node-areas which in this study were referred to as categories or classes of knowledge areas.*

Data analysis was done at the end of data collection and generally entailed a method of content analysis or textual/visual data analysis, unlike in a flexible qualitative research design which uses grounded theory approach where analysis is ongoing, and the analysis process guides the data analysis (Winter, 2001); (Henning, 2004); (De Vos, 2002); (Babbie, 2001); and (Ulin, 2002).

The search conference data which were collected during and at the end of the search conferences were grouped into unreconstructed and reconstructed perceptions of nurses and clinical officers *who are the PHC Practitioners in this study*. The unreconstructed perceptions were further reclassified into '*clinical officers*' perceptions, and '*nurses*' perceptions separately and were later *merged* thus, combining *clinical officers*' and *nurses*' perceptions.

This action was necessary to show variation of perceptions between unreconstructed perceptions of nurses and clinical officers before the merger of the two sets of perceptions. The reconstructed perceptions of the practitioners were drawn after the nurses and clinical officers (Practitioners) discussed in their various focus groups which were later presented at plenary where it was further discussed by all groups.

The exposure of these data for further discussion resulted into the regrouping of the data into classes and categories; this was the beginning of the Practitioners' change of Perception Process from the *unreconstructed to the reconstructed*. The main features of the changed Perceptions were the *changed definition of mental health* after merging the homogenous unreconstructed perceptions. The change in the definition paved the way to reconstructed regrouping of classes and categories of child and adolescent mental health problems.

The main reconstructed categories and classes of data that emerged were broadly viewed from various theoretical underpinnings of, Life Stresses (Psychological); Environmental (Socio-economic) : biophysical (biological and physical) and resource support for the children and adolescents, where as the nurses and clinical officers perceived mainly the Environmental (Socio-economic) and life stresses with focus on belief phenomenon.

These variations were important. The analysis of the content in the study dealt primarily with field notes, focus group transcripts which were audio taped, and search conference notes and audio-visual tapes which the researcher had to read, listen to and analyze.

McMillan and Schumacher define qualitative data analysis as primarily an inductive process of organizing the data into categories and identifying patterns or relationships among the categories and further stated that most categories and patterns emerge from the data and the process is influenced by the ideas and concepts that the researcher is familiar with. The duo also stated that it is also possible for the researcher to have a clear theoretical framework before hand, and use this framework to analyze the data (deductive approach), (McMillan, 1993) (1993, 486).

Strategies for analysis of data have been widely recognized and documented in a number of studies (Borgdan and Bilken, 2003), (Caffey, 1996), (Strauss and Corbin, 1990) (Weiss, 1994). To analyze the data the researcher focused on data reduction, data display and conclusion drawing and verification, (Miles, 1994). Data reduction involved selecting, focusing, simplifying, abstracting and transforming the data that appeared in written-up field notes and transcriptions. The data was collected according to the theoretical framework and the research questions.

The data reduction process was not a separate activity from analysis; it was part of the analysis. The reduced data involved organizing and sorting it into codes or categories and then looked for patterns or relationships between the categories of data. This was done with the help of the NVIVO 2.0 Qualitative Data Statistical Package Soft Ware.

Reducing data, displaying the data and drawing' conclusions as well as verifying the data were interwoven. Even though, there are many different ways of reducing data available, the most fundamental activities undertaken were coding and categorization. The study organized the data first by looking for topics or categories in the data, and coded these. McMillan (McMillan, 1993); explained the process for developing an organizing system and stated that;

“The researcher starts by reading the data set for instance the interview transcripts, the field notes and the observation notes, as a whole. This was meant to get sense out of the data during which time the researcher started to write down the ideas that began to come as reading was progressing.”

Then the researcher identified the topics, which emerged from the data. The researcher then wrote the list of topics that emerged from the different data sets to identify any duplication. At this point sets of topics with which to classify or categorize into biophysical, psychological, sociological and environmental categories were identified in line with the concept of C&A mental health described by; (Health and Welfare Canada, 1989); (Coleman, 1979) as:

‘The degree of age-appropriate bio-psychosocial development achieved using available resources’

Lastly, the study began to apply the provisional classification system on all the data sets, and assigned all topics to codes. It is important to note that topics were subsumed into categories because a category is an abstract name that represents the meaning of similar topics. Thereafter, the study developed a classification of data, and relationships between the categories or patterns in the data were sought. This gave an opportunity for the researcher to begin to understand the complex links between the various aspects of the community’s situations, mental processes, beliefs and actions (ibid, 495).

The data displays were in the form of concept maps, tables and models. These displays assisted the researcher to draw conclusions and verifications particularly in the later stream of analysis activity. The researcher started to draw conclusions in fact from the start of the data collection where patterns and possible explanations were noted but such observations could only be finalized once the analysis was completed.

7.3 Analysis by node

The analysis of the data was done using the concept of *node*. The concept of node refers to groupings and classification of knowledge aspects into general, important and critical categories from which *key nodes*, representing general to specific study knowledge areas of the study were developed, which are: *free-nodes; tree-nodes and child-nodes*. This classification was necessary in order to keep a proper catalogue of data. The researcher could not go into further reclassification of nodes, for instance, *grand-child-nodes* because it was not necessary for this kind of study, unless the study was dealing with *case-node type of classification*, which requires *attributes and variables*, such as age and sex, to mention but a few.

The nodes which were created from the collected data comprised: *free-nodes, tree-nodes and child-nodes* respectively from the four focus group sites represented as documents of the study. The focus group site documents were later named after the district towns where the study was done and contain the whole information obtained from responses of each focus group area site, and based on the interview guide, which comprised 10 Question items which are also reflected in the research questions and purpose of the study.

After careful analysis of the responses from the various community focus group sites, it was possible for the researcher to come up with knowledge classes and categories. These knowledge areas were then grouped into fourteen (14) free-nodes, twenty seven tree-nodes (27) and one hundred thirty nine (139) child-nodes. It must be pointed out that even though knowledge areas were identified, there were a lot of inter-relationships of nodes especially at *child-node level*. It was common to find that tree-nodes and child-nodes in one free-node concept areas included tree nodes and child-nodes of other free-node concept areas as well. This was expected as these node-areas complemented one another.

The analysis of the nodes was also based on the developed concept maps, which the researcher developed. Concept maps were very useful in line with node concept principles particularly in the logical and chronological analysis of concept/theory areas. The concept maps developed, resembled the task-analysis method, in which a serial analysis of a task is drawn from the main task areas to sub-task areas which may be knowledge, skills and attitudes required doing a job.

The analysis of the (14) free-nodes, (27) subsequent tree-nodes and (139) child-nodes were all based on the community's perceptions and understandings of those particular node-areas. *The numbers against each node ball in the models refers to the index numbers given to the quotation in the file of raw data analyzed; it does not indicate the frequency of occurrence of that viewpoint.* The analysis of the tree-nodes was based on the bio-psychosocial theory of child and adolescents mental health around which this study was underpinned. Data from the search conference and focus group discussions as stated earlier used the fixed qualitative analysis method (Maxwell, 2002).

This method of analysis was employed mainly because the study followed a fixed qualitative research design model, furthered by the use of a Qualitative Research Organizational Framework Model (Maxwell, 2002) and the Dual Tract Search Process Design (Herbst, 1980), which was of particular significance as it was applied for the search conference as the first step of the AR cycle (pre AR cycle step) before the cyclic steps themselves. This model had approaches that encompassed a number of other AR models as earlier stated, which were: the Lewinian model and the cogenerative AR model (Greenwood, 1994).

The fixed qualitative research design was used because this method employed a relatively structured approach, which resembled the quantitative model. The steps are the same as those in the quantitative research, because the direction of the research process is a one way-path, from the choice of the topic to the conclusions. The reason for the choice of this approach was that the researcher had a clear idea about the nature of the research topic and was personally interested to establish how the community and the practitioners

would respond to the study hence the reason for creating at the outset methodological parameters without knowing the responses of the participants.

The study through a fixed sequence as in the action research cycle steps (Lewin, 1948); Karlson in (Whyte, 1991), continued to involve interconnections and interactions among the different design components of the study as further illustrated in the five model conceptual components of the fixed qualitative action research model (Maxwell, 2002), which focused on the concerns of each component part of the framework.

Reducing data, displaying the data and drawing' conclusions as well as verifying the data were interwoven. Even though, there were many different ways of reducing data available to the researcher, the most fundamental activities undertaken were coding and categorization. The study organized the data first by looking for topics or categories in the data, and coded them. The data collected from the sites was further regrouped together and similarities of perceptions shaped up to show real classes and categories of data. Practitioner's perception of child and adolescent mental health problems changed and these problems were therefore reconstructed.

7. 4 Conclusion of the chapter

The nodes were developed from the data which was collected from the four focus group sites represented as *documents* of the study. The focus group site documents were named after the *research site towns* of the study. The analysis of the nodes was based on the developed concept maps. Concept maps were very useful in line with node concept principles particularly in the logical and chronological analysis of concept/ theory areas. Data from the search conference and focus group discussions were analyzed using the fixed qualitative analysis method (Maxwell, 2002)

All focus groups perceptions were further analyzed against the six-node areas, it allowed possibility of understanding how individual groups perceived mental health problems of

children and adolescents against perceptions of other groups on the same six-node areas. Data analysis was done at the end of data collection and generally entailed a method of content analysis. The search conference data collected during and at the end of the search conferences were grouped into unreconstructed and reconstructed perceptions of *the PHC Practitioners*. The main features of the changed Perceptions were the *changed definition of mental health* after merging the homogenous unreconstructed perceptions.

It will be noted in the next chapter (chapter 8) that the results of the 21 years age group are included in the findings. *The reason for the inclusion of the findings was purely based on the data which was entered in hospital and clinic records by record clerks which the research team extracted and instead of recording it as missing data the researcher decided to include it to illustrate further that mental health problems were not just a source of concern to the 20 and under age group as defined in the study but extended beyond. This notation is further amplified in a quoted memoir from a participant member of the focus group on page 282 of chapter 8. Even though this finding is outside the defined age group it does however signal the magnitude of the problem, it does not influence the overall results but compliments the picture of CA's mental health problems beyond the defined study group.*

The other reason for this inclusion was purely the researcher's practice based experience on the ground. In addition, experience has shown that bed occupancy at any given mental hospital in the country particularly Chainama Hospital, where the researcher practices, there are more adolescents aged 21 years and above who frequently occupy hospital beds at any given time (researcher's experience based observation) even though no study has been done to support the researcher's experience claim. This scenario gives a picture that CA face a number of serious mental health challenges in their daily life. The researcher has been motivated with the development and wishes to do a follow up study later in future.

The next chapter presents results of findings of the study. The presentation is in three phases: results of explored perceptions of practitioners and the community; Curriculum Preferences; and Hospital / OPD data of mental health problems referred for consultation.

CHAPTER EIGHT

PRESENTATION OF RESULTS

8.1. Introduction

The presentation of results in this chapter is in four phases as described in the table below which modifies table 3 from Chapter 6 (Research Design and Methodology), to put in the documents obtained at each stage in the final column.

Table 4: Overall process of data collection for the study by the researcher

S/N	Activity	Method	Participants	Chair/Facilitator	Data documents
	Context and purpose	presentation	Practitioners	Consultant psychiatrist chairs	N/A
1	Problem identification	Search conference	Practitioners	Consultant psychiatrist explains conference methods	1 doc from nurses 1 doc from COS1 doc of merged perceptions1 doc of definition of mental health1 doc definition of CA1 document about Resources1 document of questionnaire preferences on curriculum
2	Data Collection	a. focus groups in 4 sites b. OPD data collection	Practitioners and community	4 senior lecturers moderate the focus groups	a) 4 documents from the 4 focus groups b) 4 sets of hospital Data with a combined summary of findings for all sites
3	Data Analysis of feedback from 4 sites	Review conference	practitioners	Consultant Psychiatrist moderates the discussions	1 document merged the 4 focus groups documents during the Review conference7 transcripts of flip-charts discussed at Review conference
4	Core group presentation of report	Textual report	Core research group	Consultant Psychiatrist	
5	Report to the national stakeholders	Oral with flip charts	Core group member	Executive Director	
6. Data, from the 23 documents explained in final column, was analyzed by the researcher for PhD.					

This table shows 5 activities showing the process of data collection with the 6th activity analyzed by the researcher for scholarly purposes. The activities are in steps which build onto each other and form a coherent whole and primarily modifies table 3 of Chapter 6 of the research methodology and in line with figure 15 respectively. The documents analyzed from this 'first phase', of the Search Conference, consist of: 1 document from nurses. 1 document from Clinical Officers 1 document of merged perceptions of nurses

and clinical officers 1 document of definition of 'mental health' 1 document of definition of 'Child and Adolescent' 1 document about Resources The '*second phase*' presents data obtained from the interview question items used in the focus group discussions to explore the perceptions and understandings of the communities and is presented as follows:

Step 2a) of the second phase

Presents 4 documents of community explored perceptions from the 4 focus groups about mental health problems of children and adolescents (*qualitative data*). Please note that, data from the interview question items used are first represented in a general matrix table and later into subsequent tables and models as contained in the chapter.

Step 2 b) of the second phase

This phase presents 4 sets of hospital data obtained from hospital registers and out patients' clinic records (*quantitative data*) at the 4 research sites. The intention in obtaining this type of data at step 2b was to show that mental health problems of children were also being reported at health care facilities at the four sites, albeit with inadequate diagnosis as discussed in the next chapter.

Step 3) of the Table

At this stage of the study, 1 document merged the 4 focus groups documents during this Review conference. It then followed that discussion of the presentations from the 4 focus groups were categorized by the participants and put into 7 flip-chart documents consisting of: 2 on definitions (mental health and CA respectively). 4 on knowledge areas pertinent to etiology of mental health (life stressors, environmental, biological and physical). 1 on resources, mainly human resources within the Zambian health system.

Step 4 and 5) were essentially political processes which are not analyzed in this thesis.

Step 6 from Table 4 above consists of this research's analysis of the documents listed under Steps 1-3 above.

8.2 Participants Vital data

This part of the study highlights the vital statistics of the practitioners, project sites and other requisites that the study put in place at its inception and is as follows:

Table 5 Details of the Core Research Group

Designation	Gender of the members	Current position held
Consultant psychiatrist	Male	Director of Clinical Care
Lecturer 1	Male	College Registrar
Lecturer 2	Female	Academic Secretary
Lecturer 3	Female	Nurse Lecturer
Lecturer 4	Female	CO Lecturer
Researcher	Male	Director of Training

This table shows an equal balance of gender among the core research group and all were college staff except the Consultant who was from the Hospital. It was necessary to have a core group which could be easily reached at any time and that no expense would be incurred on the part of the researcher when they were needed for the study. This note also applies to the consultant who was within the premises of the institution.

Table.6. Search Conference participants' vital data and their experience in health work

	Name	Gender	Designation	Previous Experience In Health Work
1.	Jennifer Munsaka	F	Executive Director (Zambia Nurses Association,	Hospital Matron and Nursing Lecturer
2.	Concepta Kwaleyela	F	Lusaka UTH Midwifery School lecturer	Nursing Sister
3.	Sister Christetta Kapapa	F	Public Health Nurse	Hospital Matron
4.	Pauline K. Lubemba	F	Nurse Lecturer, ZEM school	Hospital Matron
5.	Milimo Syanzila Maureen	F	Nurse Lecturer Monze ZEN school	Nursing Sister
6.	Bertha Chipepo	F	Ag Registrar, General Nursing Council of Zambia	Principal of Nursing School and Hospital Matron
7.	Nduba Chileshe	F	RN Chainama Teaching Clinic	Clinic Sister
8.	Jose Justin	M	Clinical Officer General	Clinical officer general practice
9.	Davy E. Chiyobe	M	Clinical Officer Psychiatry	Clinical officer, clinical and mental health practice
10.	Esther J. Chikopela	F	Principal Nurse Tutor,	Hospital Matron and Nursing Sister
11.	Joram Kabulaya	M	Chairman of Clinical Officer's Association	Chief Clinical Officer and Administrator
12.	Getrude K. Mukanda	F	Lecturer (Chainama college	CCF Coordinator and CO Psychiatry
13.	Marvis Mtonga	F	Nurse Lecturer	Ward Nursing Sister
14.	Rose Ng'andu	F	Acting Deputy Registrar	Clinical Officer Psychiatry
15.	Annel Bowa	M	Ag Registra, Chainama College of Health Sciences	Principal Clinical Officer, Mental health

This table shows that 73% of the participants were females whose previous experience in health work ranged from ward management, hospital nursing management and teaching nursing students even though their current positions were very senior to some of them.

Table 7: Length of work experience: as a PHC practitioner

N = 25

Year of appointment	Frequency	%	Percentage
1975- 1980	05	20	
1980- 1985	10	40	
1985-1990	05	20	
1990-1995	02	08	
1995- 2000	02	08	
2000- 2005	01	04	
Total	25	100	

This table shows that the highest numbers of Practitioners 10 (40%) were appointed between 1980 and 1985, with the lowest and least appointments between 1990 and 2005 respectively.

Table 8: Current Positions of Search Conference Participants

n =25

JOB SPECIFICATION	JOB DESCRIPTION	NUMBER
Psychiatrist	Director of clinical Care	01
Specialist	Mental health services Manager	01
Education. Manager	Principal of a Nursing College	04
Nurse tutor	Educator in a nursing College	04
Lecturer	Educator at Chainama College	05
Administrator	Managing human and material resources	02
Registered Nurse	Carrying routine clinical nursing care	04
Clinical officer	Carrying routine clinical medical care	04
Total		25

Table 8: shows that Chainama College of Health Sciences had more participants (05), attending the search conference than any other institutions. The main reason being that, this is the largest College wholly owned by the Health Ministry and has about 60 lecturers with close to 800 students doing both in-service and pre-service training.

Table 9: Key Purpose of the work various PHC Practitioners do

N= 25

Category of Practice	Key Purpose of work done	Frequency	%
Executive Director ZNA	Advocacy and administration.	01	04
Ag Registrar GNC	Regulatory and Training	01	04
Chairperson COAZ	Advocacy capacity building	01	04
Education Officer MCOZ	Curriculum, and training	01	04
Registrar Training CCHS	Training and administration	01	04
Nurse tutors	Education and Training	04	16
Nursing Sisters	Clinical nursing administration	04	16
Clinical officers	Clinical diagnostics and care	06	24
Lecturers	Education and training and clinical care of patients	05	20
Mental Health Specialist	Mental Health policy and administration	01	04
Total		25	100

This table shows that of the total number of participants, 24% and 20% respectively were involved in clinical care and diagnostics of health service users or patients. These are the clinical officer practitioners who are both training pre-service practitioners and providing bed side tutorials and clinical demonstrations on the wards.

8.3: FOCUS GROUP PARTICIPANTS' TABLES

Table 10: Demographical Characteristics of Research Site Focus Group Participants

10.1. Age ranges of focus group participants

n = 96

Range	Frequency	%
20- 25	04	4.17
26- 30	05	5.21
31- 35	10	10.42
36- 40	35	36.50
40- 45	30	31.25
46- 50	10	10.42
50-above	02	2.08
Total	96	100.00

Table 10.1 shows that there were more (37%) focus group participants within the age range of 36 – 40 years even though the age range of 40 – 45 years (31%) is equally significant.

Table 10.3 shows that there were more participants attending the focus group discussions with husband status (31.30%) and peasant farmer status who were males, suggesting that there was more male dominance at these focus group meetings than females. Such a scenario had its own implications especially during the deliberations in focus group meetings where the folks tended to dominate the discussions because they were males.

10.4 Demographic characteristics of Participants in the various Focus Group sites

n = 96

District	Participants	Male	%	Female	%
1. Ndola	20	14	70	6	30
2. Kabwe	22	14	64	8	36.2
3. Lusaka	30	20	67	10	33.3
4. Monze	24	16	67	8	33.3
Total	96	64	65.6	32	33.3

Table 10.4: Generally shows that there were more male participants than females in all focus group sites with the highest number 14 (70%) of male participants in the Ndola focus group.

Table 11: Institutions responsible for Training PHC Practitioners in Zambia
n= 54

Number	Institution	Frequency	Percentage%
1	Training Clinical officers	01	04
2	Training Registered Mental Health Nurses	01	04
3	Enrolled Nurses	22	41
4	Training Enrolled midwives	14	26
5	Training registered nurses and midwives	08	15
6	Mission School-training enrolled nurses	08	15
Total		54	100

This table shows that there are **54** health training colleges and schools training PHC practitioners in Zambia. Out of this number **8** train registered nurses and **1** trains clinical officer practitioners and registered mental health nurses. The remaining schools train enrolled nurses who are not part of the practitioners included in this study. They function at a much lower level of service delivery but are a critical group in the health service industry, they are mostly found at hard to reach rural areas of Zambia.

8.4: SEARCH CONFERENCE RESULTS

8.4.1 Curriculum Preferences

Please note that, the responses to the curriculum question is reported first because it is in tables rather than utilizing NVIVO software.

Table 12: Preferred curriculum model by the PHC Practitioners in Zambia

n= 25

Category	Curriculum model	Frequency	%
Practitioner	SPICES	05	20
Practitioner	PRISMS	12	48
Practitioners	SYMBIOTIC	05	20
Practitioner	ASSET	03	12
Total		25	100

Table 12 Shows that more, 12 (48%) of the total number of participants preferred the PRISMS curriculum model at the review phase of the study when participants returned from various focus group data collection in the four research sites.

8.4.2 Procedure used:

The number of practitioners who preferred other curriculum models was by personal conviction after each model was presented, debated, and pros and cons discussed. At this point all practitioners had the precondition of required knowledge of the different curricula proposed by the researcher for review and prior to that they had adequate time with fellow practitioners to discuss the various models as they were out in the field collecting data.

The reading materials on the various curricula had been circulated to them in advance, so that as they came back from the study sites they would have had already some informed choices of the type of model they would support for possible adoption for the PHC practitioners' INSET curriculum in child and adolescent mental health. The procedure for practitioners to make informed choices about their preferred model was, each participant was given a blank piece of paper where they wrote the name of the model they preferred adopted for Zambia, out of the four proposed.

It must be pointed out that, the curriculum models that were presented were merely prototypes and were meant to share knowledge about the current curriculum shift around the globe, and these models were excellent examples of the OBE models with emphasis on competency which is the current trend in the health professional education curricula Zambia included. The participants' independence to come up with their own model was not violated, they had the liberty through their working groups and subsequent plenary to co decide their own curricula without the indulgence of the researcher.

Table 13: Reasons for selecting the PRISMS' Curriculum Model

n=30

8.4.3 Type of Curriculum Preferred

Reasons for choice of curriculum	SPICES	PRISMS	SMBIOTIC	ASSET
The model is Qualitative	03	08	06	03
The model cuts across	08	12	10	03
Increases teacher- student interaction	08	06	06	02
Multi professional	04	04	01	10
TOTAL	23	30	23	18

This table shows that the PRISMS model had the highest rating of the four proposed curricula. The model was viewed to be *highly qualitative*, cuts across various curricula models and characteristically, increases *teacher-student interaction* and takes on board various *multi professional groups and clinical education is its agenda*.

It can also be seen from this table that even though the PRISMS model had the highest rating, both the SYMBIOTIC and the SPICES models had relatively similar ranked ratings, however, the SPICES model had the highest rating on *teacher-student interaction*, while the ASSET model had the highest rating on *multi professional* and these are very important principles in innovative educational processes which promote active facilitation of learning.

The picture that this table shows suggests that although the PRISMS curriculum model was preferred, it is possible that during the actual teaching and learning process, a combination of teaching methods could be applied from both the SPICES and SYMBIOTIC curriculum models.

8.5 Search conference perceptions of CA mental health

The following report of findings was established after careful analysis of the data documents in NVIVO, which were translated into *a matrix of responses, concept maps, tables, and research models*, utilizing the classification into tree nodes and child nodes as explained in chapter 7 of data analysis about NVIVO. The pictorial models are represented by Documents (at the base) which hold all the data for each site, followed by the **node** areas, which represent the broad areas of knowledge from which subsequent sub-knowledge specific areas were drawn from.

8.5.1 Practitioners Perceptions Homogenous groups

8.5.1.1 Nurses perceptions

When nurses met together as a homogenous group irrespective of their current duty role or appointment, they discussed what they perceived as factors that precipitate or predispose children and adolescents to mental health problems while conceding that a problem of C&A with mental health problems exist in Zambia.

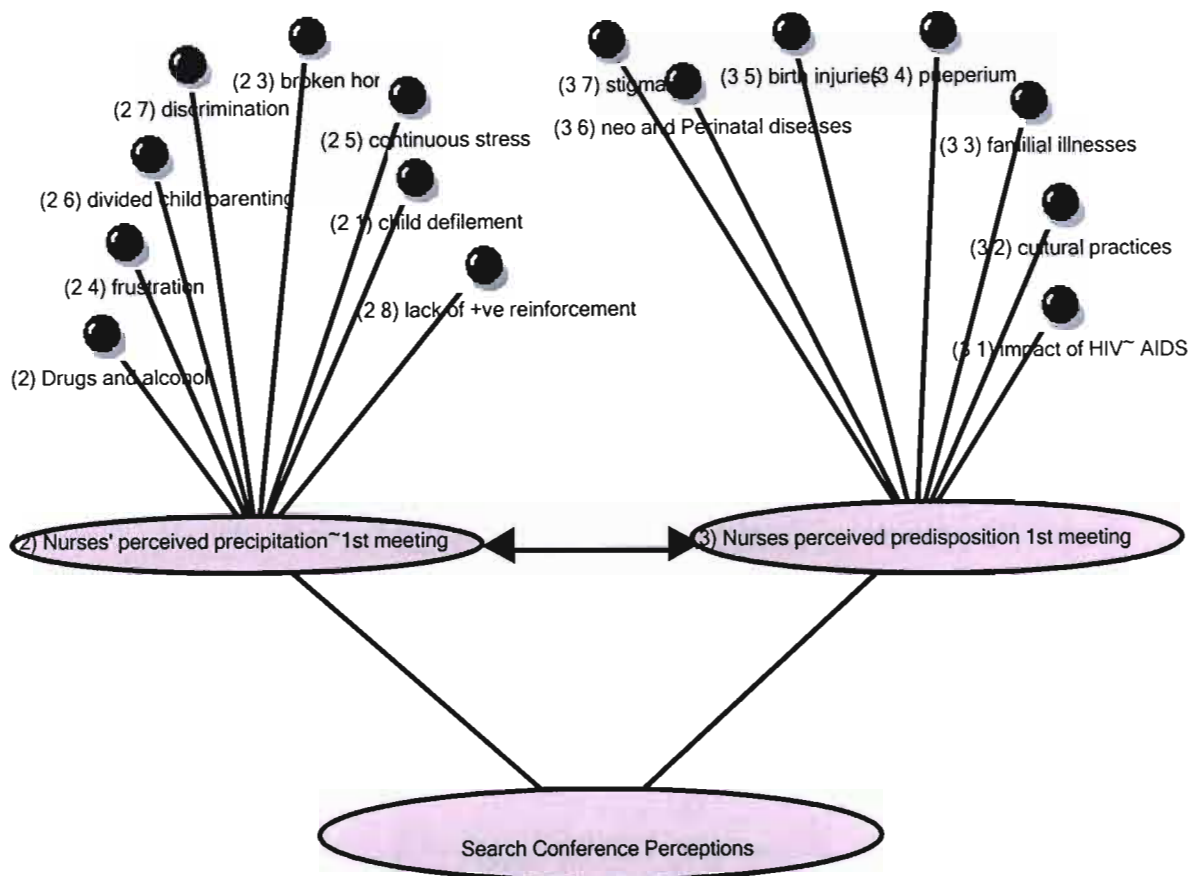
They pointed out that it was for this reason that there is an increase of orphans and extended family burn out in the average Zambian family causing some of the uncared children and adolescents on the streets. The data which follow shows the perceived factors based on the nurses' perspective prior to the reconstructed ones as follows:

- Nurses perceived the grounds for child and adolescent mental health problems from a *socio-economic* viewpoint. They felt that *precipitation and predisposition* were crucial factors in child and adolescent mental health well being.
- Several precipitating factors were perceived and among these were: drugs and alcohol abuse; continuous frustration; upbringing of children where other children were more favored than others.
- Other socio-economic view points were among others: Discrimination of children and adolescents due to their mental health state by schools, peers and community, broken homes where parents are divorced or living separately; child defilement for cultural/ traditional purposes and rituals.
- Lack of recognition and appreciation by parents for positive behaviors of children as well as several predisposing factors were perceived to underline the etiology of child and adolescent mental health problems and among these were:
 - ❖ Stigma running across the board from family, peers, school and community.
 - ❖ Neo and Peri-natal infections leading to brain diseases
 - ❖ Puerperium was particularly cited – as a condition females go through after child birth in the form of brief psychotic reactions
 - ❖ Genetic/familial conditions; including
 - ❖ Cultural/traditional practices happening early in childhood and the impact of AIDS/ HIV to parents.

Perceptions were further classified into two broad categories which were later relocated to the six broad defined classified areas of the study. Then they were compared with those of the clinical officers (figure17 below).

The figure below, illustrates a model showing the socio-economic viewpoint of nurses in which precipitation and predisposition were considered to be key factors in the etiology of mental health problems of children and adolescents.

Figure 17 Model showing nurses' perception about the possible precipitating and predisposing factors of mental health problems of children and adolescents.



From this model, it can be seen that, when Nurses met as a homogenous group, and listed factors, which they perceived as points of reference in the etiology of mental health problems of children and adolescents, the unreconstructed perceptions were viewed from the socio-economic factors' perspective.

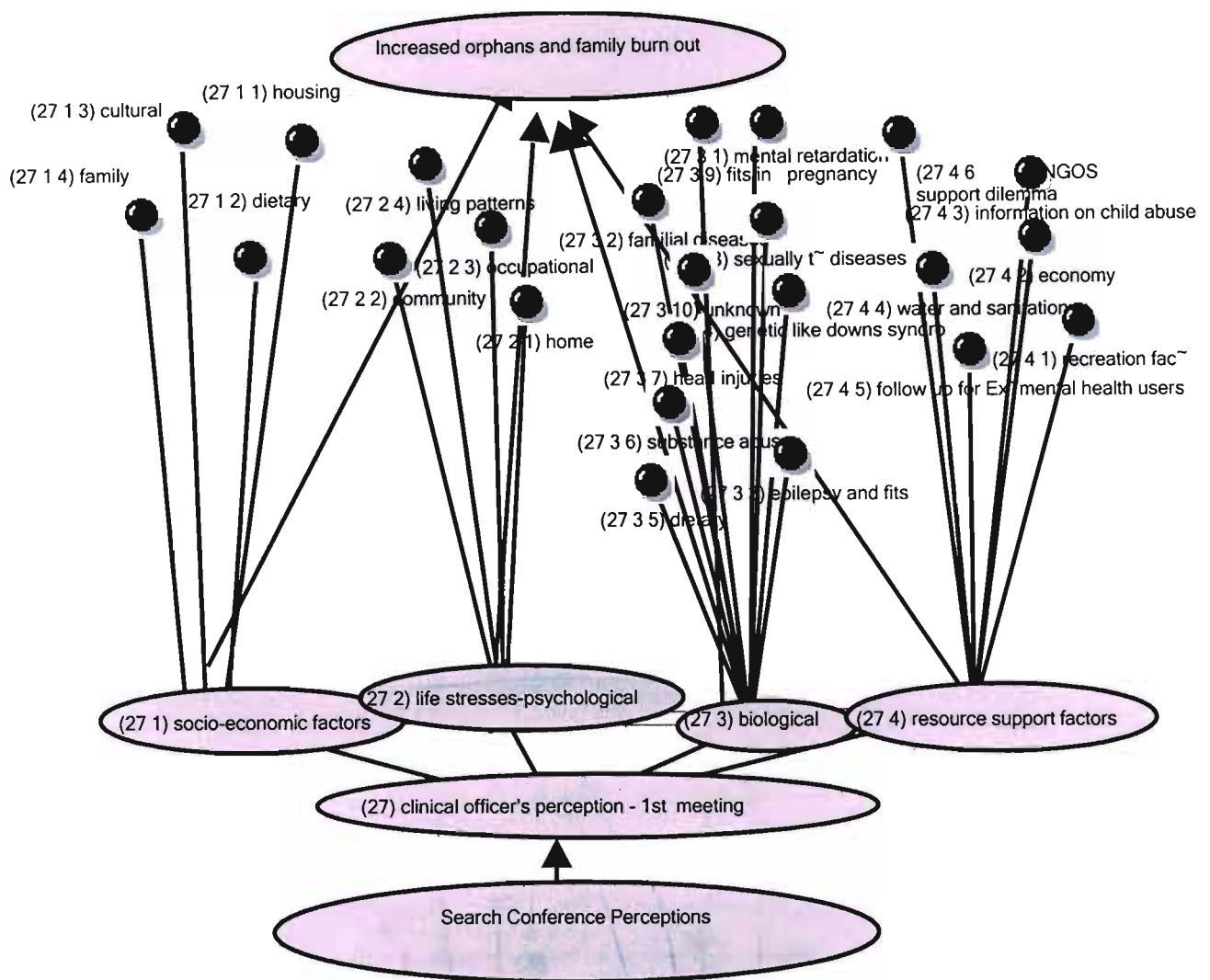
8.5.1.2 Clinical officers' perceptions

The researcher, first, wanted to establish what Clinical Officers (COS) perceived was Mental Health Problem? In response, Clinical officers, unlike the nurses perceived a description of what the community does to treat mental ailments such as epilepsy, even though epilepsy in itself is not a mental illness, but at that level of the community, it is one condition that is believed to be a form of mental health problem, with strong set of beliefs attached to it, hence described it as: "*Misconception for instance to give alcohol for treatment in large quantity to treat epilepsy*". From this result, this response does not correlate with the question, because it does not tell us what they perceived mental health problem to be, instead, they provided a scenario of what the community does to care for the children and adolescents.

The reasoning behind such a description could be that, some of the perceived problems in the community surrounding such a description could have been based on a number of factors prevailing in the community, which they considered to be part of the community routine practice and were part of the shared common belief, and felt that these constituted an important basis in precipitating mental health problems of children and adolescents.

The model presented in Figure 18 shows clinical officer's perceptions and understandings about the etiology of mental health problems based on what they considered as '*belief phenomenon*'.

Figure 18: Model showing clinical officers' perception and understandings about the etiology of mental health problems based



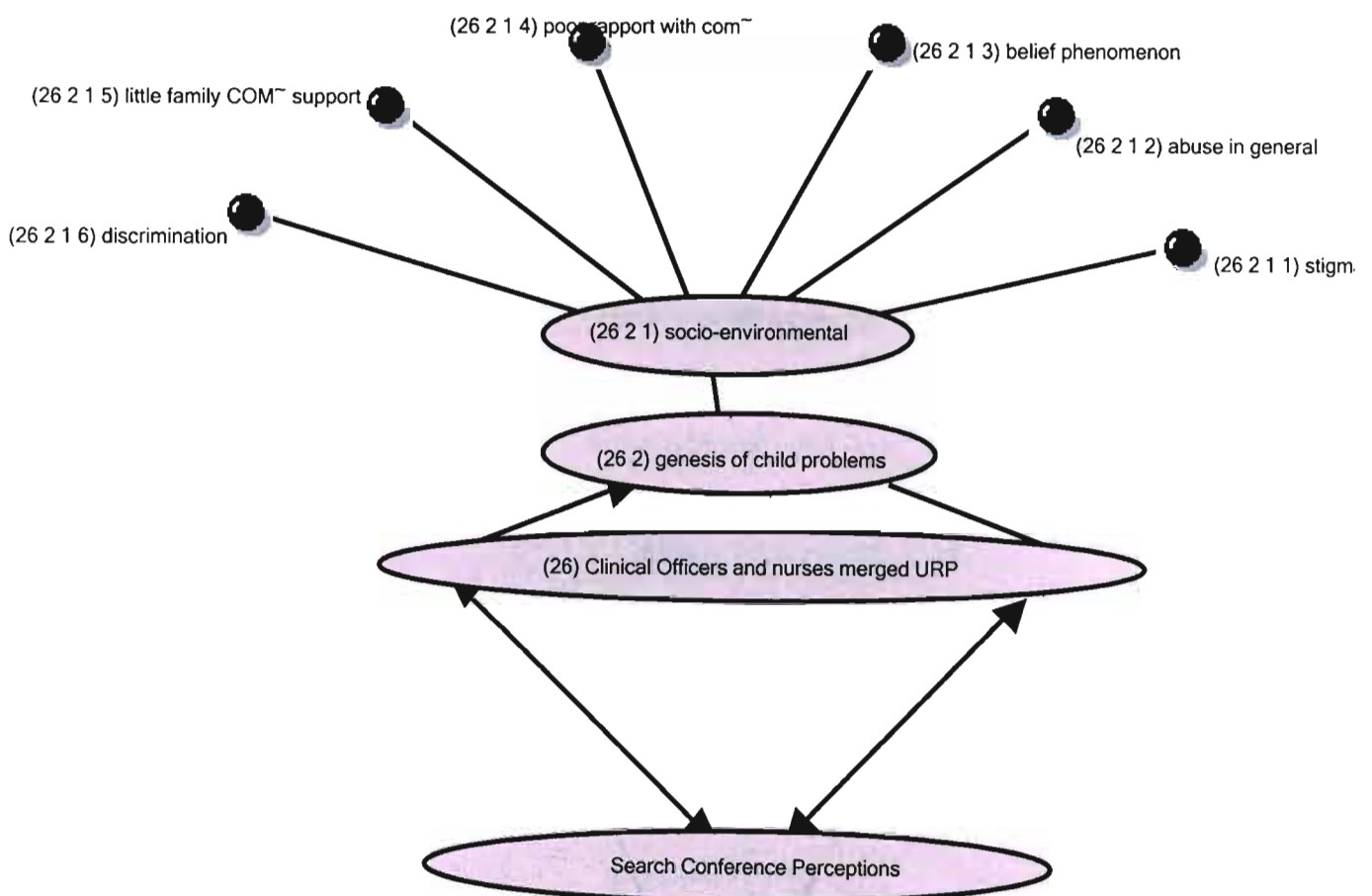
This figure shows clinical officers' perception about the etiology of mental health problems of children and adolescents. The figure further shows that life stresses, socio-economic factors and biological factors were a result of the belief that the family and community members played some mysterious activity such as magic, witchcraft or ancestral spirits. The figure further shows the variance in perception of the cause of mental health challenges in children and adolescents. Clinical officers' view were that mental health problems were largely due to beliefs

8.5.1.3 Clinical Officers and Nurses Merged Perceptions

As explained in chapter 6, this merging was done by the participants looking at the flipcharts of the perceptions of the homogenous groups and re-aligning their perceptions.

Figure 19: Merged Perceptions of Clinical Officers and Nurses at Search conference.

When the researcher considered and coded the transcript of the flipchart of merged perceptions from the Search Conference, the model of the NVIVO codes looks like this as shown in the model below:



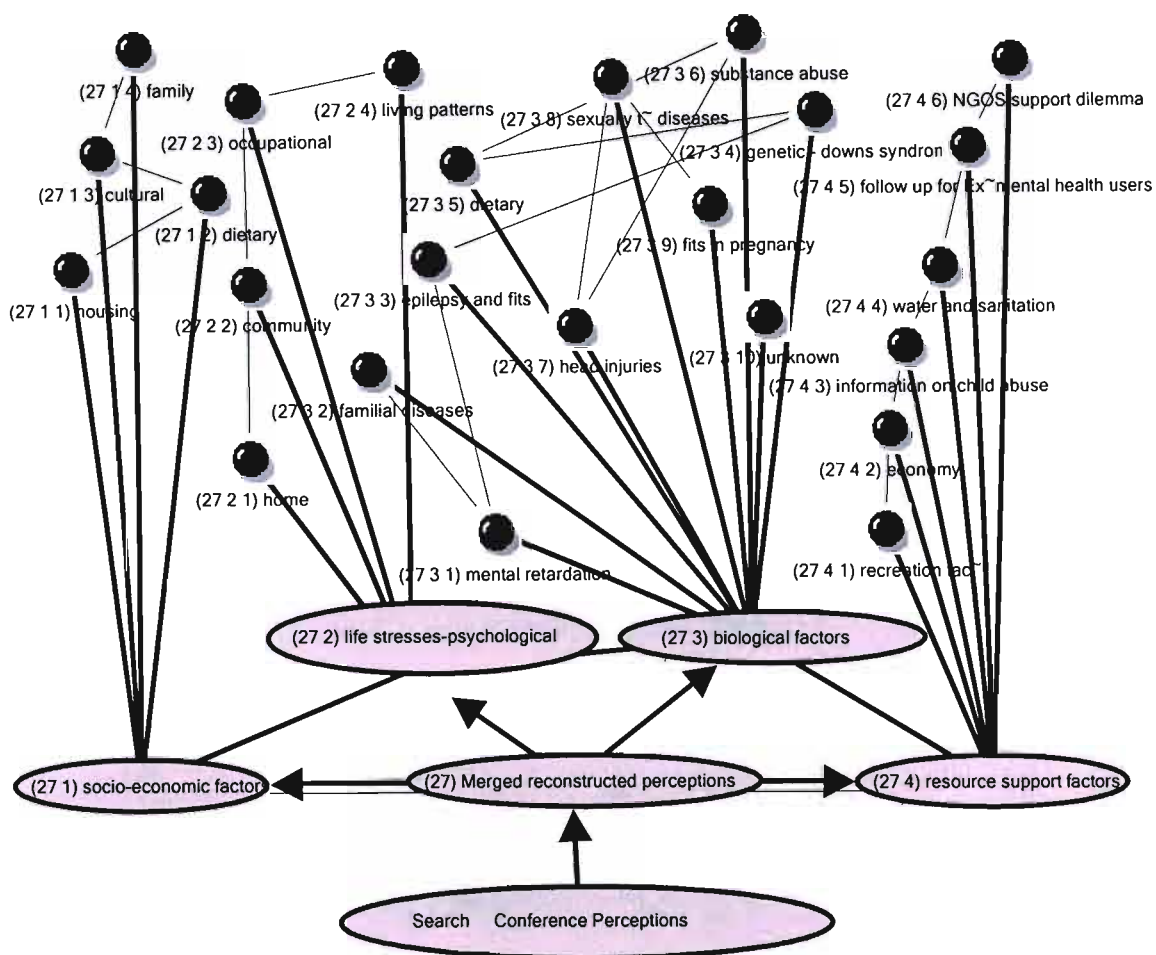
This figure shows that the most important change that took place was the view of the definition of mental health based on the reconstructed views about the genesis and socio-

environmental factors associated with mental health well being of children and adolescents. The nurse's view before the merger was that mental health challenges were largely due to precipitating and predisposing factors as shown in figure 17.

This view was sharply in variance with clinical officers who looked at mental health problems from the belief perspective. When both groups met and discussed, the result was the changed definition of mental health and the role of socio-economic impact on families and communities with resultant effect on children and adolescents who primarily depended on parents and guardians for survival and mental health development.

The figure shows further that the two factors which are: stigma and discrimination were considered to be strongly linked with mental health welfare of the children and adolescents.

Figure 20: Set of merged search conference perceptions of the PHC Practitioners illustrated in the form of tree-nodes and child-nodes contained in the two documents of the practitioners.



This model shows merged perceptions of clinical officers and nurses after they came together in the Search conferences which are: socio-economic factors, life stresses, biological factors and lack of resource support from the community. The “biological” code collapses the “biological” and “physical” of the original flip-charts. The sub categorization of these seemed to be that physical were things caused by circumstances like water and disease-related, while “biological” were the genetic or “at birth” conditions like Down syndrome or STI-which led to conditions such as syphilis. The specific factors are represented as child-nodes shown in the ‘blue color’. It can also be seen from the model that by far the biological and resource support factors have more

coding intricacies than the life stresses and socio-economic intricacies. This finding is an important outcome of the coding done to the perceptions, because the variance between the merged unreconstructed perceptions and the reconstructed ones showed that perhaps the interaction of the practitioners with each other in the heterogeneous meetings had an impact on their previously held perceptions and understandings about mental health problems of children and adolescents both as individual practitioners and homogeneous groups. The initial perceptions of the Clinical Officers at the Search Conference perceived lack of resources in the micro terms of deficiencies in the health system, whereas the above coding shows that features of the macro economy are now being discussed

8.6: PHASE THREE: PERCEPTIONS OF INDIVIDUAL FOCUS GROUPS

8.6.1 Method of categorization

Individual study site focus group perceptions were done to establish what each of the four research sites perceived about the various geneses of mental health problems of children and adolescents in the defined (from the Search conference) into six (6) categories/classes of knowledge areas of the study by the participants which is: *perception of 'child' and 'adolescent'* as well as *'mental health'* which were included by the researcher for purposes of ensuring that participants understood and appreciated the concept terms before proceeding into the other (4) concept field areas for the study (life stressors, environmental (i.e. socio-economic), biological (collapses biological and physical) and resources).

The Matrix tables are taken straight from the flipcharts of the Focus Groups, so they represent how the participants utilized the categories set up by the Search conference.

The NVIVO models show how the *researcher* coded each of the Focus Group transcripts. This focus Group coding covers fourteen (14) free-nodes from which (27) tree-nodes were identified and one hundred and thirty nine (139) child-nodes were created.. The

free-nodes shown in the model below represent the general field knowledge concept areas and categories, while the tree-nodes represent main categories or knowledge class areas of the study. The child-nodes are specific critical knowledge areas extracted from the tree-node areas. The findings from the field were based on the nodes analyzed from the 10 question items drawn from the four Focus Group sites, which are: Kabwe, Lusaka, Monze and Ndola District Towns. The report of the findings of each group is also based on the interview guide of the Focus Groups. The communities studied understood and perceived the node-areas in their own agreed perspective and context.

A matrix table is presented first to give an overall general picture of the patterns of perceptions and understandings of each and all focus group areas on what they considered as important factors associated with mental health problems at a glance. The matrix table is then followed by the NVIVO model which shows the researcher's coding.

Table 14: Matrix table showing perceptions of etiological factors by individual and all focus group sites

Focus group	child and adolescent Perception	Perception of mental health	Environmental factors	Life stresses/psychological	Biological factors	Physical factors
KABWE	Child =1-15 years	Complete and proper thinking	Poor and Inadequate water	Hunger Poverty Luck of school	Lead poisoning Unbalanced diet	Lead contaminated dust
	Adolescent= below 20 years		Contaminated soil with lead	Being orphaned Divorce of parents Broken homes Not staying well Leaving children alone	Genetic mental illness	Drugs and Alcohol Glue sniffing Lead poisoning Parents giving alcohol to teenagers epilepsy
LUSAKA	N/A	State of a person Behavior Problem Person	Many bars Selling illicit beer Wife battering	Mistreatment Peer pressure Films and TV Mistreating non-bio. child Wife battering Restrictions Accidents Poor nutrition Loss of parents Drugs-Cannabis STIs from parents Frightening noise Scalding Defilement No love	STIs from parents Epilepsy in pregnancy Genetic illnesses Poor nutrition	Accidents Alcohol Scavenging Eating from dustbins Genetic illnesses Glue sniffing
	1-18 yrs 1- 3 yrs 1- 12 yrs 1-10 yrs 0-18 yrs	Behavior State of mind Activities Presentation Dressing Eating Attitude	Poor housing plans Air pollution Lack of recreation Unsafe water Poor sanitation Lack of C&A ed	Leaving children alone Upbringing Hunger Poverty Loss of parents Parents fighting No medical care Peer pressure Mistreatment by teachers Isolation at school	Inadequate food Monotonous diet Insufficient food	Drugs and alcohol Smoking Dagga Glue sniffing Sex workers
MONZE		Thinking Behavior State of mind	Erosion from factories Alcohol	Drugs and Alcohol Epilepsy Social pressure	Epilepsy and fits Inadequate food	Drugs and Alcohol Glue Sniffing

NDOLA	N/A	Low intelligence quotient	Epilepsy and fits Social pressure Accidents Large populations Death of parents Lack of nutrition knowledge	Infant accidents Child defilement DVD and Internet Unclean water Western culture impact Examination pressure Eating pork meat Poor sanitation Pollution- smoking vehicles Dagga smoking Too many bars in residence	Lack of nutrition education Eating pork meat Lack of water sol. Vitamins in diet Nutritional problems	Epilepsy and Fits Accidents Garbage Diarrhea Unclean water Smoking vehicles Emission from factories Poor nutrition
		<u>Life stresses cont.</u>	<u>Life stresses cont.</u>			
		Socio economic pressure Poor economy Prostitution Leaving children alone	TV Channel '0' Early cultural practices Drinking in pregnancy Poor nutrition			

This matrix table shows perceptions of both *individual* and *all focus group* sites whether viewed from vertical or horizontal axis on the six areas which are: perception of child and adolescent; perception of mental health; perception of environment; perception of life stresses; perception of physical environment; and perception of biological environment.

There is variation of perceptions among focus groups, for instance, wife battering in Lusaka is both environmental and life stress while divorce in Kabwe is due to life stresses. These inconsistencies in the participants' perceptions show that each regional research site appears to have their own culturally embedded view of life situations. The table further depicts a higher number of factors perceived to be environmental and life stresses compared to other perceptions of factors considered to impact negatively the child's mental health well-being, and when the coded passage counts were done, the two areas of factors had the highest counts. ***This finding is significant as shown in the coding passage counts (table 24) below.***

The following set of tables and model figures below, show the Perception of the community about precipitating and predisposing factors as well as understandings of mental health problems of children and adolescents in each of the four focus group sites.

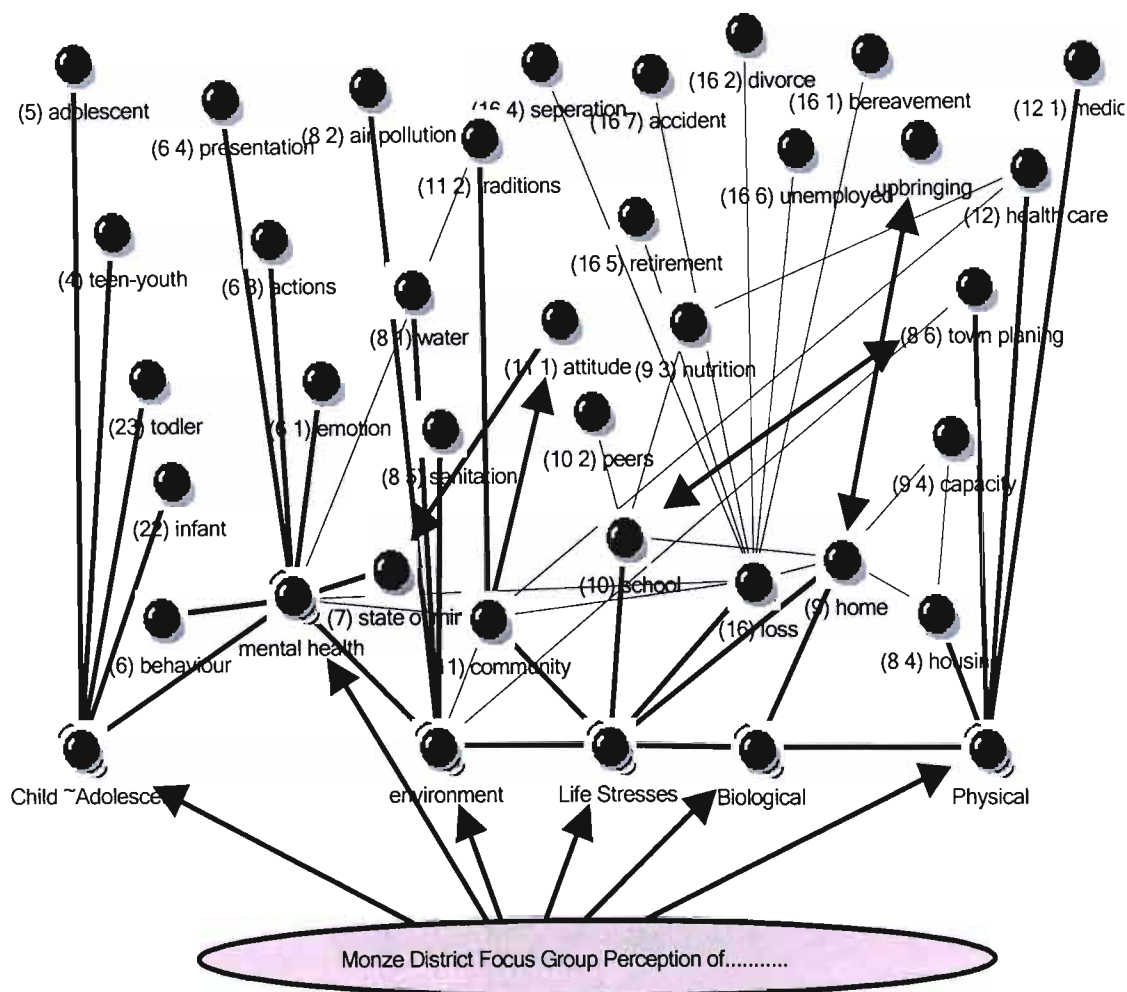
8.6.2 Monze Town District Focus Group

Table 15: Perception of etiological factors of child and adolescent mental health problems in Monze Town District.

Focus Group Site	Etiological factors of child and adolescent mental health problems					
	Child adolescent	Mental health	Environment factors	Life Stresses	Biological factors	Physical factors
Monze	A person aged between	Behavior	Poor council housing plans	Leaving children alone for long periods	Inadequate food	Drugs
	1-3yrs	Relationship with people	Air pollution	Hunger	Monotonous diet	Alcohol
	1-10yrs	State of mind	Change of life	Being young	Insufficient food	Smoking dagga
	1-12yrs	Actions	Lack of recreation	Poverty		Glue sniffing
	1-18 yrs	Presentation in form of <ul style="list-style-type: none"> • dressing • appearance • eating personality problems	Bad water	Loss of parents		Sex working
			Poor sanitation	Parents quarreling		
			No education for children	No medical care		
			Child abuse	Peer pressure		
				Bad treatment by teachers		
				Isolation at school		
				Mistreatment		
				Refusing child school		

This community perceived that drugs, alcohol, dagga smoking were the main precipitating and predisposing factors including glue sniffing as well as issues of attitudes of parents during the upbringing period. *N.B.* The Monze research site perceived a child and adolescent as someone with age ranges as shown in the table and recognize 1 year of age and not under as a child - this is the perception according to this site, even though this group could have taken into account those children under one year of age as well.

Figure 21: Model showing Monze district focus group perception and understandings of mental health problems of children and adolescents



This model shows that the focus group attributed the state of mental health of a child and adolescent to the individual’s personal presentation, such as way of thinking, and type of actions, in addition, the group considered *loss* in its general context, to impart negatively the mental health state, arising from the life stresses, either as a consequence of the home, the community, housing and biophysical insults. Both the table and the model present results of findings which show an account of perceptions of the mental health problems as perceived by the community in the six core areas of the study to be due to:

8.6.2.1 The environment

- The environment of Monze Town was described to have poor sanitation with inadequate unsafe drinking water and polluted air due smoking of vehicles which are not road worthy.
- Perception of the environment included the community itself, community attitudes, traditions and the impact of life stresses such as its subordinate factors which are loss, home, pressure and housing at macro level.
- The houses are too close to each other. Locations of industrial/commercial activities are close to residential homes, which inevitably affect the health of the residents.
- There are no recreation facilities for children. This makes children idle and finally gets them involved into dangerous avenues and activities.

8.6.2.2. Life Stresses

- Environment was perceived at macro level to comprise environmental factors such as the community, school, family/ home and housing.
- The effect of life stresses were further seen at macro level to include attitudes of the parents towards the child including upbringing and issues of culture/traditions therein.
- The element of **loss** appeared significant in this community such as bereavement, divorce of parents and others like retirement and accidents.

Children have shunned initiation ceremonies, forced on them, such as early marriages.

One member of the group complained and blamed some of the practices in the district and stated that:

“The girl child in this town is required to wear model penis when she is taught at initiation ceremonies on how to handle men when doing sexual intercourse. I don’t like this, what morals are we teaching now,”

Polygamous marriages were cited by the group as one of the aspect that has negatively impacted on the children and adolescents.

They cited absence of parents from homes on commercial undertakings for longer periods to have in turn led most children astray to the hands of peers. One member of the group stated as follows in the memoir below:

“These parent marketers are spending a lot of time at markets. When I go to the market these people are there. What time do they have to lead by moral example values and virtues of life? These issues make my heart to bleed. Children are lacking parental love and care at this stage. How will they make it on their own? Eya (Shame)!!” There is also this thing I am hearing about young girls in South Africa being recruited by America for sexual industry and the governments are watching, Eya (Shame)!

Change of housing and location by families in the event of loss was one of the most impacting aspects of most children.

Loss was defined to mean (death, loss of job, retirement, divorce, parents separated, chronic illness, and disabilities of children-physical and mental). One member in the group who was once a mental health user said this in the following memoir:

“I felt sick I was depressed. Went to a hospital in chingola where I was treated and got discharged. This time around I was in Chingola then decided to leave my guardian to join my mother in Monze Town. You see how important it is to live with your parents even if they are no longer in employment because they know you and understand you. I’m now in Monze where I’m an advocate of good mental health for the children and fellow youths. I’m chairperson of an NGO whose focus is empowering youths with resources for sustainable development for the disadvantaged. I’ve gone through the trauma of mental illness, it is not good. I should now embark on supporting the plight of the mental health users and those disadvantaged as well as the vulnerable. When I say do this, they should deliver it to the people.”

The group noted also that many people in the community do not have reliable projects which have the capacity of good profit returns, against this background; they find themselves working long hours though it has its own positive and negative effect on children, the following memoir highlights the position from one member of the group:

“I have been observing some of my fellow women in Monze, you want to visit them at home but they are never there. You are always told that they are at the market. These fellow women marketers spend long hours at markets and places of work. This has reduced the much-needed parental love to our children at this stage. Children brought up

by disjointed parenting end up failing to make their own this is now happening in Monze, what should we do now because this thing especially among us women is getting out of hand? ”.

It is common knowledge in this community for people to leave children alone as they go out in bush to hunt or to fish without any food for the children. This is done in the hope that other people will take the responsibility one member of the group had this to say:

”Poverty at village level is there but it is not as pronounced as in Town because of the well-defined extended family system in the rural places, which is very strong. Parents sometimes are away from homes weeks or even months in search of fish or hunting and selling cows. Children are left without food, this is with the assumption that they will eat anywhere in the surrounding neighborhood”.

In this tribe the community treats the man in the highest order, this means that in any household he is the best fed, given the most nutritious foods and served in good quality and quantity proportions. If men and children were eating together, the elders would eat the best portions of meat (chicken), fish or any other relish, first and served in larger quantities than children. This norm is undisputable; it does not recognize the nutritional values of feeding for the young and growing. Most children end up with diet higher in carbohydrate content and in the final analysis such children find themselves with Nutritional oriented health problems.

8.6.3 Kabwe District Focus Group

Table 16: Perception of a child and an adolescent as well as etiological factors of mental health problems (precipitating and predisposing) among children and adolescents in Kabwe district.

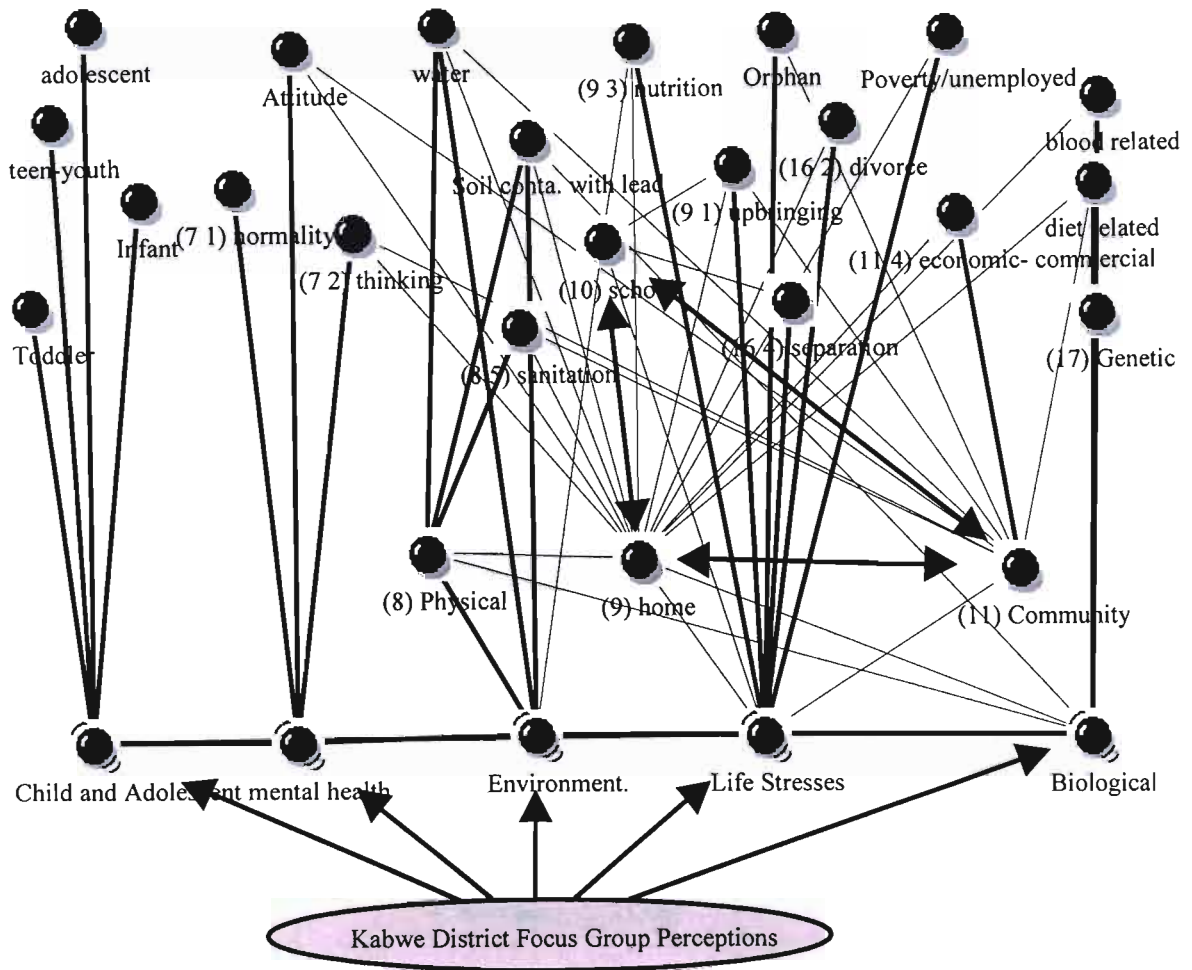
Focus group site	Perception of :		Perceived Precipitating/ Predisposing factors			
	Child and adolescent A person between 1 year to 15 years Under 20 years	Mental health Complete thinking Proper thinking	Environment Poor environment Inadequate water Lead contaminated soil	Life Stresses Hunger Poverty Lack of school Being orphaned Divorce by parents Broken homes Mistreatment Leaving child alone for long periods	Biological Lead poisoning Unbalanced diet Mental illness due to genetics	Physical Lead contaminated soil Drug abuse Alcohol abuse Glue sniffing Lead poisoning Parents giving children alcohol
Kabwe						

This table shows that the Kabwe community perceived a child and adolescent to be a person between 1 year to less than 20 years of age, with proper and complete thinking and this focus group perceived the child and adolescent in terms of age range.

The table further shows that the environment is generally considered to be poor because of inadequate water and lead contaminated soil, while life stresses were perceived to be mistreatment of children, poverty and hunger exacerbated by divorce, dysfunctional homes and children leaving alone for long periods.

Diet, genetic causes, alcohol, drug abuse and glue sniffing seemed to be perceived to be some of the causes of mental health problems of children and adolescents including: being orphaned divorced, and wife battering as some of the most threatening cultural/traditional concerns frequently observed in Kabwe communities.

Figure 22 Kabwe District Focus Group Perceptions of the Child and Adolescent Mental Health Problems



This model shows that the focal point for the child and adolescent’s mental health development as stated earlier on is the family as a home. What is further shown in this model is the strong interaction between the home, school and the community.

This strong interaction forms a solid triangular linkage not only between the family, school and community, but also with the physical environment such as water and sanitation, nutrition, as well as the vices of poverty. The issue of life stresses and the impact of biological and physical factors particularly soil contamination with lead is critical for the Kabwe Town.

8.6.3.1 Environment

The group described environment as bad because it has no adequate water. The water is not safe to drink because it is contaminated with bacteria and sanitation is very poor characterized with outbreaks of water borne related diseases. The soil itself is highly leaded and this *lead* requires covering and planting (*kapinga*) grass to ensure that the environment around the homes was safe for children to play. The community correlated the polluted soil with lead and lack of recreation as a consequence of non-productivity of children and adolescents. Substance abuse, such as drugs and alcohol and inhalants such as glue sniffing are increasingly a challenge to the communities of the town.

The community eluded this, to the redundant mine workers who got themselves out of employment when the mines closed-down.

The communities noted the increase of both blood-related diseases, HIV/AIDS- related diseases and diet-related diseases as the consequences of no employment and poor performing economy of the town.

The community expressed concern with increasing shanties in the townships and alluded this as an indicator of poverty, poor jobs, low class status and consequently, poor mental health status of children.

Diet/nutrition was not balanced particularly in the socio economic disadvantaged strata as opposed to their counter-parts the advantaged strata and cited that the effect of unbalanced diet impacted negatively on the development of children's brains. Working conditions of parents/guardians were mostly unfavorable; they stayed away from home(s) too long at the expense of the families and children in particular. Most parents give hard jobs to children whom they attribute to as (child labour) because children '*eat as well*', therefore they must in turn contribute to the eating through labour to supplement the home earnings or income.

Culture and tradition play a significant role among the Kabwe communities, children and adolescents are forced into marriage even though they are not given adequate schooling

about it The community has a lot of dos' and don'ts' to children and most children grow up not knowing a number of facts of nature and life, such as sexual relationships between mother and father (parents) because parents hold that children are not allowed to enter the parents' bedroom, one parent states this way:

"Entering the bedroom at a certain age prevents the children from knowing or seeing the secrets of the bedroom that can affect them mentally, e.g. seeing pants of parents or even finding them naked." end of quote.

Parents are seen time and again insulting and fighting each other in the presence of children without resolving their issues which sends wrong learning to children and adolescents. It was noted that an environment in which there is continuing poor performing family/community economy and negative community attitude, children are left with no other option but to drop out of school and resort to prostitution or even stealing just to have money for their daily living needs.

The group observed lack of social amenities in the community such as: drama and theatre halls, football grounds, play parks and absence of these has contributed to children's poor mental health status. In a number of homes children are rebuked, demeaned, defamed and totally neglected at both family and community levels which is completely at variance with what the group would have desired as a community, and one parent puts it this way;

"You are a fool, you will not make it, you will amount to nothing, you are abnormal" end of quote. **NB** This attitude is vindictive to those children born mentally challenged or even the double challenged ones.

The impact of tradition whose effect has impacted negatively on the children has been cited, such as single parenthood, where children are not told who the real father is because it is not traditional to tell the child who the father is. Town councils and municipalities have remained cold in the area of infrastructure development and environmental planning. There is no development in the areas of physical facilities, recreational facilities and social resources. These continue to challenge the community of the town.

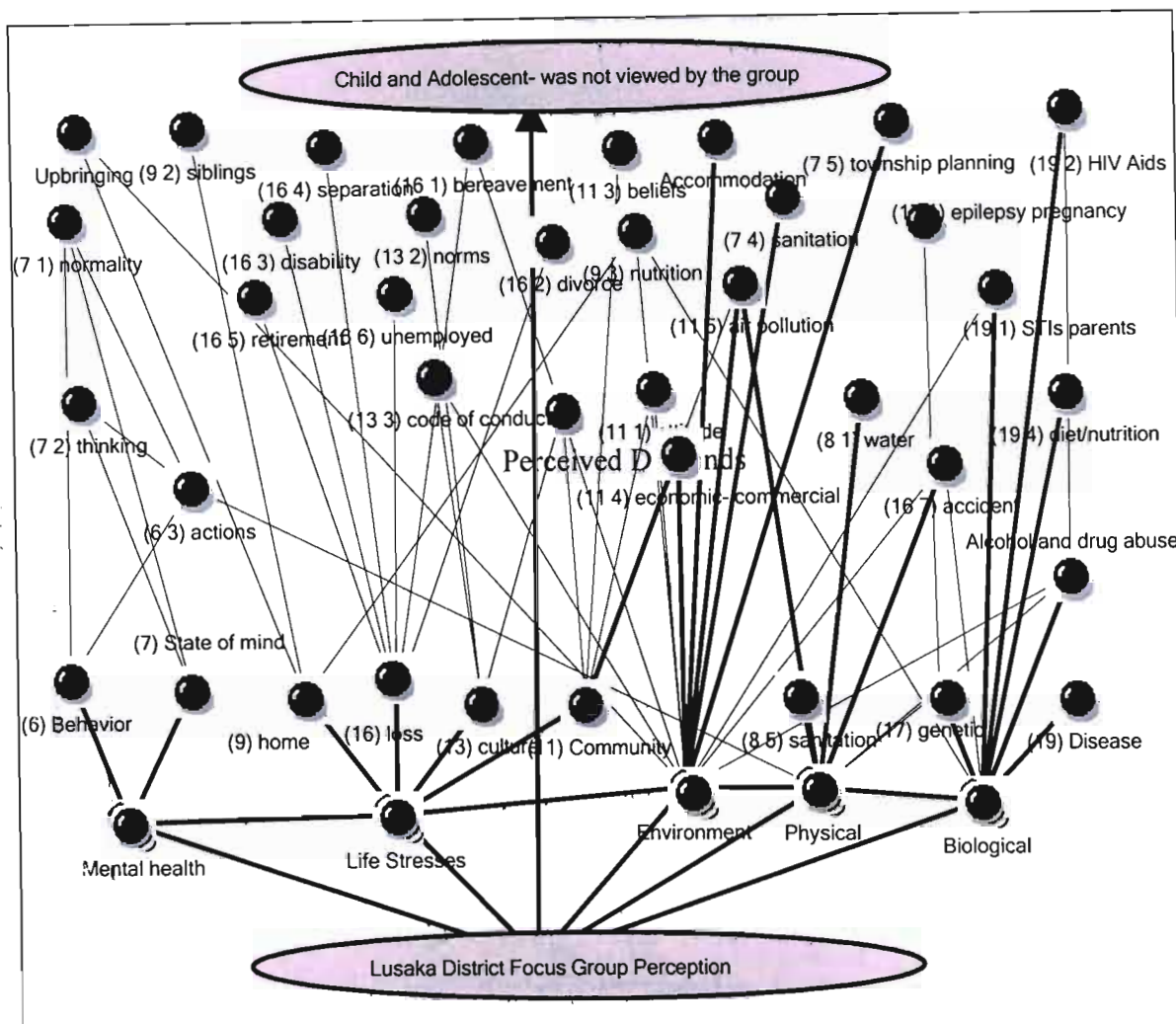
8.6.4 Lusaka District Focus Group

Table 17: Perceptions of child and adolescent mental health etiological (precipitating and predisposing) factors in Lusaka city District.

Focus Group Site	Perception of etiological factors of mental health problems (precipitating and predisposing) among children and adolescents in Lusaka District town.					
	Child and adolescent N/A	Mental health State of a person normal/ abnormal	Environment	Life Stresses	Biological	Physical
Lusaka		Behavior	Too many bars selling illicit beer Wife battering Noisy music Poor sanitation Movies and TVs Pornographic material Human rights distorting culture Dressing code Effect of dressing on male child Food contamination	Mistreatment Peer pressure Films/ TVs Mistreatment of non biological child Wife battering Restrictions Accidents RTAs Poor nutrition Loss of both parents Drugs- cannabis STI's from parents Frightening noise Scolding No love to children Defilement	STI's from parents Epilepsy during pregnancy Genetic mental problems Poor nutrition	Accidents Alcohol Eating from dumping sites Genetic illnesses Glue sniffing Scavenging Drugs

This table shows that this community perceives mental health as a state of a person, whether normal or abnormal with marked behavior and general personality problem. It further notes wife battering, noisy music, movies and TV's effects, films and mistreatments as problems of children and adolescents. The table also recognizes STDs, epilepsy in pregnancy and genetic factors, as well as alcohol and *inhalants* such as glue sniffing as serious mental health challenges.

Figure 23 Model showing Lusaka District Focus Group Perceptions of the child and adolescent; mental health; environment; life stresses; biological and physical factors



This model shows that, environment was the main focal point for most of the children’s and adolescents’ mental health problems. The community was perceived to play a focal role particularly if the child is brought up in. a strongly linked family with tradition/culture and beliefs, which encourage and practice witchcraft, magic and role of evil spirits; these are often linked to any form of mental health problem in the community.

8.6.4.1 Child and adolescent

The results of the study show that perception of '*child and adolescent*' was perceived in the context of behavior which manifests in the form of the person's presentation as well as the state of mind in which the child's/adolescent's actions are at variance with family and community expectations. Further results of the findings show that life stresses, environmental factors and biophysical factors, were the main source of mental health problems of children and adolescents in the Lusaka community and are outlined as follows:

8.6.4.2 Life stresses

It must be pointed out that within this category of stresses there are various stressors arising either from the family, peers, school or the community at large. The perception of various stresses differs in some cases with other research sites and some sites do seem to have extreme situations like the case of Lusaka and the high cases of epilepsy. The following account presents the way the Lusaka site perceived the various stressors in the context of Lusaka only. This focus group perceived

Life stresses were perceived as stressors within the context of the family particularly when loss has occurred in various forms and then culture and community traditions proceed to ameliorate the event of the loss in that family structure. The home and family was perceived within the context of the family to comprise a number of factors or stressors which are: siblings, upbringing of children, nutrition and its biological and environment implications. These were considered to play important links and relationships in the etiology of mental health stressors.

The group attributed disability of parents in whichever form it was as well as separation of parents either through divorce or death of spouse as *loss in its broader form* and negates the mental health status of children. In the same context, bereavement involving a parent or both was one of the most reported reasons for ill mental health of children. The

problem of Lusaka town being over populated, with children from rural migrating to the urban for greener pastures has caused management of these children and adolescents difficult and according to the group, this has led to too few housing units available in the townships causing sanitation hazards with unsafe and inadequate water in the city. Town planning is poor as most townships were built without any structural design for water reticulation and sanitation provisions.

8.6.4.3 Environment

Environment by this group was defined to mean the Physical nature and subdivided it into category areas such as: sanitation, housing, and town planning. They described the Lusaka town to be dirty due to poor sanitation and hygiene of the overpopulated compounds and locations.

Even though the researcher does not seem to trace the correlation between wife battering and the effects of too many bars and taverns in the townships including pornographic materials which have spoiled some children and adolescents, the wives have been blamed for this as their fault to let the children on the loose to those places. The illegal selling of illicit beer and drugs has been cited by the group because children and adolescents access these substances at a price they can afford from the community members and the scourge is on the increase. Movies, theatre halls both in central town and compounds, have mushroomed at the detriment of children and adolescents.

The group observed that when parents have sexually transmitted diseases, these diseases are in turn passed on to the fetus causing subsequent mental health problems to the unborn if the parents did not receive any treatment. The community is too busy and does not have time for families; children have resorted to adopting other behaviors which are in variance with the community such as: drug and alcohol abuse, sniffing, stealing, street kidding, begging and illegal money laundering as well as sale of stolen items, as well as foreign dress code.

Lusaka has a mixture of both local and foreign cultures; according to the group, these have confused the young people because at present they can no longer identify themselves with their parents for moral development and affiliation. These urban children can suffer restrictions of being confined to their residences because of security fears or at the opposite when the poorer children in informal settlements just wander around unmonitored. Wife battering is a daily norm as it is defended in the context of culture and tradition. The community prefers consulting traditional healers for the treatment of epilepsy using alcohol which has been cited as a success story.

8.6.4.4 The School

In terms of the School the group reported that: Children come from homes without food to eat while at school, and described this to have negative effects on performance as well as socialization with colleagues with food at school and also ascribed the same to general performance in class and periodic tests and examinations administered by the school. The communities further revealed that most good schools are expensive and even the public ones which are said to be free are not exactly free; the daily demands for contributions at these schools demanded by these schools are too expensive for the majority of the common and ordinary people.

The group also attributed some of the school drop outs to be due to inadequate feeding both at school and home giving children the children with other option but to discontinue in the hope of finding some form of livelihood. The group attributed the effects of divorce, loss of job; chronic illnesses with parents as some of the major stressors of children's mental health status as the power to earn money from the parents reduced or even vanished. The most affected ones as far as the community were concerned were the mentally challenged and handicapped children and adolescents who found themselves hidden from the public because they were a public shame and disgrace and if they at school they learned in separate classes from the rest of the ordinary able pupils, this was said to have stigmatized these children and adolescents out of proportion.

The rate of child defilement is on the increase, some of the members from the group felt that those who fall prey of defiling children did on the pretext that it was for the treatment of HIV/Aids as a ritual, but such act is unforgivable and culprits must receive stiff punishment by the state.

8.6.4.5 Biological factors

Epilepsy in pregnancy causes fits and is associated with mental health problems; they asserted that the disease tends to run in families by way of genes.

Drug and alcohol abuse were cited to have important relationship with the child's environment such as the peers, family and school, this was the time most of them got involved in unprotected sex hence contracted HIV/Aids and STIs.

Parents infect each other with sexually transmitted diseases (STI's) with resultant effect on the fetus during pregnancy. Eclampsia (fits during pregnancy) was considered to be linked to the 'biological' concept on the physiology of women.

With the increasing incidences and prevalence of HIV/Aids among families in Lusaka, the community noted that the surge of child and adolescent mental health HIV/AIDS-related problems are a challenge, one participant in the group gave this memoir:

"I regularly visit Chainama Hospital (this is a referral national hospital situated in Lusaka), what I see each time I am there, is very sad. Even if I did not take a head count, but both in female and male wards, a lot of young people in the age range of ten to twenty five years are the majority. Now I wonder where the elderly are. Most of these young people are HIV/ ADIS related cases. If we are not careful, this problem will blow out of proportion to manage."

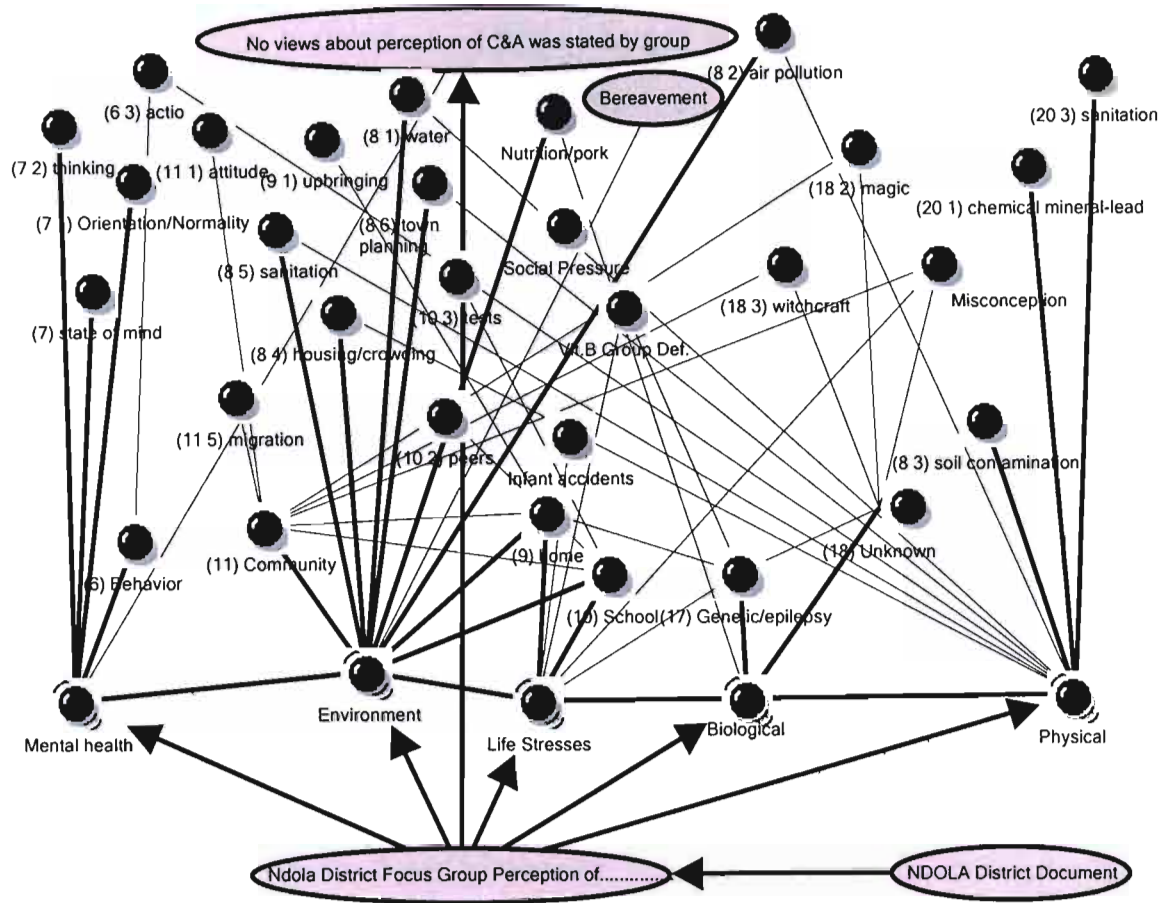
8.6.5 Ndola District Focus Group

Table 18: Perception of child and adolescent; mental health and Precipitation/predisposition of child and adolescent mental health problems

Focus Group Site	Perception of:			Perceived Participant Indicators/ Predisposition		
	Child and adolescent	Mental health	Environment	Life Stresses	Biological	Physical
Ndola District	N/A	Way someone thinks Intelligent Quotient Awareness Decision making Behavior State of mind <u>Environment</u> <u>continued.</u> Prostitution DVD and internet Contaminated water	Erosion of factories Poor sanitation Alcohol abuse Drug abuse Glue sniffing Examination pressure Epilepsy and fits Social pressure Increased population Death of both parents Pride by the well to do Inferiority complex Nutrition Pork meat Pollution-smoking vehicles Child defilement Horrible influence of western cultures ocio economic pressure Leaving kids alone	Drugs abuse Alcohol abuse Epilepsy Social pressure Infant accidents	Epilepsy and fits Inadequate food Knowledge of nutrition feeding Eating pork Lack of Vit. B group in diet Nutritional problems	Drug abuse Alcohol abuse Glue sniffing Epilepsy and fits Accidents Garbage Water contamination Air pollution-smoking vehicles Erosion from factories Prostitution/ pregnancy

The table above shows that the community perceived mental health as way someone thinks behaves and state of mind and perceived the environment of the city to be poor due to sanitation, erosion from factories, air pollution and abuse of drugs, alcohol and inhalants, such as glue sniffing.

Figure 24: Ndola District Focus Group Perceptions of the child and adolescent; mental health; environment; life stresses; biological and physical factors.



This model shows that physical factors and the environment in the Ndola district town were considered to play a key role in the etiology of mental health problems. It also shows intricate linkages with other factors and worth of note is the misconception of the community about the treatment and causes of mental disorders.

8.6.5.1 The results of the findings:

It can be seen from both the model and the table above that a number of factors are reported by this group just like the other groups and the following are the results: The community blended observations about the mental health problems around 'social pressure' which they thought was inclusive of a number of factors. Social pressure' meant not being able to be with children because of working conditions at places of work. They attributed pressure to poor performing economy of the Ndola town; their income was at variance with the financial commitments at home

Their view of mental health was mainly based on behavior and state of mind, as seen in a person's action, thinking and orientation with own environment while biological factors and physical factors were inter-linked in the genesis of mental health problems and most strongly related factors cited were genetic predisposition particularly epilepsy and fits and the deficiency of the soluble Vit.B group of vitamins as a result of biological factors which they attributed to witchcraft, magic, ancestral spirits and misconceptions. This is what one participant said:

"If you give a child alcohol, the child will be treated of the epilepsy and fits. This fallacy was strong in the community and ended up most children getting even worse than before they were put on alcohol remedy misconception in the hope of the condition getting better."

Lack of balanced nutrition, in many cases poor feeding and lack of nutrition education impacted negatively on mental health well being. Epilepsy as a biological problem was caused and strongly linked to genes, misconceptions, infant accidents, drugs and alcohol and social pressure. Physical related factors were perceived to include: poor and inadequate water and poor sanitation in the town; Soil contamination with chemical waste from industries had the consequences of children and adolescents with mental health problems with accompanying activities such as those of feeding from dust-bins and tipping sites. Environment was perceived as: the community home and school and further perceived that within the environment, a combination of factors arising from the three

stratus symbol of parents and were thought to contribute to the child and adolescent mental health well-being either negatively or positively. Other associated mental health problems due to drugs and alcohol abuse as well as epilepsy and fits were also thought to contribute to CA mental health challenge and social pressure.

Children who are involved in accidents i.e. at football in school are also considered to be most at risk of developing some mental health problems. One of the community members in the group who visited a primary school had this to say, in the *memo* below:

"I visited the Primary school for Special education to children who have learning disability. "These children would have problems at the time of birth. Sometimes it's the General combination, which is the problem, Downs's syndrome. Are such conditions like Down's syndrome documented in Zambia?" I am really concerned with the plight of these children, imagine they learn alone and are segregated from the rest of the society and everybody sympathizes with them, but why, it is better to support these children by making them part of and learn to integrate their disabilities with normal children, in this way we will be helping them to build a better future for them, I am sorry may be I have talked too much, but it is important."

When both parents died, less advantaged family members became heirs, children of the late get so distressed and first go into a denial phase when stressed because these heirs ignore their plight right away and focus on theirs'. Ndola city is a Cosmopolitan town. It has a lot of mixed cultures and traditions. It is the only city that has no tribal inclination like (Johannesburg in RSA).

The Angoni cultural initiation ceremony (a specific ceremony for the Ngoni tribe of Zambia, Eastern Province), precipitates and predisposes children and adolescents at an early stage with physical and mental devastation as it is done against their will. The girl child has more mental health problems than males because of frequent number of times they are subjected to horrible traditional and cultural practices by the community. Some of the children perform very badly at school. Some have dropped off and have gone to the streets, engaged in a variety of negative activities. Some try to gain advance copies

(leaked) of examination papers so as to “pass” without a lot of studying and homework given by the school; this was common in children from stressed families/communities.

Rate of prostitution in the city among children and adolescents is very high and people are now afraid of leaving girl-child alone in fear of child defilers at large. Pregnant adolescents drink in bars and bottle stores, municipality has not regulated age limit to enter bars. This group responded on this node by considering factors about housing, eating preferences and working conditions in a family which they felt had a direct bearing with mental health problems of children and adolescents. Overcrowding in homes caused inadequate sleeping space and privacy and as a consequence affected children’s performance at school. A case of one high school (Ibenga Girls High School) in Ndola rural area illustrates this point:

“There were visitations by parents over weekends where pupils could be brought food and they sit with their parents and chat. Then there was a pupil who was from Lusaka who was a double orphan and she felt that nobody loved her and she wrote a note that she could take her life. Before executing her intended action, the note was discovered and the management had to get her and counsel her. There after management has since banned such visitation by parents.”

On the perception of the physical factors the results of the study show that:

- Ndola city was dirty with a lot of garbage lying all over causing a number of diarrhea diseases and unpleasant odor to the environment.
- There is a lot of pollution due to erosion from manufacturing and refinery companies, there is need to put effective programmes and plans to manage the waste well.
- TV channel ‘O’ watched from bars and other places in town at only ZK200 (very cheap on Zambian standard), or the equivalent of R3.00 RSA has negatively transformed most lives of children and adolescents.

- Many children in Ndola abuse alcohol and drugs especially cannabis and the extent to which those who cannot access these drugs and alcohol, the easiest and nearest option is glue sniffing.
- The community implicated occurrence of epilepsy and fits to poor nutrition also citing pork meat as comparatively contributing factor to the incidences of children and adolescents mental health problems. Shortage of Vitamin B complex in the body was cited especially Vit. B₁, B₂ and B₁₂ as the most frequently deficient vitamins in children and adolescents' diet.

The next section which follows shows the merged perceptions of all the 4 focus groups on each of the 6 specific knowledge areas of the study, which are the free-node areas in the context of the use of NVIVO and are as follows:

8.7.PHASE FOUR: MERGED PERCEPTIONS ON SPECIFIC FREE-NODE AREAS FOR ALL FOCUS GROUPS.

In this section, all the perceptions about a particular node area from the four focus group areas are merged by the researcher utilizing all the documents in the NVIVO programme. This is important in order to see the picture these various perceptions present from those of the individual focus group perceptions presented above.

It also helps to draw conclusions especially on emerging knowledge and patterns. The perceptions are presented as tables and models as the two complement and supplement each other, and are presented as follows:

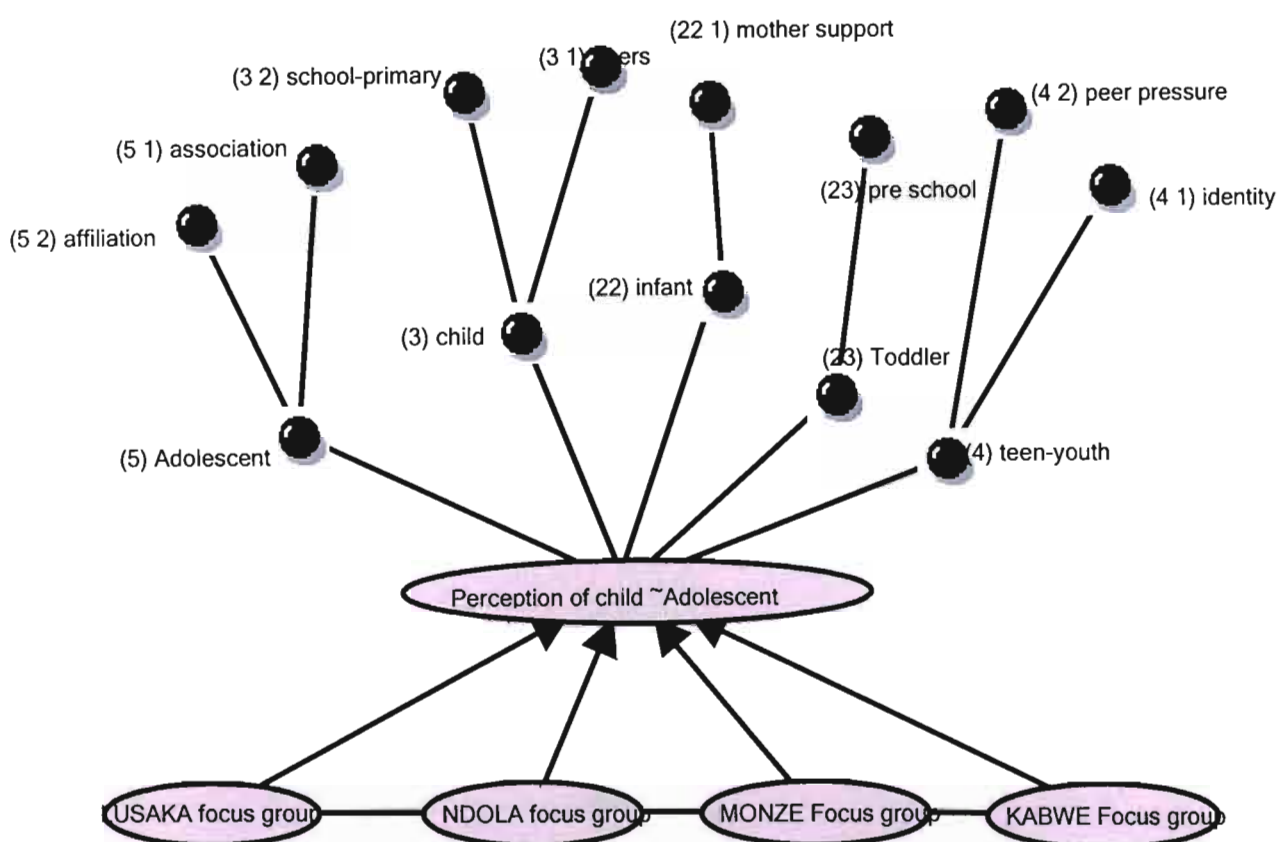
8.7.1 Perception of a child and adolescent by all groups

Table 19: All Focus Groups Perception of a “child and adolescent”.

Measurement Criteria	Focus group site			
	Kabwe	Lusaka	Monze	Ndola
Perception of child and adolescent	Person between 1-15yrs Under 20yrs	N/A	Person between 3yrs -10 years 1-10yrs 1-12yrs 1-18yrs	N/A

This table shows that only two of the four focus group sites responded. There was no reason advanced for the failure to respond to the instrument. The two focus group sites (50%) that responded to the measurement criteria, Perceived the child/adolescent to be a person in the age range of 1- 20 years even though Kabwe focus group suggested an adolescent to be someone under 20 years of age and a child to be someone up to 15 years of age. This appears to show that there was a variety of perceptions from the 4 sites and even among individual focus group members there were variations of perceptions.

Figure 25. Model showing Participants' Perception of a "Child and Adolescent."



This model shows that, the perception of the communities (Monze Focus Group and Kabwe Focus Group) perceived a child and an adolescent as an infant, toddler, teen and adolescent., while the other groups (Ndola and Lusaka) did not respond on this perception.

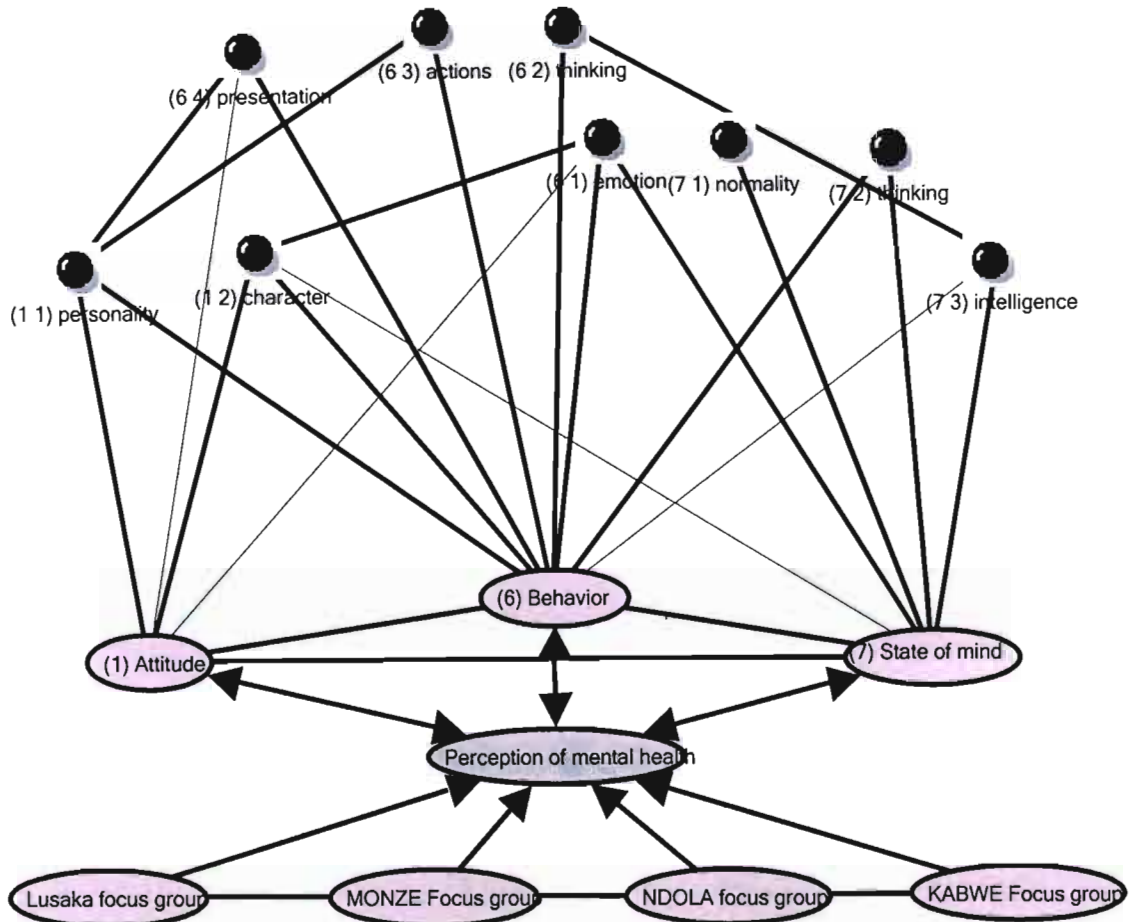
8.7.2 Perception of mental health as a concept by all focus groups

Table.20. Perception of mental health by all focus groups

Measurement criteria	Focus Group Site			
	Kabwe	Lusaka	Monze	Ndola
Perception of mental health	Complete Thinking Proper thinking	State of Mind Normality Abnormality Behavior Problem Person	Behavior Relations hip State of mind Actions of someone Presentat ion Dressing Appearan ce Eating Attitude	Way someone thinks Intelligence Quotient Awareness Decision making Behavior State of mind

This table shows that all groups perceived that the key indicators or criteria of mental health status were: thinking, state of mind, and behavior. Other indicators within the broader concepts were actions, one’s presentation, and decision making.

Figure 26: Model showing Perception of mental health by all focus groups



This model shows that all groups perceived mental health from the dimensions of attitude, behavior and state of mind which collectively give rise to observable characteristics in the child and adolescent. The connotation of the concepts of behavior, attitude and state of mind gave a reflection as shown by the nodes that the society judges a mentally challenged individual on the basis of behavior and the accompanying attitudes which is the result of the state of mind in that challenged person. Even in clinical practice the emphasis is placed on the mental state of an individual and the accompanying behavior and the state of one’s emotional welfare. They help in making a well thought clinical diagnostic formulation for that person in time.

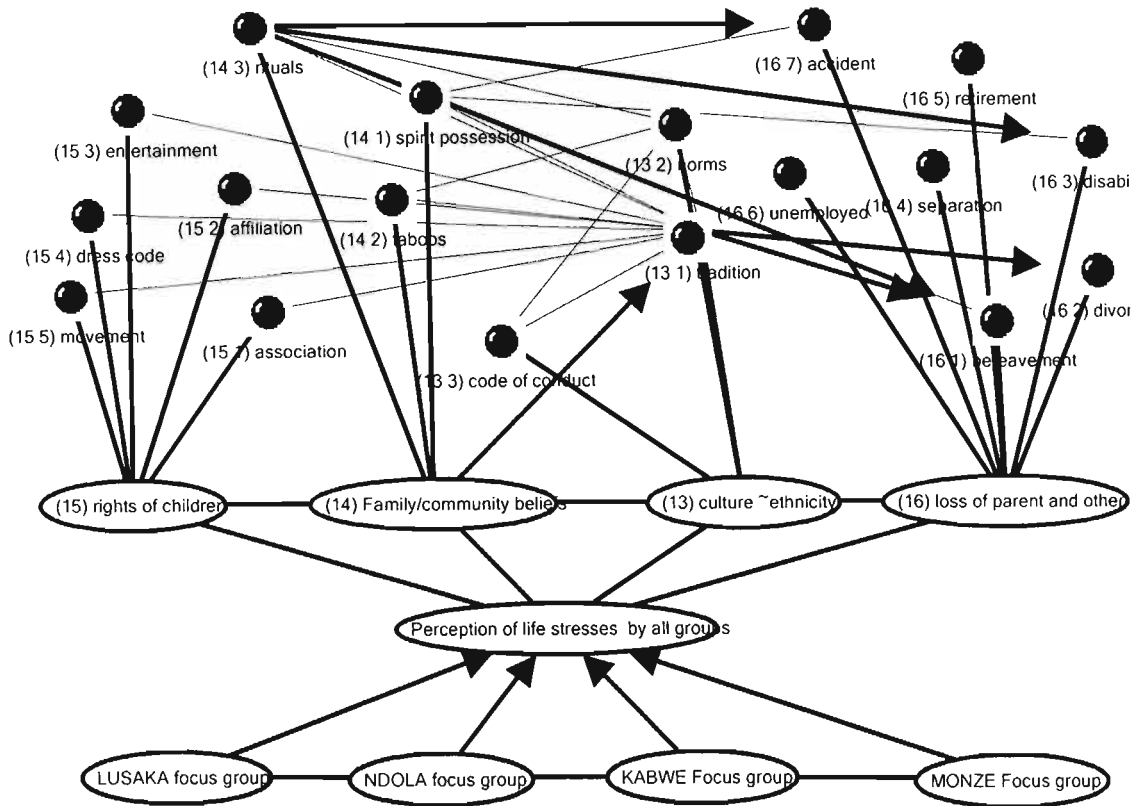
8.7.3 Perception of Life Stresses by all Focus Groups

Table.21. Perception of life stresses by all focus groups

FOCUS GROUP SITE				
Measurement criteria	<u>KABWE</u>	<u>LUSAKA</u>	<u>MONZE</u>	<u>NDOLA</u>
Life stresses	Hunger Poverty Lack of school Being orphaned Divorce by parents Problem homes Mistreatment Leaving children alone	Mistreatment Peer pressure Films/ TV's effects Mistreatment of biological children Wife battering Restriction Accidents Poor nutrition Loss of parents Drug abuse STI's from parents Noisy (frightening Scolding) Showing no love Child defilement Poverty	Leaving children alone Upbringing Hunger Poverty Being young Loss of parents fighting Parents quarrelling Lack of medical care Peer pressure Bad treatment by teachers Isolation at school Refusing children school Mistreatment	Drug abuse Alcohol abuse Epilepsy Social pressure Infant accidents Poverty

This table shows that all focus groups perceived poverty, mistreatment by parents and caregivers, loss of parents, peer pressure, drug and alcohol abuse, and hunger to affect children and adolescents much more negatively than other forms of impacts for all focus group sites in the districts, suggesting that poverty and mistreatment on the overall were a big problem.

Figure 27: General model showing perception of life stresses by all focus groups



This model figure shows that; Life stresses/psychological factors were perceived from a number of conceptual dimensions such as the environmental context, mental health and biophysical concepts in which the inter-linkages and relationships had a number of negative bearings on the child and adolescent as shown in the table above. All groups appear to have viewed that the critical areas that hit the children’s emotional wellbeing include violation of children’s rights, it also appears that family and community beliefs especially rituals, and the effects of tradition have a lot of deleterious effects to the mental health development of the children. What appears could be implied is that the influence of parental or guardian in the early years of life could have a lot of influence for the future of that particular child.

8.7.4 Summary results of individual focus group perceptions

The generic name of Life Stresses node is Psychosocial stresses: The use of the term “Life Stresses” refers to all those life threatening situations directed towards the child and adolescent. The factors in this category were among others; culture or tradition, beliefs, rights of children and adolescents and losing its relative context as bereavement, divorce, accident, retirement, disability, separation and abused. The summary of the results of findings show that: Tradition and loss were reported by all the focus groups as life stresses that the community pointed out as life stressors.

The groups (Monze, Kabwe, Ndola, Lusaka) attributed life stresses largely as a consequence of what different ethnic/or cultural groups believed. Dressing by children, has gone completely out of tradition and most parents are not happy about it in the same manner they are not happy about children and adolescents being out of home associating, affiliating, and entertaining sensational dress-code

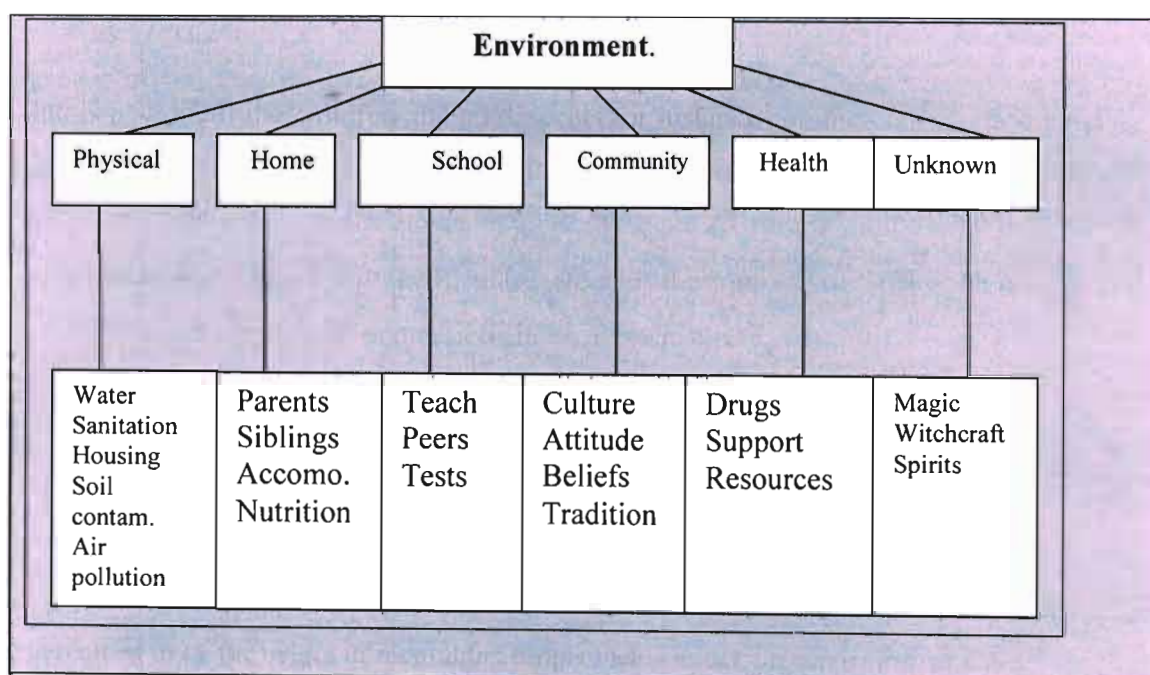
Another broad area that the community through the Loss tree-node highlighted were those to do with bereavement, divorce, accident, disability, retirement, unemployed, separation of parents and child abuse as well as effects of other forms of abuse in the context of drugs, alcohol and other substances. This node concept is relative and in the context of the community it was used to mean bereavement, divorce, disability due to accident of various forms and to a larger extent even retirement, separation from family and abuse in its various definitional terms by the community.

The impact of “Loss” as defined in the context of the communities studied has been echoed by the communities to be probably the most critical among life stresses. The role of the community in the life-world of the child and adolescent was linked to mental health well-being, environment and the biological factors. Separation of parents, upbringing of children, parents divorcing and increased number of orphans stemmed out prominently as the main area of concern for child and adolescent mental health problems. The community and family were noted to be behind the economic/commercial activities

and behaviors of the children and adolescents for instance commercial sex, pornography, and child labour and child defilement. What were most frequent in all groups also included, drugs, alcohol, accidents, peer pressure at school/home, restrictions and discrimination, upbringing, poor nutrition and the impact of social recreations i.e. TVs/films, bars, and high populations in local townships.

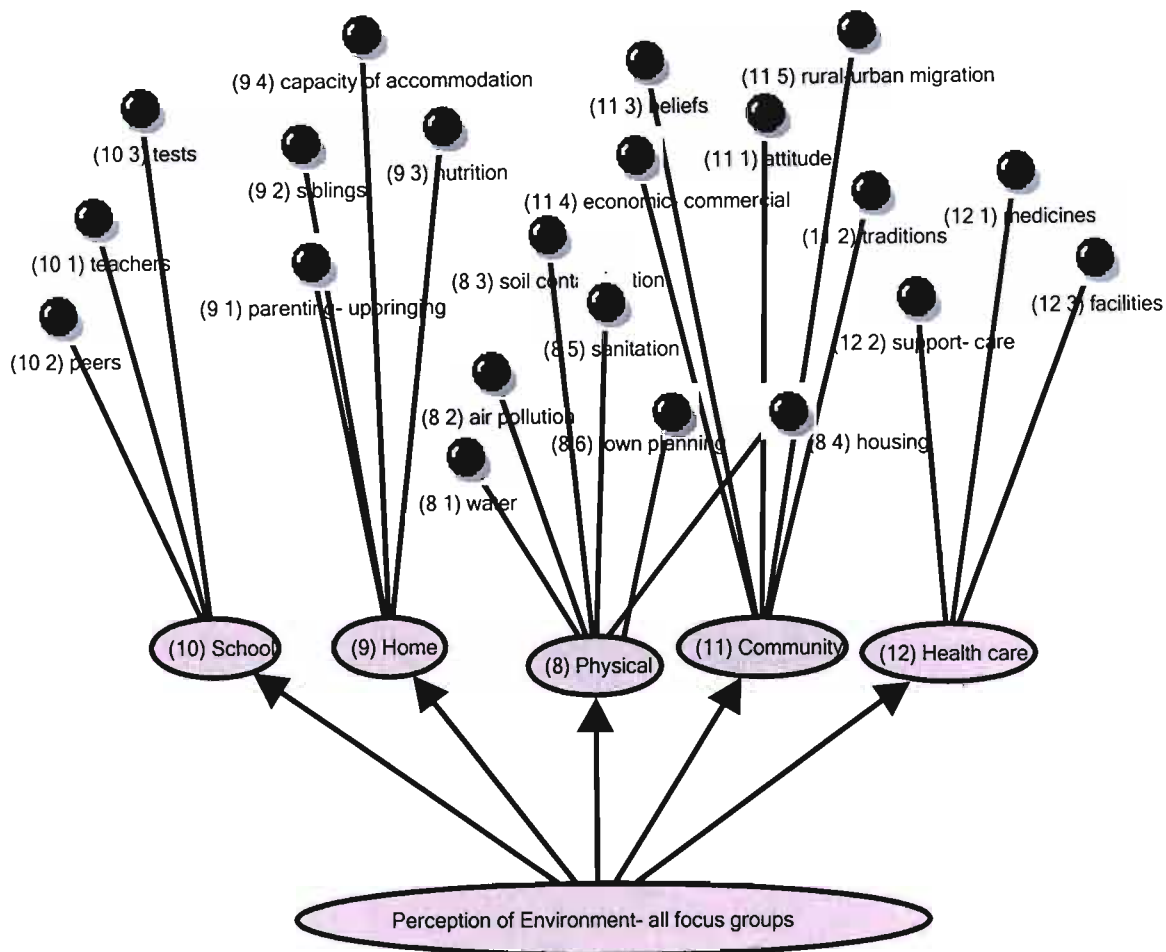
8.7.5 Perception of Environmental Factors by all focus groups

Figure 28: Concept Map showing Participants' Perceptions about the Factors they perceived to be the origin of mental health problems under the environment node.



This figure shows a concept map developed by the researcher to illustrate how nodes were developed as well as to illustrate the community's perception about the mental health problems of children and adolescents. The model below illustrates in detail the perception of the focus groups which have been raised in the above concept map presentation, starting with tree-nodes in the middle represented by the yellow color and the child-nodes on the top in the blue color.

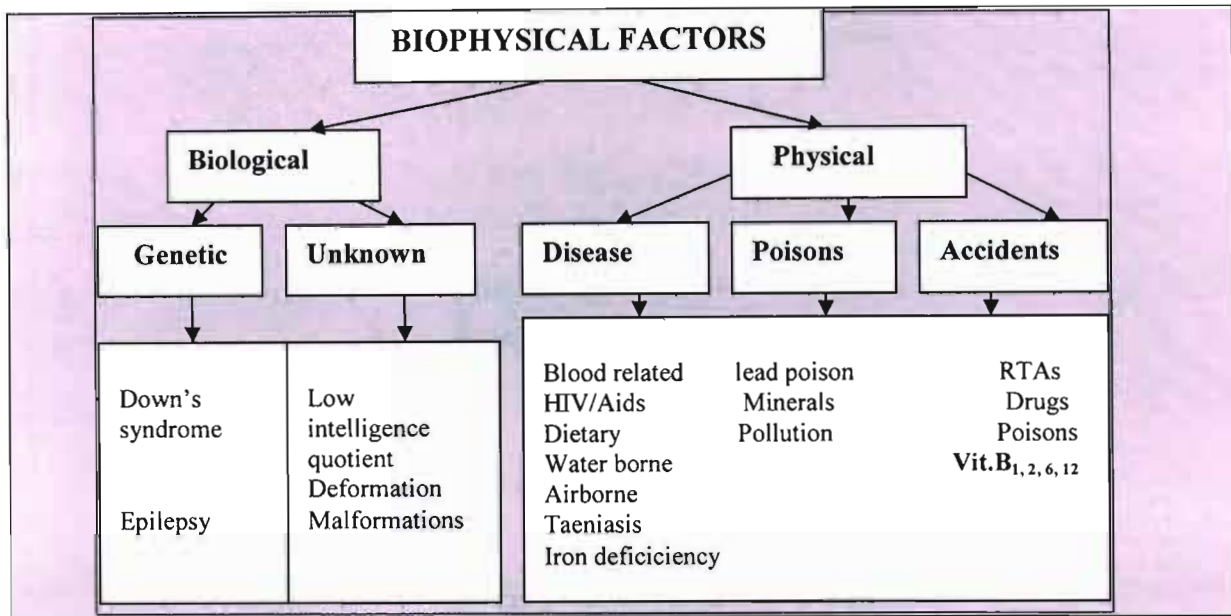
Figure 29: Model showing Perception of the environment by all focus groups



This model shows perception of all groups about environmental factors which were considered to precipitate and predispose mental health problems of children and adolescents. Indicators such as parenting/upbringing, siblings, nutrition and (capacity) of accommodation for the households were used to determine the home nature of the environment. While the (school) was also analyzed applying indicators such as role and impact of teachers, peers and tests within the school-life world environment.

8.7.6 Perception of Biophysical Factors

Figure 30: Biophysical Concept Map of Factors considered precipitating and/or predisposing mental health problems



This concept map drawn up by the researcher shows both the biological and physical factors perceived by the practitioners and the community. The key perceptions evolve around biological factors such as those to with genetic disorders or birth conditions and factors perceived as “physical” which consists of disease occurring because of circumstances such as infection, poisons and accidents. With regard to traditional culture, the distinction between these two would still emerge, with the birth conditions being attributed to ‘*malevolent*’ ancestral spirits, and the physical (circumstantial) being attributed to witchcraft.

8.7.7 Perception of Biological Factors by all focus groups

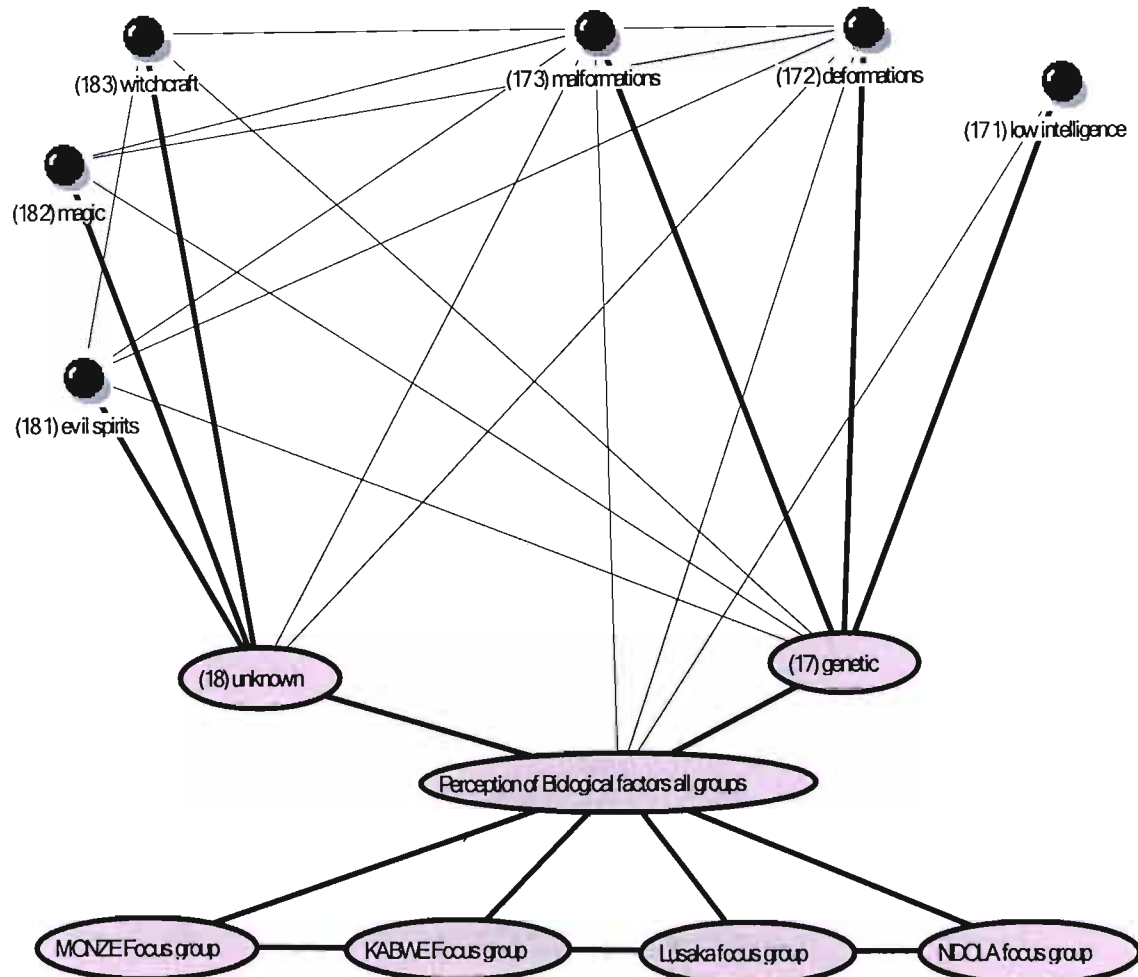
Table 22: Focus groups perceptions of biological factors

<u>Measurement criteria</u>	<u>Focus Group Site</u>			
	<u>Kabwe</u>	<u>Lusaka</u>	<u>Monze</u>	<u>Ndola</u>
<u>Biological</u>	Lead poisoning Unbalanced diet Mental illness- due to genetic	STI's from parents Epilepsy due to pregnancy Genetic illness Poor nutrition	Inadequate food Monotonous diet Insufficient balanced diet	Epilepsy and fits Inadequate food Knowledge of nutrition and feeding Eating pork mea Lack of Vit. B group in the diet Nutritional problems

This table shows that the biological perception as cause of mental health problems was commonly perceived to be due to diet, genetic, and epilepsy/fits as well as lack of knowledge for nutritional foods. These factors were perceived further to be connected with the physical factors such as sanitation and soil contamination with lead in the case of Kabwe site.

Genetic related diseases together with those related to diet/nutrition and blood-related were linked with mental health of children but the role of the ancestral spirits was still perceived to be involved though more on the genetic problems.

Figure 31: Model showing Perception of the biological factors by all focus groups



This model illustrates the community’s perceptions about the cause of mental health problems with focus around genetic and unknown factors. Most importantly was the connection of mental health problems with ancestral spirits, magic and witch craft on one

hand and low intelligence, mal/deformations on the other hand.

8.7.8 Perception of Physical Factors by all focus groups

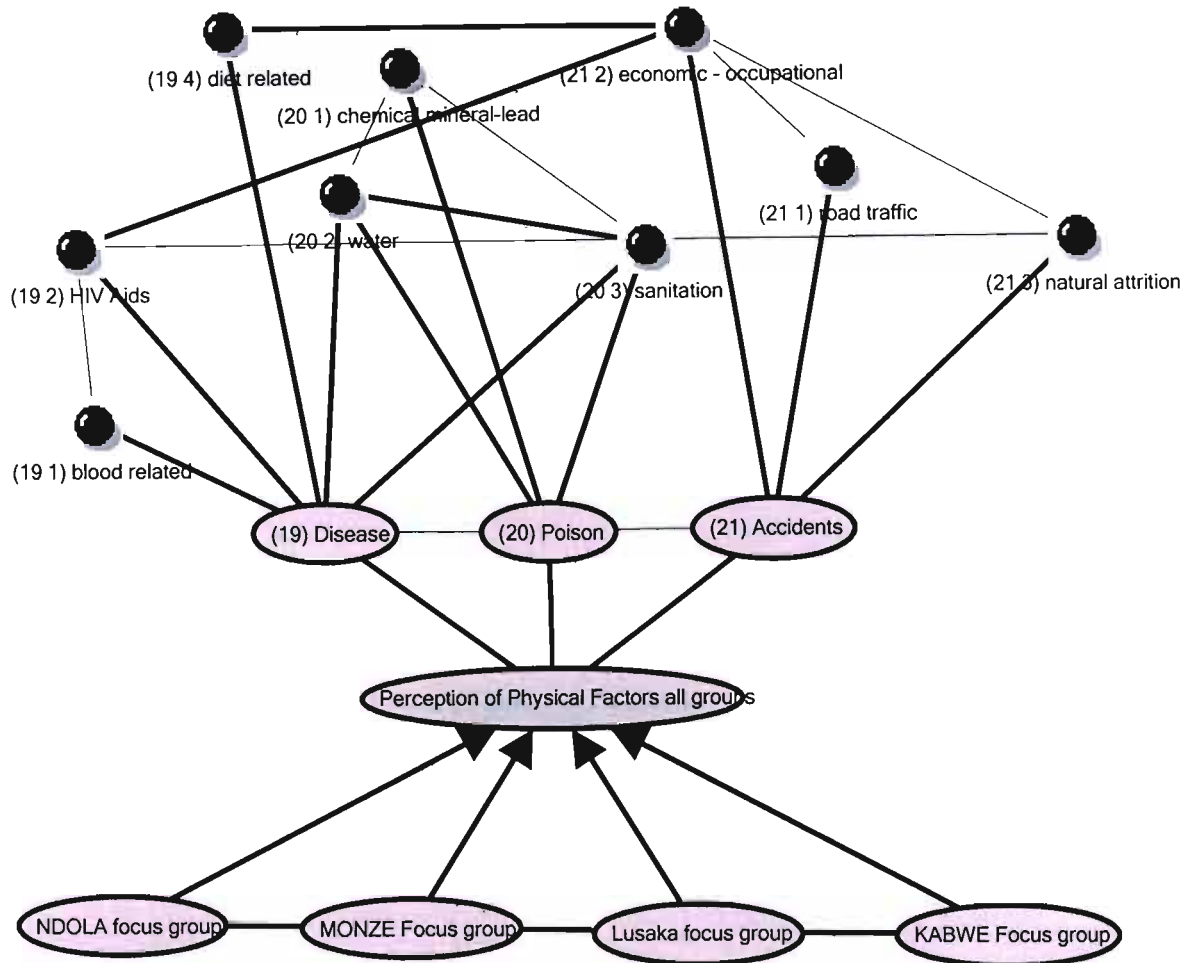
The table and figure which follow below respectively illustrate focus groups' perceptions of the physical factors-node by all groups.

Table 23: Focus groups perceptions of physical factors

MEASUREMENT CRITERIA	FOCUS GROUP SITE			
	Kabwe	Lusaka	Monze	Ndola
Physical	Lead contamination Drug abuse Alcohol abuse Glue sniffing Lead poisoning Parents giving alcohol to children	Physical accidents Alcohol abuse Eating from dust bins Eating from dumping sites Genetic illness Glue sniffing	Drug abuse (dagga) Alcohol abuse Glue sniffing Sex workers	Drug abuse Alcohol abuse Glue sniffing Epilepsy and fits Accidents Garbage Contaminated water- diarrhea Air pollution- smoking vehicles Erosion from factories Prostitution in pregnancy

The table above shows that contamination of soil, food, and pollution of air, accidents, drugs and alcohol abuse, particularly glue sniffing and erosion from industries are some of the common factors of causes of mental health problems.

Figure 32: Perception of physical factors on mental health problems of children and adolescents by all groups.



This model shows that diseases, poisons and accidents of various types are the key factors associated with mental health problems of children and adolescents in their communities. The summary of findings outlined below therefore reflects what the communities which are (Kabwe, Lusaka, Monze and Ndola) perceived as factors which constitute the physical-node area.

8.7.9 Summary of the results of section

The results of the study below show the findings of what different focus groups said about the environmental factors on their flip-chart reports and these are presented as follows: research sites perceived the environment as physical: water; air; soil; house; sanitation and township planning.

The home was perceived as the most important single and powerful critical institution with unique unit of command for the upbringing/parenting of children and adolescents with focus on the role and impact of siblings that they live within their life-world. Nutrition was considered to have deleterious effects on the child and adolescent's mental health and development should it be absent or inadequate.

The environments in all study sites were perceived by the community to be generally poor denoting that the environment was dirty at all these towns. They cited sanitation, water, pollution, food contamination, soil contamination with lead (for Kabwe), and erosion from factories (for Ndola). Influence of culture both local and Western, child defilement appeared to cut across the three (3) towns. It was also observed that the Ndola community perceived alcohol and drug abuse as an environmental problem.

The Physical Factors Free-node is a concept node of the Bio-physical concept of child and adolescent mental health. This free-node concept was necessary in order to build a coordinated understanding and appreciation that there is linkage between factors, which cause adverse effects to the physical body of a child, and adolescent and mental health problems. Against this node concept view, issues such as those related to alcohol and drugs, pollution of air and soil erosion are implicated. In addition, the communities as part of the findings have addressed accidents, which insult the general body and ultimately the brain, giving rise to organic brain diseases.

The issue of poison-related did come up under this node, though it was discussed under environment-node, in the context of lead poison in Kabwe mining town, and erosions from industries which are mainly Lusaka and Ndola district towns.

Below is a table showing a summary of *coding passage counts for the six free-node areas of the study* and of special note is the community node, of the environment which shows the highest passage counts, especially Lusaka town and the physical factors

Table 24: Summary of coding passage counts for the six free-node areas of the study.

Documents	Environment Factors	Biological Factors	Life tresses	Child & adolescence	Mental Health	Physical Factors
Kabwe 2	2	8	7	1	1	5
1	8	3	7	1	1	5
Lusaka 2	81	4	1	1	1	5
1	81	4	1	1	1	5
Monze 2	44	3	1	1	1	4
1	44	3	1	1	1	4
Ndola 2	51	6	1	1	1	10
1	51	6	1	1	1	10
Total	362	37	20	8	8	48

This table shows that there were more coding passage counts on the environmental factors, which included the community, family and school than any other nodes, even though Lusaka district focus group had the highest counts on environment factors, however, the Ndola and Monze counts were relatively significant and cannot be ignored.

8.8 QUANTITATIVE DATA FROM (Step 2b)

This data was necessary as stated earlier to establish the fact that mental health problems were reported in various hospital facilities. What are depicted on the overall with the data from all these centers are the capacity and the competences to accurately come up with diagnostic formulations by practitioners at the sites which could contribute reasonably with therapeutics prescribed for the child and adolescent who requires help.

The other view of perceiving these data at these hospitals and clinics is to hypothesize (researcher's assertion) that what is reported or seen at the hospital and clinics is just the iceberg of the whole range of un tapped mental health problems in the community itself not reported and not provided with the necessary care and support at the same time.

The curriculum which will be developed will not be based on the this data because these findings are in line with what is contained in the existing generic curricula on which both the nursing and clinical officers are trained and also the contents of the traditional curricula is similar to the old colonial prescribed curricula. The curriculum that will be developed will take a new twist in the light of the *explored perceptions* from the practitioners and the community. The figures which follow below present results of the data from the four 4 research sites of the study.

The presentation of the qualitative data from practitioners and the community as well as quantitative data collected from the sites (hospitals and clinics) is in two forms which are the tables and figures. This is necessary; tables provide the finer details while the figures provide pictorial information at a glance to help the reader who merely wants to have a quick impression of the data. This argument also goes for the quantitative data for curriculum preferences of those presented by the researcher.

8.8.1 Presentation of results

This section presents results of findings from the four research site hospitals Out Patients Departments.

8.8.2 Lusaka Chainama Hospital OPD

Table 25: Lusaka District: Chainama Hospital OPD record of patients for the 2004.

n = 273

Psychiatric Diagnosis	Age Group By Sex										Total	%
	0-12		13-15		16-18		19-21		21+			
	F	M	F	M	F	M	F	M	F	M		
Undiagnosed					1			3	1	3	8	2.93
Acute confussional states				1	1		2	1	1	1	7	2.56
Aids related psychotic disorders							1				1	0.37
AIDS related psychosis									1	1	2	0.73
Aids related psychotic disorder									1		1	0.37
Alcohol related		1				2				4	7	2.56
Conduct disorders	1	1									2	0.73
Depressive disorders			2		4	5	2	2	4	4	23	8.42
Drug induced psychosis						1		1		4	6	2.20
Epilepsy	21	34	9	5	2	9	5	9	9	20	123	45.05
Hyper kinetic syndrome	2		1								3	1.10
Manic disorders	1			1	2	3	1	8	4	9	29	10.62
Mental retardation	7	7	4	2	2			2	3	3	30	10.99
Physical illness related		2							1		3	1.10
Psychosis				1		2		4		7	14	5.13
Schizophrenia			1			2	2	2	2	5	14	5.13

This table shows all recorded mental health problems of children and adolescents at Chainama Hospital OPD for the year 2004 only. The picture of the results also suggests that epilepsy was the most diagnosed medical problem 123 (45%) with mental retardation 11%, manic disorders 30 (11%) and depressive disorders 29 (11%) respectively.

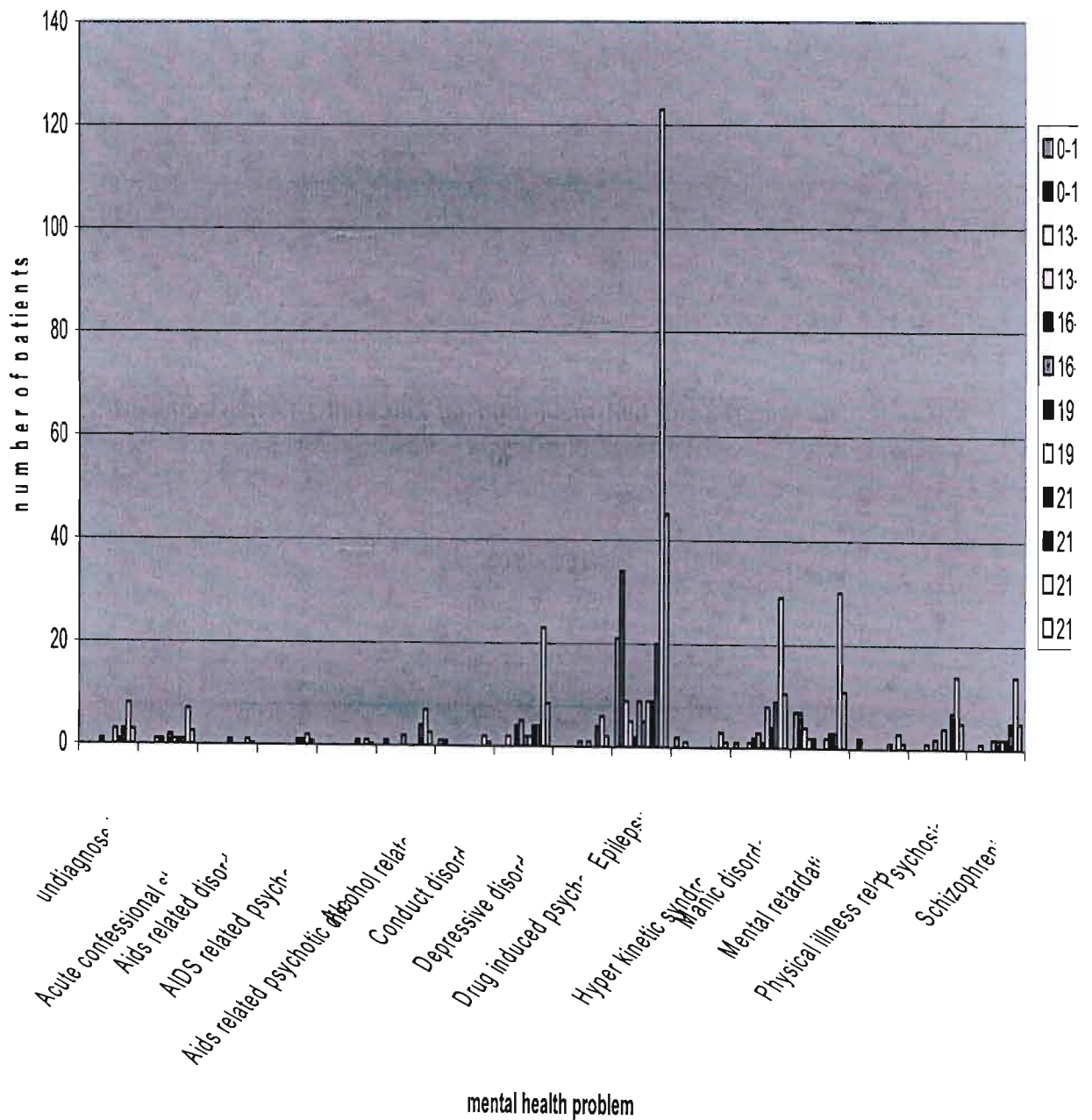
The picture of children and adolescents with mental health problems appear to be on lower side to that of the adults the explanation is most likely that most of the children and adolescents do not have services worthy of note and the few that find their way to the hospital do so on the pretext of behavior which parents are not able to cope with at home and is done as a last option.

Most of the children un seen (*this is the researchers opinion*), may be on the streets, while some adolescents may be in confinements of some kind and in other situations may be under the stress of child labor and nobody talks about it.

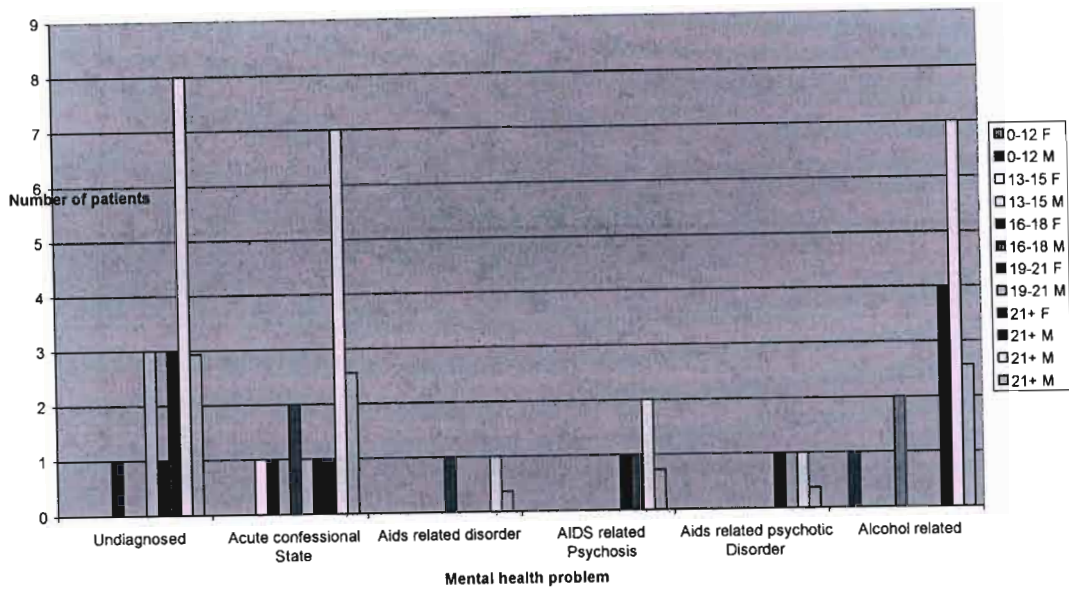
Even the number of children with AIDS related psychotic disorders, the picture shown in this model (researcher's opinion) is not representative of the real situation on the ground. The year 2004 was about the time people were not free to talk about HIV/AIDS and if a family had a child with HIV/ AIDS such a situation was simply kept in secrecy.

Figure 33: Lusaka District Chainama hospital identified out patients mental health problems in 2004.

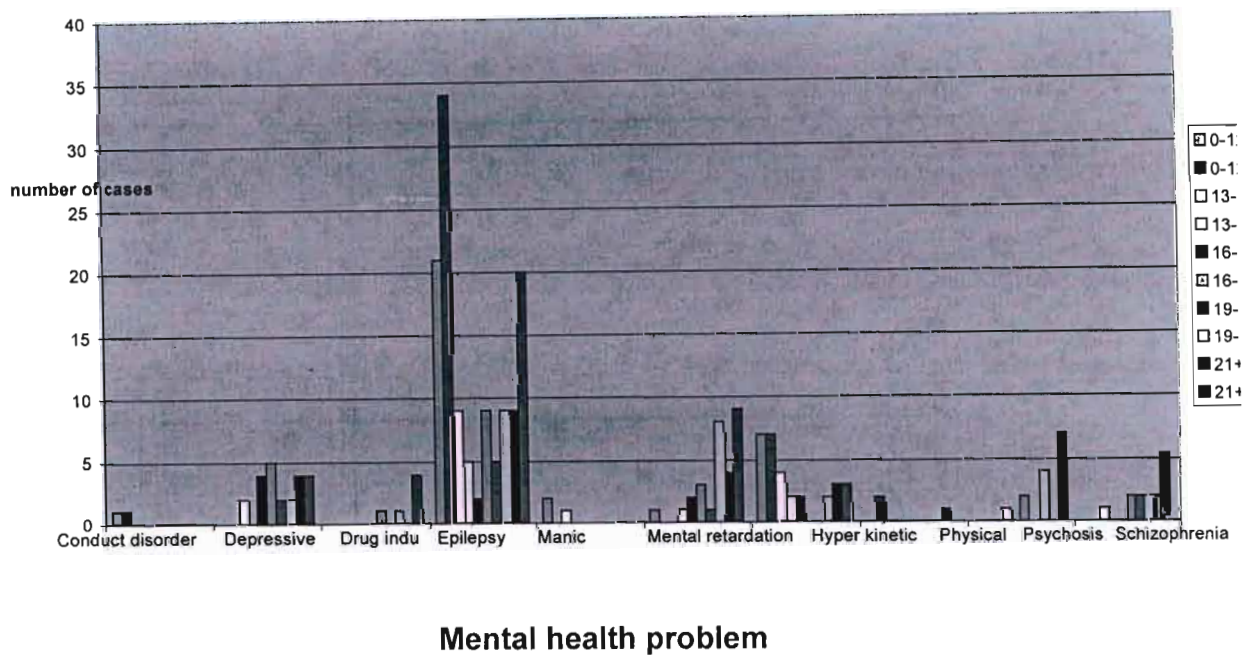
combined table



First Half of Combined table



Second half of combined table



This figure is shown in two parts, first, as a full figure and second, as split figure showing two halves of the figure. What this figure shows is the highest number of undiagnosed mental health conditions in the male age group 21 years and above at Chainama Hospital

OPD in the year 2004. The other striking result is the higher number of male patients aged 21 years and above diagnosed with acute confusional states related to alcohol abuse. On the other side the figure shows the highest number of females aged 16-18 years diagnosed with epilepsy with males aged 21 years and above following the trend. The picture depicted in this figure further shows that epilepsy is relatively high in the 19-21 years male age group.

8.8.3 Ndola General Hospital Out patients Department

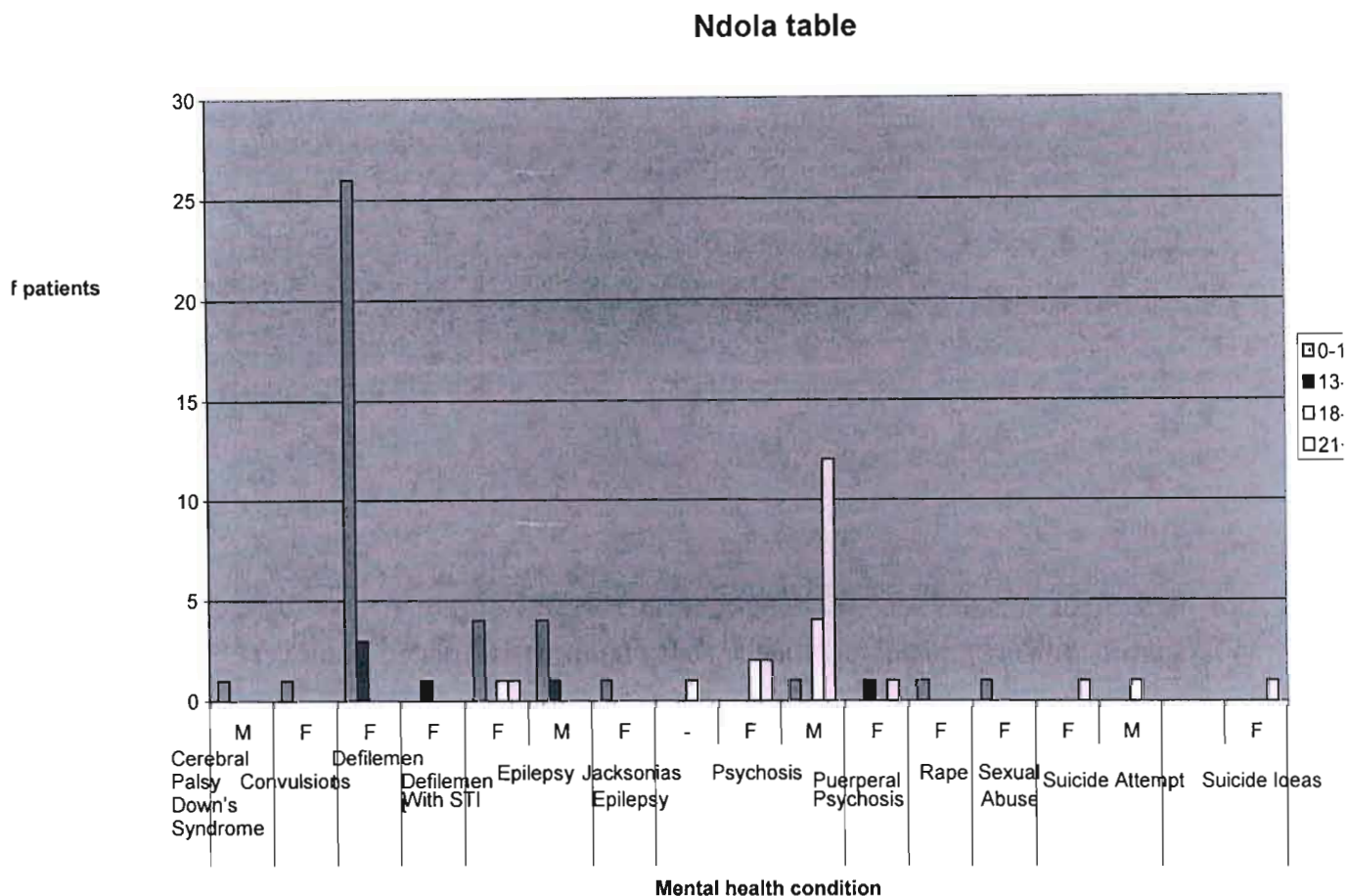
Table 26: Ndola General Hospital in-patients' 2004 data by age and diagnosis.

n = 73

Psychiatric Diagnoses	Age Group By Sex										Total	%	
	0-12		13-15		16-18		19-21		21+				
	M	F	M	F	M	F	M	F	M	F			
Downs' Syndrome	1											1	1.2
Convulsions		1										1	1.2
Defilement		26										26	40
Defilement with STI				3		3						6	8.2
Epilepsy	4	4	1									9	12.33
Jacksonian Epilepsy		1					1					2	3
Psychosis							4	2	12	2		22	30
Puerperal Psychosis				1								1	1.2
Rape		1										1	1.2
Sexual Abuse		1										1	1.2
Suicidal Attempt							1				1	2	3
Suicidal Ideas											1	1	1.2

This table shows that cases of child defilement 26 (36%) and defilement with STI 6 (8.2) respectively are a real problem in Ndola district for the girl child aged 12 years and under, and to a large extent the 13-18 years female age group. Epilepsy is affecting both male and females equally in the age group 0-12 years, with a high index among the males aged 21 years and above 12 (16%) with psychosis not specified.

Figure 34: Ndola Central Hospital 2004 identified mental health problems



This figure shows that the number of females aged 0-12 years have had the highest 26 (36%) of the reported incidences of defilement to the hospital. The figure further shows that a fairly high number 12(16%) of males aged 21 years and above were diagnosed for psychosis. Cases of defilement with STIs continued to the 13-15 age groups as well, with equal proportionate cases of epilepsy in both age groups of between 0-12 years.

8.8.4 Kabwe General Hospital Out Patients Department

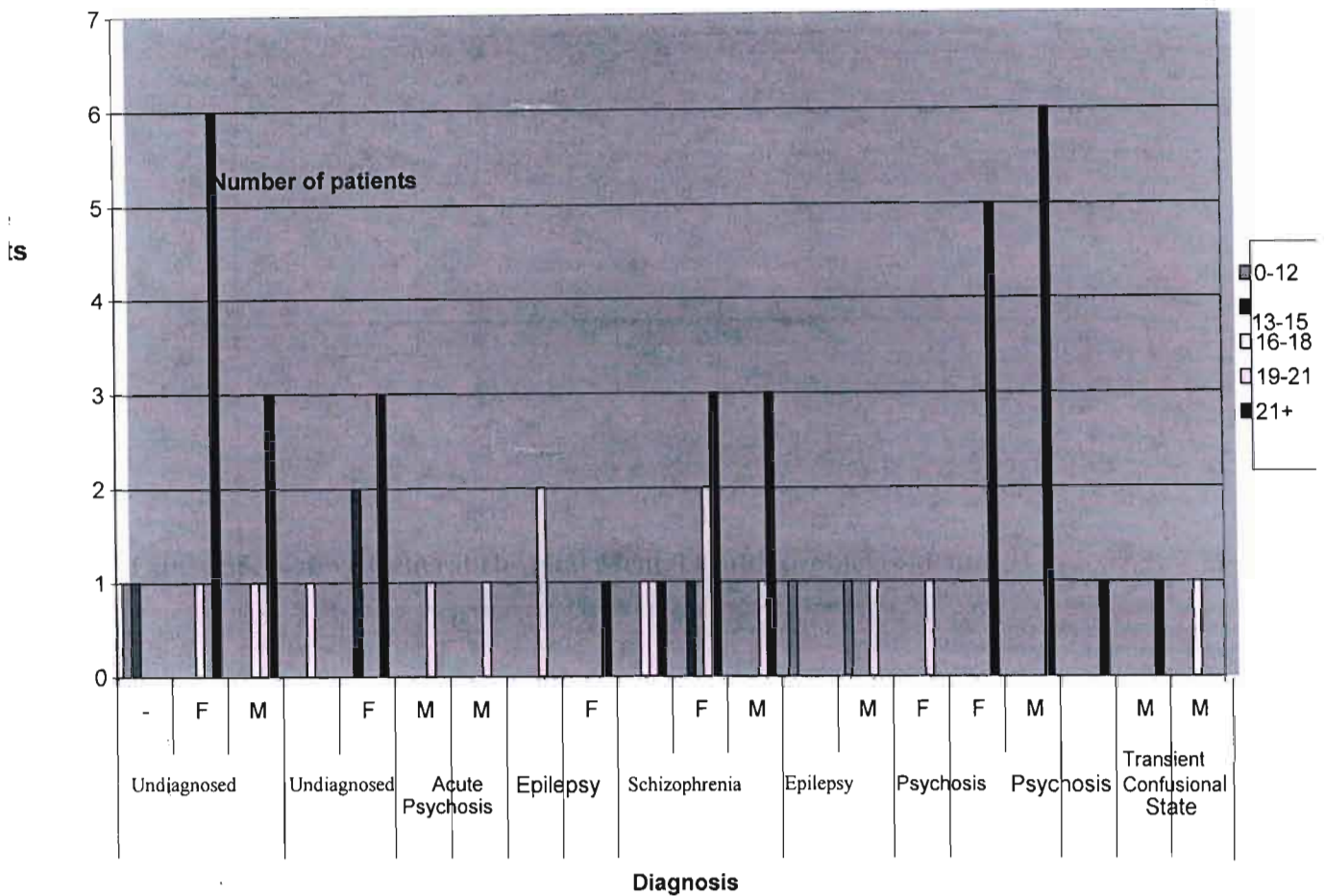
Table 27: In-patients' 2004 data by age and diagnosis

n= 56

Psychiatric Diagnosis	Age Group By Sex										Total	%
	0-12		13-15		16-18		19-21		21+			
	M	F	M	F	M	F	M	F	M	F		
Undiagnosed	1			1	1	1	1		3	6	14	25
Depression		2		2	1		1				06	10.7
Acute psychosis					2		1				03	5
Drug related psychosis					1		2				03	5
Epilepsy		1				1				1	03	5
Schizophrenia				1	1		1	2	1	3	09	16
Psychosis Unspecified	1	1					1				03	3
Psychosis			3						6	5	14	25
Transient confusional state					1						01	2

This table shows that there were more undiagnosed cases **14 (25 %)** at Kabwe General Hospital on the overall even though the female group aged 21 years and over **6 (11%) were the highest undiagnosed** with more or less equal numbers males **6 (11%)** and females **5 (9%)** respectfully for psychosis in the age groups 20 years and over at the out patients department of the hospital.

Figure 35: Kabwe General Hospital Mental health problems identified in 2004.



This figure shows that there were more un diagnosed females aged 13- 15 years and males of the same age group diagnosed with psychosis, even though the number of females with the diagnosis of psychosis was significant. The figure also shows that the trend of not diagnosing the patients continued to the males of the same age group.

8.8.5 Monze District Hospital outpatient department

Table 28: Monze Out-Patients' 2004 data by age and diagnosis

n= 28

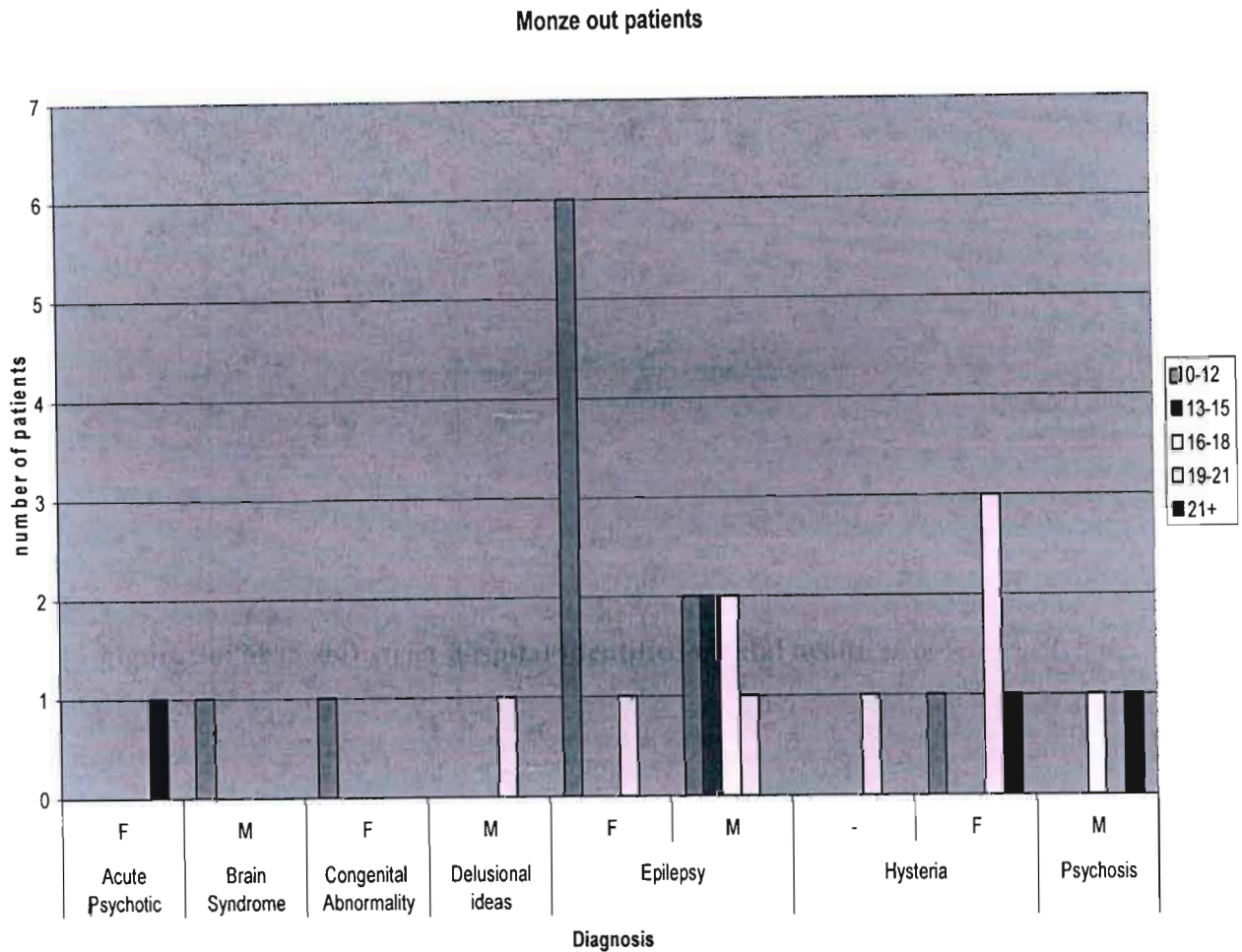
Psychiatric Diagnosis	Age Range By Sex										Total	%	
	0-12		13-15		16-18		19-21		21+				
	M	F	M	F	M	F	M	F	M	F			
Acute psychotic syndrome	1			1								2	7
Brain syndrome	1											1	4
Congenital abnormality		1										1	4
Delusional ideas							1					1	4
Epilepsy	2	6	2		2		1				1	14	50
Hysteria	1			1			1	3			1	7	25
Psychosis					1					1		2	7

This table shows that there were virtually little diagnostic activities taking place at Monze district by the practitioners at the OPD on screening children and adolescents with mental health problems. The table shows that on the overall **14 (50%)** of the diagnosis made were epilepsy with **6 (23 %)** recorded as highest in the girl child group aged 12 years and under.

The cases of hysteria **7 (25%)** were also reported with diagnosis of psychosis generally which in the real sense does not help much in the quality care of patients as it does not provide possibility of syndrome management.

The lack of more identified mental health problems at the hospital provides a scanty picture of the real situation on the ground which cannot be generalized as the true scenario of what is actually going on at the OPD of the hospital.

Figure 36: Monze District hospital Identified mental health problems in 2004.



This figure shows that cases of epilepsy were highest 6 (23%) in the age group 0-12 years. Another striking thing was the high 3 (11.5%) cases of hysteria in the female age group 19-21 yrs. Epilepsy in the age groups 0-12, 13-15, and 15-18 shows a similar trend in the male group. The numbers captured and the categories are only as good as the diagnosis by the practitioners in these health centre. Center Monze's categories look noticeably feebler than the others.

8.8.6 Summary of Quantified results for the Chapter

The results of the study in this section show the summarized attributes of the research participants, the curriculum preferences of the search conference participants and the quantitative data from hospital and OPD sites as shown below in the combined summarized analyses. The report of the quantified results is from the 5 activities done in phase 1 of the total project (stages 1-3) in line with the overall process of how data was collected particularly *under method* the first 3 stages (table 4 page 242). The analysis of the implications of the sixth activity (the analysis of all the PAR conference documents from these stages) was undertaken by the researcher alone as shown on Table 4, and these will be discussed in the next chapter.

Research Participants / Community Attributes

The results of the study show that the core research group had an equal balance of gender with 73% of the co-researchers being females with prior experience in medical/nursing education and management. The results further show that the highest numbers (24%) of the research participants were involved in clinical care and diagnosis of health service users. On the aspect of focus group members the results show that more participants were aged between 36-40 years with a general gender trend of more males than females in all groups with the highest gender index 14 (70%) in the Ndola district focus group and out of these 64 (67 %) were males with married status 30 (31.30%) respectively.

The results also show that of the 54 (100%) training institutions in Zambia, 9 (70%) train registered nurses and mental health nurses. Regarding the type of curriculum model, the results show that 12 (48%) of the total number of the practitioners preferred the PRISMS curriculum model. Their preference for this model was based on the tenet that the model was integrative, qualitative and interactive.

Hospital and Clinic data

The general pattern of the data from all the hospitals and clinics suggests that mental health problems of children and adolescents in the various communities do exist even

though *there is obvious competency problem on the part of the practitioners on identifying CA with mental health problems and diagnosing them forthwith.* Lusaka Chainama Hospital which has the advantage of psychiatrists had more psychiatric diagnoses made during the year than the rest while other centers clearly were not able to provide these diagnoses of the various conditions from the general primary care clinics and OPDs. The *combined summary of the results of the findings* of the data below *provides a conclusion of the section from all sites.* It is shown by age groups and sex (as in tables 25, 26, 27 and 28 above on pages 306 – 314) respectively. The summary analysis of the data of mental health problems diagnoses from all sites are as follows:

Diagnosis	Lusaka (n=273)	Ndola (n=73)	Kabwe (n=56)	Monze (n=28)	Total (n=430)	%
*Undiagnosed	8	-	14	-	22	5
Acute Confusional States	7	-	3	2	12	3
Aids related Psychotic Disorders	1	-	-	-	1	0.2
Aids related Psychotic Disorders	2	-	-	-	2	0.4
Aids related Psychotic Disorders	1	-	-	-	1	0.2
Alcohol related	7	-	-	7	14	3.26
Conduct disorders	2	-	-	-	2	0.42
*Depressive Disorders	23	-	06	-	29	7
Drug induced Psychosis	6	-	03	-	09	2.1
*Epilepsy	123	9	03	14	149	35
Hyper Kinetic Syndrome	3	-	-	-	3	0.7
*Manic disorders	29	-	-	-	29	7
Delusional ideas	-	-	-	1	1	0.2
*Mental retardation	30	-	-	30	60	14
Physical illness related	3	-	-	-	3	0.7
*Psychosis	14	22	14	2	52	12.1
Schizophrenia	14	-	9	-	23	5.35
Jacksonian Epilepsy	-	2	-	-	2	0.47
*Defilement	-	29	-	-	29	7
Defilement with STI	-	3	-	-	3	0.7
Hysteria	-	-	-	7	7	1.6
Rape	-	1	-	-	1	0.2
Puerperal Psychosis	-	1	-	-	1	0.2
Sexual abuse	-	1	-	-	1	0.2
Convulsions	-	1	-	-	1	0.2
Down's syndrome	-	1	-	-	1	0.2
Suicidal attempts	-	2	-	-	2	0.47
Suicidal ideas	-	1	-	-	1	0.2
Psychosis (unspecified)	-	-	-	-	3	0.7
Transient Confusional states	-	-	-	-	1	0.2
Brain Syndrome	-	-	-	1	1	0.2
Congenital abnormalities	-	-	-	1	1	0.2

This Summary of the analysis of the psychiatric diagnoses depicts on the overall the trend in all sites the type of mental health problems and more importantly *epilepsy* 123 (45%)

in the Lusaka district alone which on the overall 149 (35%) is *the most diagnosed medical condition* in all the sites, followed by the diagnoses of *Psychosis* (unclassified) in that order. The analysis further shows diagnoses of *depressive disorders, manic states and mental retardation* diagnosed in Lusaka *only* with *conspicuous undiagnosed cases highest in Lusaka and Kabwe districts respectively*. Defilement of girl child is noticeable in the Ndola district only. It is not clear to establish why it could not come out in the other centers as well but one can speculate it to be linked with lack of competency by the practitioners in these practice centers.

Drugs, alcohol, and other substance abuse were some of the reasons CA are admitted in health care facilities with *induced psychosis* such as *epilepsy related* with the highest incidence in the age *21 years and above even though this age bracket is outside the scope of this study but the information is useful*. On the aspect of substance abuse, a number of studies have been done on various theories of behavior which are: cognitive and attitudinal; personality; behavioral; social and environmental; and biological and genetic (Ajzen, 1990). These studies do assert that adolescents who use substances are less likely to know the bad effects of use, and have less negative attitudes towards substances; those with personality problems tend to be of low assertiveness, self esteem, impulsivity and alienated from the social values (Cambor, 1990); those with behavioral problems tend to have poor performance at school and antisocial.

The studies have further outlined that those with poor social and environmental weakness, the source of such weakness is from the family relationships, peer influences, bad neighborhoods, and social disadvantage; while those with biological and genetic connotation, are likely to be children of substance abusers themselves, and genetic factors appear to account for at least part of this association (Ajzen, 1990).

The picture of the results for Monze district categories looks noticeably feebler than the others. Even the old fashioned “hysteria” appears here. The inadequacy of this data reflects the lack of practice competence, which is discussed in the curriculum chapter and calls for INSET to ameliorate the situation. The next chapter discusses the overall results of the findings of the *exploratory study* and the subsequent educational and service implications to the PHC practitioners’ curriculum. The recommendations are the direct consequence of the implications of the study.

CHAPTER NINE

DISCUSSION OF FINDINGS

9.1. Introduction

This chapter presents a discussion of results of *explored perceptions and understandings of practitioners and the community* about mental health problems of children and adolescents as well as results of mental health problems referred from hospital OPD and clinics on one hand and the results of the curriculum model type preferred for the INSET of PHC practitioners on the other hand.

Taking into consideration the purpose of the study, which was to **explore** perceptions and understandings of practitioners and the community about child and adolescent mental health problems in Zambia, it is hoped that the implications of the data collected through the *exploratory process*, would be used to commence the process of developing an innovative curriculum on child and adolescent mental health for practitioners *later after phase 1 (stages 1,2,3) of the doctoral programme* as shown in *phases 2 and 3 respectively of the whole research project*, thereby impacting the mental health status of Children and Adolescents because of the improved quality of service by practitioners as well as enhanced community awareness about mental health issues of CA.

The discussion of findings is presented mainly in *two sections* which are: *Qualitative data* findings of the perceptions of practitioners and the community and *Quantitative data* findings of the OPD/Hospital records/registers and further *Quantitative data findings of the choice of the type of curriculum* PHC practitioners' prefer for 'INSET' in child and adolescent mental health.

In this particular study, *perceptions and understandings of mental health problems of children and adolescents in the community* were critical for the baseline information required to commence the process of developing the innovative curriculum. The curriculum development information was also essential to address the type and model of

curriculum that would be required for INSET as well as the content, even though part of it is already embodied in the old traditional curricula for practitioners in mental health. In addition, the practitioners selected a proposed model of curriculum which will involve more participative facilitation strategies compared to the old content-based curriculum used for PHC practitioners' training.

It is hoped that the findings in the study driven by the AR methodology process to *explore perceptions* from the community and the practitioners will contribute to the improvement of the quality of care by the practitioners through better training in order to obtain appropriate competencies. This should result in improvements in the identification and management of CA who present with mental health challenges in their practice as well as the involvement of the community in the mobilization and provision of services.

The data collected and presented in the previous chapters are also integrated in the discussion. The chapter concludes with highlights of main findings of the study and ultimately draws recommendations which are: *practice based; education and training based; policy and curriculum based* and directed to specific individuals, and institutions, such as Ministry of Health and other line Ministries with stake in the plight of children and adolescents for consideration and possible action.

Interactions with the community on the ground, during the data collection process in focus groups, found that there is a real problem of children and adolescents with mental health problems. For this problem to be realized on the ground it required proper *exploration from the community sources that were credible and had the knowledge and experience on the ground of the existing mental health problems of children and adolescents* on one hand and from *the practitioners themselves who experience competency difficulties in the care of children and adolescents with mental health problems in their practice at primary care level on the other hand.*

It is also important to note that even though the baseline data collected is a combination of data on mental health problems of children and adolescents from the practitioners and

the community as well as hospital records, *the hospital data in the context of this study will not constitute the primary source of data required to inform the later curriculum for 'INSET' programmes because the intended curriculum is not planned to be purely of medical model alone as has been the tendency in the traditional curricula but a combination with more of community environmental issues which have arisen in the study.* The discussion of results of the findings therefore follows the stated research questions stated in chapter one which addresses the key issues of the study for phase 1: stages 1-3 which are:

- The perceptions of the Practitioners and the community about mental health and mental health problems of children and adolescents.
- How the Zambian community deals with children and adolescents' mental health well being?
- Some key issues that affect the introduction of new aspects of mental health into the generic curriculum.
- Curriculum content for the planned child and adolescents' Mental Health curriculum for PHC practitioners in Zambia.
- Preferred Curriculum Model most appropriate for the 'INSET' of PHC practitioners in child and adolescent mental health in Zambia.

The discussion of the results also follows the classified knowledge and sub-knowledge areas of the study as shown below. These areas were coded, from which nodes were developed and tables and models/figures developed too which illustrate the perceptions of practitioners and the communities themselves. The significant findings drawn from individual focus groups as coded in chapter eight along with some examples drawn from narrative excerpts found in the transcripts of the focus groups are included to illustrate how focus group members based their discussion on their experiences in life.

The issues listed below are the focus of the mental health component of the study which addresses primarily the perceptions of Practitioners and the Community about mental health and factors associated with the etiology of mental health problems of children and

adolescents. Within this context, *information about how the Zambian Community deals with CA mental health well-being (research question 3) is elucidated.* After an introduction of perception in general, perceptions of child and adolescent as well as concept of mental health (see below), the remaining key areas of the study address the *key issues that affect the introduction of new aspects of mental health into the generic curriculum.*

The first, second and third research questions are all discussed within the context of the *seven areas of the study which are: general view of perception of child and adolescent; concept of mental health; perception of socio-economic factors; perception of life stresses (psychological factors); perception of biophysical (biological and physical) factors; perception of environmental factors; Perception of resources to support CA mental health.*

9.2 General view of perception

The term '*perception*' itself is a relative concept, and in this discussion, it is defined first, followed by a brief outline account of it. Most of the various perceptions which arose from the communities and the practitioners have already been elaborated in chapter 8, first by homogeneous group perceptions which were later collapsed to form merged unreconstructed perceptions. In examining the term (Flanagan, 2001) viewed the term perception broadly and acknowledged that the term was construed differently and meant several things to several people, but pointed out that the focus of the term evolved around: *judgment, opinions, views or even discernment of the participants in a study* such as the practitioners and the community about their perception of mental health problems of children and adolescents.

It was also viewed as *good practice to acknowledge that when introducing an innovation, starting where the people are is important.* In this study, it was necessary that perceptions and understandings of both practitioners and the community were explored first so that

the process of developing the curriculum would take cognizance of people's perceptions and understandings on the ground, *making the innovation authentic and community driven*. Perceptions and understandings of the practitioners and the community, critical as they may be, *merely provided the researcher with baseline data to focus on in planning the innovative curriculum process which only commences at phase 2 and 3 of the total project*.

They represent the stake holders' perceptions and views about their own situation, even though other people may have different views about the similar situation. However, prior to undertaking this study in the context of exploration of the perceptions of the community the researcher had in mind *the 'positivists' stance, whose approaches are strictly embedded in the science based paradigm. They argue that perceptions are not real and cannot be relied upon when soliciting for evidence based data to inform activities such as curriculum formation and development*.

While the positivist views may be important in their own right, the researcher's approach was underpinned right from the inception of the study *that explored perceptions from the community are adequate empirical data to show the basis for an innovation particularly in the context of the interpretivistic and critical social science approaches respectively around which the study is underpinned. The interpretivistic/critical research paradigms focus on the importance of empowering people to change society themselves, and it was for this reason that social involvement was essential right from the planning of the study*. This was done in order to generate a social change through the active involvement of the people themselves, so that the voices of the oppressed through community social representatives could be heard (Cohen, 2000) and (Usher, 1996).

The discussion which follows below addresses a number of issues as outlined above which ultimately are expected to underpin the later innovative curriculum to be developed first with the qualitative data findings of the perceptions of practitioners and the communities then quantitative data findings of the OPD and Hospital records and registers and lastly quantitative data findings of the choice of the type of curriculum PHC

practitioners' prefer for 'INSET' in child and adolescent mental health. The discussion is therefore as follows:

9.3 Perceptions of Practitioners (Nurses and Clinical Officers)

9.3.1 Introduction

This section is based on the first workshop which commenced with the discussion what the practitioners themselves perceived was the '*child*' and '*adolescent*' respectively and further what they perceived was '*mental health*' as reported in chapter 8. This was necessary so that the researcher and the participants would have a common understanding of the key working concepts of the commonly used language in the study before proceeding into the field to explore the same with the community.

The discussion in this workshop then proceeded in addressing the three research questions, (1, 2, 3) above, which focus on their perception about mental health problems of children and adolescents, and it is the most salient issues from these transcripts which are discussed below. The section also discusses how these problems are addressed by the community to improve the mental health well-being of children and adolescents respectively and within the context of their perceptions and understandings brings out the key issues that affect the introduction of new aspects of mental health into generic curricula.

In order to answer these questions, the above listed related areas of the study as contained in the moderator's Guide (annexure 5) are addressed. The data obtained from the findings provide an indication of the practitioners' perceptions and understandings about the concept '*mental health*' itself and the perception of '*mental health problems*' of children and adolescents in the community and the discussion flows as follows:

9.3.2 Nurses' Perceptions

The findings from the nurses appear to show that all perceived factors listed by the nurses, apart from those of genetics, accidents and birth injuries, showed a broad picture of factors perceived to evolve within the psychosocial dimensions and these were as follows;

- Adolescence in itself was perceived as a problem period in the life-world of children and adolescents.
- Families and communities, preferred to consult traditional healers first because they valued them most in the traditional set up, but consequently delayed hospital referral for proper medical care and consultation, and in the process patients got worse.
- Child defilement, lack of openness by the parents, child battering, child favors and lying to children, were all done on children on the understanding that it was the way of the life of the tradition and culture including the principles behind it. These were considered to be normal trends in the community.

In conclusion, nurses perceived that in situations where children were not guided, not appraised and not recognized, it was a source of child's internal conflict even in conditions where they were favored and protected. Nurses further felt that children that went through a lot of life difficulties, failed later in life to withstand the subsequent life pressures on their own particularly after demise of parents. What was also further perceived to be crucial at childhood level was the negative impact of genetic factors especially at puerperium, neo-natal and peri-natal diseases together with familial illness.

9.3.3 Clinical Officers' Perceptions

The results of the findings show that clinical officer's unreconstructed perceptions before the merger of the perceptions with those of the nurses respectively perceive that:

- Cultural and traditional beliefs are largely the most widely perceived community based factors responsible for most of the children's mental health problems. This account shows that clinical officers' (COS) focus about the cause of mental health problems of

children and adolescents were based on the cultural and traditional beliefs and as a consequence, has attributed to the increase of orphans which has resulted into subsequent extended family burn-out in which families appear not to be keen to take any extra children under their care. *This state of affairs has left many children and adolescents to the streets.*

- The COS argue that *burn-out is due to the links with family and community beliefs which are strongly considered to be as a result of both family and community attitudes which have contributed the increase of psychosocial, biological, and genetic factors within the family and community circles, even though they are not able to justify the genetic side of the perception.* They cite the adolescence phase itself as a problem phase and that most families are not able to cope with the behavior of children and adolescents at home during this phase.
- Clinical officers further perceive that stigma towards the mentally challenged children and adolescents have denied this group of the community with services and support they need most for their mental and emotional well-being. Other factors such as child defilement, lack of openness to children within the same home and subsequent, over protection and favoring other children within the same family are some of the culturally inclined attitudes which are negative practices and for whatever motives, ultimately produce negative impact on the development of the child and adolescent mental health well being later.
- Clinical officers' perceptions also further show that most affected families of children and adolescents with mental health problems perceive their situations negatively and make it subjective as though they are the ones that cause the problem and are under a curse either from God or the ancestral spirits of the dead. Such affected families commonly and frequently express statements of self blame and pity such as:

'I am to blame/ Shame upon me; this is a curse from God; it is a sign of bad luck; facing the wrath of witch craft as a punishment'.

- In the final analysis COS perceived that the genesis of mental health problems of children and adolescents were biological factors within the context of the

family/community with strongly held beliefs which do not support the children and adolescents with requisites essential for their livelihood which if made available would avert most of the biological inclined conditions as the children's trajectory would be well buffered given the support from the peers and the community.

9.3.4 Merged Perceptions for clinical officers and nurses

The results show that the merged perceptions for clinical officers and nurses *are more embedded in the belief phenomenon context*. Because of their cultural and traditional upbringing, both clinical officers and nurses after the merger of the perceptions, are conceding that *beliefs about rituals, initiation ceremonies and the negative traditional teachings during these ceremonies are among the most contested factors at the site of children's' struggle with conflict*.

The integrated picture of unreconstructed perceptions show that *the belief views point by clinical officers and the nurses views about precipitation and predisposition is an interesting outcome*. It can be speculated here that may be this variation of perception between the two groups has to do with the way the two are trained at college. The COS appear to be inclined to perceive problems of children from *a clinical model* in which beliefs of witchcraft tend to be the most reported reason for many cases of persons challenged with mental health insults, while the nurses perceive the source of mental health insults from *a biopsychosocial and cultural dimension*.

However, after COS and nurses finished working separately in their homogenous groups, the significant shift was in the *change of the definition of mental health*. The changed definition came about after a process of heated exchange of views during both homogenous and plenary sessions which influenced their perspective on the view of the factors associated with child and adolescent mental health problems *to that of socio-environmental*.

The effect of homogenous group meetings and subsequent plenary helped to view the genesis of child and adolescent mental health problems to that of a *socio - environmental Perspective*. This is an important viewpoint particularly as it came prior to focus group meetings with the communities. From this socio-environmental perspective, it is appropriate for the practitioners to perceive inadequate family support, as an aspect, which is driving a number of children and adolescents on the streets because parents and the community do not offer adequate support for their personal, educational, occupational and moral, needs.

When clinical officers (COS) and nurses continued discussing the concept of mental health at this stage together their perception of mental health changed or got modified. COS initially used the society as the focus of their perception and this created the view that the possible genesis of mental health problems from their perspective was socio-economic while it was opposite with the nurses *but both practitioners now see the mental distress as caused by the environment (either physical or social)*

The girl-children are cited most because they get involved in the sex industry largely due to parents who may not be able to meet their basic needs of daily living. Most of such children have no support to proceed with school, because the fees are prohibitive and just resort to street life as destitute, petty criminals and child laborers for lack of other alternative source livelihood.

The issue of discrimination is an important one, the results of the study reported that children and adolescents with mental health challenges are put away from the public or secluded in a number of scenarios, such as; schools, family, peers, community and other various social and communal gatherings because of their mental health status. This type of discrimination was also reported to have been extended to families of such children/adolescents. What is on the ground within the various communities as a negative effect of this discrimination, *is families who hide these children and adolescents and keep them in isolation as a sign that they are ashamed of the status of their child hence are afraid to talk about their children/adolescents to other neighbors or even have them seen at hospital.*

The merged unreconstructed perceptions for the two groups of practitioners show an improvement in respect of their views concerning the genesis of child and adolescent mental health problems. *This variation started initially with nurses viewing the etiology of mental health problems from the point of precipitating and predisposing factors while the COS viewed the etiology from cultural and traditional view where almost all illness or infirmity is associated with various types of beliefs as the source such as witchcraft, spiritual forces and magic.*

After the unreconstructed set of perceptions from the nurses and COS were merged, *the picture of the perceptions showed that both groups perceived that the attitude of the family and the community in general compounded with various cultural and traditional practices and beliefs are the underpinning forces behind mental health problems of children and adolescents.*

9.3.5 Conclusion of Section on Perceptions of Practitioners

The reconstructed perceptions of nurses and clinical officers after the merger are divided into four main areas of factors which are: ***socio-economic; life stresses (psychological); biological and resource support.*** The socio-environmental component of the four main areas comprise: *housing; diet; culture and family.* These are the most perceived factors that the practitioners considered to have the highest likelihood to impact negatively the mental health well-being of children and adolescents and these factors appear to have strong relationships with each other.

- Life Stresses/psychological factors, such as - the home, community, occupational status of parents and the way individual house-holds live with their children are considered to have a direct and strong bearing in the life- world of children and adolescents.
- The unknown biological factors, even though they are perceived to impact negatively and have not been categorized by the practitioners, are nonetheless believed to be among the causative factors underpinning children's mental health insults.

- Other biological factors such as those to do with dietary implications are perceived to have important relationships with substances commonly abused, head injuries, genetic disposition, mental retardation, STDs, epilepsy and fits in pregnancy. Epilepsy and fits are particularly considered to be highly related with mental retardation conditions, sexually transmitted infections, head injuries of the brain, fits in pregnancy and are the direct consequences of substance abuse in girl-children and female adolescents.
- Down's syndrome which is considered to be due to genetic factors has been considered to be related with epilepsy and fits, mental retardation and the effect of poor diet and nutrition at conception and developmental stage of the fetus.
- The area of support with resources is perceived to be important as long as the role of the Non Governmental Organizations (NGOs) is redefined to deter them from their current practice of putting a lot of strings to the support they provide.
- In another context of support, the practitioners also felt that the current follow-up programmes of ex-mental health users are non-existent and needs revamping. It is recognized that understaffing is a major problem in the health sector, but other mechanisms can be used to argument the few health staff to reach out the children and adolescents in the community and training of community health workers is recommended.
- Recreation facilities for children and adolescents in the community are proposed to support the families particularly in the context of the poor performing economy and as part of expanding the recreation perspective in the compounds and locations. Practitioners feel that, information systems such as cinema shows free for all, should be reinforced as part of recreation to inform children and adolescents of STDs, HIV/Aids, child abuse, and any other educational activities as part of recreation.

The section below discusses the findings from the Focus Groups which show similar issues as those explored from the practitioners. *The reason for doing this was to establish the perceptions and understandings of mental health problems from both the practitioners themselves (in order to appreciate their competence practice gaps) and from the*

community to establish the reality of the problem on the ground. The two perspectives were essential in understanding in total the real problem on the ground and hence to facilitate the making of objective and informed decisions about the way forward in the improvement of mental health well-being of children and adolescents in the community.

9. 4 Perception of the Concept ‘Child and Adolescent’ in the Communities

This inquiry early in the study before *exploring into other areas of the community perception* was essential just as their concept of *mental health* as is seen below. It enabled the researcher to appreciate early in the study what the community perceived was a “*Child*” and “*Adolescent*”. The data show that the community perceived the CA to mean an individual within an age range of 20 years and below.

The two groups out of four that responded consider that the age range factor is an important criterion to inform who is perceived to be a child and/or adolescent from the community perspective. The data shows further that the findings from the community’s perception about the child and adolescent particularly from the two (2) sites were not in variance with each other. They both perceive the child and adolescent to be a person within the age-range of 0- 20 years. In a cultural context, the term ‘child’ is relative in meaning and is used in meaning to different situations; it is applicable to adults as well regardless of age as long as they are still children of another person.

In the context of this study, a child is one whose chronological age is one under 14 years and is not socio-economically independent and this applies to the adolescent as well. During this phase of the child’s development the support and survival depends on the mother with further extended support system from ; pre-school-during which the child is relatively dependent; extends to the primary school where the child is relatively independent; at secondary school level the child (youth/ teenager) is in the phase of identity crisis and an adolescent who has passed the cross-road to early adulthood-during

goes through a difficulty phase, most adolescents may be in college training or in university.

When the community members were asked to give a rationale for classifying the child and adolescent in terms of years, their reason were the difficulty of conceptualizing who the actual child was because the term is relative and cuts across all ages and said that even in adulthood someone was still a child. In the context of this study the community categorized the age ranges with ages above 14 years one was adolescent and years under 14 someone was a child. The community had no difficulty with the adolescent perception, as one from 20 years and above, but this view is way above the age scope of this study but it was helpful information.

9. 5 Perception of Mental Health by the Community

Perception of '*mental health*' just like perception of '*child and adolescent*' was asked to participants' right from the beginning of the focus group discussions. This probe was important to determine the preliminary held knowledge and understandings of the concept by the community in order to determine the level that the discussion would take and the subsequent approach to be applied before the focus group interventions would commence. The perception of mental health by the community was an important one as the researcher used it as an indicator of prerequisite understanding by the community to determine to what extent the communities perceived were the etiological factors associated with mental health problems of children and adolescents and further to probe into the community about their awareness of the perception of mental health.

The data shows that all focus group sites responded and their perception did not show marked variation from each other except the Kabwe community (Central province of Zambia, 150 km north of Lusaka) which perceived "*mental health*" as state of mind, while the rest of the community focus groups perceived mental health as '*behavior and state of mind*'. An important finding from the data was the perception of mental health as '*the state of mind in the context of mental health which must be good, proper and*

complete'. In terms of behavior, admittedly, the community conceded that mental health refers to a "*problem*." This conceptualization was an important indicator of how the community especially in Lusaka considered mental health and how they dealt with children and adolescents with mental health problems.

This can be compared with studies from elsewhere in the world, as can be noted from the WHO concerns expressed below in respect of the perception of the communities about the mentally challenged persons. World Health Organization (World Health Organization, 1977) as has been stated above on one hand in a similar context also expressed its concern about the way the communities perceived and treated children with mental health challenges just because of their mental health status while on the other hand (Lemieux,1989) commenting on the efforts the Canadian Health and Welfare was putting to demystify the held notions, views and understandings of the concept of mental health, stressed the need for provision of better promotive/preventive PHC activities for the sick children and adolescents by the community rather than emphasis on medicalization which denotes institutionalization of the sick in hospitals which unfortunately promotes mystification of mental disorders.

The data further shows that perception of mental health was perceived by the community to include someone's attitude of mind. These levels of perceptions are definitely complex areas and relative in meaning such that their application/interpretation may be geographic specific, norm specific or culture/ tradition specific. One notable change that took place among the practitioners in respect of their perception about mental health was that the definition of mental health itself and the description of mental health changed from the first one of:

'Unsuccessful performance of mental functions resulting in unproductive activities, such as failure to fulfill relationships with other people e.g. to adapt to change and cope with adversities.' To the second one of:

"Mental Health is a complete state of mind, behavior, good and proper thinking that is acceptable by community'.

This change of the perception of the definition was as a result of the plenary sessions jointly held by all Practitioners in the search conference during which time they examined their various pre-held perceptions of the definition and the end result culminated into an agreed definition which was accepted by all as in the one above. All groups perceived “*mental health*” in the context of behavior and state of mind of the individual. Their perception was linked to their concept of *child and adolescent* in which two groups out of four perceived a child and adolescent in terms of age-range, even though two other groups did not respond.

It is important to note that ‘*child and adolescent mental health*’ is an evolving process, characterized by continuous progress in all areas of development and adaptation, so that as children become adults, they require the communities to take the leading role in their plight of care and support. This will enhance the ‘Biopsychosocial and cultural Development’ as a holistic concept approach in this context of an interactive concept, referring to the interaction of biological or physical factors, psychological factors and social cultural influences.

The community’s perception about mental health from their experience is very much in variance with the above views and need for vigorous information, education and communication (IEC) in this area is essential with full participation of the community. The focus of the community on behavior, thinking, action, and feelings of the affected persons were things which they are able to observe at home and interpret in their own cultural way and because of this practice it has negated the much needed care from the community which is denied on the pretext of negative attitude and lack of prioritization of mental health in the practice field. whereas the practitioners now see the mental distress as caused by the environment (either physical or social) the community stakeholders still focus on the feeling., attitudes etc of the afflicted individuals.

9.6 Perception of Factors Associated with Mental Health Problems

This section discusses the explored perceptions of the community about mental health problems of children and adolescents in their community, in particular what they consider as life stresses in a broad spectrum. The exploration of the perceptions focuses on five dimensions in the context of life stresses which are: psychological, sociological, cultural, biological and resource support by the community itself. It should be noted that in many instances the life stressful factors from these five dimensions are interrelated.

9. 6. 1 Life Stresses

The generic name of this concept area is '*Psychosocial stresses*'. The use of the term "*Life Stresses*" instead of '*Psychosocial stresses*' refers to all those life threatening situations directed towards the child and adolescent. The data shows that Life Stressing factors are several, varied and many, hence, the community perceptions. Life stresses in the context of this study are largely attributed as a consequence of what different ethnic/or cultural groups believe. What various cultures and traditions believe varies from one region of the country to the other, for instance, spirit possession, taboos, rituals, norms and codes of conduct differ from religion to region and tribe to tribe.

These aspects in the *Zambian* situation can be perceived and interpreted differently across cultures and social status groups e.g. the rich and poor, elite and low status groups. The data further shows that when the community refers to the term '*loss*' they actually mean *absence or lack* of support either temporarily or permanently from parents or guardians caused by '*stressors*' precipitated by the factors stated below which are: loss of parents through death; divorce; disability; accident; retirement from employment; unemployment; and separation of parents.

This application of the term '*loss*' to the child used in the wider context of the term, has been cited to adversely impact negatively on the mental health well-being of the child and

adolescent. What is known by the community about the concept of 'loss' is that children always count it as a loss, whatever is the factor that deprives them from parental nurturing and support, such, was implied to be *loss* in its justified social_construct context. Champion and colleagues, after his 20 years follow-up of school children showed that mental disorders at age 10 years were associated with a more than double in the risk of both acute and chronic life experiences in adult life that caused psychological threat and many of these events and experiences carried psychological risk involving social interactions and it was expected that these would have been influenced by the person's own behavior (Champion, 1995) and (Rutter, 2000a).

9.6.1.1 Poverty as a life stressor

Poverty in the Zambian situation is a real problem, as many communities in the country live quite and far below the poverty line and they are not able to meet the needs of daily living. The poverty issue was repeatedly cited in this study as a major contributing factor particularly among the poor families that do not have viable livelihood to sustain their families; this was referred to as a real problem.

The community cited Monze town in the southern region of the country as one community that at the end of each year's harvest men farmers sell all their farm produce for cash and when they have the cash from the bank, they quite often book themselves into hotels and drink off that money at the expense of the family that toiled to labor. According to the tradition of the Tonga tribe (inhabitants of this province), it is accepted that all the wealth including the money in a household belongs to the man and how it is used is at his discretion.

What this implies among this tribe, though the trend appears to be cross country practice is that the man uses and apportions this money and other forms of wealth at will, even though women/wives are also said to blame-because frequently when men/husbands allocate resources to them, such as money, the report from men folks also show squarely

that women too spend it on themselves and at the expense of the family. The only sad thing about this trend is that all the time, children are less considered, and go hungry.

Other studies about poverty such as those by (Duncan 1977) when he was referring to the US government, found that 19% of children in the US lived in families with income below the poverty line, which is an official measure of economic standing, and is defined as '*the income necessary for the basic support of food, clothing and shelter*'. In a further follow up study (Duncan, 1998), it was found that 50% of all US children at some point during childhood live in families whose income is near the poverty line, and almost one third of children live below the poverty line. This also gives a reflection that the issue of poverty is widespread and perceived differently.

In this study, when the community was asked about the status of poverty in their situations, they did reveal that, for children growing up in poor families, poverty usually entails a much broader set of factors and challenges than just insufficient economic resources. The community stated it was highly possible that children in poor Zambian families were more likely to have parents with low levels of education, live in single mother households and reside in neighborhoods characterized by overcrowding, sub-standard housing conditions, high rates of unemployment, inadequate schools and higher levels of crime, and these sentiments from the communities along with the experiences were similar to those findings of (Brooks-Gunn, 1997).

Research with adolescents elsewhere in the world found similar pattern, as those of (Dodge, 1994); (Duncan, 1994); with poverty depicting school behavior problems, poor achievement and both emotional difficulties and disruptive behavior problems (Conger, 1993); (Hanson, 1997). Although some recent studies found that poverty during children's preschool years is the most damaging (Duncan, 1998) period of the child. These findings demonstrate that low socio-economic status is linked to behavioral, emotional and cognitive problems for children and adolescents. These correlates of economic poverty create an ecological context that in most cases impedes social,

psychological and educational domains of the child and adolescent (Chase-Lansdale,1995).

9.6.1.2 Environmental Factors as life stressors

The concept map, fig.25 and the model fig. 26 respectively show that environmental factors were perceived by the community as “*physical*” to mean: home, school, and community. Specific factors within this physical environment which appeared to be common to all groups were: the adverse effect of inadequate and unsafe water, air pollution, soil contamination with lead poison particularly in Kabwe town, and housing especially the type of house and the location of the house after the loss.

It is important to point out that the *community* is not merely an environment in which the child and adolescent lives, the environment must be one which must transmit values and attitudes that will promote the development of the child and adolescent holistically. It is a community in which children learns to live first and foremost as children and not as adults to fend for themselves at such a tender age. In family life children learn to live with people of all ages. The results of the data show that the community perceived the environment from a socio-economic perspective with its dreadful conditions which impacts and effects on children and adolescents’ mental health.

Shortage of water as part of the critical physical environment was found to be characteristic of all the focus study sites. Kabwe town in the central part of Zambia in particular has a unique environmental problem, that of high concentration of lead in the soil. This has led to lack of recreations for children and adolescents belonging to the informed community members who know the problem of the soil for the town – This lack of recreation for the children has consequently lead to non-productivity of many children and has left them with no other options besides children roaming the streets, abusing drugs and alcohol as well as stealing in some situations.

Another equally important general finding in all study sites was the poor state of sanitation (hygiene) in the towns covered by the study. This state of affairs has led to periodic outbreaks of diarrhea diseases and the majority of the victims have been children. Also, families and the community were perceived to contribute to a larger extent the prevalence of endemic water-related diseases in the communities because of inadequate knowledge of (IEC) messages. All the four towns covered by the study except the Monze town lying in the southern part of the country have the problem of both air pollution and pollution due to industrial emission, such as (Indeni oil, Chilanga Cement, Lime factories, dry waste burning sites etc).

In all these towns, data shows that there are too many bars in residential areas which open and close at awkward hours and without any age restriction, this has had deleterious effects on children and adolescents. During times when these children are out to these bars and other places of entertainment, such as the clubs and lodges as well as motels, they have had the time to pornographic movies and materials which were thought to be among those factors that have largely spoiled the majority of the children in the townships with characteristic feature of overcrowding in those places.

Studies by (Reese, 1970), (Riegel, 1976) show some of the appropriate schemes used in other countries for care models that involve the child and the environment. The models particularly those used by Riegel, maladaptive behavior could be modified through behavior modification therapy. Other studies such as those of (Lewis, 1984) which suggested use of buffers against stress found that securely attached children with parents' environment were unaffected by the subsequent stressing environment and vice versa for the insecurely attached children who experienced the negative environmental factors and were more likely to develop psychopathology.

However, the further models that were used such as : the invulnerability models (Garmezy, 1985) (Rutter, 1974) the prototypic environmental models (Lewis, 1981) as well as the general environmental models, did show that children are protected or stress-

resistant from subsequent stressful situations if their past environment was positive and supportive.

These models further explain why not all at-risk children and adolescents develop psychopathology later in their life. In addition, these models were used to explain that exogenous factors influence the development of the child most and show that behavior normal or maladaptive is primarily a function of the environmental factors acting on the child and the adolescent. These prompting views suggest that using these models, it is possible that the child's/adolescent's behavior can remain consistent as long as the environment appears consistent too and vice versa if the environment is inconsistent.

Many children and the adolescents ignored in this way by the community have found themselves either selling illicit beer on behalf of their parents or at the same time got into abusing this local and highly toxic brew, cheap and affordable for most of the children and adolescents, with resultant multiple health and mental problems such as children drinking beer leading to deviant behavior. Studies by (Haworth, 1987) found that alcohol, tobacco and cannabis were the most abused substances among male adolescents in most towns in Zambia and more so among school boys. The following specific environment factors which stand out as the most perceived etiological factors by the community are discussed and presented as follows:

9.6.1.3. Attitude of the Family and the Community as life stressors

The results of the data shows that attitude of the family and the community were viewed as barriers to mental health particularly attitudes surrounding the life style of family and community members, this was said to have a negative effect to children and adolescents mental health development because at family level, it was reported that a lot of restrictions were slapped on children and adolescents on such areas as dress-code, free movement, entertainment and affiliation with friends outside the home and other

associations of their choice. This tendency therefore follows family rigid, strict and prescriptive rules in the home.

This aspect, though considered normal cultural practice has had various implications on the mental health of the child and is very common in the *Zambian* context especially within the context of tradition and culture. Children brought up in the “Muma Yard” (elite residential areas) which are usually out of reach by the neighborhood, wall fenced and sometimes with electrical wires so that once the child is indoors they have no more contact with the outside world, this practice denies children freedom and free association with peers. It also deprives them of social personal and emotional development due to the closed door policies of parents. Similarly, children brought up in the open society especially densely populated townships, such children have rarely no restrictions and enjoy the so called freedom.

They move at will and parents are not bothered to know where their children/adolescents are because of the open door family policy. The belief around this open door policy is that wherever those children are, there are fellow elders who in the event of anything unusual about the child will take action just like they would for their own biological child. This policy however has made some of the parents and guardians relinquish their parental roles to other families’ and hence burden them with extra Costs and other resources. Other equally important mental health issues which the data have shown involve the problem of peer pressure and not going to church by some of the children.

The community did feel that children who do not go to church miss both moral leanings and the doctrine of spiritual and religious living. Even those individuals involved in child defilement crimes according to the community were only doing so because of the lost moral and spiritual connection and there was need to ensure that the church comes into the scene and support the society to evade this malpractice. The data shows that Ndola, the Copper belt industrial town in the northern part of the country was known for child defilement particularly the tender ages below 10 years of age. It has now become common to find children being defiled on the understanding that it is a cure for

HIV/AIDS and other rituals. This very impersonal and horrible attitude to the young by the community has destroyed most of the children's mental health development.

It was nevertheless recognized by all groups that the home/family from the results of the findings was a critical environment for the child's/adolescent's development because even issues of upbringing with influence of siblings, food and nutrition as well as accommodation showed that they were linked to the overall development of the child. The community, like the family, in this perspective must be perceived to be directly impacting on the child's/adolescent's development. Specific reference of these life impacts as has been stated involve the community and the school in which it is expected that through teaching of morals and ethics, attitudes, culture and traditions, would be taught subsequently in an effort to improve their moral fabric.

9.6.1.4 Wife battering by Husbands as life stressor

On the issue of wife battering, as a life stressor, the data shows that, wife battering is traditionally tolerated in Zambia because of some held views that, on one hand, beating a woman is an act of love. On the other hand, it is said that when a woman has not been beaten, she interprets that as not being loved by the husband. Against this background the community appears to approve it, unfortunately, in the opinion of the researcher backed by experience on the ground, it appears that children do not approve it, as they find it horribly frightening and has become one of those concerns the community has reported which has sent off children to the streets particularly those who are not able to withstand their mothers being battered in front of their faces.

Another view point is that children are not allowed to question the father or parent battering the other, as quite often, such children who attempted to do so are also beaten up and even sent of from the family, and this is the setback most children and adolescents find themselves in. They wish to support their mothers but are limited by the culture and

tradition that has given the man so much power that has so far amounted to abuse and misuse of wives.

Even though, the community was asked to comment on what they felt about wife battering, their stand was centered and justified around lack of /or inadequate information, education and communication (IEC) especially from civic authorities and departments of health to educate individuals about wife battering and its consequential effects to the rest of the family members and the community around.

Wife battering which has been enshrined in some traditional husbands is a big social problem haunting the women folks and for it to be fully understood and appreciated as bad practice by men requires a lot of effort to educate the men folks at all levels with their bullying tendencies against women as a symbol of strong manhood.

9.6.1.5 Living Conditions of parents after Loss as life stressor

Among the cited conditions which had deleterious effects on parents and the family as a whole after loss were: change of housing, diet and working conditions of parents. These were found to impact negatively most of the children and adolescents especially those coming from the upper economic group or the elite who suddenly found themselves out of employment and were faced with a situation where they were not able any longer to make ends meet and resulted in their failure to meet the daily needs of the family.

The community referred such circumstances as being a big problem in the mental health development of children and adolescents. The community attributed these problems around *attitude* of parents and the community members at large. They suggested that even though, loss of parents through various ways was important, with poor or low performing family and community economies, the attitude of the family and the community in the life of the child and the adolescent were by far the most critical. In the opinion of the researcher, loss in whichever form it may be or change of status from the

previous occupation does definitely affect subsequent location sites for the family, as well as accommodation type, diet, and the subsequent effect on the previous status role of the parents in respect of the ruling conditions of service, which the parents together with the children were enjoying when still in employment.

It is important that this type of development should be understood by all parents when it occurs. It is not a new thing to lose a job or to befallen with some calamity in ones' life, but the important thing which binds the family together is their attitude towards the event and how they communicate the situation to the children and hence how they harmonize it altogether with the children.

9.6.1.6 Infringement of Children's Human Rights and the Dress-Code

9.6.1.6.1 Dress-Code

The issue of infringement of children's rights by the community was a contentious issue which most parents in Zambia nowadays are not happy about particularly in the manner children dress and conduct themselves when they are out of home with peers socializing. The data shows that this state of unhappiness is attributed with the increased frequencies children and adolescents are out of home interacting, associating and affiliating with friends and other social groups which the parents do not know about and incidentally learn different behaviors which govern the ethics and etiquettes of such social groups to which those children conform and drift to.

The issue of dress-code which has to date swept Zambia of its traditional apparel and distinctiveness because of its trans-cultural influence is an important area which the community cited. It was pointed out by the community that some parents are culprits in the area of dressing because they are involved in the so called contemporary dress code. The data shows that it is sometimes out of these parents' dress code that children learned and imitated the type of dressing. Inasmuch as the community attempts to address this

problem for a just society parents in some cases are the culprits. It was reported by the focus group community members that the view by children and adolescents is that stopping them to dress the way they would want is vindictive and tantamount to the *infringement of their human rights by the community itself*.

9.6.1.6.2 Human Rights

The community further perceived that it was as well the teaching of human rights in schools which complicated the traditional way of bringing up children and adolescents. Most children are now seen challenging parents about their human rights even though parents may explain the cultural and traditional context around which they are brought up, such explanations fall in deaf ears. The community felt that children's human rights have made children and adolescents more difficult to manage as the schools continued reinforcing the teaching of human rights education.

The community reiterated that there was nothing wrong with the teaching of human rights in schools but there must be consideration of linking the teaching with cultural norms and tradition of the community in order for the next generation not to lose sight of the good leanings and practices in their community. Parents further stated that the human rights education which children receive from schools though it is aimed at liberating and emancipating them, was observed by the community that most children have now reached a point where they challenge and disapprove in what children term as '*oppressive tendencies by parents exerted onto them in the name of tradition and culture*'.

The schools have therefore been regrettably blamed as they have been conceived to have spoiled their children through such teachings. Again the issue of poor performing economy in most homes, when one reads between the lines, has forced many children and adolescents to negotiate their own way out from the influence of parents once parents are out of gainful employment.

9.6.1.7 School as an Environment Stressor

In the contemporary society, the school has become so strong to a point that it is regarded as a source pride for any parent who successfully educates his or her children, yet in the context of this study the school is perceived by the community as an environmental stressor. The community further perceived the school as an area of the child's/adolescent's struggle within their life-world. The data shows that the communities were concerned with the role and impact of teachers when children are in school and the peers both at school and in the open community. Teachers as is known are the most influential figures in the lives of school going ages and have a very strong impact to the child's well-being because they have more contact time with children and adolescents than parents themselves.

The school system sets out deliberately to devise the right environment for children, to allow them to be themselves and to develop in the way and pace that is appropriate to them. It tries to balance chances and compensate for handicaps. It lays special stress on individual discovery on primary experience and on experience and chances for work. The influence of the teachers was also underpinned by the tests and examinations that the child/adolescent was required to do and perform well.

The link between school and family was reported to be essential, particularly on child/adolescent support while at school, on provisions such as adequate support of food, pocket money and school fees in an environment of competing needs and demands against poor performing economies at household levels where majority of the families are not able any more to provide adequate support in respect of the areas pointed out within the school-world. Children and adolescents have hence found themselves linked up with peers coming from various backgrounds which may be of: rich, poor, elite or low class.

This again subjects the children to unnecessary comparisons which adversely impact on most of them negatively especially the inferior ones in terms of resource support from

home/parents. It is the influence of this poor performing family economy in the opinion of the researcher that has seen an increased drop-out rate from school by most children and adolescents and most members that were talked to attributed this trend as economic related and strongly linked it with the attitude of the community and the society. This trend has since seen most of the children on the streets engaged in evil devices such as: prostitution, cheap labor, destitution, crime activity and truancy, manifesting real poverty. These outcome behaviors were described by the communities as real challenges both at family and community levels.

9.6.1.8 Township planning, Housing, and Location as life stressors

Housing, Location, and Township planning are issues that have aroused a lot of concern to many families, particularly the inadequacy of room space in homes to accommodate a typical Zambian family with large family members. In the event of loss of any description, this seems as stated earlier to stress and worry children and adolescents who were used to a different type of life style.

It must also be pointed out that in Zambia, the location where you live has a lot of status symbol and recognition in the society. It is against this background that children who were brought up in these status locations, at the time of untimely loss in the family find it hard to reconcile their held status from the previous. This point was particularly cited by the communities in reference to people who retired, lost employment and were previously well employed and accommodated in high status residential areas, and only to find themselves in smaller housing units in compounds, low status areas after this loss/fate.

The general notion appears to suggest that children who were not brought up in this type of environment get emotionally and psychologically challenged as a result of this status change. All groups appeared to perceive that most townships in the districts studied which are: Kabwe, Lusaka, Monze, and Ndola were not well planned. The other effect of Poor Township planning has been poor sanitation which contributed largely to the

epidemics of water and food borne diseases in these areas which are also highly and densely populated.

One other view of the community was the implications of Poor Township planning. The communities were referring to situations where because of the way the townships were designed, there were high densities of populations in these areas, the absence of or lack of recreation facilities for children and adolescents in the townships, has prompted a number of young people to join unplanned groups in which they found themselves involved into activities such as crimes because staying home had nothing for them.

9.6.1.9 Culture and Ethnicity as life stressors

The views about culture and ethnicity were perceived from two perspectives, which are: traditional Zambian culture and the western culture. These two cultures were not in competition, but children and adolescents were found on the cross-road of the two cultures, not knowing which culture to take. Consequently, they got carried away, especially when entangled with influential peers and parents who held to no fixed culture and tradition as well as morals of conduct and good living.

Generally, the results of the study show that various focus groups perceived culture and ethnicity particularly tradition and attitudes of the community as the center of all child and adolescent mental health problems. Osborne referred to cultural diversity in child rearing practices when she was referring to the difficulties parents go through in bringing up children and adolescents (Osborne, 1987). The question is then which aspects of Zambian tribal cultures are conducive (or not) to CA mental health.

First, it must be recognized that in poor communities, economic or commercial motives become paramount. This means that children are regarded as economic assets (for their labour) or liabilities (as a food Cost if they do not or cannot work). This means that some customs, such as early marriage for the girls, are justified by tradition, and deemed

necessary for economic motives. Even if not sanctioned by tradition, the girls can be prostituted by hard-up families in need of groceries.

Some spoke of cultural practices in some places e.g. initiation ceremonies at an early age exposed girls to casual sex, and this did not have the approval of the focus group community members. On the other hand it can be postulated that culture moulds children's behaviors e.g. a cultured child keeps a stable home and will have stable children mentally, that will have respect for elders, hardworking and productive. One parent said:

'Restricting children, for instance, from entering their parents' bedroom when they reach a certain age is viewed as good culture in their own context in fear of them seeing and knowing secretes of the bedroom':

This is a view to which the rest of the focus group concurred. There was discussion in all groups around the cultural/traditional practices which the children and adolescents had to be oriented to and subjected to them regardless of how the affected children and adolescents felt and the impact of these traditions on them.

Torturing cultures e.g. circumcision of children and human rights restriction and at times violation, were however, cited to have contributed to the distortion of culture, and in this quagmire, the community did suggest that overall, girls with mental health problems belonged to groups which would have been subjected to horrible cultural practices in addition. Within the context of culture, the community disapproved the inculcation of the teaching of borrowed culture to children and adolescents. They cited the western culture as one that was not in matching with the Zambian culture. Quite often, children who are taught this culture, found themselves in a situation in which they were actively contributing to the misunderstanding and dilution of own local cultures.

Overseas sociological studies by (Rutter, 1970), have found that cultural and ethnicity issues in the life of the child and adolescent are very important and recommend that these need to be given the increasing relevance and attention by the powers and services that

may be which are: the political, social and health care. These studies also suggest the application of cultural and social contextual issues when dealing with the children and adolescents in mental health. The sociologists even suggest the deliberate cognizance of ethnic diversity rather than emphasis on class, and to do this requires assessment of the ethnic differences in psychosocial environments, social values, behaviors and child upbringing patterns. But other overseas sociologists (Duncan, 1977} have further used models about the crucial element of culture and ethnicity but also stressed living conditions in which there are complexities of poverty, overcrowding, absence of community resources that derive from discriminatory value systems or from a lack of educational or employment opportunities or from housing and other policies

These studies conclude that such approaches are likely to address interfamilial discords and divorce. In the *Zambian* situation, a good feature of the cultures is that extended family systems usually protects the impact of interparental conflict of the child and in most times ameliorate marital conflicts. However, a regrettable feature is that in the scenario of the married adolescents and young women, the community has consistently acted to their disadvantage because traditionally *wife battering* is seen to be morally justifying the extent of the man's love for the woman.

9.6,2.0 Polygamy and early marriages as life stressors

Zambian culture, on the whole, supports and recognizes polygamy and intermarriages, notwithstanding their impacts (Duncan 1977) on families and the children. The discussion transcripts show participants report that polygamy and intermarriage were found to be confusing children, because on one hand, children found themselves to be too many in one household against few and limited resources to be supported adequately by the parents/fathers who also on the other hand, have an obligation of supporting their many wives with needs of daily living like food, shelter and clothing.

This kind of development suddenly increases the family size and constrains the capacity of the household to provide adequate support forthwith, and those children who find

themselves not getting the support they require or generally not accepted by the parents or perceive themselves as burden or probably not fitting in that household, parents are often left with no other option but to force those young girls into early marriages. These early marriages have been cited not to work because the married-off girls are too young to understand the institution of marriage and be able to cope with married life status hence get stressed and finally defect to the urban or simply the open world.

This illustration just given suggests that culture and tradition driven by the community, has such an impact on children and adolescents, and as said earlier, initiation ceremonies, as an example, which are often forced on children and adolescents have deleterious effects. On the aspect of marriages, which are quite often early for children and adolescents to bear, it has currently been seen from the researcher's experience, as a way of family income but regrettably such marriages are not working because they are forced on children for some commercial motives on the part of the parents at the time these young girls are not yet ready to assume roles of wives and mothers respectively.

9.6.2.1 Cultural Beliefs as life stressors

The issue of beliefs from the results of the study shows that beliefs have a dual role in the community, first as life stressors and secondly as environmental factors. In the context of cultural beliefs as life stressors, the community perceived the following which are: spirit possession, taboos and rituals as the most contested perceptions in respect of factors associated with mental health problems of children and adolescents and these were the most significantly noted factors on grounds of the *Zambian* communities at whatever cultural location in the country.

Beliefs around these areas hold that children and adolescents may have mental health problems because certain taboos and rituals were disregarded hence; it is believed that it annoys the spirits of the dead. It is also believed as one parent puts it that:

'When a brother dies, soon after burial in the evening the surviving brother must perform sexual intercourse with the widow as the succeeding husband. If this is not done, the spirit of the dead becomes upset and can influence some form of mental disorders to the brother, relatives along with other associated sicknesses in the family'.

It is further believed that a young widow (who in Zambian society often is an adolescent) must undergo the following ritual:

The widow must be smeared with mud from the face to the toe. Just after the burial ceremony is over, the widow is subjected to leave the grave yard running very fast at the sound of the drum behind her while in her front some elderly woman with some burning fire will be leading her running as well to the village. The drum beaten at the time of this ceremony is said to confuse the dead and it is said that the dead are afraid of the fire. It is believed that Spirits get scared and run away heading to the west, and why the west, it believed that, that is where the spirits of the dead go. It is also said that the drum conveys some message to the dead and how that message gets to the dead is not known. The widow is told never to look back until she reaches the funeral home, where she is given herbs to drink, anoint, and wear around her waist, wrist, neck and ankles after a bath. Then they say, once these rituals have been performed, the widow is free from the dead and is ready to meet sexually the incoming husband. It is also believed that the late husband will not be able to recognize her after she has performed that ritual and when she disguises her face with mud.

Such situations and scenarios such as the one just illustrated are real and do happen in the Zambian village life especially among the Tonga tribe in the southern region of the country. However, those tribesmen and women who live in the urban set up have not gone with this type of tradition.

This scenario is a reality on the ground and those who defy and don't do it, are subjected to spiritual torment and there have been incidences of reports to say that a number of some of the defilers have gone mentally sick or some mysterious event has happened to them or their children. It is against this background that most young widows in their adolescence, who have gone through this experience, have hated it and have influenced fellow young ones never to try; they describe it as emotionally burning and torturous. Another set of taboos for a young woman who has a miscarriage, is reported thus:

A woman who has had a miscarriage in whichever form, it is believed that she must not cook or greet people by hand shaking and must not have any sexual intercourse with a man. The belief around this scenario is that during this period the woman is in a serious

ancestral spirit turmoil as well as cultural and physical warfare and should be absolutely isolated in everything.

A number of mental health problems have been cited to be associated with abortion. The woman is isolated, has her own cutlery, room and does not sit on a public chair until some rituals have been done and medicines administered. These types of traditions based rituals and taboos depress a lot of young women, they hate it, don't like it, are avoiding it especially when they have tasted urban life where these are not practiced. At close examination, assuming one forgot about beliefs - the focus of such a ritual appears to suggest high standards of hygiene after an abortion.

The difficult which one finds with such kind of belief is the link of passing infection to others, such as TB and Pneumonia, because these are very well known in respect of how and what causes them and that they are treatable as well. The question of annoying the spirits of the dead is a conspicuous one; it needs further inquiry to establish how it is strongly associated by the community as a source of continued mental health disorders. It is well known in the conventional wisdom how infection is transmitted but in the absence of justified evidence these claims will remain for long periods of time without solution to the situation.

The belief phenomenon has not spared any status grouping in Zambia; it has swept with it even the academics to believe that certain happenings in their lives including academic life are related to aspects such as witchcraft, and magic, yet the community does not clearly understand it in terms of its '*modus operandus*'. These beliefs are said to be quite strong in all Zambian communities irrespective of tribe and standing in the society. They perceive that most of the child and adolescent mental health problems are linked with factors like: witchcraft, magic and/or evil spirits as well as the ancestral spirits.

Such belief understandings and conceptions are strongly believed to exist in the families and communities and when they were asked to illustrate real examples of effects and impacts it was not possible for the focus group participants to illustrate the effect they have on young people in mental distress. An explanation of this is that the belief systems

are still so strong, even among the elite and medically trained, that they are unable to persist with any truthful analysis of the impact, or avoid doing so in deference to custom.

9.7 Biological and Physical Factors

There are far-reaching biological and physical influences on mental health and mental illness. The major categories are genes, infections, physical trauma, nutrition, hormones, and toxins (e.g., lead). Examples have been noted throughout the data obtained from the community and the practitioners. Genes and infections are among the most relating factors to biological influences on mental health and mental illness. These factors hold that child and adolescent mental health problems are related to the biological and physical insults to the biophysical well being of the child and adolescent.

Genes for instance influence normal and abnormal behavior and it has long been established that Genes influence behavior across the animal spectrum, from the lowly fruitfully all the way to humans (Plomin, 1997). Sorting out which genes are involved and determining how they influence behavior present the greatest challenge. Research suggests that many mental disorders arise in part from defects not in single genes, but in *multiple* genes. However, none of the genes has yet been pinpointed for common mental disorders.

The factors are sub-categorized into genetic and unknown for the *biological*: and disease poisons and accidents for the *physical* as shown in Table 23 and the concept map (figure 27 and figure 28) respectively. The community referred to these factors when they cited some of the 'life threats' of the child and adolescent as a result of genetic possibilities such as low intelligence quotient (IQ), diseases, malformations and deformations which were further sub-categorized as specific sub-areas within the nodes classification.

As the community cited these factors, they also wondered if such conditions as the Down's syndrome were treatable in Zambia, suggesting that the condition was a cultural

challenge, though again it is one of those conditions they considered to be a result of witchcraft and/or ancestral spirits.

The observation made was really out of cultural challenge and desperation. The findings therefore reflect generally the communities' perception about the core issues which the communities considered to be critical which were: unbalanced diet (poor feeding practices); malformations and deformations as a result of disease-related consequences resulting from the lack of valuable nutritional ingredients to the diet. Consequently, the communities further felt that diseases such as those running in families (genetic), STDs from parents, epilepsy, HIV/AIDS related syndromes and Vit. B₁, B₂, B₁₂ deficiencies were core issues among the factors associated with mental health of children and adolescents in all focus group sites.

On the aspect of accidents, all groups did note that C&A were victims of accidents of varying types along with incapacitating illnesses and diseases, they further said that most children and adolescents resorted to abusing substances and other drugs because they had no other choices left to them to make while in some cases change of environment i.e. through retirement and transfer of parents were said to impact a lot of children and adolescents negatively especially if the change of life style was by far in variance with original one.

Certain diseases which run in families e.g. Down's syndrome and epilepsy, were cited as some of those conditions in which conventional wisdom has not yet been able to provide satisfactory explanation for the ordinary people to appreciate and understand. What most community members know is information and knowledge passed on to them from their forefathers and is passed on from generation to generation.

Infectious Influences has been known since the early part of the 20th century that infectious agents can penetrate into the brain where they can cause mental disorders. A highly common mental disorder of unknown etiology at the turn of the century, termed "*general paresis*," turned out to be a late manifestation of syphilis.

The sexually transmitted infectious agent-*Treponema pallidum*-first caused symptoms in reproductive organs and then, sometimes years later, migrated to the brain where it led to neurosyphilis. Neurosyphilis was manifest by neurological deterioration (including psychosis), paralysis, and later death. With the wide availability of penicillin after World War II, neurosyphilis was virtually eliminated (Barondes, 1993).

Neurosyphilis for instance may be thought of as a disease of the past (at least in the developed world), but dementia associated with infection by the human immunodeficiency virus (HIV) is certainly not HIV-associated dementia continues to burden HIV-infected individuals worldwide. HIV infection penetrates into the brain, producing a range of progressive cognitive and behavioral impairments.

Early symptoms include impaired memory and concentration, psychomotor slowing, and apathy. Later symptoms, usually appearing years after infection, include global impairments marked by mutism, incontinence, and paraplegia (Navia, 1986). The prevalence of HIV-associated dementia varies, with estimates ranging from 15 percent to 44 percent of patients with HIV infection. The high end of this estimate includes patients with subtle neuropsychological abnormalities (Navia, 1986).

The concept map (figure 27 and figure 28 as well as Table 23,) depict what the community perceived and attributed such factors to the family and the community itself. The findings are supported with distributions of Tree-nodes and child-nodes on *matrices* from each focus group site and are based on both the biological Tree-node concept with adjoining Tree-nodes and child-nodes as well as the physical tree-nodes and child-nodes as well

9. 8 Physical Factors

These factors are described in detail in chapter 7 where they are known as free-node knowledge areas within the *Bio-Psychosocial* theory of child and adolescent mental health. The concept “*Physical*” as applied in the context of this study varies from the

ordinary use of the term '*environment*' to the term '*Physical*' as applied in the socioeconomic theory, which refers to *hard matter* such as water, air, soil, and waste.

These factors are critical in the aetiological consideration of mental health problems of children and adolescents. *If there is some confusion and overlap in the terms used, this comes from the actual discussion of the participants, and not from the researcher's analysis.* In the natural sciences context in which this term '*Physical*' is referred in this study, it is implied to mean '*soft matter*' such as disease, poison and accident which impact on the physical body causing ill health that will eventually have harmful effects on the mental health and emotional state of the child, therefore this study uses the term in this context.

The focus of the discussion on physical factors as etiological issues perceived by the community centers on three (3) tree-nodes and three (3) child-nodes comprising those which are blood-related, HIV/AIDS-related and diet-related. Epilepsy and fits are also linked in this category by the community but these were perceived to be associated with *genetic predisposition* in a family as well as effects of *substance abuse*, such as *drugs and alcohol*, *infant accidents such as road traffic* and *Vit B_{1, 2, 6, 12} deficiencies in the diet.*

The community further linked epilepsy to community beliefs and taboos which hold that when it occurs it is a sign of misfortune in the family and a sign of some spiritual force working in that person because he is guilt or punished for some misdeeds in life of some kind mostly through their parents and/or guardians. In this study the results show that the community is aware of the issue of certain foods such as *pork meat*, which according to them, '*if it is infested*' with some pig worm (*taenia solium*), and is ingested by human beings, it is possible for the child to develop some kind of fits or epilepsy later in life.

They also are aware of people in the community who have been mental challenged because of the pork eaten infested with *taenia solium* which lodged in the brain and its consequential effects resulted into mental health insult of some kind while some of the members even isolated some cases of children and adolescents who became brain

damaged due to the same. The basis for this information from the community could not be justified as they stated that this was common community knowledge which had no empirical evidence but incidences were there to show of people suspected to be victims of the scourge.

This information, even though they did not have the working scientific knowledge, it appears this was correct. This particular tapeworm is hermaphroditic, meaning that the worm is both male and female and if its segments lodge in the brain it begins to grow, and eventually, in some people features of psychopathology begin to manifest gradually, and this is only if the pork infested has not been well cooked.

On the issue of how the community deals with children and adolescents with this kind of problem, the community believes that giving children alcohol when they are sick is treatment for epilepsy, traditionally, people think that epilepsy with alcohol administration, should be able to control fits and/or epilepsy. They did reiterate that people with poor eating habits lack balanced diet and can lead to poor development of children's brain, hence the epilepsy and fits. Their basis for giving alcohol to persons with epilepsy is on the understanding that alcohol is food.

Lacking adequate food in families may sometimes be as a result of poor system of food distribution within homes by the households. A number of families have had their children especially the girl child out on the streets with bus drivers or conductors for search of money to buy food and at times these girl children have ended up with unwanted pregnancies while boys were on the streets pick-pocketing, selling cigarettes and street begging with no fixed sleeping destination.

While these developments are taking place within the community, there are no studies that have been done in Zambia to show the magnitude of the problem along with the various perceptions which could be correct from the community perspective.

9.9 Resource Support for children and adolescents in the community

The issue of resource support from the community proposed the need for the inception of Non Governmental Organizations in the communities that will be involved in developmental projects and programmes. The hope for this support was that it would help create employment for young people. The community also felt that introduction of and enhancement of learning opportunities through various media and availability of information materials in various areas of child and adolescence mental health along with effective communication was important and proposed that it be commenced.

The community recommended that Information, Education and Communication (IEC) programmes on moral education, HIV/AIDS, and literacy clubs be introduced as these are excellent innovations to build information capacity in the young. They proposed that movies, films and communal leanings must be well planed and censored if they have to contribute to the overall development of culture, norms, conduct and creativity- this would be good resource support for the children and adolescents.

The community called upon the church and the NGOs, together with government to assist families through information sharing to shape up model parents for more model homes and model parents in the community. Town councils, municipalities and communities were proposed to be drawn into the support venture by ensuring that they provide recreation facilities to keep and capture children and adolescents thereby reduce them from activities that endanger their life away from home.

9. 10. QUANTITATIVE DATA

This section presents discussion of the results of findings from the data obtained from hospital OPD records and registers for the year 2004 only. The data collection tool for the OPD and Hospital Records showed a lot of missing information on socio demographic data such as: *age, sex, religion, tribe, level of education, nationality, and date when diagnosis was made*. Even the psychiatry diagnosis made, it was common to find mostly broad working formulations such as *psychosis, and drug induced psychosis*. *This practice has not helped much to get the clearer picture of the trend of mental health problems for the year 2004 as most conditions are hiding in the broad formulations and giving appropriate treatment or support following this kind of practice is not practical.*

The other view of looking at the pattern of how these tools were filled, *gives an impression that the practitioners working at the OPDs have a problem of competency in the practice of mental health at primary care level. The evidence has already been recognized in their failure to provide adequate diagnosis even though it may not necessarily be the correct one.*

The other view point is one that questions the *competency of Record Clerks in filling and management of OPD record charts as well as hospital registers* once the patient has been admitted and discharged respectively. The problem therefore is not a mean one; *it requires the total review of competence practices at OPD together with hospital managements and training colleges.*

The discussion of the data below would have been more comprehensive if it was backed with more *socio demographic information* which would help to make informed decisions about the magnitude of the problem and who in the category is the most affected in terms of tribe, specific psychiatry diagnosis, religion and nationality. The discussion of the results focuses on the following categories of diagnosis *even though the 21 years age group is reflected it does not influence over and above the perceptions in the understandings of mental health problems perceived by the practitioners and the community* as reflected in the data collected from the OPD Clinics and the Hospitals which are:

- Epilepsy
- Manic Depressive Disorders
- Mental retardation
- Child Defilement
- Psychosis
- Conversion disorder and
- Undiagnosed

9.10.1 Epilepsy

The data shows that Lusaka diagnosed more children and adolescents, 123 (45%) with epilepsy out of the total number 273 (100%) seen in (2004). The highest incidences were in the males aged 0-12yrs. Significant incidences of the same were noted to be more or less similar in the age groups 0-12yrs and 21yrs and above in the females.

This pattern of disease incidence and presentation in the 0-12 year's male age group and 0-12 year's female age group is suggestive of several factors during this phase of life. Most probably, the problems could be factors related to poverty, malnutrition, and infections such as malaria, meningitis and home accidents. With such results, it is difficult to establish what the real problem is. It can only be postulated that the highest incidences in the male age group of 0-12 years could be as a result of a number of factors, and the most probable one could be early obstetric care as well as antenatal and post- natal care.

Lusaka being a cosmopolitan town, with a lot densely populated townships growing, it is possible that that the element of poor feeding with consequential impact on the children may be the main reason. Most of the people in Lusaka townships do not have gainful employment and their livelihood is dependent on brewing illicit beer and there have been reports of children and adolescents involved in the indulgence of drinking and eventually abusing other drugs and inhalants such as glue sniffing and petrol. Such substances abused

have ruined the future of many young boys who smilingly have taken the substance for pleasure but in the long run the impact on their life has been deleterious.

9.10.2 Manic Depressive Disorders

The data shows cases of child and adolescent manic disorders, 29 (11%). It was also further noted that depressive disorders 23(8%) were a source of concern in males and females aged 16-18 years and 21 years. One of the most probable possibilities associated with these manic depressive pictures presented by these young adolescents in this age period, would be mostly due to abuse of drugs, alcohol and inhalants.

In the case of depressive reactions, the most likelihood would be withdrawal symptoms from the substances whereas manic reactions; could either be suggestive of excitement states induced by the same substances, which could be manic depression or psychosis in general. According to (Flisher, 1993, 1994, 1998: 1045), he noted that use of drugs and alcohol begins as early as age 8 or 9 and typically occurs in groups and more common in boys. Inhalants are abused mainly because they are easily accessible, legally obtainable and present in most households (Cambor, 1990). Street children commonly abuse it, even though all other children of other social groups abuse it as well.

9.10.3 Mental retardation

Mental retardation 30(11%) were quite significant in the age group 19-21 years males and 0-12 years both sex groups. The implications of such a scenario appears to suggest several things some of which reflect on either inadequate mother and child health care services at an early age which all governments have to make available to their citizens or health education to the communities about the need for change of living habits which may not have filtered to the critical mass so that the effect of such inadequacy has resulted into such deleterious effects on the children.

On the part of the 19-21 years age group, in the opinion of the research, this development could be associated with early child labor in which case especially some of the boys are subjected to child labor either involving them into risk jobs such as working in jobs that involve heights or forced to do other hazardous jobs. Another possibility could be ignored MCH services such as vaccinations against conditions such as measles and poliomyelitis in that order which could have resulted children getting into such situations. The curriculum which will be developed will need to stress in the content and field practice the education component of the community about the importance of preventing physical and mental health challenges early in the children's lives.

9.10.4 Child Defilement

The issue of defilement of young girls by the elderly is an urgent and serious problem especially at present, when defilers tend to give the justification for the act as an excuse for a non scientific assertion that, sleeping with a young child or even a baby, is treatment or remedy for HIV/AIDS, or even a charm for promotion at work or for the accumulation of wealth.

In this study Ndola town in the Copperbelt town far northern part of Zambia was rated the highest in child defilement of young girls, this trend needs to be followed up and if culprits are discovered they need to be punished by the courts of law. One of the participants read to the group a BBC news item in which the Zambian members of Parliament viewed the scourge of child defilement as barbaric and deserves castration, they put it this way:

“Child rapists must be castrated to curb a growing problem in this country. Police say that 400 cases of child rape were reported in the first half of 2003 - a 68% increase on the previous year. Some men say they rape children in the belief that having sex with a virgin can cure Aids. Some 20% of Zambians are HIV positive. We make this recommendation as a result of the numerous cases of child defilement in the country, and we need as a country Good Governance and Human Rights. Even three-month-old babies have been raped.

It's too barbaric to be allowed to happen, People have observed that existing laws are weak [and] not deterring people, how the castration should be carried out, should be answered when the Parliamentary bill is drafted but it was "likely" that the recommendation would become law. The incidence of child rape is one factor behind the high number of young girls who are HIV positive. Some Zambian women's rights activists also back the MPs' position for instance the umbrella grouping leadership of women's rights campaigners, say that cattle-rustlers can be sentenced to 25 years in prison, while child rapists get just one or two years. Do we value our animals more than our children? "Castration is nothing compared to raping a nine-month girl," BBC News Online was told." (BBC NEWS, 2003).

The high rates of defilement could also be the result of boys and men acting under the influence of drugs and alcohol. Dagga has been commonly used by many boys to commit various crimes including defilement. The increase of this defilement could as well be under the influence of some active psychopathology developing in the individual, induced by some physical disease, genetic factors and exogenous stress impacted by socio-environmental factors or even economic and cultural factors respectively.

9.10.5 Diagnosis of Psychosis

The data also shows that diagnosis of Psychosis in general was made and highest in the male age group 21 years and above while schizophrenia was noted to be high 5(2%) in a population of 237(100%) for the 2004 year records on the registers.

The general diagnosis of Psychosis at these centers/hospitals, appears to suggest the difficulty, the health practitioner has with the complexity of mental health problems in the advent of HIV/AIDS. Most children and adolescents on admission or attendance show more physical related features and end up with a general working diagnosis such as 'Psychosis'.

This type of clinical practice shows that there is a problem of competence to practice mental health clinical case identification. In situations such as this one the most likely remedy would be further training in clinical diagnosis of patients' conditions.

9.10.6 Conversion disorder

The age group 19-21 year females showed a marked feature of the conversion disorder (hysteria), 3(11.5%) particularly in the Monze Town, south of Lusaka. The issue of Hysteria in the Tonga Tribe Town where most activities were farm-based could suggest of conversion as a cover for most girl children to avoid farm-based roles which separate them from active town life.

Another notion might be suggestive of attention seeking from parents to meet their need. Perhaps this might explain why if their attention-seeking behavior is not rewarded, some children opt to the streets for money to meet their needs with negative results such as HIV/AIDS, STIs with bus drivers and conductors.

9.10.7 Undiagnosed Cases

Data shows that there were more 6 (11%) undiagnosed female patients aged 21 years and over with more or less equal members of male (6) and female (5) with psychosis in the age groups 20 years and over. Managing a patient without a working formulation is a practice misnomer. The increase in diagnosed cases without a working diagnosis may be suggestive of competence deficiencies.

It may be a reflection of the status of the practitioner, If the practitioner was a generalist, such would be expected, but if it were a trained mental health practitioner, it would most probably be a reflection of need for in-service to update the practitioner on the latest trends and just improving the state of the art ad acumen of the practitioner(s).

9.10.8 Conclusion of Section on Quantitative Data

Bio-data for practitioners and focus group community members have already been summarized on p 316 and 317 respectively. This section shows data collected from Hospital/OPD Records and Curriculum preferences **only** by PHC practitioners.

Hospitals/Clinics Data

Quantitative data was collected from 3 sources which are: hospitals/clinics; participants' bio-data and curriculum model preferences by practitioners. The general trend shown in these data suggests that Chainama Hospital has the highest reported number of children and adolescents with epilepsy as well as those with mental retardation even though the trend for manic and depressive disorders appeared to be on the high side. The general diagnosis of children and adolescents with psychosis and schizophrenia is indicative of a geminating problem which needs community and professional intervention.

How this can be addressed requires the good will of policy makers and the improvement of service delivery for the children and adolescents through well qualified practitioners and community link support. The Ndola child defilement problem for girls aged 12 years and below is a source of worry with the growing trend of epilepsy reported cases as is in Lusaka affecting both males and females with more psychotic problems in the males than the females needs further study to understand why it is happening the way it is happening. The picture of the results in Kabwe Town is rather different in that there are more undiagnosed cases of mental health problems in females aged 21 years and above than the males in the same age group while the diagnosis of psychosis as in Chainama is more in both groups of the same age group.

The Monze situation is more on human resource as it appeared to show no active screening in the OPD of the hospital to nip the children and adolescents from the bud on routine screening. However the available data showed that epilepsy was the highest reported problem to the hospital as has been reported in Lusaka and Ndola research sites. What make the Monze data conspicuous are the noticeable cases of females reported with

some 'conversion' disorders (hysteria) in the 19-21 years age group. The uniqueness of conversion disorders in a more rural town unlike the urban to develop such disorders whose chief livelihood is farming is an important finding.

9.11 CURRICULUM DEVELOPMENT

In this section the discussion of Curriculum Development focuses on the *fourth and fifth research questions* as stated in chapter one of the study which are:

1. Curriculum content for the planned child and adolescents' Mental Health curriculum for PHC practitioners in Zambia.
2. Preferred Curriculum Model most appropriate for the 'INSET' of PHC practitioners in child and adolescent mental health in Zambia.

Individual groups debated the 4 models of curriculum and later on each group presented their views on each of the models at joint plenary where practitioners generally felt that all models were quite appropriate and useful depending on the focus and the purpose of the study even though each one of them had its own pros and cons.

The following definition of curriculum was adopted following the conceptual framework and the theory of the study which was shared to the practitioners. Also, the prior learning through short orientation they had on curricula development and their implications assisted them to come up with a more balanced definition of curriculum such as the one below:

“all aspects of what is taught, who the intended teacher and learners are, the purpose of the programme, what outcomes are expected for the learner, the aspects of assessment and evaluation, even timetable planning and their unplanned activities”.

Drawing from these views about curriculum conceptions and controversies, this study viewed and construed curriculum as a *social construct* and *ideology*, written as an intended plan and process, derived as a *social construct view of the community* from

which it was conceived, based on choices that are made primarily by the community itself, and these choices reflect the values and beliefs of the society (Young, 1976).

The decision to adopt which curriculum model was largely due to the afore mentioned background in addition to the conceptions from the systems and ecological perspectives that view curriculum from the *constructivist dimension* in which the community constructed their views of curriculum from their own perspectives particularly the *perceptions and understandings* of mental health problems of children and adolescents perceived from their own setting.

The number of practitioners who preferred other curriculum models was by personal conviction after each model was discussed. All practitioners had been given the full orientation of various models and have had the time to discuss among themselves the various curricula to be able to make informed decisions of the type of curricula they would prefer for Zambia. The procedure which was used to determine their perception about the preferred model was through a secret ballot. Plain white pieces of paper were circulated to all and when they had completed filling, the results were computed using the flip charts. The results were compared in table forms to show the frequencies and the actual numbers of practitioners who selected which curricula model? Another task was that of them providing the reasons for the preferred model.

This was important in order to appreciate some of the critical issues they were likely to raise which would be of great use to the researcher for further use. To do this task, all participants were given a matrix sheet on which the curricula models were listed with their subsequent qualities and properties, and what they were required to do was to merely fill in the appropriate box based on their prior leaning and understandings including discussions in heterogeneous groups and the time they were out for field work on focus groups with colleagues and the community.

The results of the data showed that out of the total number of the participants, 12 (48%) of them preferred the PRISMS curriculum model. The PRISMS model had the highest

rating of the four proposed curricula. The model was viewed to be highly qualitative, cuts across various curricula models and characteristically, increases teacher-student interaction and takes on board various multi professional groups and clinical education is its agenda.

The data showed that even though the PRISMS model had the highest rating, both the SYMBIOTIC and the SPICES models had relatively similar ranked ratings, in other strategies, for instance, the SPICES model had the highest rating on teacher-student interaction, while the ASSET model had the highest rating in multi professional integration and involvement and these are very important principles in innovative educational processes which promote active facilitation of learning of students. In explaining the preference for the PRISMS model, the practitioners stated that they liked it because it integrates teaching with a wide variety of clinical practitioners, and integrates work in the community early in the training.

The data results of findings suggest that although the PRISMS curriculum model was preferred, it is possible that during the actual teaching and learning process, a combination of teaching methods could be borrowed from both the SPICES, SYMBIOTIC, and the ASSET curriculum models. The data also show that in all the three models except the ASSET model, the curricula are problem based and most importantly, is student centered. The focus of the curricula is learner empowerment through self-directed and motivated learning with the support of peer groups. The role of the lecturers change to that of facilitators but also entails that the facilitator must always be available for learners' feedback, guidance and direction, more than it is in the traditional curricula models which focus on lectures and the assessment.

In formulating the new curriculum content, the shift in focus to socio-environmental factors which emerged in the participant perceptions must be central. This means that the curriculum to be developed will have a shift of emphasis to focus on the environment factors as perceived by the community and practitioners during the exploration of the

perceptions. The PRISMS model of the innovative curriculum preferred is a dynamic model. Its focus is clinical education integration of teaching/learning and the practice field. The rich mix of teachers from both the training institutions and the practicum areas as well as the integration of strategies from the SYMBIOSIS and SPICES models is a challenge to the teaching fraternity in the health training institutions. It is against this background, that the content areas of the INSET curriculum should be those content knowledge areas which will tally with the explored perceptions of the community and the practitioners in the field about CA mental health.

9.12. CONCLUSION OF THE STUDY

The purpose of the study was *to explore perceptions and understandings of Practitioners and the community* about mental health problems of children and adolescents with subsequent implications to innovative curriculum for PHC 'INSET' in Zambia. The study was both qualitative and quantitative using focus groups and Document Analysis Interview Guides to obtain the data in Hospitals and Clinics.

The stated research questions which all deal with phase 1 of the whole project (stages 1, 2, and 3) respectively were fulfilled through this doctoral part of the research with subsequent recommendations which if applied, are likely to contribute to the alleviation of mental health problems experienced by children and adolescents in the community and enable them to develop within the supportive health trajectory.

The next phases of the project which are: 2 and 3 (stages 4,5,6,7 and 8) of this part of the total project is curriculum construction, curriculum piloting, and curriculum reconstruction and integration in the main stream curricula for PHC practitioners' INSET. These specified phases and stages of the total project are outside the scope of this study. It will require separate funding and time outside the doctoral period of the study.

The focus of the conclusion of this study is outlined in 12.1 and 12.2 below and shows that the perceptions of mental health problems of children and adolescents which were *explored from the community and practitioners as well as the hospitals have been*

elucidated to inform the next phases of the curriculum development process. The conclusion also highlights the choice of the curriculum model preferred by the practitioners as well as the type of curriculum content for the INSET of PHC practitioners in child and adolescent mental health.

9.12.1 Perception of the community and Practitioners about mental health problems

Taking into account the results of the findings of the study from the three perspectives which are: Perceptions of practitioners and the community: Hospital and OPD records: and Curriculum model option selected by the practitioners: This study was able to explore perceptions of the practitioners and the community about mental health problems of children and adolescents in their own setting. This measure of success was possible because the study was able to bring together all relevant stake holders and the community to address the problem of child and adolescent mental health agenda. The *exploration of the perceptions* was done within the context of the set first three research questions which wanted to determine: What were the perceptions of the Practitioners and the community about mental health and mental health problems of children and adolescents?

1. How the Zambian community deals with children and adolescents' mental health well being? and
2. What were some of the key issues that affect the introduction of new aspects of mental health into the generic curriculum?

Learning from the experience obtained from this study in which these three research questions above were investigated, the results suggest that: *Involving the practitioners and the community in exploring their own perceptions and understandings right from the beginning of the study works and it is an effective way of providing solutions to practical issues that affect practitioners, and the community and a curriculum borne out of such partnership has the chance of standing the test of time because it has the support of the community with its dual legitimacy. Experience during*

this study along with recorded literature in context has shown that it is very difficult for AR to fully extricate itself from the researcher-community relationship and that in itself affects the local power dynamics if disregarded.

Therefore, community participation in such a context of a study like this one was recognized for what it is as an externally motivated political act (Chambers, 1981). In the process of the study, perceptions of practitioners about etiological factors of C&A mental health problems inevitably changed, this was primarily the effect and impact of the various interactions with the community and several meetings among practitioners themselves.

It was important during the study to appreciate that people in the community had more information about mental health problems of children and adolescents than what practitioners had preconceived before interaction with the community, the saying below illustrates this point from the researcher's experience:

'It's not what you think that carries the day, but what the community thinks and feels about their problems and situations, which are part of their daily life experiences in the homes and the community at large that is important, they continue and say when you come learn about us as a stranger and when you have known all about us depart as a friend, then we begin to work together for development.'

The changed perception about the definition of mental health influenced both the nurses and clinical officers to conceptualize the geneses of child and adolescent mental health problems from a '*biopsychosocial-economic to environmental dimension*'. This variation of views was important at the initial stage of the study; it showed that even though nurses and clinical officers were all practitioners, they had different perceptions and understandings about the etiology; this could have been due to their pre-service training background received.

Considering all factors perceived by the community which underpin the etiology of child and adolescent mental health problems – *environment related factors* are the most perceived as shown on the coded passage counts (table 25), while stressful life situations

in children and adolescents are perceived to be strongly linked to family, community, environment and biological factors as illustrated by the ecological model (figure 3). The onset of mental illness in the family was perceived to be a sign of bad luck, demon possession, curse from God, bewitchment, magic, ancestral spirits' power over the living and all these were said to be at the helm of mental health problems of CA.

The reported effect of mental health problems of children and adolescents upon their families has led to social stigma and consequently to isolation and discrimination of such children from the public resulting at times in delayed hospital consultation and treatment as most families prefer consulting the traditional healers first before hospital referral only to deal with complications. Epilepsy and fits were linked to dietary implications, while drugs and alcohol abuse, inhalant abuse, were perceived to trigger epilepsy later in life if those children continued abusing the substances.

In respect of head injuries, genetic disposition, fits in pregnancy and Down's syndrome, the general perception of the community as to the cause were witchcraft and the impact of spiritual forces by the ancestors through sins of their parents. Referred cases of child defilement in the year 2004 were highest in girls aged 0-12 years whereas, a number of children and adolescents were also referred to hospital and out patients facility in the same year for acute psychotic episode (unspecified) and/or psychosis also (unspecified), with the highest number of such referrals in male adolescents.

At all OPD sections of the hospitals the study observed that a lot of information is missed in the registry forms and registers, indicating that there is a problem among the staff in data management even though health Information Management System (HIMS) has been incorporated in the curricula, it seems there is misapplication of some information. The significant number of children and adolescents treated at various hospitals without a working diagnosis suggests that, in the area of practitioners' performance, competency in diagnostics and case management of patients is a problem.

The obvious practice gap disclosed through poor diagnostics for case management is indicative of contents of the type of curriculum practitioners went through during their pre-service training which did not prepare them for the type of mental health problems of children and adolescents in the community in the reality of practice.

The question of how the Zambian community deals with CA mental health well-being, appear to indicate the following which is typical for these groups only and may not be generalized :

- The results of the study show that the uninformed community about conventional medicine and practice believes that giving children alcohol when they are sick is treatment for epilepsy on grounds that alcohol administration with its nutritional value controls fits and/or epilepsy.
- The other aspect of the community believes that lack of openness to children, doing them favors and even lying to them, thus, failing to fulfill the promises pledged are perceived to be a good way of bringing up the children and promoting their mental health well being, these tendencies however have negative effects on the mental health status of the children.
- The assertion that subjecting children and adolescents to certain taboos and rituals is a way of promoting the mental health well-being of the CA to avoid them have mental health problems later in life is particularly one area that need a lot of public education for community reformation because it has not shown any positive benefits to the C&As.
- Children and adolescents need access to comprehensive physical and psychosocial support services and activities which should be flexible, adequately coordinated, integrated, child and adolescent user friendly and be child and adolescent centered

- It should be evidence based drawing information from the recent research work on child and adolescent mental health done either locally or outside. This means that the curriculum should train practitioners to be ongoing researchers.

9.12.2 Preferred Curriculum Model and Content for PHC Practitioners' INSET:

In addressing the last two research questions of the study which were intended to determine:

1. What would be the curriculum content for the planned child and adolescents' Mental Health INSET for PHC practitioners in Zambia? and
2. What would be the preferred Curriculum Model most appropriate for the 'INSET' of PHC practitioners in child and adolescent mental health in Zambia?

This study was able to come up with the content that would be incorporated when developing the innovative curriculum in child and adolescent mental health. This was based on the perception of classes of knowledge areas that emerged after the analysis of the data. It was as well on the basis of considering that *the highest index of perceptions were focused on factors related to the environment in which the child lives in such as the family, the school, the community and national policies, culture, traditions and others such as rituals and traditional ceremonies.* Some of the content areas are as follows:

- The content of the curriculum to be developed should take into account the description and definitions of the UN Rights of Children: Children's Laws in Zambia: Contextual background of CA Mental Health in Zambia: blended with the latest Situational analysis of CA mental health in Zambia

- Child Development to include descriptions of various biopsychosocial and cultural models of children and developmental stages of a child; predisposing factors; and developmental psychopathologies.
- Child Abuse to address the different types of abuse; Causes of abuse and; Management of the abused children and adolescents in the community first before medical support.
- Psychosocial support to address most importantly children's needs in the community and at family level; Models of working with parents/care givers; and the role of teachers as models and the NGOs.
- Clinical and Medical issues should include: Common disorders of childhood and adolescence which need medical support: Child and Adolescent psychosocial counseling with parents and care givers and Nutrition, Mental Health and related health education.

9.13. IMPLICATIONS OF THE STUDY

Having considered the findings of phase one (1) of this study which has derived perceptions and understandings of mental health problems of children and adolescents from the practitioners and the community, and noting mental health as an important component of the overall PHC, the following are the implications of the study to both CA mental health service delivery and innovative curriculum development for education:

Implications to Mental Health Service Delivery:

9.13.1. Safety and good health habits

- Personal safety of children and adolescents is a primary health concern.
- Children and adolescents in the community need more recreational facilities to prevent drug and alcohol use related to boredom.

- Health of children and adolescents is more about quality of life than disease and illness.

9.13.2. Health information, Education and Communication

- Health information needs to be accessible to Children and Adolescents anonymously.
- Healthy lifestyles need to be promoted throughout the whole community, using adolescent workers and sporting leaders as role models.
- Health education must enable young people to make wise choices for the future.
- Children and adolescents need to trust their service providers and will only see a doctor if they perceive themselves to be severely ill.
- The transition from childhood to adulthood is often characterised by risk-taking and other behaviour associated with substantial morbidity and mortality.
- Access to health services is of concern. More education is required on how the health care system operates.

9.13.3. Child and Adolescent Mental Health Services in PHC:

- Children and adolescents value meeting PHC practitioners in the school and community setting and not just in the doctor's consulting room.
- Children and adolescents desire a whole lifestyle approach to health rather than the traditional model based on diagnosis and disease
- Children and adolescents find it difficult to access primary health care services because of barriers which include cost, lack of knowledge about health care system, concerns about confidentiality, embarrassment, fear and shame.
- General practice encounters may not identify important health problems in adolescents, and, even when young people have a trusting relationship with a general practitioner, it is not necessarily accompanied by improved health behaviour.
- A holistic approach is suggested as necessary to improve the physical, mental and social wellbeing of children and adolescents. This strategy is to involve adolescents in planning their own services.

- Any strategies to improve the health of children and adolescents need to be informed by an understanding of their health beliefs in an attempt to reduce the gap in the community's understanding of knowledge, attitudes and perceptions of children and adolescents regarding health and wellbeing.
- Equity, social justice, universal access to services by the children and adolescents, multisectoral action and community participation must be re-aligned as the basis for strengthening mental health system of children and adolescents in the country.

Implications to PHC Practitioners' Education:

9.13.4. PHC Practitioners' Curriculum

- The type of curriculum model (**PRISMS MODEL**) together with the proposed content form the basis for an innovative curriculum to be developed for the practitioners (Phases 2 and 3 of the whole Project).
- The (**PRISMS MODEL**) type of curriculum preferred by the Practitioners is intended to enhance the research capacities of the PHC practitioners, so that they are able to respond to evolving social and environmental problems that impact on CA's mental health.
- Noting also the growing consensus in the global health community this model of curriculum (**PRISMS MODEL**) will enhance the practitioners' competencies in the management of vertical PHC education approaches, such as disease-specific programmes, and integrated health systems approaches which include C&A mental health services.
- The PHC innovative Curriculum (**PRISMS MODEL**) shall address training issues which recognize the need to draw on the experiences, both positive and negative, of PHC in the years since the Declaration of Alma-Ata in 1978.

- The training programmes of Practitioners shall have some inbuilt competencies taught to build sustainable national mental health systems within the National health Services.
- The designed practitioners' curriculum on CA mental health be piloted first in the four towns where the research study took place and a working document be put in place to address further issues of child and adolescent mental health required for the final development of an innovative curriculum.

9.14. RECOMMENDATIONS

9.14.1 Strengthening of Mental Health Services for Children and Adolescents

- A programme of action be designed and integrated within the main stream PHC to provide guidance to policy makers and service providers on the implementation of specific mental health care support programmes at health and community care levels.
- A political commitment by the government be pronounced and documented including the values and principles of the Declaration of Alma-Ata, in keeping with the issue of overall strengthening of child and adolescent mental health systems of the country based on the PHC approach.
- Ministry of Youth and Sport together with Ministry of Community Development and Child Welfare be encouraged to collaborate with Ministry of Health in the review of *the Mental Health Policy component on Child and Adolescent Mental Health Service and Care focusing all levels of care including their input in the development of the planned curriculum for PHC practitioners.*
- The MoH and the Ministry of Community and Child Development be motivated to set aside a common fund for *a national dissemination meeting of the results of phase I of this study* with implications to curriculum development to mitigate the impact of mental health challenges and wellbeing of children and adolescents.

- A secretariat on child and adolescent mental health be established by the MoH to appeal to the emotional, physical, psychological and social needs of Children and Adolescents with Mental Health Problems.
- The functions of the secretariat be regulated to include Sensitization and Awareness Campaigns in order to reduce stigma and discrimination in the community through Families, Churches and Schools.
- The MoH to set aside funds for a core group *to begin incorporating child and adolescent mental health in the draft approved mental health policy of the MoH* in mental health which should guide both human resource development and service delivery in Zambia.
- Include a clause in the policy guidelines which Protects health budgets allocated for purposes of children and adolescents' programmes in the context of the current national financial crisis.
- Encourage development and implementation of vertical programmes for children and adolescents' mental health including disease-specific programmes in the context of primary health care.

9.14.2. Medical Education in Child and Adolescent Mental Health

- Train adequate numbers of PHC workers in child and adolescent mental health able to work in a multidisciplinary context, in order to respond effectively to children and adolescent mental health needs.
- Develop competencies through training of primary health care providers on the usage of appropriate medicines, health products and technologies such as health information systems in order to facilitate evidence-based policies and programmes, all which are required to support child and adolescent mental health in primary health care.

- The MoH through training institutions and hospital in-service wings be encouraged to *introduce in-service courses (INSET) in child and adolescent mental health at both hospital and provincial health offices with an approved budget for all PHC practitioners (nurses and clinical officers).*
- The MoH through the HIMS unit to work with various health training colleges to *introduce HIMS modules in all nursing and college curricula in order to equip all trained health Care cadres with HIMS information necessary for them to function effectively on completion of their training.*
- The teaching must emphasize the importance of data collection, documenting it correctly and storing it with easy accessibility at these facilities for both research and practice purposes.
- MoH to plan orientation courses for OPD departments and hospital registry clerks including professional staff (Lecturers and Tutors) in HIMS to improve the teaching of HIMS to all trainee Practitioners.
- The Mental Health Unit of the Ministry of Health to support with funds a Core Group which will work on Developing the Curriculum for COS and Nurses PHC practitioners in child and adolescent mental health.
- *The curriculum to be developed be more focused on Environmental and Cultural issues.* This will entail that learner-participants will continue to explore community perceptions and attitudes on CA mental health problems in the field to perfect their acumen in managing mental health problems in their communities.
- The MoH to sub-contract General Nursing Council and Medical Council of Zambia respectively to start the process of consultative meetings with critical human resource development training institutions and health care services administrators to address

the integration of the perceptions and understandings of the practitioners and the community that merged in phase 1 of the study including midwifery.

9.14.3. Further Research in Child and Adolescent Mental Health

The data obtained at the hospital OPD departments in all the 4 research sites showed increased cases of girl child defilement by male adults. This development is morally serious and shows the extent of moral decay the society has become.

The MoH through its research unit to allocate funds for further follow up research to determine how these children should be supported and emancipated from the scourge to promote their mental health development.

9.14.4 Innovative Curriculum

The data collected on perceptions and understandings of mental health problems of children and adolescents in phase 1 stages (1, 2, 3) of the whole project required to inform the curriculum development suggest that there is need for further participatory action research with administrators and educators to be done to complete phases 2 and 3 of the total project process and implementation in training institutions as INSET for PHC practitioners.

10. ANNEXURES

ANNEXURE 1: PROJECTED RESEARCH PROGRAMME

I-ACTIVITY	2004 Quart 1-4				2005 Quart 1-4				2006 Quart				
	Jan - Dec				Jan - Dec				Jan - Dec				
Literature study	*												
Write research proposal		*											
Finalize research proposal			*										
Submit research proposal HDC and UKZN ethical clearance committee				*									
MoH permission to do study in Zambia					*								
Ethical clearance to do study Zambia						*							
Data collection									*				
Preliminary report to MoH Zambia										*			
Data analysis													
Writing up of Thesis, conclusions & Recommendations													
Submission of Thesis													*

ANNEXURE 2 Summary of how the procedure of data collection and Analysis will be managed

Key Research Questions	Source of Data	Instruments and Methods	Data (Composition)	Analysis (Processing)
1. What are some of the key issues that affect the new aspects into the INSET and curriculum?	Group meetings of practitioners Analytical commentaries upon practice.	Questioning Listening Reflective dialogue Audio taping	Tape recorded discussions Own notes	Transcription Critical reflections
2. Which key competences are required for in-service training of PHC practitioners	1. Functional analysis 2. Portfolios of evidence 3. Group meetings of practitioners 4. Analytical commentaries upon practice.	1.Observing 2.Questioning 3.Listening 4.Reflective dialogue 5.Triangulation 6. Audio taping	Tape Recorded discussions -Own notes -Translations	-Transcription -Critical incidents -Critical reflections
3. Which mental health problems of children and adolescents have been reported by the community	Practitioners will collect data using focus groups meetings in the community, clinic records, hospital records, and school records.	Focus group Participants' changed view Interviews Meetings	Tape recorded discussions Written notes Focus groups transcriptions	Transcriptions
4. what models would various Stakeholders see as most appropriate for the INSET of PHC workers in C&A mental health?	Analysis of practitioners competences Data from the field Pre and post basic curricula. Trainers Researchers	Functional analysis Focus groups Brainstorming Decision making		Transcriptions of discussions Group consensus Decision NVIVO application

**ANNEXURE 3: PHC PRACTITIONERS DATA COLLECTION GUIDE.
INSTRUCTIONS TO THE MODERATOR (S)**

1. During the Search Conference;

- 1.1. The main objective is to identify perceptions and understandings of key mental health problems by PHC Practitioners to manage children and adolescents with Mental Health problems in homogenous groups. To do this there is need;
- 1.2 To collect unreconstructed perceptions from both the educators and PHC practitioners about Child and Adolescent Mental Health problems.
- 1.3 To collect the unreconstructed perceptions, the following methods should be applied:
Let participants;
 - a) Narrate some community case histories about C&A mental health.
 - b) Discuss community habits, which may have negative effects on C&A mental health.
 - c) Bring out perceptions of other role models about mental health problems in their communities.
 - d) Share personal experiences between educators, practitioners and stakeholders on mental health issues.

The format of the discussions with PHC practitioners will follow the process as outlined below;

Establish a framework of tasks and work roles. Ensure that each of the statements in turn are developed further by probing in each case, 'what the PHC practitioner has to do to achieve the key purpose'.

(A) In order to establish key purpose of the PHC practitioners work, the following four (4) questions should be prompted;

- 1 Think of one phrase that sums up the focus of the work that you do as a clinical officer or nurse.
- What is the key purpose of the work that you do in your practice?

ANNEXURE 4: DATA COLLECTION TOOL FOR OPD AND HOSPITAL RECORDS

(January 2004 to December 2004 period)

Place of data collection.....

Town/ location.....

Socio Demographic data

Age.....

Sex.....

Religion.....

Tribe.....

Level of education.....

Nationality.....

Psychiatry Diagnosis.....

Date when diagnosis was made.....

COMMENTS.....
.....
.....
.....
.....
.....
.....
.....
.....
.....

ANNEXURE 5: FOCUS GROUP DISCUSSIONS INSTRUMENT

MODERATOR'S GUIDE.

1. In your own opinion, what do you consider is mental health?
2. What would you perceive are the common social and psychological problems that may lead to mental health problems of children and adolescents in this community?
3. Are there any childhood and adolescent mental health problems that may be encountered due to housing, eating patterns or working conditions of the community members in this locality?
4. What would you consider as the environmental health concerns of community members, which would have an effect on childhood and adolescents?
5. Does the culture of the community members' influence their ways and conditions of living with resultant effect on children/adolescents' mental health?
6. Do the children and adolescents in this community have any mental health problems that are related to stress? Which ones are these?
7. Are there any conditions or patterns of living you may think are caused by economic problems and have negative impact on children and adolescents in this community?
8. What resources do you think the community members would like to have to improve the mental health well being of children and adolescents?
9. What are the barriers to mental healthy life styles among community members, which have an effect negatively to children and adolescents in this community?
10. Are there any other mental health problems and /or issues that you may wish to be addressed in this meeting?

ANNEXURE 6: WORKSHOP PROGRAMME

PHASE 1	TIME	ACTIVITIES	FACILITATOR
Search Conference	09.00 – 10.00	Presentation of the content and purpose of the workshop	J. Mudenda
	10.30 – 13.00	Functional Analysis of the Practitioners' competencies	J. Mudenda/Consultant
	14.00 – 15.00	Formulation of key unreconstructed Child and Adolescent Mental Health problems (Homogenous Group work)	Mental Health Specialist
	15.30 – 17.00	Revised participants' constructed formulation of key mental health problems of Child and Adolescent (Plenum, all groups meet)	Consultant Psychiatrist
PHASE 2			
Field Diagnosis	08.00 – 12.00	Focus Group discussions	J. Mudenda
	14.00 – 17.00	Documentary Analysis of hospital and clinic records	Rose Ng'andu Mavis Mtonga J. Mudenda
PHASE 3			
Post Search Conference	08.00 – 13 hours	Post Search Conference Feedback Meeting	Consultant Mental Health Specialist Registrar Training
PHASE 4			
Training of Trainers	14.00 – 17.00	- Piloting the new curriculum on the trainers - Training of Trainers (ToT) on Child and Adolescent Mental Health problems	Registrar Training Mental Health Specialist J. Mudenda
PHASE 5			
Training of Practitioners	08.00 – 17.00	- Training of Practitioners on identified Mental Health Problems of Child and Adolescent - Piloting the new curriculum on the practitioners	Consultant Mental Health Specialist Registrar Training
PHASE 6			
Practicum in the Hospital	08.00 – 17.00	- Identifying Mental Health Problems - Diagnosing Mental Health Problems - Prescribing Care and Drugs - Managing the Users	Consultant Registrar Training R. Ng'andu M. Mtonga J. Mudenda
PHASE 7			
Consultative Meeting with Stakeholders	08.00 – 12.00	Presentation of report from the Secretariat (Plenary)	R. Ng'andu M. Mtonga
		Conclusions	Mental Health Specialist
		Way forward and end of workshop	Mental Health Specialist and Executive Director

ANNEXURE 7: WORKSHOP PARTICIPANTS

	NAME	DESIGNATION	PHONE NUMBER
1.	Jennifer Munsaka	Executive Director (Zambia Nurses Association, Lusaka)	097 674385
2.	Concepta Kwaleyela	Lusaka UTH Midwifery School	097 844789
3.	Sister Christetta Kapapa	Public Health Nurse Monze Mission Hospital	097 403001
4.	Pauline K. Lubemba	Nurse Lecturer Kabwe ZEM school	097 581985/223213 (05)
5.	Milimo Syanzila Maureen	Nurse Lecturer Monze ZEN school	
6.	Bertha Chipepo	Ag Registrar General Nursing Council of Zambia	095 759915
7.	Nduba Chileshe	RN Chainama Teaching Clinic/ Lusaka	097 709795
8.	Jose Justin	Clinical Officer General/ Chainama Teaching Clinic/ Lusaka	097 435175
9.	Davy E. Chiyobe	Clinical Officer Psychiatry (Ndola District Health Management Tea m)	095 993972
10.	Esther J. Chikopela	Ndola Registered Nursing School	097 633422/614859
11.	Joram Kabulaya	Clinical Officer's Association of Zambia	097 886095
12.	Getrude K. Mukanda	Lecturer (Chainama college of Health Sciences)	096 755449
13.	Marvis Mtonga	Lecturer (Chainama College of health sciences)	097 746060
14.	Rose Ng'andu	Acting Deputy Registrar (Chainama College)	097 815779
15.	Annel Bowa	Ag Registra Chainama College of Health Sciences	097 283827

ANNEXURE 8: VOTE OF THANKS FROM A PARTICIPANT

To the Executive: Director, Dr Mary Zulu.

- The consultant psychiatrist specialist: Dr Patrick Msoni
- The Director Training: Mr. John Mudenda
- The Mental health Specialist from central Board of health Mr. John Mayeya in absentia.
- The Registrar Mr. Annel Bowa, Academic and supportive staff

My fellow participants from Monze, Ndola, Kabwe and Lusaka Districts and Schools Nursing.

I am very privileged to be given this time to give the vote of thanks. This is a workshop that is starting the process to develop a curriculum for training institutions in the medical field in C&A mental health in Zambia.

The participants will agree with me that the rule which we used to collect data from the communities was very helpful, from reports we brought it showed that there is indeed need to sensitize the communities to the care for the baby antenatal and postnatal until adolescent age, for this determines that state of the adult age in future. In this workshop we saw that there are certain conditions which can be controlled if started at an early age just like any other problems for mental e.g. emotional health disorder and conduct disorders could be called if done early.

The community said that if nurses were trained in mental health these nurses would help the community they are serving to desensitize the community on detecting sign of mental problems at an early age.

The clinicians if are trained will make diagnosis early hence help will be given at the right time

The Consultant psychiatrist and Director clinical care in the workshop was praised with the teaching models proposed by Mr. John Mudenda which are: SPICES curriculum model; SYMBIOTIC curriculum model; PRISMS curriculum model; and the ASSET curriculum model

The model of choice by us was the *PRISMS* curriculum model. Then we were given a very helpful professional summary of the workshop by the consultant Dr Msoni. It was really educative and if the community is well approached, it has very good suggestions to contribute to the development of the curriculum. We hope this desire will come to its fulfillment. That one day there will be a curriculum which the trainers will follow and that the community will have scientific explanation to what is a mystery in terms of mental health among our people at country level. For the main belief of mental problems is witchcraft.

Thank you very much once more again.

By Sr Christetta Kapapa

ANNEXURE 9: PERMISSION TO CARRY OUT STUDY IN PROVINCES
CHCHBM/PCM//mm/2005

16th June 2005

The Provincial Health Director
Monze Mission Hospital
P.O Box 660029
MONZE

Dear Sir

RE: PERMISSION TO CONDUCT FOCUS GROUP DISCUSSION IN THE COMMUNITY AND DOCUMENTARY ANALYSIS OF OPD AND HOSPITAL RECORDS ON CHILD AND ADOLESCENT MENTAL HEALTH PROBLEMS IN YOUR PROVINCIAL DISTRICT – SISTER CHRISTETTA C. KAPAPA AND MRS MILIMO SYANZILA MAUREEN

The above captioned subject refers. Central Board of Health Unit in conjunction with Chainama College of Health Sciences is carrying out a workshop on child and adolescent mental health. The purpose of this workshop is to determine and identify constructed perceptions of PHC Practitioners and the community about Mental Health problems of children and adolescents in Zambia.

The expected outcomes of this workshop study shall include among others; policy direction by the Ministry of Health/Central Board of Health in the area of Mental Health viz child and adolescent mental health in Zambia; innovative curriculum development for PHC Practitioners (Registered Nurses and Clinical Officers General). The developed innovative curriculum shall be tested then rolled out in Nurse Training Colleges and Chainama College of Health Sciences.

We shall be most grateful if the above officers were permitted to conduct focus group discussion with members of the community in your district and further collect data from OPD and hospital records of children and adolescents identified with mental health problems by practitioners during the period January to December 2004 only. Permission to collect this information was already sought from the Director General and Permanent Secretary and was granted.

I am directing this workshop study in my capacity as Consultant Psychiatrist including all the processes involved therein together with the Ministry of Health/Central Board of Health Mental Health Specialist with participation of Chainama College of Health Sciences Staff.

The data collection is planned for 17th June to 19th June 2005 at the four selected sites which are; Lusaka, Ndola, Kabwe and Monze Districts.

Your favorable consideration will go a long way in the improvement of mental health services for children and adolescents as well as training of PHC practitioners in Zambia.

Yours faithfully

DR. P.C. MSONI
CONSULTANT PSYCHIATR
FOR/ EXECUTIVE DIRECTOR

ANNEXURE 10: REQUEST LETTERS TO PARTICIPANTS IN PROVINCES

Dear all.....

RE: REQUEST FOR SUPPORT TO MOTIVATE THE COLLABORATIVE ACTION RESEARCH PROCESS WORKSHOP AND SEMINAR TO BE HELD AT CHAINAMA COLLEGE OF HEALTH SCIENCES ON CHILD AND ADOLESCENT MENTAL HEALTH IN ZAMBIA, LUSAKA

A workshop has been planned to carry out a study on the Development of an innovative Curriculum in Child and Adolescent Mental Health at Chainama College of Health Sciences, Monze District, Lusaka District, Kabwe District and Ndola District Centers in Zambia.

You have been identified as a key resource person and facilitator in the workshop.

The purpose of this Workshop will be to draw the expertise of Educators and PHC Practitioners from the identified sites as well as communities from the same sites to determine what they perceive as Mental Health problems of Children and Adolescents in Zambia. Clinics and Hospital records will be analyzed to support empirical evidence of the problems.

I will appreciate your indication of willingness to support us in this workshop.

Yours sincerely

JOHN MUDENDA

ANNEXURE 11: INVITATION LETTER OF EXECUTIVE DIRECTOR

13th June 2005

The Executive Director
Chainama Hills College Hospital Board of Management
LUSAKA

Dear Madam,

RE: INVITATION TO A WORKSHOP AND SEMINAR ON CHILD AND ADOLESCENT MENTAL HEALTH AT CHAINAMA COLLEGE OF HEALTH SCIENCES FROM 15TH JUNE 2005 TO 21ST JUNE 2005

You are a key stakeholder in the above Workshop in your capacity as Executive Director of a Training College and National Mental hospital in Zambia

The purpose of this Workshop/Seminar is to draw your expertise in an effort to come up with information about constructed Mental Health Problems of children and adolescents in Zambia.

The ultimate goal of the Workshop will be to come up with an innovative curriculum in the area of child and adolescent mental health which will be integrated in the pre-service and post basic training curricula for Clinical Officers and General Nurses in Zambia.

The workshop will be co-facilitated by CBOH Mental Health Unit and Consultant Psychiatrist – Dr. P. Msoni along with Registrar Training.

I will appreciate your participation and support. The meeting starts at 08:30 hours on 15th June, 2005 and ends on 21st June 2005. The critical dates that your input will be required are 15th June, 2005 and 21st June, 2005. On the other days participants will be out conducting FGDS in Monze, Kabwe, Ndola and Lusaka districts. I will appreciate an indication of your willingness to participate and support the programme.

Yours Sincerely

JOHN MUDENDA

**ANNEXURE 12: INVITATION LETTER OF THE CLINICAL OFFICERS
ASSOCIATION**

7th June 2005

The Chairperson
Clinical Officers' Association of Zambia
LUSAKA

ATTENTION: MR Y. M. KABULAYA - CHAINAMA COLLEGE

Dear Sir

**RE: INVITATION TO SEARCH CONFERENCE ON CHILD AND
ADOLESCENT MENTAL HEALTH AT CHAINAMA COLLEGE
HOSPITAL AT CHAINAMA COLLEGE HEALTH SCIENCES**

Greeting! You have been identified as a key Stakeholder in the area of Child and Adolescent Mental Health in Zambia.

The purpose of this conference is to obtain information about constructed Mental Health problems of children and adolescents to inform the development of an innovative curriculum for PHC Practitioners (General and Nurses and General Clinical Officers) in Zambia.

I will appreciate an indication of your willingness to participate and support the process. My contact mobile number is 096 757212 or 01 – 283827.

The conference will be held on Wednesday, 15th June 2005 first one and 21st June 2005 final one.

I will appreciate your usual support.

Yours faithfully

JOHN MUDENDA

ANNEXURE 13: RESEARCH FUNDS

The Chairperson
Sida Institutional Collaboration
General Nursing Council
LUSAKA

Dear Madam

RE: REQUEST FOR RESEARCH FUNDS – K20 MILLION

I wish to request for Research funds to enable me undertake data collection. The following is the breakdown of the planned expenditure, which will comprise search conference, fieldwork, ToT, ToP practicum and consultative stakeholders meeting.

The breakdown is attached herewith.

Yours faithfully

JOHN MUDENDA
PhD STUDENT

ANNEXURE 14: RESEARCH BUDGET AND FUNDS

	SUBJECT	NO. OF PEOPLE	NO. OF DAYS	UNIT PRICE (K)	TOTAL
1.	Focal Persons	2	10	100,000	2,000,000
2.	Research Assistants	3	10	100,000	3,000,000
3.	Stakeholders	4	3	100,000	1,200,000
4.	Educators	7	10	100,000	7,000,000
5.	Practitioners	5	10	100,000	5,000,000
6.	Transport	12	2	50,000	1,200,000
7.	Contingency				600,000
TOTAL					20,000,000

ANNEXURE 15: MATRIX TABLE SHOWING REASONS FOR CHOICE OF CURRICULUM

Reasons for choice of curriculum	SPICES	PRISMS	SMBIOTIC	ASSET
The model is Qualitative				
The model cuts across				
Increases teacher- student interaction				
Multi professional				
Total				

ANNEXURE 16: INFORMED CONSENT AND AFFIDAVIT (ASSISTANT RESEARCHERS)

INFORMED CONSENT AND AFFIDAVIT
(ASSISTANT RESEARCHER)


I, ANNE C. BOWA.....lecturer at Chainama College of Health Sciences, participated in the research study as an Assistant Researcher at the request of Mr. John Mudenda in his capacity as a researcher reading for the PhD programme entitled “**perceptions and understandings about mental health problems of children and adolescents in Zambia. Implications for innovative curriculum development for PHC Practitioners**”

I hereby confirm that I facilitated the focus group discussion held a ...ADOLA.....district research site and that prior to the collection of the data from the participants, Mr. John Mudenda explained the purpose of the research study to me and together with him went through the research document and the data collection instrument and consented forthwith my willingness to support the research study. I was also at liberty to withdraw from the study at any time if I so wished.

Before the focus group discussions started, the purpose of the research was explained to all participants at my study site, I explained to the participants who I was in the study and the role I would be playing during the discussions together with my core facilitators who would be note taking and recording the proceedings of the focus group discussion.

All participants expressed their willingness to participate in the study. It was therefore felt not necessary at this point in time to subject participants to signing individual consent since they all orally and willingly consented to participate in the discussions.

Both English and Vernacular were used freely by all participants as most of them had attained at least minimum educational level where they were able to speak reasonable English. Participants were reassured that the information obtained would be anonymous and confidential.


.....

Signature of Research Assistant

24/07/07

Date

**INFORMED CONSENT AND AFFIDAVIT
(ASSISTANT RESEARCHER)**

I Ngalandu Rosemary.....lecturer at Chainama College of Health Sciences, participated in the research study as an Assistant Researcher at the request of Mr. John Mudenda in his capacity as a researcher reading for the PhD programme entitled “**perceptions and understandings about mental health problems of children and adolescents in Zambia. Implications for innovative curriculum development for PHC Practitioners**”

I hereby confirm that I facilitated the focus group discussion held at Uabwe.....district research site and that prior to the collection of the data from the participants, Mr. John Mudenda explained the purpose of the research study to me and together with him went through the research document and the data collection instrument and consented forthwith my willingness to support the research study. I was also at liberty to withdraw from the study at any time if I so wished.

Before the focus group discussions started, the purpose of the research was explained to all participants at my study site, I explained to the participants who I was in the study and the role I would be playing during the discussions together with my core facilitators who would be note taking and recording the proceedings of the focus group discussion.

All participants expressed their willingness to participate in the study. It was therefore felt not necessary at this point in time to subject participants to signing individual consent since they all orally and willingly consented to participate in the discussions.

Both English and Vernacular were used freely by all participants as most of them had attained at least minimum educational level where they were able to speak reasonable English. Participants were reassured that the information obtained would be anonymous and confidential.

.....Ngalandu Rosemary.....

24th July 2007

Signature of Research Assistant

Date

**INFORMED CONSENT AND AFFIDAVIT
(ASSISTANT RESEARCHER)**

I Gertrude H. Mwakanda lecturer at Chainama College of Health Sciences, participated in the research study as an Assistant Researcher at the request of Mr. John Mudenda in his capacity as a researcher reading for the PhD programme entitled “**perceptions and understandings about mental health problems of children and adolescents in Zambia. Implications for innovative curriculum development for PHC Practitioners**”

I hereby confirm that I facilitated the focus group discussion held at Mponze.....district research site and that prior to the collection of the data from the participants, Mr. John Mudenda explained the purpose of the research study to me and together with him went through the research document and the data collection instrument and consented forthwith my willingness to support the research study. I was also at liberty to withdraw from the study at any time if I so wished.

Before the focus group discussions started, the purpose of the research was explained to all participants at my study site, I explained to the participants who I was in the study and the role I would be playing during the discussions together with my core facilitators who would be note taking and recording the proceedings of the focus group discussion.

All participants expressed their willingness to participate in the study. It was therefore felt not necessary at this point in time to subject participants to signing individual consent since they all orally and willingly consented to participate in the discussions.

Both English and Vernacular were used freely by all participants as most of them had attained at least minimum educational level where they were able to speak reasonable English. Participants were reassured that the information obtained would be anonymous and confidential.



24-07-07

Signature of Research Assistant

Date

**INFORMED CONSENT AND AFFIDAVIT
(ASSISTANT RESEARCHER)**

I MAVIS D.M. MTONGA.....lecturer at Chainama College of Health Sciences, participated in the research study as an Assistant Researcher at the request of Mr. John Mudenda in his capacity as a researcher reading for the PhD programme entitled “**perceptions and understandings about mental health problems of children and adolescents in Zambia. Implications for innovative curriculum development for PHC Practitioners**”

I hereby confirm that I facilitated the focus group discussion held at LUSAKA.....district research site and that prior to the collection of the data from the participants, Mr. John Mudenda explained the purpose of the research study to me and together with him went through the research document and the data collection instrument and consented forthwith my willingness to support the research study. I was also at liberty to withdraw from the study at any time if I so wished.

Before the focus group discussions started, the purpose of the research was explained to all participants at my study site, I explained to the participants who I was in the study and the role I would be playing during the discussions together with my core facilitators who would be note taking and recording the proceedings of the focus group discussion.

All participants expressed their willingness to participate in the study. It was therefore felt not necessary at this point in time to subject participants to signing individual consent since they all orally and willingly consented to participate in the discussions.

Both English and Vernacular were used freely by all participants as most of them had attained at least minimum educational level where they were able to speak reasonable English. Participants were reassured that the information obtained would be anonymous and confidential.

Mtonga.....

24-07-07

Signature of Research Assistant

Date

ANNEXURE 17: RESEARCH PARTICIPATION CONSENT FORM FOR PHC PRACTITIONERS

Research Participation Consent Form for PHC Practitioners

I, NDUBA... NHOVA... CHILESHE.....(full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT



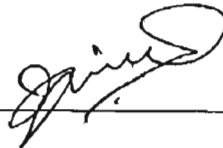
DATE 18.06.05

Research Participation Consent Form for PHC Practitioners

I, JOSE JUSTIN.....(full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT



DATE 18/06/05

Research Participation Consent Form for PHC Practitioners

I, GEORGE K. MUKANDA.....(full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT



DATE 15/06/05

**ANNEXURE 18: PERMISSION TO CARRYOUT THE STUDY FROM
PERMANENT SECRETARY MINISTRY OF HEALTH**

All correspondence should be addressed to the
Permanent Secretary
Telephone: 253040/5
Fax: 253344

Prof. Mubwa



REPUBLIC OF ZAMBIA

MINISTRY OF HEALTH

In reply please quote

No:.....

29th March 2005

NDEKE HOUSE
P.O.Box 30205
LUSAKA

Mr. John Mudenda
Director Training and PhD Student
Chainama College of Health Sciences
P.O. box 33991
LUSAKA

**RE: PERMISSION TO CARRYOUT A RESEARCH STUDY IN CHILD
AND ADOLESCENT MENTAL HEALTH AS PARTIAL FULFILLMENT
OF PhD STUDIES WITH KWAZULU NATAL UNIVERSITY IN
SOUTH AFRICA.**

I am in receipt of the letter with the above subject matter.

I wish to state that I have no objection in you carrying out the said study.
The Ministry will be pleased to have such research conducted in order to have
evidence based planning and policy development.

Yours faithfully

Dr. S. K. Mitt
Permanent Secretary
MINISTRY OF HEALTH

**ANNEXURE 19: PERMISSION TO CARRYOUT THE STUDY FROM THE
DIRECTOR GENERAL IN HOSPITAL BOARDS**

Prof. Mbal:



CENTRAL BOARD OF HEALTH

P.O. BOX 32588, Ndeke House, Lusaka, Zambia
Telephone: 260-1-253180/81/82. Telefax: 260-1-253173

13th June 2005

Mr John Mudenda
Director, Training & PhD Student
Chainama College of Health Sciences
P O Box 33991
LUSAKA

Dear Sir

**PERMISSION TO CARRYOUT RESEARCH STUDY IN CHILD AND
ADOLESCENT MENTAL HEALTH AS PARTIAL FULFILMENT OF PhD
STUDIES WITH KWAZULU NATAL UNIVERSITY IN SOUTH AFRICA**

We wish to acknowledge receipt of your letter and summary outline of your study proposal dated 2nd March 2005. The Central Board of Health grants you approval to conduct the study proposal provided there is approval from the UNZA/SOM/UTH ethical committee.

We wish you all the best.

Yours faithfully


Dr B U Chirwa
DIRECTOR GENERAL

11. REFERENCES / BIBLIOGRAPHY

- 21ST CENTURY SCHOOLS (2004) *Designing a Curriculum- Curriculum Theory and Critical Pedagogy in the 21st century.*
- ABBATT, F. R. (1980) *Teaching for Better learning*, Geneva, World Health Organization.
- ABBATT, F. R. (1988) *Teaching for better learning: a guide for teachers of primary health*, Geneva.
- ACACE (1979a) *Towards Continuing Education*, Leicester.
- ADELSON R (1974) Reasons for participation in and needs for continuing professional education among health workers.
- AINSWORTH, M. D. S. (1973.) *The development of infant mother attachment: Attachment theory and its utility in cross-cultural* Chicago, University of Chicago Press.
- AJZEN, I. (1990) The theory of Planned Behavior. *Organizational Behavior and Human Decision Processes.* 50, 179 - 211.
- ALBANESE, M. A., MITCHELL S. (1993) Problem-based learning: a review of literature on its outcomes and implementation issues. *Acad Med* 68, 52-81.
- ALTRICHTER, H. (1990) Do We Need an Alternative Methodology for Doing Alternative Research? *Action Research for Change and Development.* Brisbane.
- ALTRICHTER, H. (1991) Towards a Theory of Teaching Action Research: Paper presented at the First World Congress on Action Learning. *World Congress on Action Learning*, Brisbane. Action Research and Process Management,.
- ALTRICHTER, H. (1994) *Action research for change and development*, Aldershot, Gower.
- AMERICAN EDUCATIONAL RESEARCH ASSOCIATION (1985) *Higher education Handbook of theory and research: Association for Institutional Research.* .
- ANDERSON, L. (1993) Espoused theories and theories in use: bridging the gap. Breaking through defensive routines with organization development consultants. The University of Queensland , Department of Psychology.
- ANNA FREUD (1937) *The Ego and the Mechanisms of Defense*, London Horgath Press.
- ANTHONY, E. J. (1970) *The Behavior Disorders of Children.* In P. H. Mussen (Ed), *Carmichael's Manual of Child Psychology*, New York, Willey.
- APPLETON, J. (1992) At my Age I should be sitting under that tree. 8, 19-27.
- ARENA, L. (1977) International Classification of Diseases (ICD).
- ARGYRIS (1985a) *Strategy, change and defensive routines*, Boston, Pitman.
- ARGYRIS, C. (1991) Teaching Smart People How to Learn. *Harvard Business Review*, 69(3), 99-109.
- ARGYRIS, C. H., AND SCHÖN, DONALD A. (1989) Participative action research and action science compared: a commentary. *American Behavioral Scientist*, 32, 612 - 623.

- ARGYRIS, C. P., ROBERT AND SMITH, DIANA MCLAIN CA. (1985b) *Action science: concepts, methods and skills for research and intervention.* , San Francisco, Jossey-Bass.
- ARGYRIS, C. S., DONALD A. (1974) *Theory in practice: increasing professional effectiveness.* San Francisco, Ca Jossey-Bass.
- ARIÈS, P. (1960, 1982.) *Centuries of Childhood*, Australia Ltd.
- ASBURY, J.-E. (1995) Overview of focus Group Research, *Qualitative Health Research*. Vol. No 5(4), 414-420.
- ASHLEY, M. (1989) Ideologies and Schooling in South Africa. 2.
- BABBIE, A. M. (2002) *The Practice of Social Research*. University Press.
- BABBIE, E. A. M., J. (2001) *The Practice of Social Research*. Oxford University Press.
- BAHNSON, C. B. (1969) Premorbid psychological factors as related to cancer incidenceloss. The statistics on bereavement of spouses, by the way, are very intriguing. *Health* 64, 1034-1055.
- BAIK, H. Y. (1992) Curriculum Development: Problems, Processes, and Progress.
- BAIRD, L. (2003) U.K Study of what being a Practice Nurse really means.
- BARNETT, J. E. (1994) Working with Student Diversity: Contexts, Issues and Strategies in the University of South Australia. *The CUTL Inclusive Curriculum Research Project*. Underdale, Centre for University Teaching and Learning.
- BARONDES, S. (1993) Mental Health: A Report of the Surgeon General - Chapter 2: Etiology of mental disorders.
- BASSEY, M. (1998) *Action Research for Improving Educational Practice*, Open University Press.
- BAUGH, P., T. (1990) *closing the gap between research and policy*, Washington (DC), National Academy Press.
- BAUMRIND, D. (1975) *Early Socialization and Adolescence Competence* New York John Willey.
- BAWDEN, R. J. (1991) Systems Approaches to Agricultural Development: *Paper presented at the International Symposium on Systems Approaches to Agricultural Development*. The Hawkesbury Experience.
- BBC NEWS (2003) Castrate Child Rapists in Zambia. *Parliamentary Committee on Legal Affairs*. London, BBC News Online.
- BEAUCHAMP, T. C., J. (1995) Principles of Biomedical Ethics. *Clinical Research and Regulatory Affairs*, 12, 95109.
- BELL, J. S. (1993) Discussion of the Teacher as a Bridge Between Programme and Practice Vol 27, No 3, 467-475.
- BELL, J. S. (1999) An action research study of the effectiveness of problem-based learning in...
- BEM, S. L. (1987) Masculinity and Femininity exist only in the mind of the perceiver. (Eds). . *Masculinity / Femininity : Basic perspectives*. New York, Oxford University Press.
- BENEDICT, R. (1938) Continuities and Discontinuities in Cultural Conditioning. *Psychiatry*. Vol 1, 161-167.
- BERNSTEIN, B. (1971) *Open Schools, Open society?*, Cambridge Massachusetts, MIT Press.

- BERNSTEIN, B. (1996) *Pedagogy, Symbolic Control and Identity*, London, Taylor and Francis.
- BERTALANFFY, L. V. (1968) *General Systems Theory: Foundations, Development, and Applications*. New York, Braziller.
- BEYER, L. E. (1986) The Reconnstruction of Knowledge and Educational Studies *Journal of Education*, 168.
- BISH, A. J. (1992) An action research evaluation of mechanisms for reflection in a postgraduate psychology course. *St Lucia: Department of Psychology*. St Lucia:.
- BLIGH, J. (1986) PRISMS Curriculum Model. , Vol 35, 520-521.
- BLIGH, J. (1995) Problem-based learning in medicine: an introduction. *Postgrad Medical Journal.*, 71, 836.
- BLIGH, J. (1997) Models of Faculty Development for Problem-based Learning.
- BLIGH, J. (2001) Learning from uncertainty: a change of culture. *Medical Education*, 35, 2-3.
- BLOCK, J. H., & BLOCK, J. (1980) The role of ego-control and ego-resiliency in the organization of behavior. Hillsdale, N.J., Lawrence Erlbaum Associates (Wiley).
- BLOS, P. (1962, 1967) *On Adolescence*. London Collier-Macmillan.
- BLUMBERG, P., AND ECKENFELS, E. (1998) environment in a traditional and a problem-based curriculum
- BORGDAN, R. C. & BILKEN, S. K. (2003) *Qualitative Research for Education: An introduction to Theory and Methods*, Boston, Mass:, Allyn and Bacon.
- BOSK, C. (1979) *Forgive and Remember: Managing Medical Failure.*, Chicago University of Chicago Press.
- BOUMA, G. D. (2000) *The Research Process IN 4TH* (Ed.) New York Oxford University Press.
- BOWLBY, T. E. (1969) *Attachment and Loss*, New York, Basic Books.
- BRANDA, L. A. (1986) Changes in Medical Education for National Health Manpower for the 21st Century.
- BRIM, O. G. (1965) Adolescent Personality as Self-Other Systems. *Journal of Marriage and the Family*, Vol 27, 155-162.
- BRONFENBRENNER, U. M., P. A. (1998) The ecology of developmental processes. IN LERNER, I. W. D. S. E. R. M. (Ed.) *Handbook of child psychology: : Theoretical models of human development*. New York, Wiley.
- BROOKFIELD, S. D. (1986) *Understanding and Facilitating Adult Learning*. England Open University Press 12 Cofridge Close, Stony Stratford.
- BROOKS-GUNN, E. A. (1997) Concentrated Poverty vs. Concentrated Affluence: Effects on Neighborhood Social Environments and Children's Outcomes
- BRUNNER, G. (1961 1) *Retardation and Idiocy:the Intellectual and Conceptual Development of Retarded Children*, New York, London: Butterworths.
- BURNARD, P. (1990) A method of analysis interview transcripts in qualitative research. *Nurse Education Today*, Vol.2, 461-466.
- BURNS, R. B. (1990) *Introduction to Social Research in Education*. Melbourne, Longman Cheshire.

- CAFFEY, A., AND PAUL ATKINSON. (1996) *Making Sense of Qualitative Data*, Thousand Oaks, CA, Sage Publications.
- CAMBOR, R. L., MILLMAN, R B. (1990) Alcohol and drug abuse in adolescents: Substance Abuse and Centre for Addiction and Mental Health
- CANAVAN, G. H., AND LILLEY J. F. (1985) Managing Public Sector Research and Development: Innovation Versus Responsiveness. . IN TECHNOLOGIES., I. D. (Ed.) New York, Praeger.
- CANNON, W. B. (1914) The interrelations of emotions as suggested by recent physiological researchers. *American Journal of Physiology*, 25, 256-282.
- CAREY, J. (1995) Children's Understanding of Illness: The Generalization of Illness
- CARR, W. K., S (1986) *Becoming Critical: Education, Knowledge, and Action Research*, London, Falmer Press
- CARTER, C. S., A. C., BAKER, M., & MIWA, K. (2003) Developmental and behavioral needs and service use for young children in child welfare.
- CASSEL, J. C. (1976) The contribution of social environment to host resistance. *Am J Epidemiol: PubMed*, 104, 107-23. .
- CFRA (1999.) Manuel de Formation en Research Action.
- CHAMBERLIN, C. W.-C. D. (1889) *The Uncommon Sense Of Applied Psychology*.
- CHAMBERS, R. (1981) Rapid rural appraisal: rationale and repertoire. *Public Administration and Development*.
- CHAMPION, L. A., GOODALL, G. & RUTTER, M. (1995) Behavior problems in childhood and stressors in early adult life. *Psychological Medicine*, I 25, 231-246.
- CHANSHI, J. (1987) Government Statement and Call for Care and Support of Children and Adolescents with Mental Health Problems. *National Mental Health on Child and Adolescent Mental Health Lusaka*, Unpublished.
- CHASE-LANSDALE, E. A. (1995) Children and Familial Economic Welfare: The Effect of Income on Child Development.
- CHATLOS, J. C., S. (1996) *Recent Trends and a Developmental Approach to Substance Abuse in Adolescents, in Child and Adolescent Psychiatric Clinics of North America*, Phila, W.B. Saunders.
- CHECKLAND, P. (1981) *Systems thinking, systems practice*, Chichester:, Wiley.
- CHECKLAND, P. (1990) *Soft systems methodology in action* Wiley.
- CHECKLAND, P. (1991) From Framework Through Experience to Learning: the Essential Nature of Action Research. Amsterdam, Elsevier.
- CHILD, D. (1997) Psychology and the Teacher IN 6TH (Ed.) London Cassel.
- CHINTU, L. (1987) Pediatrics' Practice and the Children/Adolescents with Mental Health Problems. *National Mental Health Resource Center Conference Lusaka*, Unpublished.
- CHRISTIE, P. (1992) Curriculum: Report of the NEPI Curriculum Research Group Cape Town Oxford University Press.
- CLIFFORD, D. (2007) *Designing and Conducting Research in Education*.
- COHEN, L., MANION, L. AND MORRISON, K (2000) Teaching and Learning for Health Professionals: Research Methods in Education. . IN 5TH (Ed.) London and New York. , Routledge Falmer.
- COHEN, L. A. M. L. (1994) *Research Methods in Education.*, Routledge

- COLEMAN, J. V. E. A. (1979) Collaboration, Consultation and referral in an integrated health mental health program at an HMO. *Social in Health Care*, 5, 833-896.
- COLLINS, E. W. A. S., M. (1999) The Role Of Public Policies In Reducing Mental Health Status and treatment plan and delivery of services matching each child's needs. *Annual Review of Public Health*, 20.
- COLLINS, J. W. A. S., M. (1991) Impact of Child, Adolescent, and Women's Health on Maternal and in Maternal and Child Health and mental health status 35-37.
- CONGER, R. D., GE, X., ELDER, G. H., LORENZ, F. O., & SIMONS, R. L. (1993) Economic stress, coercive family process, and development problems of adolescents. *Child Development*, 65,, 541-561.
- COOMBS, P. H. A. A., M. (1974) *Attacking Rural Poverty. How non-formal education can help*, , Baltimore, John Hopkins University Press.
- CORNBLETH (1990) Curriculum in Context.
- COUGHLAN, F. J., AND COLLINS, K. J. (2001) Participatory Developmental Research. 4, 505-518.
- CRESWELL, J. W. (2002) Educational Research: Planning, Conducting, and evaluating Quantitative and Qualitative Research. Upper Saddle River, NJ: Merrill Prentice Hall.
- CRIBB, A. (2000) The Diffusion of the Health Agenda and the Fundamental Need for Partnership in Medical Education. *Medical Education*, Vol. 34, 916-920.
- CRONBACH, L. J. (1971) *Educational Measurement. A Comprehensive Discussion of Validity*, Washington D.C., American Council of Education.
- CYERT, R. (1990) Problem Solving and Educational Policy. Hillside, NJ: Laurence Erlbaum Associates.
- DAVIES, L. L., P. (1991) *Information in Action: Soft Systems Methodology.*, Houndmills, Hampshire, MacMillian Education Limited.
- DAWES, A. (1994) Understanding the Psychological Consequences of Diversity. . IN PHILIP, D. (Ed.) Cape Town.
- DAWES, A. ET AL (1997) Child and Adolescent Mental Health. Cape Town Multimedia Publications.
- DE VOS, A. S. (2002) Qualitative Data Analysis and Interpretation.
- DENSCOMBE, M. (1998) *The good research guide for small scale social research projects*, Buckingham:, Open University Press.
- DENZIN, N. K. (1970) *Sociological Methods: A Source Book*, Chicago, and Aldine.
- DENZIN, N. K. A. Y. S. L., ED. , (1994) *Handbook of Qualitative Research*, Thousand Oaks, CA, Sage.
- DENZIN, N. K. Y. S. L. E. (1985) Inquiry and Fourth Generation Evaluation.
- DEWEY, J. (1897, 1961) 'My Pedagogic Creed'. . *Pragmatism, Education, Democracy* Bloomington Indiana University Press.
- DEWEY, J. (1916) Method in Science Teaching. *Science Education*, 1, 3-9.
- DEWEY, J. (1929) *Art and education* Barnes Foundation.
- DEWEY, J. (1961) *Democracy and Education* New York Macmillan
- DEWEY, J. (1998) *The moral self*, Bloomington, IL, Indiana University Press.
- DICK, B. (1990b) *Rigor Without Numbers: the Potential of Dialectical Processes as Qualitative Research Tools.*, Chapel Hill, Interchange.

- DICK, B. (1994,1995) *Courage To Change: The Christian Roots of the Twelve-Step Movement*. 2 ed.
- DICK, B. (1995) *Rigor and Relevance in Action Research*, Chapel Hill: , Interchange.
- DICK, B. (2000) *A beginner's guide to action research Lismore:* , Southern Cross Institute of Action Research.
- DICK, B. (2001) *Action research: Action and research*. . Lismore, Southern Cross University Press.
- DICK, B. A. D., T. (1990) *Values in action: applying the ideas of Argyris and Schön*. , Chapel Hill, Qld, Interchange.
- DICK, B. K. (1990) *Search: a Participative Community Planning Process including Participant workbook*
Chapel Hill, Interchange.
- DIMATTEO, M. R., HASKARD, K.B., & WILLIAMS, S. L. (2007) Health beliefs, disease severity, and patient adherence: A meta-analysis. *Medical Care*, 45, 521-528.
- DODGE, K. A., PETTIT, G. S., & BATES, J. E. (1994) Socialization mediators of the relation between socioeconomic status and child conduct problems. . *Child Development* 65), 649-665.
- DUBOW, E. F., & IPPOLITO, M. E. (1994) Effects of poverty and quality of the home environment on changes in the academic and behavioral adjustment of elementary school-age children. *Journal of Clinical Child Psychology*, 23, 401-412.
- DUFFY, T. M. J., D.J., EDS. () . (1992) *Constructivism and the Technology of Instruction: a Conversation*, Hillsdale, , NJ: Lawrence Erlbaum Associates.
- DUNCAN, G. J., BROOKS-GUNN, (1997) Economic deprivation and early childhood development. . *Child Development*, 65,, 296-318.
- DUNCAN, G. J., BROOKS-GUNN, J., & KLEBANOV, P. K. (1994) Economic deprivation and early childhood development. . *Child Development*, 65, 296-318.
- DUNCAN , G. J. A. R., W. H. (1977) The Influence of Parental Income on Children's Outcomes. *Statistical papers. Series*
- DUNCAN, S. C. ET AL, (1998) Contributions of the Social Context to the development of the Adolescent substance use: A multivariate latent growth modeling approach. *Drug and Alcohol Dependence*, 50, 57-91.
- DURRHEIM, K. A. W., D. (2002) *“Putting Design into Practice: Writing and Evaluating Research Proposals”* Cape Town University of Cape Town Press.
- EDUCATION FACILITATORS (1998) *Theory of Education* . , Azaliah College of Further and Higher Education.
- EISNER, E. (1994) *The Educational Imagination: On the Design and Evaluation of School Programs*, New York MacMillan College Publishing.
- EIZENBERG, N. (1990) *Action Research in Medical Education: Improving Teaching via Investigating Learning*. . Brisbane:, Griffith University.
- ELDER, G. H. (1968) *Adolescent Socialization and Development*, New York, John Wiley.
- ELLIOT, J. (1991) *Action Research for Educational Change*, Buckingham: , Open University press.

- ENGEL, G. L. (1977) The need for a new medical model. 196, 129–136.
- ENTWHISTLE, N. J. (1988) *Styles of Learning and Teaching: An Integrated Outline of Educational Psychology*. London David Fulton:.
- EPSTEIN, R. M., BORRELL-C. F, (2005) The biopsychosocial model: exploring six impossible things. *Families, Systems & Health*.
- ERICKSON (1963) *Childhood and Society*, , New York, WW Norton.
- ERNEST, P. (1991) *The Philosophy of Mathematics Education*, London Farmer Press.
- FAGOT, B. I. P., G. R. (1969) An in vivo analysis of reinforcing contingencies for sex role behaviors in the pre-school child. *Developmental Psychology*, 1, 566- 568.
- FIELDING, N. G. A. F., JANE L. (1986) *Linking data: The articulation of qualitative and quantitative methods in social research*., Beverly Hills, Ca, Sage.
- FINK, A. (1995) *Health Education System With Older Primary Care Patients: MS, Division of Alcohol Studies Pacific*.
- FLANAGAN, J. R., LEDERMAN, S.J. (2001) Neurobiology: Feeling bumps and holes, News and Views. *Nature*, 412(6845), 389-91.
- FLISHER, A. K., R.GROSSER, R. ET AL. (1997) Correlates of unmet need for mental health services by children and adolescents. . *Psychol Med*, 27, 1145-54.
- FLISHER, E. A. A. R.-S., ANDERSON, (1993, 1994, 1998) Drug use among South African young people: Alcohol, cigarettes, illicit, injecting, inhalants; and illicit drugs. .
- FOUCAULT, M. (1965) *Madness and Civilization: A History of Insanity in an Age of Reason. Nonfiction; Mental Health and Mental Illness*, Resources.
- FRANCIOSI, L. P. (2003) Setting Priorities and Directions. World Health Organization
- FRASER, W. E. A. (1993) *Didactics for the Undergraduate Student*. , Durban Butterworths.
- FREIRE, P. (1972) *The Pedagogy of the Oppressed*, London Sheed and Ward.
- FREIRE, P. (1990) Mentoring the mentor: A critical dialogue with Paulo Freire. IN AL., J. F. E. (Ed.).
- FREIRE, P. (1998) *Teachers as Cultural Workers : Letters to Those Who Dare to Teach* Boulder, Colorado, West view Press.
- FRENCH, W. L. B., C. H. (1995) *Organizational Development: Behavioral Science Interventions for Organization Improvement*, Englewood Cliffs, Prentice Hall.
- FREUD, A. (1937) *The Ego and the Mechanisms of Defense*, London Horgath Press.
- FRIEDENBERG, L. (1995) *Psychological testing: Design, analysis, and use*, W. & Peake, P. K.
- FRIEDMAN, H. L. (1989) The health of Adolescents: Beliefs and Behavior. *Social Sciences and Medicine*. 29, 309-315.
- FULLAN, M. (1993) *Change Forces: Probing the Department of Educational Reform*. , London, New York and Philadelphia, The Falmer Press.
- FULLAN, M. W. S., S. (1991) *The New Meaning of Educational Change*, New York Teachers Collage Press.
- GAMBLE, D., BLUNDEN, S., KUHN-WHITE, L., VOYCE, M. & LOFTUS, J. (). (1995) *The Transfer of the Farm Family Business in a Changing Rural Society*. , University of Western Sydney, Hawkesbury.
- GARMEZY, N. (1985) Protective factors in children's responses to stress and disadvantage. Hanover, NH: University Press of New England.

- GELLER, B. E. A. (2001) Bipolar Disorder at Prospective Follow-up of Adults who had Pre-pubertal Major Depressive Disorder. *American Journal of psychiatry.*, 158, 125-127.
- GENERAL NURSING COUNCIL OF ZAMBIA (1997) Education and Training of Nurses and Midwives. IN ZAMBIA, G. N. C. O. (Ed.), General Nursing Council of Zambia.
- GERBER, R. L., C. LARSSON, S. & SVENSSON, L. (1995) Approaches to learning in a work context. *6th EARLI Conference*. Nijmegen, The Netherlands.
- GIEL, R. A. E. A. (1981) Childhood disorders in the Primary Health Care. *Pediatrics* 68, 677-683.
- GIROUX, H. (1988) *Schooling and the Struggle for Public Life: Critical Pedagogy in the Morden Age* Minneapolis Minnesota Press.
- GIROUX, H. E. A. (1983) *Curriculum and Instruction*, McCutcheon, Berkely, California.
- GLIK, D. C. P. K. (1990) Empowerment Process Model for Implementing Participatory Strategies
- GOLAFSHANI, N. (2003) *Education for the Professions: Quis custodiet*, Surrey., Society for Research into Higher Education and NFER-Nelson.
- GOLDON (1960) Qualitative Methods in Research on Teaching. *Handbook of Research*.
- GOODLAD, J. (1984) A place called school: Prospective for the future. . *Journal of In-service Education* 24 441-457.
- GOODLAD, J. A. R., M. (1966) *The Development of a Conceptual System for dealing with the Problem of Curriculum and Innovation*, Los Angeles, University of California Press.
- GOODSON, B. (1993.) *Articulation, Policy change, Curriculum Development, and the Generation of Change in Schools-Equity and Choice vn*.
- GOODYER, I. M. ET AL (1990) The friendships and the recent life events of anxious and depressed school-age children. *British Journal of Psychiatry*, 156, 689-698.
- GOODYER, I. M. ET AL (2000a) Recent life events, cortizol, dehydroepiandrosterone and the onset of major depression in high - risk adolescents. *British Journal of Psychiatry*, 177, 499-504.
- GOUWS, D. J. (1998) *Research with a view to implementation* Human Sciences Research Council,
- GRAZIANO, A. M. R., M. L. (1993) *Research Methods: A Process of Inquiry*, New York: , Harper Collins.
- GREEFF, M. (2002) *Information Collection: Interviews*, Pretoria., Van Schaik Publishers.
- GREENE, K. (1991) *Health Promotion Planning: An Educational and Environmental Approach maintain view.*, Mayfield Publishing Company.
- GREENFIELD, P. (1994)) Independence and interdependence as developmental scripts: Implications for the theory, research, and practice. New Jersey, Hillsdale Erlbaum.
- GREENWOOD, J. (1994) *Action Research and Action Rearchers: SomeI Introductory Considerations* . .

- GRIFFIN, C. (1983) *Curriculum Theory in Adult and Lifelong Education* London, Croom Helm.
- GRORTY, M. (1993) Curriculum issues related to the newly developed Nursing Diploma Courses. *Nursing Education Today*, 13244- 269.
- GRUNDY, S. (1982) *Three Modes of Action Research*.
- GRUNDY, S. (1988) *Three modes of action research*. . Geelong: , Deakin University Press.
- GRZ/UNICEF (1986) *Situation Analysis of Children and Women in Zambia. "The Turner Report" Report to the Government of Zambia on Incomes*
- GUBA, E. G. (1981) *Criteria for assessing the trustworthiness of naturalistic inquiries*, San Francisco, Jossey-Bass.
- GUBA, E. G. (1990) *The paradigm dialogue*, Newbury Park, Sage.
- GUBA, E. G., & LINCOLN, Y. S. (1989a) *Fourth generation evaluation*, Newbury Park CA, Sage.
- GUBA, E. G. A. L., Y.S. (1989b) *Fourth generation evaluation*, Newbury Park, Ca, Sage.
- GUEYE, B. (1999) *Wither participation? Experience from Francophone West Africa*, London.
- GUMMESSON, E. (1991) *Qualitative methods in management research*, Newbury Park, Sage.
- GUSTAVSEN, B. A. E., P.H (1986) *The Design of Conferences and the evolving role of democratic dialogue in changing working life. Human Relations*.: , : .
- GWELE, N. S. (2005) *Curriculum Development in Nursing: Process and Innovation*. . London and New York, Routledge, Taylor and Francis Group.
- HALLIGAN, P. W., & AYLWARD, M. (EDS.) (2006) *The Power of Belief: Psychosocial influence on illness, disability and medicine*, , London, Oxford University Press.
- HAMMERSLEY, M. & ATKINSON, P. (1995) *Action Research in Health and Social Care*.
- HANNERZ, U. (1984) *Cultural Complexity: Studies in Social Organization of Meaning*, New York, Columbia University Press.
- HANSON, R. K. (1997) How to know what works with sex offenders. *Sexual Abuse. A Journal of Research and Treatment*, 9, 129-145.
- HARDEN, J. (1996) "Enlightenment, empowerment and emancipation: the case for critical pedagogy in nurse education." *Nurse Education Today* 16, 32-37.
- HARDEN, R. M. (1984) Educational Strategies in Curriculum development. 18, 284-297.
- HARDEN, R. M. (1986) Ten Questions to ask when planning a course or Curriculum. . *Medical Education Booklet*. 20 ed.
- HARMSE, M., POTHAS, A., M., & DE WET, A. G (2002) Action research on operations research for street children. . 15(1), 37-49.
- HARRINGTON, R. A. H., L. (1999) Unproven assumptions about the impact of bereavement in Children and Adolescents. *Journal of Child Psychology*.
- HART, E., & BOND, M. (1984) *Action Research for Health and Social Care*, Buckingham:, Open University Press.

- HAWORTH, A. (1987) Alcohol and Drug Abuse in Youth. Lusaka, National Mental Health Resource Center.
- HAWORTH, A. E. A. (1972) Introduction of 'INSET' at Chainama Hills Hospital for Thursday Clinical Demonstrations for Doctors, COS and Nurses.
- HEALTH AND WELFARE CANADA (1989) Canadian Statistics : Health and Welfare Canada: Alcoholism, Drug abuse, Domestic Abuse, Child Neglect, and Substandard Housing and Heavy Drinkers in the Aboriginal population. .
- HEIDER, E. R. (1997) Probability, Sampling, and Ethnographic Method: The Case of Dani Color Names. 448-466.
- HELLRIGEL, D. (2002) *Management : a competency-based approach* Publisher: South-Western
- HENDERSON, N. R. (1995) A Practical Approach to Analyzing and Reporting. Focus Groups Studies. *Qualitative Health Research*. , 4.
- HENNING, E. H. E. A. (2004) *Finding your Way in Qualitative Research*, Pretoria, Van Shaik Publishers.
- HERBST, D. (1980) Model of Representation in Meetings and Issue of Ownership
- HERON, J. (1985) The Role of Reflection In a Co-operative Inquiry. New York:, Kogan Page.
- HICKMAN, L. A. (1998) Introduction. Reading Dewey: Interpretations for a postmodern generation. Bloomington Indiana University Press.
- HOLLINGSWORTH, S., DADDS, M., & MILLER, J. L. (1997) Issues in in-service education. Impact: . *The Journal of New York State Association for Supervision*.
- HOLMES, A. R. (1967) Men's Health. Mental Health. *Stem Cells Women's Health*
- HOLTER, I. M., & SCHWARTZ-BARCOTT, D. (1993) Action research: What is it? How has it been used, and how can it be used in nursing? *Journal of Advanced Nursing*,, 18, , 296-304.
- HOPKINS, D. (1996) Models Presented at Seminar at the Innovation Centre, . *Innovation Center Durban* University of Natal. Durban.
- HOPKINS, D. E. (1999) International Handbook of Educational Change *Association for Supervision and Curriculum Development (ASCD)*.
- HOPKINS, D. E. A. (1994) *School of Improvement in an Era of Change*, London, Cassel.
- HOULE, C. O. (1967) The Role of Continuing Education in Current Professional Development. *American Library Association Bulletin*, vol.61(3), 259-267.
- HUSSEIN, K. (1996) *Francophone and Anglophone Approaches to local People's Participation in Development*, London:, IDP.
- INGRAM, I. M. (1985) Social Adversity in Childhood and the Risk of Developing Psychosis.
- JACKSON, M. C. (1991) *Systems Methodology for the Management Sciences*, New York, Plenum.
- JACKSON, P. W. (1968) *Life in Classrooms*, New York:, Holt, Rinehart & Winston.
- JAMA (1977) The journal of the American Medical Association. *Journal of continuing education in nursing*54, 56-69.
- JARVIS, P. (1983) *Adult and Continuing Education*. , London, Groom Helm.
- JARVIS, P. (1988) *Adult and continuing education: theory and practice*., London.

- JARVIS, P. (1999) *International dictionary of adult and continuing education* Kogan Page.
- JESSOR, R. D., J.E.AND COSTA, F. (1991) *Beyond Adolescence: Problem Behavior and the young Adult Development.*, New York, Cambridge University Press.
- JOHNSON, B. (2007) *Educational Research, Quantitative, Qualitative, and Mixed Approaches.*
- KAMMER, L. (1935) *Child Psychiatry : Recognition of Childhood Stages*, Springfield, Illinois, Charles, C. Thomas.
- KAPUSA, E. R. A. G. P. (1978) Introduction of 'INSET' for Nurses and Clinical Officers Chainama Hospital. Lusaka Chainama Hospital.
- KAstrup, M. (1976) Psychiatric Disorders Amongst Preschool Children in Geographically Delimited Areas of Aarkus Country. *Acta Psychiatry: Scandinavia*, 54, 29-42.
- KELLY (1982) *The Curriculum: Theory and Practice* London, Paul Chapman.
- KELLY (1989) *The Curriculum: Theory and Practice.*
- KEMMIS, S. (1991) Improving education through action research. IN O. ZUBER-SKERRITT (Ed.) *Action research for change and development.* Aldershot: , Gower. .
- KEMMIS, S. A. M., R. (1988) *The Action Research Planner*, Geelong,, Deakin University Press.
- KEMMIS, S. M., R. (1988a) *Introduction.* , Victoria Deakin University.
- KEMMIS, S. M., R. (EDS.). (1988b,) *The Action Research Planner*, Melbourne:, Deakin University
- KEMMIS, S. P. (1990) *Improving Education Through Action Research*, Brisbane, Q, ,Centre for the Advancement of Learning and Teaching (CALT).
- KERR, J. (1968) "The Problem of Curriculum Reform": In: Kerr, T.(Ed).*Changing the Curriculum.* London, ULP.
- KILGOUR, D. (1995) Whither Educational Thinking? . *Canadian Social Studies Magazine.*
- KINCHELOE, J. S., S. AND TIPPINS, D. (1976) Evaluation of Training in Robert L. Craig.
- KITUA, A. Y., MARSHALLA, Y. J. S., & SHIJA, J. (2000) Coordinating health research to promote action: The Tanzanian experience. *British Medical Journal*, 321, 821-823.
- KLIEBARD, H. M. (1992) *Curriculum Development in the Postmodern Era. Historical Perspectives.*
- KNELLER, G. F., 1968. (1974) *Education and economic thought*, New York: , John Wiley.
- KNOWELS, M. S. (1978) *The Adult Learner: A Neglected Species.* , Texas, Gulf.
- KNOWELS, M. S. (1980) *The Modern Practice of Adult Education Andragogy Versus Pedagogy*, Chicago, Follet.
- KNOWLES, J. G. (1998) Reforming teacher education through self-study.
- KOLB, D. (1984) *Experiential Learning. Experience as the Source of Learning and Development.*, New Jersey Prentice-Hall.

- KONAYUMA, J. (1987) The Problem of Teenage Sub - Culture and Control. *National Mental Health NRDC Lusaka*, Unpublished.
- KOTLER, L. A. E. A. (2001) Longitudinal Relationships in Childhood, Adolescent and Adult Eating Disorders. *Journal of American Academy of Child and Adolescent Psychiatry*, 40(12), 1434-1440.
- KOVACS, M., & WEISSMAN, A. (1975) Hopelessness and suicidal behavior. *Child and Adolescent Social Work Journal: P HF. Kary*, 14 129-137.
- KOZOL, J. (1975) *The Night is Dark and I am Far From Home: A Political Indictment of the United States Public Schools*, New York, Continuum.
- KRAMMER, H.-J. A. S., M.V. & (1999) Neurogastroenterology: From the Basics to the Clinics: Proceedings of the Falk Symposium. *Falk Symposium*. reiburg, Germany.
- KRUEGER, R. A. (1988) *Focus groups: a practical guide for applied research*, Newbury Park, Sage.
- KRUEGER, R. A. A. C., M.A. (2000) *Focus Groups*. Thousand Oaks, Thousand Oaks, Sage . .
- KRUGER (1995) Successful focus groups: Advancing the state of the art in analyzing focus group content. IN (ED.), I. D. L. M. (Ed.).
- LAMB, M. E. A., AND CHARNOV, E. (1985) *Infant- Mother attachment : The origins and significance of individual differences in strange behavior.*, Hillsdate, NJ : Laurence Erlbaum.
- LANCY, M. (1993) Backgrounds, Strengths, and Limits of Execution, and Analysis of Videotape Data among those with ... comment on their observed teaching methods in a study 225.
- LANGENBACH, M. (1988) *curriculum theory and practice : Curriculum Models in Adult Education*, Malibar, Krieger.
- LANKSHEAR, C. A. M., P. (1995) *studies in education and culture series*, Westport, Conn, Bergin & Garvey.
- LECOMPTE, M. D. (1993a) The Nature of Qualitative Inquiry: The Research Problem and Sample Selection. A research study.
- LECOMPTE, M. D. (1994) *Qualitative Research: What It Is, What It Isn't, And How It's Done* JAI Press.
- LECOMPTE, M. M. D., AND PREISSLE, J., (1993b) *Ethnography and Qualitative design in Educational Research* San Diego, Academic Press.
- LEMIEUX, P. (1989) *Canadian Health Welfare: Socialized Medicine: The Canadian Experience*.
- LEMMER, E. M. B., D.C (1997) *Introduction to Education for South African Teachers:*, Kenyan, Juta & Co.Ltd.
- LESHAN, L. (1966) Advocacy, Research, and Support for Children and Adolescents and their family members. *Choices in Healing*.
- LEVIN, M. G., D. J. (1998) *Introduction to Action Research: Social Research for Social Change*. , Thousand Oaks, CA: Sage Publications.
- LEWIN, K. (1946) *Action Research and Minority Problems*. *Social Issues*.
- LEWIN, K. (1948) Resolving social conflicts. New York:, Harper.
- LEWIS, M., AND FEIRING, C (1981) Role of Peers Friends and Lovers: The Role of Peer Relationships in Adolescent Romantic Relationships.

- LEWIS, M. A. F., C. (1989) Infant, Mother and Mother-Infant Interaction Behavior and Subsequent Attachment. *Child Development*, 60, 831-837.
- LEWIS, M. E. A., AND JASKIR, J. (1984) Predicting psychopathology in six- year-olds from early social relations. *Child development*, 55, 123-126.
- LIGHT, R. J., SINGER, J., & WILLETT, J (1990) *By design: Conducting Research on Higher Education*, Cambridge MA, Harvard University Press.
- LINCOLN, G. A. (1981) *Effective Evaluation: Improving the usefulness of Evaluation Results*, San Francisco, Jossey Bass Pub.
- LINCOLN, Y. S. A. G., EGON G. (1985) *Naturalistic inquiry* ., Beverly Hills, Ca, Sage.
- LOCHEAD, K. (1985) Indigenous Self-Determination in Canada and Australia.
- LOMAX, P. P., Z. (1995) Accounting for Ourselves: the Problematic of Representing Action Research. *Cambridge Journal of Education*, 25(3),, 301-314.
- LOVELL, R. B. (1984) *Adult Learning*, Croom Helm. .
- LYTARD, J. (1973) *The Postmodern Condition: A Report on Knowledge*. Minneapolis, Minnesota, : University of Minnesota Press.
- MAMBWE, C. (1985) Setting Up a National Mental Health Resource Centre: An Alternative Approach to an Institution in Crisis. Lusaka, Chainama Hospital,.
- MAMBWE, C. A. H., A (1982) Introduction of a Saturday Journal Club Lusaka, Chainama Hospital.
- MARINCOWITZ, G.J.O. (2004) *Putting Practice into Action: Article on Participatory Action Research*, 46 (5) 31-36. *University of Medunsa, South Africa*
- MARINKER, M., ED. (1990) Medical audit in general practice. *Canadian journal of medical radiation technology*.
- MARROW, A. J. P. (1969) Action Research and Scientific Method: Presumed Discrepancies and, Action research and minority *Journal of Social Issues*, .2, 34-46.
- MARSHALL, C. R. G. B. (1989) *Designing Qualitative Research*.
- MARXWELL, L., J. A. (1995) *Qualitative Research Design: An interactive Approach*, California, Sage.
- MASON, M. (2000) Teachers as Critical Mediators of Knowledge. *Journal of Philosophy of Education*, 34, 343-352.
- MAXWELL, J. A. A. L., D (2002) *Mixed Method Designs. An Alternative Approach*, Thousand Oaks, CA; Sage.
- MAXWELL, L., J. A. (1986) Investigations and Mediation to Resolve Conflicts in the Workplace.
- MAY, R. (1994.) What's happening in the Humanities Program. *The Hoover Link*. San Diego California.
- MAYER, D. (1957) Adolescent circumstances and aspirations as the stepping-stone to earnings, measures, and physical and mental health measures
- MCCUTCHEON, G., & JUNG, B. (1999) Alternative perspectives on action research: Theory into Practice,. 24(3) , 144-151.
- MCKERNAN, J. (1991) *Curriculum action research: a handbook of methods and measures for the reflective practitioner*, London, Kogan Page.
- MCLAREN, N. (2004) The Biopsychosocial Model and Scientific Fraud.

- MCMILLAN, J. H. A. S., S. (1993) *Research in Education. A Conceptual Introduction.* , New York. , Harper Collins Collage Publishers.
- MCNIFF, J. E. A. (2000) *You and Your Action Research Project*, London, Routledge Falmer.
- MEDICAL COUNCIL OF ZAMBIA (1977) Medical and Allied Professions Act IN ZAMBIA, M. C. O. (Ed.), Medical Council Zambia
- MEZIROW, J. (1991) How critical reflection triggers transformative learning. . IN J. MEZIROW, A. E. (Ed.) *Fostering critical reflection in adulthood. San Francisco,* . CA: Jossey-Bass.
- MICHELLE, H. (1999) *Developing focus group research : politics, theory, and practice*, London :Thousand Oaks, SAGE Publications.
- MILES, M. B., & HUBERMAN, A. M. (1994) *Qualitative Data Analysis: A Source of New Methods*, Beverly Hills, CA: Sage.
- MILLER, G. (1967) Continuing education for what? Education, Medical, Continuing*Education Models, Theoretical *J Med Educ.*, 42(4), 320-6
- MILLER, S. (2001) *Handbook of Action Research: Participative Inquiry and Practice.*
- MILLVILLE, A. A. J., C. (1982) *Cured to Death*, London Newbury. Stage Publications.
- MINISTRY OF HEALTH (1991) NHPS. IN UNIT, P. (Ed.), MoH.
- MINISTRY OF HEALTH (2000) Mental Health Position Paper,. IN HEALTH, C. B. O. (Ed.), Ministry of Health.
- MORGAN, D. L. & (1997) *Focus groups as qualitative research*, Sage,.
- MORSE, J. M. (1991, 2003) *Inquiry in Action and Reflection.*
- MORSE, J. M. (1997) *Completing a Qualitative Project: Details and Dialogue.* , London, Sage.
- MUTEMA, A. E. A. (1990) Innovative Techniques in the Training of Health Professions.
- MUTEMA, A. M., NGATIA, P.M. (1986) Paper on development of testing and evaluation of Health of Health personnel education. Nairobi.
- NATIONAL RESEARCH COUNCIL, A. I. O. M. (2000) Core Concepts of Development Research Council and Institute of Medicine
- NATIONAL RESEARCH COUNCIL, A. I. O. M. (2000) *The Science of Early Childhood Development.* .. Washington, DC., National Academy Press
- NAVIA, E. A. (1986) Sub cortical dementia impairments in the disease that bears impairments of the sub-cortical regions of the brain.
- NMHRC (1987) National Mental Health Services in Zambia. IN NMHRC (Ed.) NRDC Lusaka.
- NOVACK, G. (1975) *An appraisal of John Dewey's philosophy: pragmatism versus Marxism.*
- NYERERE, J. K. (1968.) *Socialism and Rural Development in Ujamaa: Essays on Socialism.*, Dares Salaam: Oxford University Press.
- O' KEEFFE, M. (1987) Overview of Mental Health Problems In Zambia. *National Mental Health.* NRDC, Lusaka, Un published
- OJA AND SYMULYAN (1990) *Collaborative Action Research: A Developmental Approach*, London Falmer Press.

- OJA, S. N. A. S., L. (1989) *Collaborative action research: a developmental approach.*, London, Falmer Press.
- OSBORNE, C. M. (1987) Traditional and Modern Practices of Child Rearing in Preparation for Child Rearing in Adult life and their Role in Childhood and Adolescent Mental Health. *NRDC, National Mental Health Resource Center.* Lusaka, Unpublished.
- OSBORNE, J. (2007) Best Practices in Quantitative Methods.
- OSLER, W. (1900) An Address on the Importance of Post Graduate Study. *Lancet*, vol. 2.
- PATCHING, D. (1990) *Practical soft systems analysis.* , London, Pitman.
- PATEL, J. (1995) Allopathic or Ethnopathic Traditional Healing Methods Among the Traditional Healers in Zambia.
- PATERSON, G. R. (1975) *Application of social Learning to Family life to children and adolescents*, Campaign IIResearch Press.
- PATTON, M. Q. (1990) *Qualitative evaluation and research methods.*, Newbury Park,, Ca.: Sage.
- PAUL, R. W. (1993) Critical thinking: What every person needs to survive in a rapidly changing world. *Santa Rosa: Foundation for Critical Thinking.*
- PAYKEL, D. E. A. S., JOHNSON, AND SIEGEL 1978 (1974 and 1978) Men's Health. Mental Health. Real Estate.
- PEEL, D. (2002) Peer observation of teaching in higher education. . London, University of Westminster.
- PELTO, P., & PELTO, Q. (1975) Intra-cultural Diversity: Some Theoretical Issues. *American Ethnologist*, 2, 1-18.
- PENDER, C. A. (1996) Infant, Child, and Adolescent Health ... Mental Health and Substance Abuse.
- PIAGET, J., & INHELDER, B. .. (1969) *The psychology of the child development* Lincoln H. Weaver, trans.
- PILGRIM, D. (2002) The biopsychosocial model in Anglo-American psychiatry: Past, present and future. *Journal of Mental Health*, 11, 585 - 594.
- PINAR, W. F. A. G., M.R. (1976) *Toward a poor curriculum*, Dubugne, 1a:, Kendall/Hunt.
- PLOMIN, E. A. (1997) The genetic basis of complex human behaviors: . *Science*, 264, 1733.
- POLIT, D. F. A. H., B.P (1983) *Nursing Research Principles and methods*, Philadelphia, JB Lippincott Co.
- POSTMAN, L. J. A. W. & (1971) *Verbal learning and memory : selected readings*, Penguin.
- PRIDEAUX, D. (2001) Triangular Organic Whole Description of the PRISMS and the SYMBIOTIC Curriculum Model.
- PROZESKY, D. R. J. (1984) Strategies in curriculum development : the SPICES model. *development. In L. R. Goulet and P. B. Baltes (Eds)*, , New York, Academic Press.
- PUNCH, M. (2001) Are there risks in Qualitative Research? *Qual Health Res*, 11, 3-4.

- REASON, P. A. B., H (2001) *Handbook of Action research: Participative Inquiry and Practice*, London, Sage.
- REESE, H. W., AND OVERTON, W.F. (1970) *Models of development and theories of*
- REVILLE, M. (1989) An evaluation of the Australian Traineeship System Clothing Machinist program.: University of Queensland, Department of Psychology
- RIEGEL, K. F. (1976) *Psychology of development and history*, New York, Plenum Press.
- RIESE (1969) Changes in Outlook on the Future between Childhood and Adolescence. *Journal of Personality in Childhood and Adolescence*, 507
- RN B/COLU, I. J., S. (1974 and 2000) Educational input and patient outcomes: exploring the gap *Journal of Advanced Nursing* 31, 461- 47.
- ROBERTSON, B. (1996) *Handbook of Child Psychiatry for Primary Care*, Oxford University Press Southern Africa.
- ROBERTSON, M. J., COUSINEAU, M.R. (1997) Health status and access to health services among children and adolescents. *Community Mental Health Journal*, 33, 113–122
- ROGERS, E. S., F.F (1971) *The communication of innovations.*, New York, The Free Press.
- ROOT, N. (1957) A Neurosis in Adolescence. *Psychoanalysis Study of the Child*. . 12, 320-334.
- ROTY, R. (1985) ‘Solidarity or Objectivity’. IN J. RAJCHMAN AND C. WEST (EDS) (Ed.) *Post Analytic Philosophy*. New York Columbia University Press.
- RUTH, K. (2004) “Hidden trauma” in infancy: Attachment, fearful arousal, and early dysfunction of the stress response system. NY, Guilford Press.
- RUTHERFORD, J. (2007) New Labour and the end of welfare
- RUTTER, M. (1974) Coping with loss: Bereavement in childhood : Children of sick parents. *BMJ*, 316 931
- RUTTER, M. (1981) Stress, Coping and development. Some issues and some questions. *Journal of child psychology and psychiatry*, 22, 323-356.
- RUTTER, M. (1985) Resilience in the face of adversity, protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry*, 147, 598-611.
- RUTTER, M. (1999) Antisocial Behavior by Young People : Key issues in designing and undertaking evaluations of interventions. *Social Information Systems & Policy Research Bureau*.
- RUTTER, M. (2000a) Protective factors in children’s responses to stress and disadvantage. . *Annals of the Academy of Medicine*. Singapore.
- RUTTER, M. A. N., J. (1970) cultural group as well as ethnicity and culture will be used interchangeably
- RUTTER, M. E. A. (1979) Protective factors in children's responses to stress and disadvantage. . Hanover, NH, University Press of New England.

- SADLO, G. (1994) "Problem-based Learning in the Development of an Occupational Therapy Curriculum, Part 2: the BSc at the London School of Occupational Therapy." *The British journal of occupational therapy* 57, 79-83.
- SALFER, B. A. T. T. (1981) *Education Politics and the State: The Theory and Practice of Educational Change*, London, Grant.
- SAMPSON, R. J., & LAUB, J. H. (1994) Urban poverty and the family context of delinquency: A new look at structure and process in a classic study. *Child Development*, 65, 523-540.
- SARACENO, B. (2003) Caring for Children and Adolescents With Mental Disorders: Setting WHO Directions. *Mental Health and Substance Dependence*. Geneva, Department of Mental Health and Substance Dependence WHO.
- SARANTAKOS, S. M. M. B. A. H. A. M. (1993, 1998, 2005, 1984,) *Social Research* Hampshire, New York. , Palgrave Macmillan, Houndmills, Basingstoke,.
- SARNO, J. E. M. D. (1998) The Mind body Prescription: Healing the Body, Healing the Pain. 1.
- SCHEIN, E. (1985) *Handbook of action research: Participative inquiry and practice*, London, Sage.
- SCHEIN, E. (1987) *The clinical perspective in fieldwork*, Newbury Park, Sage Publications.
- SCHEIN, E. H. E. A. (1992,1996a, 1999b) Seeing Organizational Learning: A Cultural' View.
- SCHMIDT, T., KANENDA, O., AHLUWALIA, I., & KOULETIO, M. (2001) Transportation for maternal emergencies in Tanzania: Empowering communities through participatory problem solving. *American Journal of Public Health*, 9, 1589-1590.
- SCHON, D. (1983) *The Reflective Practitioner: how Professionals Think in Action*. , New York, Basic Books.
- SCHON, D. A. (1987) *Educating the Reflective Practitioner*, San Francisco, San Francisco.
- SCHÖN, D. A. (1983) *The reflective practitioner: how professionals think in action*, New York, Basic Books.
- SCHUBERT, W. H. (1986) Curriculum Perspective, Paradigm and Possibility. New York Macmillan.
- SCRIVEN, M. (1997) "Pros and Cons About Goal Free Evaluation" in `Evaluation Comment`.
- SEARLE, J. (1995) *The Construction of Social Reality*, New York, The Free Press.
- SELDÉN, L. (1989) Library Education In Sweden: A continuing education programme in documentation 12, 39-56.
- SELENER, D. (1979) *Participatory Action Research and Social Change*, Ithaca, :Cornell Participatory Action Research Network.
- SENGE, P. M. (1990) *The fifth discipline: the art and practice of the learning organization*. , New York, Doubleday.
- SERPELL, R. A. N., D. (1987) Mental Sub normality and the slow Learner *National Mental Health Resource Center Conference*. NRDC, Unpublished.
- SHATKIN, J. P. A. B., M.L. (2003) The Global Absence of Child and Adolescent Mental Health Policy. In press.

- SHIRLEY, G. (1987) *Curriculum Product Or Praxis?*, London, Taylor and Francis Ltd.
- SHWEDER, R. (1990) *Cultural psychology—what is it?* Cambridge, UK, Cambridge University Press.
- SIBLEY, J. ET AL. (1982) A randomized trial of continuing education. . *N Engl J Med* 306, 511-5. 2. .
- SILVERMAN, D. (2000) *Doing Qualitative Research: A Practical Handbook*, Thousand Oaks, CA, Sage.
- SKINNER, B. F. (1953) *Science and Human behavior*, New York, Macmillan.
- SLATTERY, P. G. (1995) *Curriculum development in the postmodern era*. , New York, The Guilford Press.
- SMITH, D. (1981) *Strategies of Social Research: The Methodological Imagination*. Basingstoke, Hampshire, New York. , Palgrave Macmillan.
- SMITH, K. K. B., D. N. (1995) A Paradoxical Approach to Teaching Group Dynamics: First Thoughts, First Findings. *Applied Behavioral Science*, 31(4), 398-414.
- SMITH, S. A. S. (1957) Psychological Concepts, Explication, and Ordinary Language. *Journal of Philosophy* 54.4 94-100.
- SOMMER, R. (1990) Local Research. *Journal of Social Issues*, 46(1), 203-214.
- SOMMER, R. (1987) Crime and vandalism in university residence halls: A confirmation of defensible space theory. *Journal of Environmental Psychology*, 7, 1-12.
- STARFIELD, B. E. A. (1980) Psychosocial and Psychosomatic Diagnosis in Primary Care of Children. *Pediatrics*., 66, 8.
- STENHOUSE, L. (1975) A matter of Style
- STERN, B. S. A. R., K. L. (2002) Historical Legacy: Linking Harold Rugg and Social Reconstructionism to 'authenticity' in theory and practice. . *Curriculum and Teaching Dialogue*, 4(2), 113-121.
- STEWART, D. (1976) *Relationship between Curriculum Development and Examination*, New York
- STOLLER, A. (1972) Social Psychiatry and Public Health. *Aust. N.Z.J. Psychiatry*, 6(1), 9.
- STRAUSS, A. (1987) *Qualitative Analysis for Social Scientists*, Cambridge. UK, Cambridge University Press.
- STRAUSS, A., AND CORBIN, J. (1990) *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*., Newbury Park: , Sag.
- STRAUSS AND CORBIN, S., A., & CORBIN, J. (1990) *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*, Newbury Park, CA, Sage.
- STRINGER, E. (1999) *Action research*, Thousand Oaks, Sage.
- SUCHMAN, E. A., EVALUATIVE RESEARCH: PRINCIPLES AND PRACTICE IN PUBLIC SERVICE AND SOCIAL ACTION PROGRAMS . NEW YORK: RUSSELL SAGE FOUNDATION. (1967) *Evaluative research: principles and practice in public service and social action programs* New York: , Russell Sage Foundation.
- SUPER, C. M. (1960A) The developmental niche:A cocconceptualization at the interface of Child and Culture. *Journal of Behavioral Development*, 9, 545-569.
- SUSMAN, G. I. (1983) *Action research: a sociotechnical systems perspective*. Newbury Park CA, Sage.

- SWANTZ, M. L., NDEDYA, E., & MASAIGANAH, M. S. (2001) *Participatory Action Research in Southern Tanzania, with Special Reference to Women.* . London:, Sage.
- TABA, H. (1962) *Curriculum Development: Theory and Practice*, New York, Harcourt, Brace and World.
- TABA, H. (1999) *Curriculum development, theory and practice: New Principles of curriculum reconstruction*, New York, Harcourt & Brace World.
- TANNER, D. A. T., LAUREL (1995) *Curriculum Development Theory into Practice.*, Columbus, OH, Prentice Hall.
- TAYLOR, A. E., & GOTTESMAN, E.H. (1975) *Arieti's Interpretation of Schizophrenia and Manic Depressive*
- TERRI, S. (Ed.) (1984) *The Meaning of Educational Change.*
- THAKHATHI, M. (2001) *Citizen Participation in the Delivery of Public Service in Cameroon*
- THE WORLD HEALTH ORGANIZATION (2003a) *Caring for Adolescents and Children With Mental Disorders: Setting WHO Directions. Journal of adolescent Children With Mental Disorders.*
- THE WORLD HEALTH ORGANIZATION (2003b) *Prevention and Care of Illness, Adolescents*".
- THE WORLD HEALTH REPORT (2001) *World Health Organization, The World Health Report*
- THOMAS, E. (1968a) *Role Theory. Personality and the Individual*, Chicago., Rand-McNally.
- THOMAS, J. (1968b) *Doing Critical Ethnography (Qualitative Research Methods Series*, Newbury Park, Calif: Sage.
- THORNDIKE, R. L., HAGAN, E (1969) *Measurement and Evaluation in Psychology and Education*, New York, John Willey & Sons.
- TOWELL, M. C. A. (1997) *Educational Technology Research and Development.*, Bateman10.
- TRIPP, D. (2003) *Action Inquiry. Action Research. e-Reports 17.*
- TURNBULL, E. (1993) *Action Research for Change and Development*, Sydney (Hawkesbury), Richmond.
- TYLER, R. W. (1949) *Basic Principles of Curriculum and Instruction*, Chicago, The University of Chicago Press.
- ULIN, P. R. R. E. T., TOLLEY, E.E AND NEILL, M.C. (2002) *Qualitative Methods. A Field Guide for Applied Research in Sexual and Reproductive Health.*, North Carolina, Family Health International.
- UNICEF, W. H. O. (1998) *Alma Ata Declaration of Health for All by the Year 2000 and Beyond.*
- USDHHS (1999) *Mental Health: A report of the Surgeon General.* Rockvile, M.D: U.S, Government Printing Office.
- USHER, R. (1996) *Neglected Epistemological Assumptions'* . London and New York. , Routledge.

- VAN DE HORST, H. A. M., R. (1997) *Outcomes-based Education: Theory and Practice*, Pretoria: , Kagiso Publishers.
- VAN SCOTTER, R. D. K., .RJ. HAAS, J. D. (1979) *Foundations of Education: Social Perspectives*. Prentice-Hall.
- W H O (2002) The implications of health sector reform for human resources development *Bulletin of the World Health Organization* 80, 10.
- WATSON, J. C. (1999) The Effects of Cognitive-Affective Stress Management Training on Game-Time Stress in High School , *D. (, September)*.
- WEBBER, L. (1993) *Action Research with Pastoralists in Western New South Wales*.
- WEINBERG, N. Z., RAHDERT, E., COLLIVER, J. D., & GLANTZ, M. D. (1998) Adolescent substance abuse: A review of the past 10 years. . *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 252–261.
- WEISS, R. S. (1994) *Learning from Strangers: The Art and Method of Qualitative Interviewing*, New York Free Press.
- WEISSMAN, M. M., WOLK, S., GOLDSTEIN, R.B. ET AL (1999) Depressed Adolescents Grown Up. . *Journal of the American Medical Association* 28(18).
- WELMAN, B. (2002) Praxis Imperfect: John Goodland and the Social Reconstructionist tradition. *Educational Studies*, 34, 61- 83.
- WFMH (2000) Proceedings of the Inaugural World Conference on the Prevention mental health and prevention of mental and Behavioral Disorders. *World Federation of Mental Health*. Alexandria, Virginia, WHO.
- WHEELER, H. (1967) *Curriculum Process*. , London ULP.
- WHO ALMA ATA (1978) The Alma Ata Declaration of "Health for All by the Year 2000". IN WHO (Ed.) Geneva, WHO.
- WHO, W. H. O. (1977) *Manual of the international statistical classification of diseases, injuries, and causes of death*. , Geneva.
- WHO/UNHCR (1996) Mental Health and Substance Abuse in Children and Adolescents. . *Mental health of Children and Adolescent Refugees*.
- WHO/UNICEF (1978) Primary Health Care (definition).
- WHR (2000, 2001 and 2003) H.V 1969 Human Development and Learning.
- WHYTE, W. F. (1989) Advancing scientific knowledge through participatory action research. *Sociological Forum*, 367-385.
- WHYTE, W. F. (1991) *Participatory action research* Sage.
- WINTER, R. (1989) *Learning from experience: principles and practice in action research*. , London, Falmer Press.
- WINTER, R. A. M., M. (1996) Professional Competence and Higher Education.
- WINTER, R. G., C.M. (2001) *A Handbook for Action Research in Health and Social Care*, Title Page, Routledge.
- WORLD HEALTH ORGANISATION (1999) Programming for Adolescent Health and Development.
- WORLD HEALTH ORGANIZATION (1977) Child Mental Health and Psychosocial Development. *Technical Report Services*, .
- WORLD HEALTH ORGANIZATION (1998) *Adolescent Health Development Programme: Family and Reproductive Health "The Second Decade: Improving Adolescent Health Development Programme"*. Geneva.

- WORLD HEALTH ORGANIZATION (1999) Programming for Adolescent Health and Development. *Technical Report Series*, 886.
- WORLD HEALTH ORGANIZATION (2001) Technical Report Series 886.
- WORLD HEALTH ORGANIZATION (2003) Caring for Children and Adolescents with Mental Disorders: Setting WHO Directions. Geneva, Department of Mental Health and Substance Abuse.
- YACH, D. (1992) The Performance of Health Workers in Ethiopia : Results from Qualitative Using Focus Groups.
- YATES, M.-A. E. (1994) Emotional, Behavioral, Social, and Academic Outcomes in Adolescents: Parent-child agreement.
- YOUNG, L. A. W., R. (1984) Effectiveness of continuing education for health.
- YOUNG, M. F. D. (1976) *An Introduction to Curriculum Research and Development*, London, Heinemann.
- ZAIS, R. S. (1986) *Curriculum Principles and Foundations*, New York, Thomas T. Crowell
- ZEITLIN, H. A. S., H (1991) Adolescence: the Genesis of Addiction. London, Routledge.
- ZUBER-SKERRITT (ED.) (1993) *New Directions in Action Research*, London, Falmer Press.
- ZUBER-SKERRITT, O. (1982) *Action Research in Higher Education*, London, Kogan
- ZUBER-SKERRITT, O. (1990, 1996) *Action research for change and development* Avebury.
- ZUBER-SKERRITT, O. (1992a and 1992b) *Introduction: Action Research for Change and Development*, Brisbane. *Medical Education*, 18, 3:60–61.

ANNEXURE 20: UNIVERSITY OF KWAZULU – NATAL ETHICAL CLEARANCE

RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL: ximbap@ukzn.ac.za



25 APRIL 2007

MR. J MUDENDA (204520130)
ADULT AND HIGHER EDUCATION

Dear Mr. Mudenda

ETHICAL CLEARANCE: "PERCEPTIONS AND UNDERSTANDINGS ABOUT MENTAL HEALTH PROBLEMS OF CHILDREN AND ADOLESCENTS IN ZAMBIA: IMPLICATIONS FOR INNOVATIVE CURRICULUM DEVELOPMENT FOR PHC PRACTITIONERS"


I wish to confirm that ethical clearance has been granted for the above project, subject to:

- Informed consent document being provided in line with standard ethics guidelines (format attached)

This approval is granted provisionally and the final clearance for this project will be given once the above condition has been met. Your Ethical Clearance Number is HSS/0152/07

Kindly forward your response to the undersigned as soon as possible

Yours faithfully


.....
MS. PHUMELELE XIMBA
RESEARCH OFFICE

cc. Faculty Research Officer (Derek Buchler)
cc. Supervisor (Prof. C Mbali)
cc. Prof. D Mkize

2007-05-02