A STUDY TO DETERMINE THE KNOWLEDGE AND ATTITUDE OF PARENTS / GUARDIANS TOWARDS THE MENTALLY RETARDED : A CASE FOR CHAINAMA DAY CENTRE.

BY

ESTHER CHIRWA
Z.R.N. (1989) NDOLA
R.M.N. (1994) CHAINAMA, LUSAKA.

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LIST OF ABBREVIATIONS

AAMR	-	America Association of Mental Retardation
CBR	-	Community Based Rehabilitation Service
CSO	-	Central Statistical Office
IQ	-	Intelligence Quotient
MHAZ	-	Mental Health Association of Zambia
NGO	-	Non-Government Organisation
UNZA	-	University of Zambia
UTH	-	University Teaching Hospital
WHO	-	World Health Organisation
ZAMISE	-	Zambia College for the Handicapped

DECLARATION

I hereby declare that the work presented in this study for a Bachelor of Science degree in nursing has not been presented either wholly or in part for any other degree, and is not being currently submitted for any degree.

Signed.....E. Chirwa.....

Candidate

Signed.....Ngoma.....

Lecturer

STATEMENT

I hereby certify that, this study is entirely the result of my own independent investigation. Various sources to which am indebted are clearly indicated in the text and in the reference.

Signed.....E. Chuma.....

Candidate

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DEDICATION

This study is dedicated to my dear father Mr Enock Chirwa and my mother Mrs Elizabeth Chirwa for whose patience, love and care made me where Iam today, to my brother Moses and sisters Hildah, Dorothy, Lillian, Rebecca, and Suzyo for their spiritual and moral support.

ABSTRACT

The aim of the study was to determine the knowledge, attitude of parents/guardians towards the mentally retarded children.

The study was conducted at Chainama Hills Hospital. A descriptive, explorative and non-experimental research design was used because it involved the identification of the Independent Variables affecting the knowledge and attitude of parents/guardians towards the mentally retarded children, to gain insight into the situation/phenomena and didn't not require manipulation of subjects.

The data for the study was collected in August 2000. A sample of (50) respondents both males and females from different ethnic origin, religion, educational level and of different socio-eonomic status were drawn from the attendance register containing names of mentally retarded children admitted or discharged from F-Ward and those attending or had stopped attending Chainama Day Care.

Literature review was based on studies done globally, regionaly and within the country Zambia. Literature was also obtained from books, newspapers, and magazines, which were relevant to the topic.

The systematic sampling was used to choose the names from the study unit. Data was collected by focus group discussion and an interview schedule. After data was collected it was analyzed manually using a calculator.

Results from the study revealed that parents/guardians of mentally retarded children who were educated were more knowledgeable about mental retardation, and were able to send their children to special school unlike who belonged to low income group and had low knowledge on mental retardation, found it difficult to provide for these children adequately and send them to special school. Most respondents had positive attitude towards their mentally retarded children, although the majority of single and widowed parents had negative attitudes towards their children. Level of education and socio-economic status of the parents/guardians were the main factors mentioned to have an effect on the knowledge and attitude of the carers of the mentally retarded children.

From the above findings, it was recommended that Ministry of Health should start funding Chainama day care centre seperately so that it provides transport and food to these children. Government and Non-governmental organisations should intervene through small scale industry so as to empower these families with mentally retarded children to enable them provide basic needs for their children like shelter, clothing, education etc. Mental Health Association of Zambia (MHAZ) should set up the educational compaigns to educate families on mental retardation according to the families' level of education.

CHAPTER ONE

1.1 INTRODUCTION

Mental retardation has been a subject of fear and sometimes centres of attraction since time immemorial because the afflicted person's have sub-average intellectual functioning and impaired adaptive behaviour, which was constantly defied therapeutic endeavours and scientific understanding for a long time. Hence it imposes a heavy burden on an individual and the family.

Mental retardation cuts across the lines of racial, educational, social and economic background. It occurs in any family, world over; for example, in America one out of ten families are directly affected by mental retardation (Alexander 1998).

An individual is considered to have mental retardation based on the following three criteria: Intellectual functioning level (IQ) below 70-75; significant limitation exists in two or more adaptive skills area ; and the condition is present from childhood (defined as age 18 or less), (AAMR, 1992). Mental retardation is not a disease or syndrome but comprise a wide range of conditions which may be determined by many factors of a biological, psychological and social in nature.

Mental retardation can be caused by any condition which impairs development of the brain before birth, during birth or in early childhood years. The causes of mental retardation can be categorised as follows :

- **Genetic conditions** which result from abnormality of genes inherited from parents errors when genes combine, or from other disorders of the genes caused during pregnancy by infections, over-exposure to x-rays and other factors for example, Down Syndrome, phenylketonuria, chromosome disorders.

- **Problems during pregnancy**-Use of alcohol or drugs by the pregnant mother can cause mental retardation. Other risks include smoking , malnutrition, HIV, and certain environmental contaminants and illness of the mother during pregnancy such as rubella, syphilis and so on.

- **Problems at birth**- Although any birth condition of unusual stress may injure the infant's brain, prematurity and low birth weight predict serious problems more often than any other conditions.

- **Problems after birth**- Childhood diseases such as whooping cough, chicken pox, measles; accidents such as blow to the head or near drowning, seed, mercury and other environmental toxins can cause irrepairable damage to the brain and nervous system. Meningitis and encephalitis can also cause damage to the brain.

- **Poverty and cultural deprivation**- Children in poor families may become mentally retarded because of malnutrition, disease producing conditions, inadequate medical care and environmental health hazards.

The effect of mental retardation vary considerably among people, just as the range of abilities varies among people who do not have mental retardation. It has been documented that above 87% will be mild affected and will be only a little slower than average in learning new information and skill (Batshaw 1997). As children, such people's mental retardation is not readily apparent and may not be identified until they enter school. As adults, many will be able to lead independent lives in the community and will not be viewed as having mental retardation. The remaining 13 percent of people with mental retardation, those with IQs under 50 , will have serious limitations in functioning . However , with early intervention a functional education and appropriate supports as an adult , all can lead satisfying lives in the community (Batshaw 1997).

People with mental retardation as stated above when given the functional education acquire skills which make them useful in life. Adaptive skills are

those very skills needed to live , work, and play in the community .They include , self care, home living, social skills , leisure , health and safety , self direction functional academic (reading , writing basic mathematics) community use and work .

In the awake of providing the mentally retarded children with required skills and in accordance with the United Nation Organisation declaration (1976) on the basic right of children (that physically , mentally or socially handicapped child to receive special treatment , education and special care), Zambia adopted the education policy (1967) to establish special schools attached to ordinary schools . Children with handicaps began appearing in public schools from 1972 when the policy became effective . In Lusaka the special educational units for the mentally handicapped are attached to Kabulonga secondary school , Munali secondary school, Chilanga primary school , Mount Makulu , Nangongwe Basic in Kafue , Kamwala South Middle Basic School and Roma Secondary school .Other areas in Lusaka are Bauleni community school, UTH Special School, Cheshire homes and Chainama Day Centre. These units are found all over the country. Some examples are St Mulumba in Choma, Magwelu school in Chipata, Ndola Lions in Ndola , Chongo Basic in Monze to mention a few.

The mentally retarded are enrolled into these educational special schools through various ways. They are referred from hospital after thoroughly examination to diagnose their disabilities. Some people in some communities have some knowledge on the identification of some of these disabilities and may refer their families either to special schools or psychological centres found at UTH, Chainama, UNZA and Kamwala School for special education. Other children are identified in school by their teachers to have difficulties in learning and these may be referred to the special school directly.

In these special education units, mentally retarded children are assessed of their capabilities so that a programme is formulated to suit their mental age. The term mental age "means that the individual received the same number of correct responses on a standardised IQ test as the average person of that age in the sample population" (Arch, 1982).

Skills taught to these children include the activities for daily living such as feeding, dressing, general personal hygiene, toileting and bathing so that mentally retarded children become independent in everyday life. Other skills offered in to older children is carpentry, woodwork, mental work, knitting , secretary, tailoring and cutting so as to empower them earn a living. These mentally handicapped children are also taught to read and write so that they can communicate to others in their communities .

The teachers who teach these mentally retarded children are trained in special education. This training assists them to understand these children with learning disabilities and know the type of materials which suits each child . Some of these teachers graduate with a certificate from Kamwala School for Special Education whilst others with a diploma from the university of Zambia. Recently, UNZA introduced a degree and masters programme in special education and the first graduates will complete this year.

However, the biggest problem in the implementation of the functional education among communities in Zambia is ignorance. Most relatives are ignorant about mental retardation, its causes and what these children can do in terms of rehabilitating them. These rehabilitative measures empower these children with skills (WHO 1990) .

The above scenario is coupled with negative attitudes of the families and communities as a whole , towards mental retardation and those having the condition. In Zambia , it is commonly believed that any form of mental illness is caused by supernatural forces such as witchcraft, cursing, evil spirits or failure to fulfill traditional rites. Hence families tend to take their mentally retarded children to traditional healers for treatment before considering scientific treatments.

It is therefore, imperative that families to have knowledge on mental retardation in order to change their attitude towards it. Knowledge is critical to maximising household health .

This research topic was perceived by the researcher during many occasional visits to Chainama Day Centre Special School and F-ward (children's ward). During these visits the researcher observed that there were very few parents/guardians bringing their mentally retarded children to special school and the number of children being admitted to the children's ward (F-ward) was increasing at Chainama Hospital . This stimulated interest into the researcher to carry out a scientific investigation into the problem so that the measures could be taken to rectify the situation .

1.2 STATEMENT OF THE PROBLEM

All over the world , mental retardation has been regarded as an unmodifiable and incurable condition which has constant defied therapeutic endeavours and scientific understanding for a long time .Hence mentally retarded children in Zambian culture and many other developing countries have been of parents, aunties, uncles and grandparents . In this way they are protected and sheltered from mixing publicly. For a long period , society did not see the need to educate these children.

A review of case notes of the children at the centre showed that despite the existence of this centre and its benefits to the mentally retarded , still parents / relatives are reluctant to bring their children to the day centre. For example the five year period unit report at the day care centre and F-ward (1994 - 1998) showed that there was an increase of mentally retarded children being admitted to F-ward and a decrease on the number of children attending day centre special school . The above situation is depicted in table one below :

TABLE 1 : ATTENDANCE OF CHILDREN AT CHAINAMA DAY CARE CENTRE AND THOSE ADMITTED IN F- WARD

YEAR	DAY CENTRE	F-WARD
1994	46	4
1995	30	5
1996	19	5
1997	22	7
1998	20	8

CARE CENTRE / F-WARD REPORT

When Chainama day centre special school was opened as far back as 1970, it catered for more children than it is now , but F-ward had more children as well because when Chainama hospital was opened in 1968 it became, a dumping area for unwanted mentally retarded children.

However, the drop in the number of children attending the centre and increase in children being admitted on the ward could be due to :

- Traditional community absorption of such children influenced by traditional beliefs and customs.

- Ignorance about the fact that mentally retarded children learn very slowly and need to spend more time in school than a normal child.

- Previously, Chainama hospital management used to supply food to children attending the special school but due to erratic funding from the Government , the day centre is no longer supplied with food .

- Negative attitude / guardians that mentally retarded children are useless and cannot learn , therefore should not be sent to school but dumped on the ward.

- Economic status of the family also contributes to the above scenario because poor families have no means to care for these children.

Most of the mentally children may be adaptive , therefore , it is crucial that families understand the causes, management and rehabilitation of mental retardation rather than shifting the responsibility of the health worker to look after their relatives.

According to case notes of admitted mentally retarded children , the psychiatric team has written to the parents / guardians requesting them to come to the ward and participate in the care of their children and relatives since mental retardation is not mental illness, for these children to be kept on the ward for a long period of time .But many parents / guardians do not turn up despite the letters sent to them .

Perhaps, many family members who brought these mentally retarded children for admission , considered admission as a way of getting rid of these children from their home environment rather than seeking treatment because most of the parents / guardians indicated that they were useless.

The government's efforts to improve the quality of life for mentally retarded children started as far back as in 1970 when Chainama day centre was opened . Before that , between 1961 and 1963, the mentally retarded patients were served by the mental health service at Chainama hills hospital when the hospital was built and opened. Mentally retarded children were regarded as 'mad' and as such were admitted for curative and care service at Chainama hospital and later in mental annexes. By 1968, F-ward became a dumping ward for all unwanted mentally retarded children by parents / guardians and the public, hence a decision was reached by psychiatrists and mental health management team at Chainama hills hospital to involve communities and families in the

care of these children and more especially to include future adult care (Chongo 1986).

Therefore in 1968, mental health Association of Zambia was formed .The objectives of the Association was to educate and create awareness about mental health and mental illness to the public. MHAZ, since its formation has established branches all over the country .In 1979, Zambia adopted the community based mental health approach as recommended by W.H.O at ALAMAATA conference in 1978.

The Government also saw the plight of the mentally handicapped children by adopting one of the ten basic rights of children declared by the United Nations Organisation (1976), entitled "the physically , mentally or socially handicapped child to receive special treatment, education and appropriate care". It is from this background that Zambia adopted the education policy (Zambia special enquiry committee for handicapped 1967) which recommended that ministry of education should take charge and open special education units for the handicapped attached to ordinary schools that these handicaps can also receive the education.

Despite the Government's effort to educate and inform the public about mental retardation , many families still have negative attitudes towards these mentally retarded children and their education.

Although the extent of mental retardation is difficult to assess on international scale , it is obvious that mental retardation is a challenge to all societies throughout the world including Zambia. In Zambia , the true incidence of mental retardation still remains obscure though the 1990 census shows that 6.2 to 7.5 million people have mental retardation in the world (Batshaw 1997).

Mental retardation is 10 times more common than cerebral palsy and 28 times more prevalent than neural tube defect such as spinal bifida. It affects 25 times as many people as blindness (AAMR 1992).

Although Lusaka has a population of 987,106 (CSO 1994) with an annual growth rate of 3.08 and population density of 2137.1 people per square kilometres has about 906 mental retarded patients . However , nowadays , more children surviving from trauma ,anoxia , cerebral infection and nutritional insults as a result of improving standard of medical care ,the long term consequences will be a increase on the incidence of mental retardation in the environment (Batshaw 1997). Because of the anticipated increase in the incidence of mental retardation as stated above , it is therefore ,paramount that people's attitude and knowledge should improve if these children have to receive the special treatment and education.

There are many factors that influence knowledge and attitude of parents/guardians towards mentally retarded children. Inadequate knowledge about mental retardation may affect the ability of the parents/guardians to know how to care for those mentally retarded children and the importance of these children attending rehabilitation centre. Knowledge according to Dewey (1968) is 'power'; he explains that when one has knowledge about something, the individual knows what is to happen. Lack of knowledge may also bring negative attitudes toward the mentally retarded children because the person may only look at them as useless.

The second factor could be socio-economically related. The poor economic status of the parents / guardians may make rehabilitative services unaffordable for their mentally retarded. Only a few parents / guardians may afford to take their children to rehabilitation centres with meals and transporting them to and from these centres.

The educational level of parents / guardians may affect their ability to understand the care and rehabilitation programmes for the mentally retarded children. The parents / guardians who have access to information about mental retardation, may be well informed that these mentally retarded children may be useful in life after rehabilitation and may have positive attitude towards them than those who have no access to information.

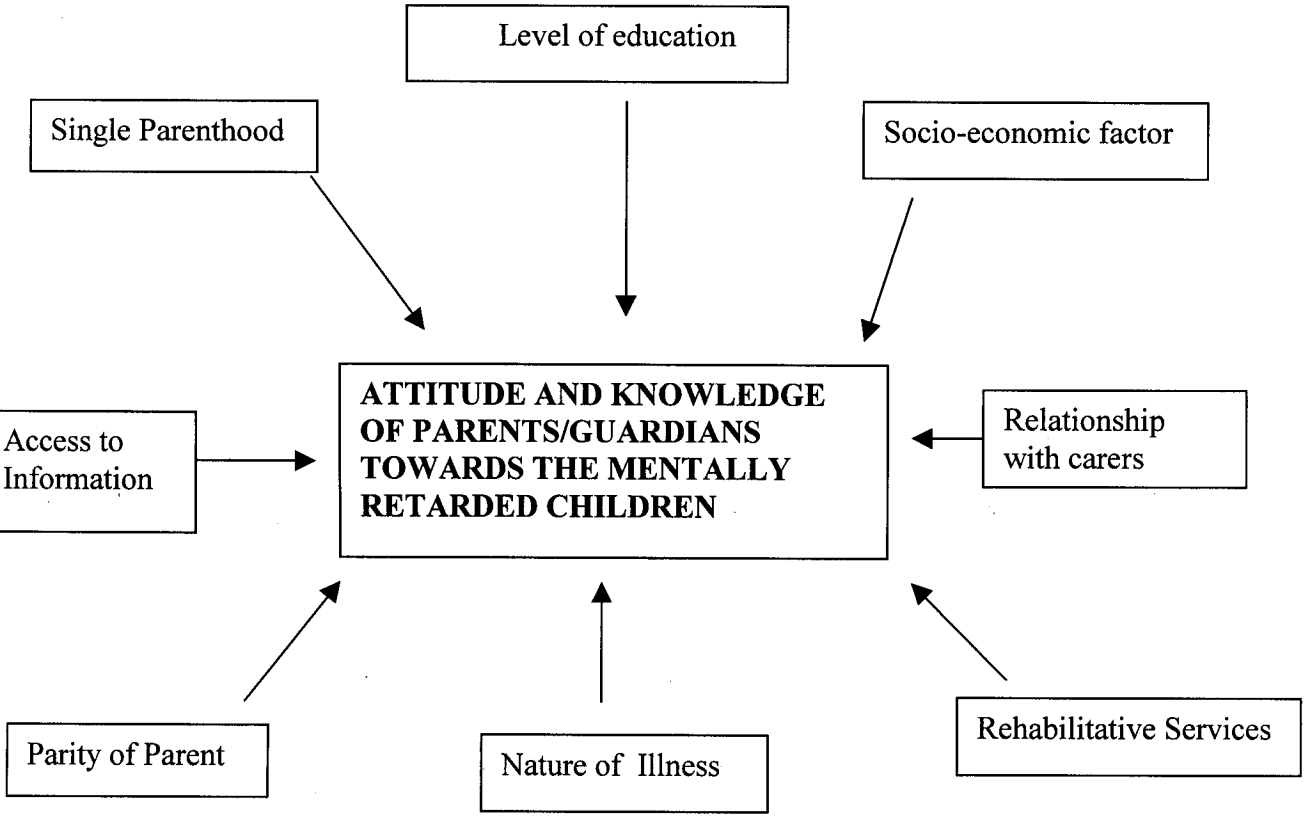
Mental retardation is a chronic condition where there is a delay in development abilities. Mentally retarded children do not learn skills spontaneously like normal children, this may increase the work load on the family, therefore, the family may view these children negatively. The other factor is parity. The high parity of the parent / guardian may also influence their attitude negatively and parents / guardians would rather give adequate attention to normal children rather than mentally retarded children.

The relationship of the mentally retarded children to the head of the family may affect the way the child is treated in the family. If the mentally retarded child is not their own blood child, the family may not even want to keep such a child in their home and may dump him/her in the ward and may equally not see the need to take that menally retarded child to the rehabilitation centre.

The availability of rehabilitation facilities for mentally retarded children may influence the parents knowledge and attitude, in that parents may be motivated to take their children to the centres. However, if the mentally retarded child learns some skills, this may motivate the parents / guardians and may develop positive attitudes towards their children. In the situation where rehabilitative services are unavailable, parents/guardians may be ignorant about their existence and importance to their children, hence parents may continue to have negative attitude towards their mentally retarded children.

The other factor may be single-parenthood, where the parent is single with no partner to assist him/her in looking after the mentally retarded, they may become frustrated thus have a negative attitude towards the child.

DIAGRAM OF FACTORS INFLUENCING KNOWLEDGE AND ATTITUDES OF PARENTS / GUARDIANS TOWARDS THE MENTALLY RETARDED CHILDREN.



1.3 JUSTIFICATION

In view of the above ,the researcher found it necessary to carryout a study to determine the knowledge and attitude towards the education of mentally retarded children. No similar study has ever been done in Zambia on the subject.

It is hoped that the findings will be utilised by both mental health staff, teachers trained in special education , families with mentally retarded children in Lusaka. Recommendations will be made to Ministry of health , Chainama Hills Hospital and NGO'S in Lusaka.

1.4 HYPOTHESIS

- Socio-economic status of the parents / guardians affect the knowledge and attitude towards the mentally retarded children .
- Knowledge level has an adverse influence on the parents / guardians towards the education of the mentally retarded children .
- Parents / guardians attitude on mental retardation has inverse effect on the care of these children and ability to send them to the special school.

1.5 OBJECTIVES OF THE STUDY

GENERAL OBJECTIVE

To determine the knowledge and attitudes of parents / guardians towards the care and education of the mentally retarded children.

SPECIFIC OBJECTIVE

- To determine the knowledge the families have about mental retardation, care and their education.
- To establish whether there is a difference in knowledge and attitude towards mental retardation between males and females.
- To determine factors that influence parents / guardians attitude towards mental retardation.
- To find out the community support that families receive from individuals , Organisation and others.
- To find out whether these families able to send the mentally retarded children to special school.
- To make recommendations to the ministry of health ,Chainama Hills Hospital and NGO's.

1.6 DEFINITION OF TERMS

- **Mental**: state of the mind
- **Retardation**: Holding back or slowly down or delayed mental or physical responses due to pathological conditions .
- **Mental retardation**: refers to sub average general intellectual functioning which originates in the development period and is associated with impairment of adaptive behaviour.
- **Attitude**:subjective manner or feeling or behaviour towards something.
- **Community support**: assistance from the community members (individuals, organisation).
- **Knowledge**: Understanding.

1.7 VARIABLES USED:

INDEPENDENT VARIABLE: It is the variable that stands alone and is not dependent on any other. For example in this study, the dependent variables are level of education, socio-economic status etc.

DEPENDENT VARIABLE: It is effect of the action of the dependent variable and cannot exist by itself. In this study, the independent variables are level of knowledge and attitude.

VARIABLES	INDICATOR CATEGORY	CUT OFF POINTS
Knowledge	High	Responses to questions with score 8.
	Moderate	Responses to questions with scores 5-8.
	Low	Responses to questions with scores 4 and below.
Attitude	Positive	Acceptance of relative/child with Mental retardation and able to send them to special school.
	Negative	Non-acceptance of relative/child with mental retardation and inability to send them to special school.
Socio-economic status	Good	Able to provide the basic needs for the family i.e. food, shelter and clothing.
	Poor	Inability to provide the above
Community support	Yes	Not willing to assist the mentally retarded children
	No	Not willing to assist the mentally retarded children

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

Mental handicap is defined as a degree of arrested intellectual development that disqualifies a child from ordinary education or an adult from employment (Batshaw, 1997). A child with a diagnosis of mental retardation or other development delays affects the entire family system and creates enormous problems for public health, educational welfare and vocational services. Though the extent of mental retardation is obvious a challenge to all societies throughout the world.

All over the world mental retardation has been recognised as a problem in children , although it is the least considered by health planners. Many countries both developed and developing have adopted different strategies of educating their nationals about mental retardation. The world health organisation (WHO) special committee meeting on psychiatry , of 1978, ALMAATA conference resolved that the implementation of community mental health services be adopted as the most appropriate model for promoting mental health.

The mention of mentally retarded child is one that evokes in most people pity or disgust, hostility or even criticism of the child. Thus the rejection and stigmatisation have characterised the behaviour or the families of mentally retarded persons such that acceptance of these children into their homes is a problem. These parents / guardians do not even see the need to educate these mentally retarded children.

However, today , there is a steady trend towards process of 'normalisation' that is promoting conditions which allows the mentally retarded child to lead as ordinary life as possible .It implies a realisation of skills given the appropriate conditions in the formal education system. The issue of parents fostering their

children's early development through education has obviously been seen as of central importance . (Hornby 1995).

In order for the families to participate in the care and education for their mentally retarded children , mental health workers and teachers should work closely with these families and help them understand more about mental retardation, so as to change their attitudes.

Many more studies need to be done in this area if people have to acquire the needed knowledge so as to change their attitudes .Very few studies have been conducted in this area and therefore the researcher found alot of difficulties to find literature.

In order to discuss literature review systematically ,the researcher discussed it from three (3) perspectives:

- Globally
- Regionally and
- Nationally.

2.2 GLOBAL PERSPECTIVE

About 5-15% of all 3-15 year old children in the world are mentally impaired. In fact , 0.4 -1.5 % (10-30 million) are severely mentally retarded and an additional 60-80 million children are mildly or moderately retarded. (WHO 1991). It has been found that Asphyxia and birth trauma account for most cases of mental retardation in developing countries than other causes. Thus provision of good maternal-child health prevention is important in the prevention of the disabilities.

It is reported that many people in developing countries still believe that mental illness is caused by supernatural forces such as witchcraft, evil spirits and failure to fulfil traditional rites (WHO 1972). Because of the above reasons

many families with mentally retarded children prefer going to see traditional healers . The above scenario is similar in Zambia.

According to Talbot (1967), in a study conducted in Washington, on the care of the mentally ill, concluded that the body of knowledge concerning the care of these children has changed dramatically since the de-institutionalisation period but this knowledge has not been translated uniformly into systems of mental health care because of difficulties resided in the priority set by National policy makers.

The problem of labelling the mentally handicap is a world-wide concern which may be due to inadequate knowledge on the illness. Reddy 1997 researched on the neglect the mentally handicapped children suffer in India. He found out that a female child suffers discrimination for both being born female and being handicapped. The author recommended that education and public awareness on this issue would encourage self awareness, informed decision-making and appropriate actions by the public, parents and guardians and would improve their care of these children.

The same sentiments were echoed by Joseph (1992) in the article , the status of the disabled in Pakistan. He found that there was social stigma attached to persons with disabilities such that mentally retarded children are concealed within families .

Since these children are concealed within families , they may not be given the opportunity to go to school and learn the skills which would empower them to lead an independent life. Clarke 1984 emphasised that a basic principle of special education has been the meeting of individual needs of disabled children. This entails fitting the process of instruction into the uniqueness of a particular child .The child's pattern of difficulties and strengths would be assessed after which a special education programme is developed to suit the child's individual needs. In recent years , therefore there has been a move towards separate individualised programmes of education for special school. These have essentially been home based programmes , an example of this is

the Portage project , originally designed for children in remote rural areas of the United States of America and now adopted in a number of third world countries.

However , for the education programmes to succeed , parents / guardians of the mentally retarded should participate in education of their children .There is constant references to the influential position of the parents as reinforcers of social change in the child and secondly , that the parents of the mentally retarded children are actually the pillar of all necessary formal education for their children. The Warnock report 1978 points out that special education needs for children with disabilities or significant difficulties need to be elaborately taught, things that other children learn spontaneously and recommends that " in the earliest years , parents rather than teachers should be regarded whenever possible , as the main educators of their children ". Mehta (1991) in an article- Behavioural training for mothers of mentally handicapped children : Teaching of self-help skills in India described how a psychiatrist enrolled 37 mothers of 3.5-8 year old children with an IQ <70 came to child guidance clinic at all India institute of medical science of New Delhi in a behaviour training study designed to give the mothers the skill to care and continue the home - school programmes at home. When parents are involved in the education of their children , they firstly , come to terms with their child's difficulties and seek guidance in coping with the child's behaviour at home . Second , they assist the teachers to provide the most effective education for their children with special needs . (Hornby, 1995) .

The Government and NGO's around the world have worked in collaboration in order to give the mentally retarded children some skills. A case study which was done in Rajanukul hospital in Bangkok a good example of NGO-Government collaboration in providing education in for over 700 mentally retarded children from birth to age 18 which provided early intervention programme for the youngest children , a pre-school , a primary school and vocational training activities and community based rehabilitation (Kunmahern, 1992) .

However a trial community -based rehabilitation services (CBRS) which was conducted in Bacolod city in Philippines because 70% of the disabled people in Philippine live in rural areas by WHO (1993) failed .The major obstacles were lack of referral services , the low priority given to the project by the Government and difficult in gaining co-operation from some families and misunderstanding of the role of the local supervisors. This resulted in the inability to deliver rehabilitation to disabled children. CBR in countries where it has succeeded is very beneficial to the disabled children. It emphasises the mobilisation of human and material resources available within the community to provide effective rehabilitation services.

Mentally retarded children are discriminated world wide since time immemorial by the public and even their own parents / relatives . This is signified in a report by Bach (1993) of German in an article ; compulsory sterilisation and euthanasia where on July 14 ,1933 , the law on the prevention of the birth of off-spring with hereditary disorders was promulgated , which came into force in November 1934 in Nazi Germany were 30,000 - 40,000 people were sterilised included were the mentally retarded , schizophrenics, epileptics, etc. This discrimination has continued. Recently, in New South Wales , Australia , an officer from the council of intellectual disability sought a restraining order to prevent the mother of a 15 year old girl severely intellectually disabled girl with epilepsy from having hystereomy perfomed on her. The court granted permission for the surgical procedure to be done though the council argued that surgical procedure to be performed on a person incapable of consent is non-therapeutic and involves interference with the basic human rights such as procreation. (Elizabeth , 1989)

2.3 REGIONAL PERSPECTIVE

Physical and mental disabilities in Africa like any other place in the world poses as a health problem.

Though the causes of mental disabilities are the same world-wide ,in Africa , they have identified iodine deficiency as the commonest cause of physical and

mental retardation. Hence in 1990 , world summit of children was held in Gaborone, Botswana, acknowledging the magnitude and seriousness of this problem and called for efforts to eliminate the root cause of mental disabilities by the year 2000 . The countries in attendance were Botswana , Lesotho , Malawi ,Mozambique , Namibia ,Zaire ,Zambia and Zimbabwe where participants agreed to iodise salt for human and animal consumption .

In Africa, studies have reviewed that the disabled are not readily accepted in the community. Some uncaring people even ridicule them because of their disabilities for instance a nickname high-lighting the disability. Some these disabled become isolated and thereby do not receive any skill to make them independent .(Matome ,1987). It is worth noting that mental retardation of the family member is often shocking and source of great stress to the family . Mental health workers should assist the families and community to cope with the stress and provide enough knowledge on metal retardation to change their attitude towards these children.

Despite having limitations on financial and manpower resources , in Africa , different countries have adopted various methods that focus on the need of the disabled . The Botswana Government and non-government agencies have organised institutions that meet the needs of the disabled. They adopted the WHO community based rehabilitation Manual (1993) where family welfare educators based in clinic and health centres supervise the disabled and their families .The community based rehabilitation was found to be beneficial to the children because they learnt the skills within their environment and the families participated and taught them to perform household tasks to become independent .This is reflected in the report :community based services for young children with mental handicap and Development disabilities in Botswana by Matome .A case study which was undertaken by the researcher on a four year old child in Serowe village under C.B.R found that family participation and familiar environment made the child to grasp the skills fast.

However, a survey was conducted in Zombe mental Hospital in Malawi to compare community based rehabilitation to institution care and found that CBR is

better that institution care (Kamwendo, 1987). The limitations in institution care found where that -since these children had inmates to interact with and children being what they are draw lessons from the principle of social learning theory , imitated the behaviour of other patients .C.B.R is best preferred in the training of the mentally handicapped because it offers the opportunity of training and preparation for real life in one's own community in as normal a manner and setting as possible . As learning is occurring in the parent's and child's natural environment , there is greater likelihood of the learned behaviour being generalised and maintained. In Africa home-based education and rehabilitation is emphasised because a great percentage of the mentally handicapped are found in the rural areas .

The importance of parents collaboration in their children's education has been recognised as essential (Warnock report 1978).The rationale of parent involvement is that parents are the primary influence on their children and are already teachers . Parents in turn understand the information and help on practical activities done by their children. In a natural survey carried out in 1982 in Zimbabwe , it was discovered that the greater percentage of the mentally retarded children are in rural areas . The country developed an out reach programme to deliver home-based learning programme to children in which parents / guardians were part of the programme. The findings were that parent's involvement enhanced designing teaching activities to suit the identified children and worked on public awareness by educating their communities and at the same time identify their attitudes and expectation (Mariga 1987).

2.4 NATIONAL PERSPECTIVE

Like other third-world countries , the field of mental handicap in Zambia has acquired a status of non problem as a result of it never been considered a policy issue. Yet as Meyers (1981) recognises ' in individual and family terms, the burdens of suffering caused by severe mental retardation cannot be doubted but in community terms the answer may vary ''.

It must be emphasised that though there is an imbalance in the distribution of public health facilities in favour of the urban areas , there are generally more children surviving today than was previously the case . It is plausible to assume that some of these children are mentally retarded . As a result, the problem of mental handicap is no longer hidden. However , it is encouraging to note that since the Zambian National Campaign to reach out disabled children (1981-83) was mounted ,there has been widespread commitment to the goal of optimising the development of retarded children .Unfortunately services in the rural areas for this sector of society are still lagging behind .

The true incidence of mental handicap in Zambia at present remains obscure . This is probably due to several factors such as traditional community absorption of such children influenced by traditional beliefs and customs , ignorance and negative attitude adopted by parents and in the rural areas , poor access to primary school education facilities where more cases could be picked

Cunningham (1984) established that most families go through predictable stages in adopting to handicap , proceeding through shock , denial hostility to adoption and orientation . The implication of this is that the stages through which a parent goes in adopting to a handicap usually determines the parent - child and parent-teacher relationships and overall attitude towards social education training for the mentally handicapped children .

According to a study conducted by Phiri (1993) in Lusaka on attitudes of parents towards mentally retarded children , revealed that most parents had positive attitude though at first parents felt punished , hopeless due to the handicap of their children . The term 'attitude ' has been given an operational definition in the study which encompasses parental behaviour , perceptions , values and feelings to help elucidate what is and what is not addressed in the study

A similar study was done by Zulu (1993) in Lusaka province again ,on the attitude of parents of mentally retarded children towards formal education. The researcher concluded that 90% of the respondents had a positive response

towards formal education. Meaning that parents were ready to carry out instructions or rather to meet the conditions that would enhance the social education training of their mentally retarded children . Thus , this implies that they were willing to assist the teachers (professionals who seek to diagnose the reasons for a child's lack of progress educationally and socially).

However , it should be noted that attitude may be influenced by several factors such as lack or availability of community support to the families ,socio-economic factors , past experiences with the parents or lack of information by family members on how to look after the mentally retarded children .

Early identification of mentally retarded children in the community as soon after birth as possible is important and rests on the common sense premises that the earlier you intervene , the greater are the prospects of assisting children to overcome developmental disabilities .This has been observed as a problem in Zambia .This is confirmed in a study conducted at Chainama day centre by Echun (1984) entitled ' a profile of mentally handicapped children and concluded that there is a significant lag between the time of recognition of the handicap by parents and admission into the day centre .This signified a general lack of awareness of the facilities available amongst parents or practitioners or lack of appreciation of possible means and advantage offered by child day centre to improve the condition of the retarded children .

In Daily mail of Zambia of 3rd May ,2000 appeared an article by sister Chilufya that mentally retarded persons can do wonders if given an opportunity to have access to loans and allowed to exercise their skills in formal or informal employment . She further argued the government to enact a law to guarantee the rights of the disabled . The above shows that they are not employed in most sectors as the normal persons .

CONCLUSION

From the literature reviewed , it is clear that the families of the mentally retarded children may not have adequate information on mental retardation and

how to care for their children / relatives at home . Hence the families require comprehensive information on mental retardation and the services available in Zambia .

However knowledge and attitude may be influenced by many factors such as socio -economic factors , education achievements ,availability of community support , number of parity , sex , stigma and so on.

It is therefore imperative that the mental health providers should develop strategies to inform the public about mental retardation .

CHAPTER THREE

3.0 RESEARCH METHOLOGY

3.1 RESEARCH DESIGN

This is the scheme of action for answering the research question or questions. The design and conduct of the study is the heart of the research report. It contains all important information related to the strategy and methodology and describes the instrument.

3.1.1 STUDY TYPE

A descriptive, explorative and non-experimental research design was considered appropriate for the study because it involved the identification of the independent variables affecting the knowledge and attitude of parents/guardians towards the mentally retarded children at the Chainama day care centre and F-ward. The purpose of using explorative research was to gain insight into the situation/phenomena. The design was non-experimental because it didn't require manipulation of subjects.

3.2 RESEARCH SETTING

The research was conducted at Chainama day care center and F-ward which was part of Chainama Hills hospital. Chainama Hills hospital is the only mental hospital in Zambia and it is in Lusaka province, which is the capital city of Zambia. The hospital is situated in the eastern side of the city. It is about twelve (12) kilometers from the town centre on the Great East Road leading to the International Airport. Chainama Hills hospital services is a referral centre for all mental illness in the country. It offers curative and rehabilitative services.

The hospital is divided into two sections. There is Chainama East, the section for forensic psychiatric which has one hundred and ten (110) beds. The other section is Chainama West with four hundred and twenty (420). This section has six wards, two

admission wards, one fee paying ward, two rehabilitation wards and one children's ward.

Chainama Hills Hospital trains registered mental nurses, clinical officers general, psychiatric clinical officers and environmental health Technicians. Medical and nursing students from the University of Zambia and nurses from the University Teaching Hospital and Kitwe Central Hospital also come to Chainama Hills Hospital for their psychiatric clinical experience.

Chainama Hills Hospital was chosen by the researcher because she is familiar with the environment and considered the fact that such a study has never been done in this hospital.

3.3 SAMPLING POPULATION AND APPROACH

3.3.1 STUDY POPULATION

These were the parents/guardians living in Lusaka whose mentally retarded children are admitted or discharged from in F-ward and those attending or had stopped attending Chainama day centre from 1st January to 31st August, 2000.

3.3.2 STUDY UNITS

Consisted of the parents/guardians whose children are admitted or discharged from F-ward and those attending or had stopped attending Chainama day center.

3.3.3 SAMPLE SIZE

The sample size consisted of 50 parents/guardians. This was the number that the researcher managed to meet with the meager resources available and time.

3.4 SAMPLING AND SAMPLING METHODS

Sampling is the process by which the study subjects are chosen from large population (Treece W. and Treece J., 1986). Sampling is a crucial part of research process

because the method is used to determine whether or not the study sample which has been selected represents the entire number of units under study.

The attendance register containing the names of mentally retarded children admitted or discharged from F-ward and those attending or had stopped attending Chainama day care center. The systematic sampling was used to choose the names from the study unit. The names and addresses of the mentally retarded children listed was used to help in the identification of their parents/guardians. The parents/guardians were followed up as they visited their children in F-ward, others as they brought their children to Day centre and the rest were followed up at their homes.

3.5 DATA COLLECTION AND DAYA COLLECTION TECHNIQUE

This allows for systematic collection of information about the subjects and their setting in which they occur (Treece W. and Treece J., 1986).

It was facilitated by the use of two techniques. Focus discussion and structural interview schedule. Focus group discussion method is effective for obtaining information about attitudes, opinions, beliefs, feeling, perception and behaviour patterns (Alchola and Bless, 1988).

An interview schedule involves an interaction, face to face between the interviewer and interviewee. The tool is regarded as the approporiate method of data collection because it is applicable to both the illiterate and literates

Data was collected between July and August, 2000. This is the period which was convenient for the researcher. The researcher was also assisted by 2 Research Assistant with collection of data to ease the workload.

ADVANTAGES OF STRUCTURES INTERVIEW

- Repetition of questions not understood by the respondents will be done.
- The instruments save time and money for postage.

- An interview is appropriate for probing and will enable the researcher to gather supplementary information relevant to the topic.
- The structured interview offers greater ease of processing data.

From each family, only one family member will be interviewed. To ensure confidentiality, the clients will be informed that the information will be used only for the purpose of the research and treated with utmost confidentiality.

FOCUS GROUP DISCUSSION

Focus group discussion is a discussion comprising of not more than 12 respondents and should be led by a facilitator and a note taker should be present. Focus group discussion with two (2) groups of parents/guardian, first group consisted of eight (8) parents/guardians who had their children attending or had stopped attending Day Centre. Each group had eight (8) participants. Discussion for each group was held on separate days.

3.6 PILOT STUDY

A pilot study is a "mini study conducted before the major study in order to make revisions and find faults in the methodology. It should include every step expected in the major study". (Treece E.W and Treece W.J., 1986).

A pilot study was conducted at the Zambian college for the handicapped (ZAMISE) in Kamwala involving parents/guardians who were bringing their mentally retarded children to the centre, in order to test the data collection tools. Ten subjects were selected for the pilot study so as to assess the reaction of the respondents to the research procedure. Time needed to complete the study was estimated after pilot study. The feasibility of the sampling procedure was assessed as well as the appropriateness of the format of the questionnaire. The sample size of the subject was determined by the availability of time because only a fraction of the total was reasonably devoted to the pilot study.

3.7 ETHICAL CONSIDERATION

Written consent to do the study at Chainama Day centre and F-ward was sought from the hospital Director written to the Ethical Committee of Chainama Hills Hospital. Verbal consent was also sought from parents/guardians for the purpose and benefit of the study. No names of the respondents were asked for. Information collected from each parent / guardian was treated with utmost confidence.

3.8 UTILISATION OF FINDINGS

The findings would be used by the Ministry of Health who are the policy makers to come up with strategies to improve strategies used in carrying out health education campaigns in relation to imparting knowledge to the parents/guardians of the mentally retarded children and the public to have positive attitude towards these children, if the mental retarded children have to receive adequate care and education to enable them lead a useful life.

The findings would also be utilised by both mental health staff and teachers at Chainama Day centre to improve on the care of the mentally retarded children.

CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

Data was collected from both questionnaire and interview schedule, then checked for completeness and internal consistency and then tallied on a master sheet.

Data analysis of the study was done manually and findings were presented in table form. Data analysis is "a process by which the investigator summarises and describes data and if possible, makes generalisation from the study sample to the population from which the sample was drawn" (Seam and Verhomic, 1982).

The raw data was collected from the field and put into categorised development for the open-ended questions.

The tables were used to present the findings because they were the most effective and simple way to communicate the results of the study and statistical data can be put together as a basis for computation. Frequency table and cross tabulation were used as well to aid in the visualisation and comparing the relatives of variables.

SOCIO-DEMOGRAPHIC DATA OF PARENTS/ GUARDIANS WITH MENTALLY RETARDED CHILDREN

TABLE 2

VARIABLES	FREQUENCY	PERCENTAGE
SEX		
Male	14	28
Female	36	72
Total	50	100
AGE		
16-25 years	10	20
26-35 years	15	30
36-45 years	13	26
46 and above	12	24
Total	50	100
MARITAL STATUS		
Married	27	54
Separated	6	12
Divorced	5	10
Widowed	7	14
Single	5	10
Total	50	100
RELIGIOUS DENOMINATION		
Roman Catholic	23	46
Protestants	14	28
Pentecostal	13	26
Total	50	100
EDUCATIONAL STATUS		
Never attended School	9	18
Primary	16	32
Secondary	17	34
College	7	14
University	1	2
Total	50	100
OCCUPATION		
Unemployed	22	44
Employed	17	34
Self-Employed	11	22
Total	50	100
MONTHLY INCOME		
Less than K99, 000	23	46
K100, 000-K199, 000	20	40

K200, 000-K299, 000	5	10
K300, 000 and above	2	4
Total	50	100
RESIDENTIAL AREAS Low density area	6	12
Medium density area	7	14
High density areas	37	74
Total	50	100
HEAD OF HOUSEHOLD Father	31	62
Mother	11	22
Relative	4	8
Sibling	4	8
Total	50	100

Table 2, illustrates that 72% of the Respondents were Females with the majority falling in the age range of 26-35 years. Many of the Respondents (54%) were married and 100% are Christians under different denominations. Majority of the respondents had attained secondary school education level, 44% being unemployed and 46% earn a monthly income of less than K100, 000. 74% of the respondents were from the high-density area and male head 62% household.

TABLE 3: AGE IN RELATION TO SEX DISTRIBUTION.

AGE GROUP	SEX		TOTAL
	MALE	FEMALE	
16-25 years	3 (6%)	7 (14%)	10 (20%)
26-35 years	4 (8%)	11 (22%)	15 (30%)
36-45 years	3 (6%)	10 (20%)	13 (26%)
46 and above	4 (8%)	8 (16%0	12 (24%)
Total	14 (28%)	36 (72%)	50 (100%)

Table 3, shows that 28% of the respondents were males whilst 72% were Females, with the majority of the respondents, falling in the age range of 26-35 years.

TABLE 4: EDUCATIONAL LEVEL IN RELATION TO SEX OF RESPONDENTS.

EDUCATIONAL LEVEL	SEX		TOTAL	
	MALE	FEMALE		
Never attended school	1 (2%)	8 (16%)	9	(18%)
Primary	4 (8%)	12 (24%)	16	(32%)
Secondary	7 (14%)	10 (20%)	17	(34%)
College	1 (2%)	6 (12%)	7	(14%)
University	1 (2%)	0	1	(2%)
Total	14 (28%)	36 (72%)	50	(100%)

Table 4, shows that majority of the females have attended primary school education (24%), whilst 14% of males have attended secondary school education. Majority of those who have not attended school are females (16%).

TABLE 5: UNDERSTANDING THE CAUSES OF MENTAL RETARDATION IN RELATION TO THE SEX OF THE RESPONDENTS.

UNDERSTANDING OF THE CAUSES OF MENTAL RETARDATION	SEX		TOTAL	
	MALE	FEMALE		
Cursing	1 (2%)	3 (6%)	4	(8%)
Witchcraft	1 (2%)	5 (10%)	6	(12%)
Genetic factors	10 (20%)	17 (34%)	27	(54%)
Evil spirit	0	6 (12%)	6	(12%)
Epilepsy	2 (4%)	5 (10%)	7	(14%)
Total	14 (28%)	36 (72%)	50	(100%)

Table 5, shows that majority 54% of the respondents knew the causes of mental retardation.

TABLE 6: LEVEL OF KNOWLEDGE ON MENTAL RETARDATION IN RELATION TO AGE DISTRIBUTION OF RESPONDENTS.

KNOWLEDGE LEVEL	AGE IN YEARS				TOTAL
	16-25	26-35	36-45	46 and above	
High	7 (14%)	7 (14%)	9 (18%)	7 (14%)	30 (60%)
Moderate	2 (4%)	7 (14%)	3 (6%)	3 (6%)	15 (30%)
Low	1 (2%)	1 (2%)	1 (2%)	2 (4%)	5 (10%)
Total	10 (20%)	15 (30%)	13 (26%)	12 (24%)	50 (100%)

Table 6, indicates that all age group had high level of knowledge about mental retardation but the age range 36-45 had higher knowledge than the others.

TABLE 7: SOURCES WHERE INFORMATION WAS SOUGHT/OBTAINED BY PARENTS/ GUARDIANS ABOUT THEIR CHILDREN'S CONDITION.

SOURCES OF INFORMATION	FREQUENCY	PERCENTAGE
Health Centre	16	32
School	20	40
Media	3	6
Didn't seek for information	11	22
Total	50	100

Table 7, shows that 78% of the respondents sought and obtained information about their children's condition from either the health centre, school or the media, whilst 22%, didn't obtain any information.

TABLE 8: EDUCATIONAL LEVEL IN RELATION TO OCCUPATION OF RESPONDENTS.

LEVEL OF EDUCATION	OCCUPATION			TOTAL
	EMPLOYED	UNEMPLOYED	SELF-EMPOLYED	
Never attended school	1 (2%)	7 (14%)	1 (2%)	9 (18%)
Primary	4 (8%)	8 (16%)	4 (8%)	16 (32%)
Secondary	7 (14%)	6 (12%)	4 (8%)	17 (34%)
College	4 (8%)	1 (2%)	2 (4%)	7 (14%)
University	1 (2%)	0	0	1 (2%)
Total	17 (34%)	22 (44%)	11 (22%)	50 (100%)

Table 8, shows that majority of the respondents who attained at least secondary education's were in employment than those who attained primary education and those who never attended school.

TABLE 9: OCCUPATION IN RELATION TO THE ABILITY BY THE PARENTS / GUARDIANS TO SEND THE MENTALLY RETARED CHILDREN TO SPECIAL SCHOOL.

OCCUPATION	ABILITY TO SEND THE MENTALLY CHILDREN TO SPECIAL SCHOOL		TOTAL
	YES	NO	
Employed	15 (30%)	2 (4%)	17 (34%)
Unemployed	14 (28%)	8 (16%)	22 (44%)
Self-employed	8 (16%)	3 (6%)	11 (22%)
Total	37 (74%)	13 (26%)	50 (100%)

Table 9, shows that 30% of the employed respondents had the ability to send their mentally retarded children to special school than those who were not in formal employment.

TABLE 10: MONTHLY INCOME IN RELATION TO SEX OF RESPONDENTS.

MONTHLY INCOME	SEX		TOTAL
	MALE	FEMALE	
Less than K99,000	2 (4%)	21 (42%)	23 (46%)
K100,000-K199,000	9 (18%)	11 (22%)	20 (40%)
K200,000-K299,000	1 (2%)	4 (8%)	5 (10%)
K300,000 and above	2 (4%)	0	2 (4%)
Total	14 (28%)	36 (72%)	50 (100%)

Table 10 shows that more males are in the higher income group than females.

TABLE 11: EDUCTIONAL LEVEL IN RELATION TO MONTHLY INCOME OF RESPONDENTS.

EDUCATION LEVEL	MONTHLY INCOME				TOTAL
	Less than K99,000	KI00,000-K199,000	K200, 000-K299,000	K300,000 and above	
Never attended school	7 (14%)	2 (4%)	0	0	9 (18%)
Primary	7 (14%)	8 (16%)	1 (2%)	0	16 (32%)
Secondary	9 (18%)	6 (12%)	2 (4%)	0	17 (34%)
College	0	4 (8%)	2 (4%)	1 (2%)	7 (14%)
University	0	0	0	1 (2%)	1 (2%)
Total	23 (46%)	20 (40%)	5 (10%)	2 (4%)	50 (100%)

Table 11, shows that majority of the respondents who were educated were in higher income group than those who had never attended school.

TABLE 10: MONTHLY INCOME IN RELATION TO SEX OF RESPONDENTS.

MONTHLY INCOME	SEX		TOTAL
	MALE	FEMALE	
Less than K99,000	2 (4%)	21 (42%)	23 (46%)
K100,000-K199,000	9 (18%)	11 (22%)	20 (40%)
K200,000-K299,000	1 (2%)	4 (8%)	5 (10%)
K300,000 and above	2 (4%)	0	2 (4%)
Total	14 (28%)	36 (72%)	50 (100%)

Table 10 shows that more males are in the higher income group than females.

TABLE 11: EDUCTIONAL LEVEL IN RELATION TO MONTHLY INCOME OF RESPONDENTS.

EDUCATION LEVEL	MONTHLY INCOME				TOTAL
	Less than K99,000	KI00,000-K199,000	K200, 000-K299,000	K300,000 and above	
Never attended school	7 (14%)	2 (4%)	0	0	9 (18%)
Primary	7 (14%)	8 (16%)	1 (2%)	0	16 (32%)
Secondary	9 (18%)	6 (12%)	2 (4%)	0	17 (34%)
College	0	4 (8%)	2 (4%)	1 (2%)	7 (14%)
University	0	0	0	1 (2%)	1 (2%)
Total	23 (46%)	20 (40%)	5 (10%)	2 (4%)	50 (100%)

Table 11, shows that majority of the respondents who were educated were in higher income group than those who had never attended school.

TABLE 12: RESPONDENT'S MONTHLY INCOME IN RELATION TO THE ABILITY BY THE PARENTS / GUARDIANS TO SEND THE MENTALLY RETARDED CHILDREN / RELATIVES TO SPECIAL SCHOOL.

MONTHLY INCOME	ABILITY TO SEND THE CHILDREN TO SPECIAL SCHOOL				TOTAL	
	YES		NO			
Less than K99,000	14	(28%)	9	(18%)	23	(46%)
K100,000-K199,000	15	(30%)	4	(8%)	19	(38%)
K200,000-K299,000	6	(12%)	0		6	(12%)
K300,000 and above	2	(4%)	0		2	(4%)
Total	37	(74%)	13	(26%)	50	(100%)

Table 12, shows that majority of the respondents in all income groups were able to send their mentally retarded children to special school. Only respondents in low and medium income groups were unable to send their mentally retarded children to school (9% and 4% respectively).

TABLE 13: EDUCATIONAL LEVEL OF RESPONDENTS IN RELATION TO ABILITY BY RESPONDENTS TO SEND THE MENTALLY RETARDED CHILDREN / RELATIVES TO SPECIAL SCHOOL.

EDUCATION LEVEL	ABILITY TO SEND THE MENTALLY RETARDED CHILDREN TO SPECIAL SCHOOL				TOTAL	
	YES		NO			
Never attended school	5	(10%)	4	(8%)	9	(18%)
Primary	13	(26%)	3	(6%)	16	(32%)
Secondary	11	(22%)	6	(12%)	17	(34%)
College	6	(12%)	1	(2%)	7	(14%)
University	1	(2%)	0		1	(2%)
Total	36	(72%)	14	(28%)	50	(100%)

Table 13, shows that majority of respondents who have attended school was able to send their mentally retarded children to special school.

TABLE 14: LEVEL OF KNOWLEDGE ABOUT MENTAL RETARDATION IN RELATION TO SEX OF RESPONDENTS.

LEVEL OF KNOWLEDGE	SEX		TOTAL	
	MALE	FEMALE		
High	9 (18%)	20 (40%)	29	(58%)
Moderate	4 (8%)	13 (26%)	17	(34%)
Low	1 (2%)	3 (6%)	4	(8%)
Total	14 (28%)	36 (72%)	50	(100%)

Table 14 shows that males were more knowledgeable about mental retardation than the females.

TABLE 15: LEVEL OF EDUCATION ABOUT MENTAL RETARDATION IN RELATION TO LEVEL OF KNOWLEDGE

LEVEL OF EDUCATION	LEVEL OF KNOWLEDGE			TOTAL
	HIGH	MODERATE	LOW	
Never attended school	4 (8%)	3 (6%)	2 (4%)	9 (18%)
Primary	7 (14%)	9 (18%)	0	16 (32%)
Secondary	13 (26%)	2 (4%)	2 (4%)	17 (34%)
College	4 (8%)	3 (6%)	0	7 (14%)
University	1 (2%)	0	0	1 (2%)
Total	29 (58%)	17 (34%)	4 (8%)	50 (100%)

Table 15, shows that majority of the respondents had high knowledge about mental retardation whilst those who had not attended school had low knowledge.

TABLE 16: LEVEL OF KNOWLEDGE ABOUT MENTAL RETARDATION IN RELATION TO THE ABILITY BY THE RESPONDENTS TO SEND THEIR MENTALLY RETARDATED CHILDREN TO SPECIAL SCHOOL.

LEVEL OF *KNOWLEDGE*	ABILITY TO SEND MENTALLY *RETARDED CHILDREN TO SPECIAL* SCHOOL		TOTAL
	YES	NO	
High	25 (50%)	4 (8%)	29 (58%)
Moderate	12 (24%)	5 (10%)	17 (34%)
Low	0	4 (8%)	4 (8%)
Total	37 (74%)	13 (26%)	50 (100%)

Table 16, shows that respondents with high and moderate knowledge were able to send their mentally retarded children to special school than those who were less knowledgeable.

TABLE 17: LEVEL OF KNOWLEDGE ABOUT MENTAL RETARDATION IN RELATION TO ATTITUDE TOWARDS THE MENTALLY RETARDED *CHILDREN.*

LEVEL OF KNOWLEDGE	ATTITUDE		TOTAL
	POSITIVE	NEGATIVE	
High	23 (46%)	6 (12%)	29 (58%)
Moderate	10 (20%)	7 (14%)	17 (34%)
Low	0	4 (8%)	4 (8%)
Total	33 (66%)	17 (34%)	50 (100%)

Table 17 shows that 58% respondents who were highly knowledgeable about mental retardation have positive attitude whilst those who were less knowledgeable have negative attitude.

TABLE 18: ATTITUDE OF RESPONDENTS IN RELATION TO AGE DISTRIBUTION.

ATTITUDE	AGE IN YEARS				TOTAL
	16-25	26-35	36-45	46 and above	
Positive	8 (16%)	10 (20%)	9 (18%)	6 (12%)	33 (66%)
Negative	2 (4%)	5 (10%)	4 (8%)	6 (12%)	17 (34%)
Total	10 (20%)	15 (30%)	13 (26%)	12 (24%)	50 (100%)

Table 18, indicates that majority of the respondents in all age groups had positive attitude towards mental retardation but the age range 26-35 had more respondents who were positive than any other group.

TABLE 19: ATTITUDE OF RESPONDENTS IN RELATION TO SEX DISTRIBUTION.

ATTITUDE	SEX				TOTAL	
	MALE		FEMALE			
Positive	9	(18%)	24	(48%)	33	(66%)
Negative	5	(10%)	12	(24%)	17	(34%)
Total	14	(28%)	36	(72%)	50	(100%)

Table 19, indicates that majority of the females had positive attitude towards mental retardation than the males.

TABLE 20: MARITAL STATUS OF RESPONDENTS IN RELATION TO ATTITUDE TOWARDS MENTAL RETARDATION.

MARITAL STATUS	ATTITUDE		TOTAL
	POSITIVE	NEGATIVE	
Married	22 (44%)	5 (10%)	27 (54%)
Separated	4 (8%)	2 (4%)	6 (12%)
Divorced	3 (6%)	2 (4%)	5 (10%)
Widowed	2 (4%)	5 (10%)	7 (14%)
Single	2 (4%)	3 (6%)	5 (10%)
Total	33 (66%)	17 (34%)	50 (100%)

Table 20, shows that majority of the married respondents (44%) had positive attitude towards mental retardation, whilst the majority of the single and widowed respondents had negative attitude.

TABLE 21: ATTITUDE TOWARDS MENTAL RETARDATION IN RELATION TO TYPE OF THE FAMILY.

ATTITUDE	TYPE OF FAMILY		TOTAL
	EXTENDED	NUCLEAR	
Positive	8 (16%)	25 (50%)	33 (66%)
Negative	8 (16%)	9 (18%)	17 (34%)
Total	16 (32%)	34 (68%)	50 (100%)

Table 21, shows that majority of the respondents (50%) who were looking after their own bloody children were positive about mental retarded children, whilst only 16% of those taking care of their relatives' mentally children had positive attitude.

TABLE 22: EDUCATIONAL LEVEL OF RESPONDENTS IN RELATION TO ATTITUDE TOWARDS MENTAL RETARDATION.

EDUCATION LEVEL	ATTITUDE		TOTAL
	POSITIVE	NEGATIVE	
Never attended school	5 (10%)	4 (8%)	9 (18%)
Primary	9 (18%)	7 (14%)	16 (32%)
Secondary	13 (26%)	4 (8%)	17 (34%)
College	5 (10%)	2 (4%)	7 (14%)
University	1 (2%)	0	1 (2%)
Total	33 (66%)	17 (34%)	50 (100%)

Table 22, shows that 66% of the respondents had a positive attitude towards mental retardation regardless of their educational level.

TABLE 23: ATTITUDE IN RELATION TO THE ABILITY BY PARENTS /GUARDIANS TO SEND THE MENTALLY RETARDED CHILDREN TO SPECIAL SCHOOL

ATTITUDE	ABILITY TO SEND MENTALLY RETARDED CHILDREN TO SPECIAL SCHOOL		TOTAL
	YES	NO	
Positive	27 (54%)	6 (12%)	33 (66%)
Negative	10 (20%)	7 (14%)	17 (34%)
Total	37 (74%)	13 (26%)	50 (100%)

Table 23, shows that majority of the respondents who had positive attitude towards mental retardation were able to send their mentally retarded children to the special school than those who had negative attitude (14%).

TABLE 24: COMMUNITY SUPPORT IN RELATION TO THE ABILITY OF RESPONDENTS TO SEND THEIR MENTALLY RETARDED CHILDREN TO SPECIAL SCHOOL.

COMMUNITY SUPPORT	ABILITY BY PARENTS / GUARDIAN TO SEND MENTALLY RETARDED CHILDREN TO SPECIAL SCHOOL		TOTAL	
Yes	11	(22%)	1	(2%)	12	(24%)
No	26	(52%)	12	(24%)	38	(76%)
Total	37	(74%)	13	(26%)	50	(100%)

Table 24, shows that 76% of the respondents were able to send their mentally retarded children to special school even though they didn't receive any community support.

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS AND IMPLICATIONS TO THE HEALTH CARE SYSTEM

5.1 INTRODUCTION

The study sought to determine the knowledge and attitude of parents / guardians towards the mentally retarded children in view of making recommendations to relevant authorities for action. The researcher was prompted to carry out the study due to the reduction in the number of parents / guardians bringing their mentally retarded children to Chainama day care special school and the increase in the number of children being admitted to Chainama F-ward (children's ward).

The assumptions of the study were socio-economic status of parents / guardians, knowledge level and attitude of parents / guardians which have adverse influence on the care of the mentally retarded children and the ability to send them to the special school.

In the study, the researcher looked at the factors which affect the knowledge and attitude of the parents / guardians towards the care of the mentally retarded children. Some of the factors were; educational level, nature of illness, socio- economic status, relationship of these children to carers, parity of parents and community support. The target group for the researcher consisted of parents / guardians whose mentally retarded children attend Chainama special school or had stopped and those parents /

guardians whose mentally retarded children are admitted or discharged from Chainama F-ward. The discussion was based on data collected and analysed.

5.2 DISCUSSION OF FINDINGS

5.2.1 SOCIO-DEMOGRAPHIC DATA OF RRESPONDENTS

The study sample size comprised of 50 parents / guardians. Socio- demographic table 2 shows that 36(72%) respondents were females and only 14 (28%) were males. This is attributed to the harsh economic situation prevailing in Zambia, that most males are out working or looking for employment or money.

Majority of the respondents' age ranged between 26-35 years (30%) (Table 3). Most respondents were married 27 (54%) while the other few 5 (10%) were single. More respondents were married because in Zambian culture, marriage is considered universal and every woman and man need to marry.

All the respondents were Christians. The educational level was satisfactory as most of them 17 (34%) had attended secondary education except for a few 9 (18%) who had never attended school and most of those who didn't attended school were females (16%). I n Zambian culture, families would rather educate a male sibling than female sibling because male children are considered as heir's to families (table 4).

Most of the respondents were unemployed 22 (44%), 11 (22%) were self employed and only 17 (34%) were in formal employment. Problem of employment is adverse due to retrenchments and redundancies, hence there is need for the Government and

non- Governmental organisation's intervention through small- scale industry to enable families provide the basic needs for their children i.e. food, shelter, clothing etc.

As the majority of the respondents were not in formal employment, 23 (46%) of them earned a monthly income of less than K100, 000. More of the respondents 37 (74%) were from the high-density area because it's the high-density compounds like Kalikiliki, M'tendere, Kaunda Square, Kalingalinga etc, which are near to Chainama Hospital, and most pupils are drawn from these areas. Majority 32 (64%) of the households are headed by males because majority of the respondents were married.

5.2.2 KNOWLEDGE ON MENTAL RETARDATION

The majority of respondents 29(58%) had high knowledge followed by moderate 17 (34%) and low 4(8%) (table15). The majority 27(54%) knew that mental retardation was caused by genetic abnormality during embryonic development of the foetus while 4 (8%) attributed it to cursing, 6 (12%) to witchcraft and 6 (12%) to evil spirits (table 5). Even in focus group discussion, participants mentioned a number of causes of mental retardation as disobeying cultural rituals like cleansing, old age, punishment from God, hereditary factors, meningitis and cerebral malaria. The majority mentioned genetic factors as the main cause of mental retardation. Arguments arose in all groups when few participants mentioned that mental retardation was curable. Eventually all the participants agreed that the illness was not curable, since it is hereditary and sometimes results from death of some brain cells and hence this process is irreversible.

The above findings coincide with WHO report (1972) that many people in developing countries still believe that mental retardation is caused by supernatural forces.

The study findings also confirmed that all age group had some understanding about mental retardation but the age group between 36-45 years had the majority with high level of understanding of mental retardation (table 6). These findings are similar to the findings of Phillip (1964) who attributed the phenomena to the fact that most of the families in this age group are more responsible and tend to have the majority of mentally ill relatives.

The study also revealed that 20 (40%) of the respondents obtained information on mental retardation from schools, 16 (32%) from the health centres and 3 (6%) through the media. Whilst 11 (22%) of the respondents, didn't not ask for information from anywhere concerning the nature of illness, care and education of mentally retarded children (table 7).

However this findings could be alluded to the fact that most of the parents / relatives tend to wait for information from the medical staff and teachers and when they don't get the information they expected, they would get frustrated. It also came to light during focus group discussion, that some participants learnt about the care of their mentally retarded children after obtaining information and educational materials about mental retardation. Miyoba (1987) confirmed that about 92% of the relatives expect information from the health workers about the nature of illness, treatment and any assistance to be rendered to their ill relatives.

The study findings also confirmed that they were more males who were highly knowledgeable about mental retardation than the females (table 14). The above findings have been echoed by Gupta and Sethi (1970) that males are more open in their interaction with others and seek information when in doubt unlike the female counterparts who are usually shy and reserved.

The research findings also revealed that educated respondents knew the importance of education and most of them send their mentally retarded children to the special school than the lowly educated respondents (table15). This fact was also confirmed during a focus group discussion. This could be attributed to the fact that the educated parents /guardians have access to educational material and tend to seek more information or facts about the illness and are critical thinkers.

The above findings correlate with the findings reported by Ramsely and Siepp (1968) that educated persons tend to be more enlightened, more humanitarian and scientific about mental illness.

It was further confirmed that the majority of the educated were able to send their mentally retarded children to the special school whilst the majority of the lowly educated were not (table 23). The findings could be due to the fact that majority of the educated are more likely to be in employment (table 8) and are in higher income group (table 11). Therefore, they are able to support their mentally retarded children both financially, materially and manage to send to them to the special school (table 12). While those with little education are in low income group and find it difficult to support their mentally retarded children and sometimes reject them completely. This

fact was also confirmed during a focus group discussion where majority of the participants who were not able to send their mentally retarded children to the special, mentioned financial constraints as the major reason. This proves my two hypotheses that socio- economic status and knowledge level of the parents / guardians have adverse influence on the care and ability to send the mentally retarded children to the special school.

The study also proved that few parents / guardians 6 (12%) with high knowledge on mental retardation had negative attitude towards the mentally retarded children (table 17) and rejected them. However, the above finding is similar to the finding of Goldfarb (1974) who reported that some family members who knew much about the condition of their relatives tended to be pessimistic towards the care of these relatives. In focus group discussion, half of the respondents in the first group knew the skills taught at the special school but were not sure as to whether these skills could make their mentally retarded children independent after acquiring them. Various beliefs were held about the ability of the mentally retarded children to learn some skills. Parents / guardians in both groups stated that these children are slow in grasping new skills, are useless and too playful to learn the skills. Such beliefs should be offset by intensive health education to let parents / guardians of mentally retarded children know facts about the condition and the importance of rehabilitation.

Majority of the participants in the second group pointed that the idea of rehabilitating their mentally retarded children was to empower their children with skills to live independently and the families to learn some knowledge on the care of these mentally retarded children. They agreed, however that Chainama day centre special school has

been neglected by the policy makers, as regarding rehabilitation the parents / guardians to the mentally retarded children.

5.2.3 ATTITUDE

The majority of the respondents had positive attitude towards mental retardation (table 17). These findings are contrary to the findings postulated by health education unit (Bwino magazine 1999) that most of the relatives of mentally ill individuals had negative attitude towards mental illness. The study findings could be attributed to the fact that most Zambian families show strong feelings about sickness of a family member, such that when a family member is admitted to the hospital, the relatives feel they have a joint responsibility with the health workers to care for their sick and help them recover. If that family member were not admitted, the relatives would look for some herbs to treat their sick and refer to a spiritual healer or traditional healer for further treatment.

The study also revealed that the age range 26-35 years had the majority with positive attitude towards mental retardation than other age groups (table 18). Chun-shong (1968) had similar findings and postulated that the younger people are less likely to reject their mentally sick relatives. Therefore, if mentally health awareness campaigns would involve this age group then one would expect to have a well-informed adult group in future.

It was also confirmed in the study that the majority of the females had positive attitude towards mental retardation than males (table19). This could be attributed to the fact that females are more tolerant than males.

The research finding revealed that majority of the married respondents had positive attitude towards the mentally retarded and were able to care for these children than other groups. The majority of the widowed 5 (10%) and the single parents 3 (6%) had negative attitude towards these children(table 20). This could be attributed to the fact that widowed and single parents have no partners to assist in looking after these mentally retarded children, which could lead to frustrations and eventually negative attitude toward the children.

The study further confirmed that children who were part of the nuclear family were more cared for by their parents than those from the extended family (table 21). This findings could be attributed to the fact that naturally the closer the relationship between the individual, the greater the concern for each other's well being.

The study also confirmed that the majority of the respondents who were employed accepted, cared and send their mentally retarded children to school than those who were unemployed (table 9). The above finding therefore reflects that the employed families have adequate resources to look after their mentally retarded children unlike the unemployed families. Therefore the unemployed parents / guardians require more assistance from the community. Availability of community resources for the mentally retarded children would reduce the burden on these families.

However table 12, confirms that the majority of the respondents in all income groups were able to send their mentally retarded children to special school. Only respondents in the low and medium income groups were unable to send their mentally retarded

children to school (18% and 8%) respectively. This could be attributed to the fact that in Zambia, education is considered important to the future of the children.

During a focus group discussion parents / guardians felt that at the moment, the suitable place for the caring of the mentally retarded children was the psychiatric unit. The reasons given by half of the parents /guardians in the first group were that they had financial constraints and were unable to look after these children properly at home. Whilst majority of the participants in the second group mentioned unacceptable behaviour manifested by these mentally retarded children as the reasons for keeping them in the psychiatric hospital and few stated that they were fearful that the mentally retarded children could be abused by the unruly youths in the compounds and it was safer to nurse them in the psychiatric hospital. However the researcher alluded to the importance of nursing the children in their own community to reduce on stigmatisation. There is need for intensive health education if these children can be accepted in their communities.

In the study, it was confirmed that majority of the respondents didn't receive any assistance from the community (table 24). However, those who received support from the community, assistance was negligible, 18% was from the church, local non-governmental organisation (Mapode) 4% and 2% from Red Cross. Despite not receiving help from the community, 36 (72%) of the respondents were able to send their mentally children to Chainama Special School.

5.3 IMPLICATIONS FOR HEATLH CARE SYSTEM

With the majority of the parents / guardians having adequate knowledge on mental retardation, the researcher is inclined to think that the dissemination of information on mental retardation would be met with little resistance. The research findings also revealed that the majority of the respondents have positive attitude towards mental retardation. These findings imply that the health care providers should manipulate the knowledge and positive attitude of the parents / guardians to their advantage and work out strategies to intensify mental health campaigns. It is however, the duty of the health care providers to provide enabling environment for knowledgeable parents / guardians to interact freely with each other and share their experiences.

It had also come to light in this study that some areas are not in reach of the special school / rehabilitative centres. In view of this problem, the health care providers through multisectoral collaboration should consider rehabilitation centres for mentally retarded children as a matter of urgency and lobby to the government and Non-Governmental Organisations to build more of these rehabilitative centres / special schools. Health care providers are expected to support parents / guardians of mentally retarded children through follow up programs and comprehensive counselling. It is worthy noting that collaborative relationships between mental health care providers, community and community agencies are absolutely essential if rehabilitation is to succeed. Therefore it is imperative that health care providers forge closer links with key people in the community through such organisation as Mental Health Associations of Zambia (MHAZ) and other interested non- government organisation.

CHAPTER 6

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

The study sought to determine the knowledge and attitudes of the parents / guardians towards the mentally retarded children.

The findings from the study showed that the majority of the parents / guardians are knowledgeable about mental retardation. Although it was observed that those parents / guardians who have never attended school had low knowledge on mental retardation.

The study further showed that majority of the parents / guardians had positive attitude towards mentally retarded children, whilst majority of the widowed 5 (10%) and the single parents 3 (6%) had negative attitude towards these children.

However, it was noted that in both cases that the main factors influencing knowledge and attitude of the parents / guardians were educational level and financial status. It was brought to light, that the educated respondents were knowledgeable about mental retardation and that, majority were able to care for their mentally retarded children and manage to send them to the special school while the uneducated respondents, whose majority were not employed, were in low income group, and had inadequate knowledge about mental retardation and majority of them were not able to send their mentally retarded children to chainama special school.

Above findings will need to be addressed by relevant authorities to improve the socio-economic status and educational level parents / guardians with mentally retarded children. Consequently, the mentally retarded children would be well cared for and sent to Special Schools to acquire the skill that will empower them to lead an independent life and hence reduce the burdens on the families and society at large.

6.2 RECOMMENDATIONS

1. Mental health care providers should consider establishing counselling services to the parents / guardians with mentally retarded children.

2. Referral system from the special school and f- ward to the clinic should be well defined. Mentally retarded children discharged from f- ward should have a record at a nearest clinic for the purpose of follow up and easy management at the local clinic.

3. Community department should be revamped at Chainama Hills Hospital, because the present trend in medical world is on preventive measures as opposed to curative. Hence community based mental health services should be encouraged.

4. More rehabilitation centres / special school should be established in Lusaka to cater for the over growing population of mentally retarded children. Non-governmental organisation, Religious groups, clubs, and interested individuals should come to the aid of these families by building more workshops and special school for mentally retarded children where skills are provided to enable them live independently and thus reduce the burden on the families.

5. Government and Non-Governmental Organisations to spearhead small scale programmes so as to empower these families with mentally retarded children and enable them provide basic needs for their children such as shelter, education, food, etc.

6. Ministry of health should start funding Chainama day separately so that transport and food could be provided to these children to the centre on regular basis. However provision of transport and food is not the responsibility of Ministry of Health and Education alone but all well wishers Non-governmental Organisation etc

7. Mental Health Association of Zambia (MHAZ) should step up the educational campaigns to educate parents and public on mental retardation and make itself known to the ordinary Zambian. This way, many parents/guardians with mental retarded children are hoped to join MHAZ and voice out their grievances. Reading materials and strategies of health education should be different according to the families' level of education.

8. I recommend that a study on the evaluation of the services rendered to mental retarded children such as welfare, education, medical and social/vocational rehabilitation services should be conducted. The way would be helpful both to the policy makers, mental health professionals and teachers because it will highlight as to whether these services are beneficial to these children and are in line with the health reform and primary health care approach.

6.3 LIMITATIONS OF THE STUDY

Major limitation of the study was the limited resources such as funds because sponsors did not fund the researcher. Time was also limited because the researcher was doing other courses at the same time.

Lack of published literature in psychiatry especially mental retardation was another big hindrance as most of the literature done locally is unpublished and the available material is old.

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UNIVERSITY OF ZAMBIA,
SCHOOL OF MEDICINE,
DEPT OF PBN.
P.O BOX 50110,
LUSAKA.

24th July 2000.

THE EXECUTIVE DIRECTOR,
CHAINAMA HILLS HOSPITAL,
P.O BOX 30043,
LUSAKA.

U.F.S. The Head of Department,
Post Basic Nursing
P.O Box 50110,
Lusaka

Dear Sir,

RE: RESEARCH STUDY: REQUEST TO COLLECT DATA AT THE DAY CENTRE AND F-WARD

I am a final year student in the school of Medicine, Department of Post Basic Nursing, pursuing a Bachelor of Science degree. In partial fulfilment for the degree programme, I am required to carry out a research study.
My chosen topic is "Study to determine Knowledge and Attitude of parents/guardians towards mentally retarded children: A case for F-ward and Chainama Day Centre". It is in this respect that I am seeking permission to collect data at the above-mentioned centre and ward.
I intend to collect data between July and August 2000. Your assistance in this regard will be highly appreciated.

Yours faithfully,

Esther Chirwa.

SCHEDULE NO.....

DATE OF INTERVIEW.....

STRUCTURED INTERVIEW SCHEDULE TO ELICITE INFORMATION FROM THE PARENTS / GARDIANS WITH MENTALLY RETARDED CHILDREN

INTRODUCTION TO THE INTERVIEWER

1. Introduce yourself to the respondents.
2. Explain the purpose of the interview.
3. Inform the respondents that information collected will be held in confidence.
4. Indicate the correct answers by either a tick or filling in the space provided. Clarify if question has been misunderstood.

DEMOGRAPHIC DATA

1. What is your sex?
    1. Male [ ]
    2. Female [ ]

2. What was your age on your last birthday?
    1. 16-25 [ ]
    2. 26-35 [ ]
    3. 36-45 [ ]
    4. 46 and above [ ]

3. What is your marital status?
    1. Married [ ]
    2. Separated [ ]
    3. Divorced [ ]
    4. Single [ ]

4. What is your Religious denomination?
    1. Roman Catholic [ ]
    2. Protestants [ ]
    3. Hindu [ ]
    4. Moslem [ ]
    5. Pentecostal [ ]

5. What is your educational level?
    1. Never attended school [ ]
    2. Primary [ ]
    3. Secondary [ ]
    4. College [ ]
    5. University [ ]

6. What is your occupation?

    1. Less than K 99,000 [ ]
    2. K100,000-K199,000 [ ]
    3. K200,000-K299,000 [ ]
    4. K300,000 and above [ ]

1. Where do you live.....
2. Who is the head of this household

    1. Father [ ]
    2. Mother [ ]
    3. Relative [ ]
    4. Sibling [ ]

3. How many children do you have?.....

KNOWLEDGE OF MENTAL RETARDATION AND REHABILITION SERVICES

4. What do you understand by mental retardation?

    1. Abnormal behaviour [ ]
    2. An illness for the deviants of society [ ]
    3. Sub- average general intellectual functioning which originates in the development period and is associated with impairment of adaptive behaviour. [ ]

5. What do you think is the cause of mental retardation in your child / relative.

    1. Cursing [ ]
    2. Witch craft [ ]
    3. Genetic factors [ ]
    4. Evil Spirit [ ]

6. Others specify.....

7. Where did you get information about your child's condition (mental retardation)?

1.Health centre [ ]

2. Media [ ]

3. Books [ ]

4.Others specify.....

8. At which centres are the mentally Retarded children rehabilitated.....

9. Have you ever approached any organisation or rehabilitation centres in Lusaka regarding the care of your mentally retarded child?

1. Yes [ ]
2. No [ ]

10. If answer to question 15 is yes, what was their reaction?..... .....

11. Has your child ever attended any rehabilitation centre or special school?

1. Yes [ ]
3. No [ ]

12. If No why.....

13. If your child used to attend rehabilitation centre, why has he/she stopped?.....

13. What skills are taught to mentally retarded children at the special school?

(a).Activities of daily living like washing, eating, cleaning, reading, writing. [ ]

(b) Playing football, Netball [ ]

(c) Fighting others [ ]

(d) Vocational skills like carpentry, sewing [ ]

ATTITUDE TOWARDS MENTAL RETARDATION

21 How many times has your mentally retarded child been admitted in F-ward?..... [ ]

22. What is your relationship with the mentally retarded child?

1. Son [ ]
2. Niece [ ]
3. Auntie [ ]
4. Uncle [ ]
5. Nephew [ ]
6. Others specify.....

23.Where would you want your mentally retarded child be cared for?

1.At home [ ]
2. Psychiatric Institution [ ]
3.Others specify.....

24. Do you get any support from any Organisation in the care of your mentally retarded child?

1. Yes [ ]
2. No [ ]
3. If the answer to question 28 is yes, which Organisation?..... [ ]

26 Do you think that education is important to these mentally retarded children?

1. Yes [ ]
2. No [ ]

27. If answer to question 28 is yes, why do you think so? .....

27. If answer is no, why not? .....