CONSTRAINTS AFFECTING THE ADMINISTRATION OF MENTAL HEALTH SERVICES IN ZAMBIA : WITH SPECIAL REFERENCE TO MANPOWER TRAINING AND UTILIZATION.

A Thesis Presented

By

WILFRED W. BANDA

Submitted to the University of Zambia in partial fulfil-
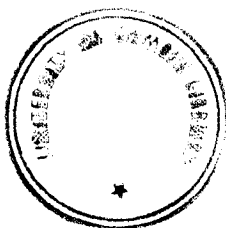ment of the requirements for the degree of

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APPROVAL

This dissertation of **WILFRED WELUZANI BANDA**
is approved as fulfilling part of the requirement
for the award of the degree of Master of Public
Administration by the University of Zambia.

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2/1/1990

DECLARATION

I hereby declare that the work presented in the thesis
for the degree of Master in Public Administration (M.P.A.),
has not been presented either wholly or in part for any other
degree and is not being currently submitted for any other
degree.

Signed...................

Signed...................

Supervisor.

STATEMENT

I hereby certify that this thesis is entirely the result of my own independent investigation. The various sources to which I am indebted are clearly indicated in the text and in the references.
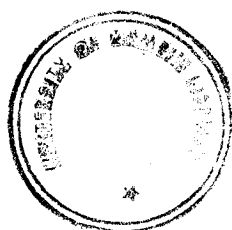

Signed...............

STATEMENT

I hereby certify that this thesis is entirely the result of my own independent investigation. The various sources to which I am indebted are clearly indicated in the text and in the references.

Signed...........................

DEDICATION

Dedicated to my late father, Mr. Weluzani Banda and to my mother Mrs. Yakiwe Phiri - who were the first to administer me.

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ABSTRACT

Zambia's mental health services date back to 1962 when
Chainama Hills Hospital was opened. Before this period,
Psychiatric services in this country were primarily part of
the prisons service.

However, nearly 26 years later the mental health service
has only achieved about 15% coverage of the at-risk population
in the country such as students, detainees, prisoners,
unemployed etc.

One explaination which has been given for this lack of
coverage of the at-risk population is that mental health workers
are being utilized on general medical work as well as on mental
health work.

This study is therefore an attempt to discover whether
mental health workers are actually being utilized on general
medical work, and if so, the degree to which they are deployed
on general medical work. The study is also intended to find
out whether general health workers too are being assigned to do
mental health work. In addition, we also want to find out the
factors (other than training) which have led to such a
situation.

The study is conducted in three provinces of Zambia and
covers 23 mental health facilities (50% of all mental health
facilities in these three provinces). The interviewee
population consists of 46 mental health workers, 44 general
health workers, 18 supervisors, 3 provincial medical officers
and 2 deputy directors of medical services responsible for
planning and development; and medical care administration. This
is based on random sample of 113 health personnel out of 208
population:

The eclectic approach - combining the Historical,
Sociological and Psychological approaches - is used during
the collection and analysis of primary data.

The findings of the study reveal that forty per cent
of mental health workers' training programme is devoted to
general medical work as compared to only three per cent of
general health workers' training programme devoted to
mental health work.

Mental health workers are involved in general medical
work more regularly than their counterparts the general
health workers, involvement in mental health work.

In terms of career anchorages, there is a widespread
agreement among the respondents that mental health workers
are given poor facilities, are rarely visited and have
fewer opportunities for promotion to administrative positions
within the Ministry of Health and that the Central Adminis-
tration is not responsive to the needs of mental health
workers in the country. This appears to result in frustra-
tions and low morale among mental health workers.

As a result of this negative assessment by the
majority of the respondents about mental health workers'
professional position, we recommend that organizational
changes be made at the national (Ministry), provincial,
district, hospital (institutional) and community levels to
ensure the proper control and coordination of mental health
services in the country. Thus, there ought to be a Deputy
Director of Medical Services (Mental Health) at the national
level and mental health worker(s) at each provincial,
district, hospital and community levels. There is also a
need to develop a polyvalent health worker capable of
dealing with a variety of health problems facing the
country.

INTRODUCTION

The administrative structures adopted by health care
organizations in developing countries can either promote or
hinder health care services and professional growth and
functioning. While recognizing the significance of the kind
of organizational structure adopted by a given country in the
administration of mental health services, yet the training given
to the role occupants within the administrative framework as
well as the actual utilization of the trained staff carry for
much negative or positive consequences for the well-being of
an organization.

In developing countries in particular, the dearth of
skilled manpower presents not only a challenge to the quality of
any social delivery system in question but also constitutes
a major concern about the urgent need to provide adequate
training so as to prepare the necessary ground work for the
field staff. It also follows that once training is provided, the
operatives be utilized as efficiently as possible by assigning
them according to the type of training and providing them with
adequate incentives to prop up their morale.

The delivery of mental health services in developing
countries, Zambia in particular, does not escape the picture
potrayed above. While the delivery of mental health services
may be cast in well-knit administrative structural framework,
trained manpower is rarely adequate enough to support the
efficient running of mental health delivery services. Thus,
the shortage of skilled manpower is a source of great concern,
stems in part from a recognition of increasing costs of health
care services and the desire of these countries to maximise
the value gained from money spent on training programmes and
the utilization of trained personnel.

Concerns about efficiency also reflect ideology about the way training programmes are to be managed and how and where skilled manpower is to be deployed.

In Zambia, this ideology is primarily reflected in the way mental health workers are trained and utilized and the way their field is generally administered by the Ministry of Health.

Thus, this study focuses on the administrative problems facing mental health workers in the country particularly with regard to their training and utilization. The organization of the study is centred around this theme and is meant to highlight the feelings of mental health workers about the way they are being governed and their services needs attended to by their superiors.

Organization of the Study

This study is organized in five chapters. The first chapter discusses mental health problems in relation to mental health services administration and tries to explicate the concept as such. A critique of the style of mental health services administration is also made in the last section of the chapter.

Chapter 2 discusses historical background and contingency factors during the period of colonialism and after Zambia's independence in 1964. Our analysis looks at goals of mental health services administration and how these were applied by both the Federal and Zambian Governments. Chapter 2 therefore provides the background knowledge to causes of the present constraints affecting mental health services administration in Zambia; the chapter concludes that the present administrative structure at the Ministry of Health is the continuation of the colonial administration with mental health services being treated

as a functional area rather than as a professional one
requiring its own administrative structure.

    In chapter 3, our discussion centres around mental health
workers' training programmes. We specifically deal with content
and output, scope and nature of the training programmes. The
purpose of this chapter is to show how the Zambian Government
tries to graple with manpower problems in the country through
the various training programmes. Chapter 4 centres around
discovering what mental health workers accually do in the field
and the Ministry's responsiveness to the needs of mental health
workers in the country. The chapter discusses health workers,
administratiors' assessment of mental health workers' career
anchorages within the Ministry of Health. We conclude by saying
that mental health workers are over burdened and at the same
time being discriminated against by the Central Administration
when it comes to promotion.

    Finally, we end our discussion with a summary of the main
constraints affecting the administration of mental health
services in the country: With specific reference to manpower
training and utilization. Our conclusion is that there is need
to establish a Mental Health Unit at the Ministry of Health
Headquaters. Such a unit would be responsible for controlling
and co-ordinating mental health services and resources in the
country. We further make the point that unless mental health
service is treated as a professional domain rather than a
functional one, the problems now facing mental health workers in
the field will continue resulting in the service being accessible
only to the small population in the country. We also advocate for
the development of a polyvalent health worker to suit the
Zambian situation. This is in view of the multitude of health
problems prevalent in the country.
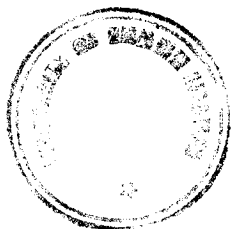
CHAPTER 1

MENTAL HEALTH SERVICES ADMINISTRATION: CONCEPTUAL FRAMEWORK

Zambia's mental health services date back to 1962 when
Chainama Hills Hospital was opened. Before this period,
Psychiatric services in this country existed but needed to be
changed into a Therapeutic service. As patients and their relatives
had to travel long distances from all parts of the country to
Chainama Hills Hospital, a policy of establishing mental health
units at general and district hospitals was adopted. With this
expansion, it again became evident that staff would be needed to
manage mental health problems both at Chainama Hills Hospital
itself and mental health units throughout the country. Thus, the
training of indigenous mental health workers was started in
December, 1962. There are now over 600 such workers in the country
running over 200 mental health outlets including 1290 psychiatric
beds. (Constituting 6.2% of all the beds in the country). (Zambia
1982(1):2), (1987)(ii):7).

In addition, the magnitude of mental health problems in
the country is now estimated at:-

(a)   70,000 people with incapacitating major functional
      psychoses. (Zambia 1987:7)

(b)   700,000 will suffer from these conditions sometime in
      their life. (Zambia 1987:8)

(c)   20% (1 in 5) of all the patients attending general out-
      patient clinics in Zambia, the majority of whom are
      suffering from physical illness, a few have mental health
      problems requiring treatment (Zambia:1987 Ibid:9-11).

NOTE: Mambwe's data are quoted here despite his lack of
          indicating their source and defining the "at-risk"
          population and "coverage" because they are the only
          Zambian figures available on the country's mental health
          problems.

The above statistics appear to suggest that mental health problems are on the increase and constitute a major frontier for the Zambian Government, which has accordingly responded by establishing the aforementioned mental health facilities. However, the quality of the mental health services requires a responsive administration to attend to the needs of the profession.

Statement of the problem

Nearly 26 years later, the mental health service has only achieved 15% coverage of the at-risk population in the country such as students, detainees, prisoners, unemployed etc. Mental Health Workers have not been able to visit all the patients, police cells, prisons, schools, colleges, community leaders and services organizations in their community to follow up patients and to give mental health education respectively (Zambia 1987:op.cit). Why is this so?

One explanation being given for this lack of coverage of "the at-risk population" in the country is that mental health workers are utilized in general medical work as well as mental health work. (Zambia: 1982 op.cit:7).

Hypothesis

If mental health workers are well trained but not properly utilized, then we would expect a high level of dissatisfaction amongst their professional group.

We will try to investigate the above hypothesis with the following questions:-

(1)   Are mental health workers actually involved in general medical work; if so to what extent are they involved?

(2) What kind of training do mental health workers
     undertake to prepare them for mental health in the
     field and how adequate is it for the polyvariant
     problems (mental and general health) found in the
     field?

(3) To what extent are general health workers being
     utilized on mental health work?

(4) What factors other than training have contributed to
     deployment of mental health workers on general
     medical work?

(5) How do mental, general health workers and
     administrators generally evaluate career anchorages
     for mental health workers in Zambia vis-a-vis the
     responsiveness of the Central Administration to the
     needs of mental health workers in the country?

Thus, the purpose of this study is to investigate how the
utilization of available manpower in mental health delivery system
could account for the lack of coverage of the at-risk population
in the country.

Specifically, this study critically assesses how health
workers generally and mental health workers in particular are
deployed and how they evaluate career anchorages for mental health
workers in Zambia vis-a-vis the responsiveness of the Central
Administration to the needs of mental health workers in the
country.

In order to provide a backcloth of the nature and type of
mental health problems confronting developing countries such
as Zambia, a review of literature will be done, for it is
within these perspectives that manpower constraints affecting
the training and utilization of mental health workers in the
country could ultimately be understood.

Delimination of Key Terms And Concepts

Below are some terms and concepts as used in this text:

Therapeutic: Pertaining to treatment.

General Health Workers: Clinical Officer (General) and General Enrolled Psychiatric Nurse.

Mental Health Worker: Clinical Officer - (Psychiatric) and Enrolled Psychiatric Nurse.

Mental Disorder: General term for all mental illnesses, mental subnormality and character disorders.

Mental Illness: Psychological illness with or without structural change in the brain.

Neuropsychiatric: Pertaining to neurological and psychiatric disorders.

Neurotic: Pertaining to a mental disorder where the whole personality is not affected and is characterized by exaggerated anxiety.

Functional Psychosis: A severe mental disorder affecting the working of the brain without any structural change in the brain.

Health Worker: General and mental health worker.

Organic Psychosis: A severe mental disorder resulting from structural change in the brain.

Mental Subnormality: Incomplete development of the mind occuring in childhood.

Pellagra: A deficiency disease due to lack of Vitamin B.

Trauma: Injury.

Psychotropic Drug: A drug used to treat mental illness or a drug that has an effect on the mind.

Schizophrenia: A functional psychosis where a patient's thoughts are disordered and he may feel himself to be influenced in a strange way by external forces.

Manic-Depressive Disorder: A mental disorder in which a patient's mood changes. A patient may experience severe sadness or extreme happiness.

Hospital Care Style: A mental health service dependent on the professional skills of the health workers. Also known as Institutional Care Approach.

Community Care Style: A mental health service dependent on intersectoral approach, family and community participation.

Health Centre: A clinic with admission facilities.

Responsiveness: Sensitivity to the needs of workers or clients.

Lunatics: Derogatory term for a mentally ill person.

Principal Clinical Officer: Promotion from Senior Clinical Officer.

Senior Clinical Officer: Promotion from a Clinical Officer.

Principal Nursing Officer: Promotion from Senior Nursing Officer.

Senior Nursing Officer: Second promotion from first appointment as Registered Nurses.

Dominant Coalition: Deputy Directors of Medical Services and their Assistants.

Central Hospital: A hospital which provides specialist treatment in addition to general treatment.

General Hospital:: Also known as District Hospital and provides general treatment.

Special Hospital: A hospital which provides specialist treatment to special group of patients such as psychiatric, leprosy and children.

Literature Review

The prevalence of mental health problems in developing countries has convinced many governments that the administration of national mental health service cannot be considered in isolation from the wider problems of public health, and of social and economic development that confront them. In these countries, mental disorders constitute a very serious problem. Studies carried out in different parts of the world including Africa have persistently revealed that between 2 and 3 percent of the population of every country suffer from serious psychiatric disorders. (German 1972: 461) Leon (1972: 121), Neki (1973: 257), Castairs (1973: 271). But whether these figures can be translated into the Zambian situation is open to debate. Nonetheless, on the basis of these prevalence rates Mambwe, (1983: 1) reveals that in Zambia, about 60,000 people suffer from incapacitating major functional psychoses at any one time and 600,000 will suffer from such conditions at some time in their life.

It has also been argued that Zambia has a disproportionately high prevalence of organic psychoses and epilepsy, and mental subnormality. Thus, in 1982 alcohol and nutritional deficiencies (pellagra) were together responsible for 6% of all admissions to psychiatric institutions throughout the country; while epilepsy and mental subnormality constituted another 5.5% of all admissions throughout the country. (Mambwe, 1982: 9). Other studies have also

confirmed that non-psychotic mental health problems account for a large percentage of health problems both in developing and developed countries.

Giel and Luijk (1969: 149) Harding (1973: 190) Ndetei and Muhangi: (1979: 269) Harding (1980: 359) have estimated that between 13.7% and 20% of patients attending out-patient clinics, health centres, and other primary health care (PHC) facilities complain of physical symptoms which are basically related to underlying mental health problems and psychosocial problems.

Thus, in Africa mental health problems and psychosocial problems appear to be directly linked to dramatic changes in the social structure and way of life which are occuring throughout the continent. In his opening speech to the WHO Regional Expert Panel meeting on mental health held in Brazzaville from 26th to 30th March, 1979, the Regional Director Dr. Cowlan Quenum explained that uncontrolled urbanisation, inappropriate industrialization, the break up of the traditional family life and the abandonment of traditional values have led to a rising incidence of crime, abuse of drugs and alcohol, educational failure and other signs of deterioration of community mental health. In addition, there is also evidence that pre-natal submalnutrition, trauma associated with delivery, infections in early childhood and tropical infections contribute directly to an increased incidence of neuropsychiatric disorders in both children and adults (WHO 1979: 2).

In the Southern African Region, political factors, the struggle against apartheid in particular, also contribute heavily to the high incidence of acute psychosocial mental health problems because of loss of shelter, families, friends and cultural practices (Ibid: 2).

While these problems are in themselves enough, the suffering on the part of the family and the interference with the social-economic functioning of the patient's household and the community at large call for effective administrative strategies to cope with these pressing problems. In the quest for trying to resolve mental health problems, various competing yet interrelated styles have been advanced.
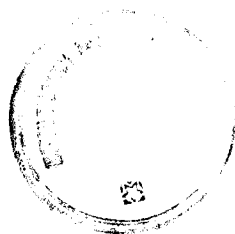
There are primarily three styles to mental health
administration which try to grope with mental health problems
particularly with regard to manpower utilization in mental
health services administration.

Styles To Mental Health Administration: A Universal Perspective

The three styles which various researchers and practitioners
have posited as solutions to how best manpower could be deployed
in mental health delivery system the world over range from
'Hospital Care" style through "Community Care" style to
"Integration" of mental health services into the general health
service delivery system. We will now examine each of these three
styles to determine how it affects manpower utilization in mental
health and its practical limitations.

(a)   Hospital Care Style

Advocates of the hospital care style have an arsenal of
historical evidence to support the efficacy and "superiority"
of the "Hospital Care" style over that of "Community Care"
and "Integration". For example Maddison (1975: 6) argues
that hospitals for the mentally ill were known to exist in
Egypt and the Middle East around 700-1200 A.D. The role
of mental health workers was therefore confined to providing
professional services specifically to mental hospitals.
Mental health employees were therefore geographically and
functionally separated from other hospital employees without
due regard to the manpower costs this might have entailed.

Consequently, given the kind of manpower training and
utilization, mental hospitals tended to become sacrosanct
for mental health workers who tended to use their connections
with these hospitals to advance their power and authority
over others interested in social policy towards the mentally

ill (Scull, 1981: 122). The public was equally convinced
that mental illness was a curable disease best treated in
a mental hospital (Ibid: 122). This view has since been
ingrained in the minds of the protagonists of mental
health administration through "Hospital Care" style and
its dual nature which has been kept intact. In the case
of Zambia for example, one of the effects of policy
influence by mental health professionals is that the
administration of mental health services is based at
Chainama Hills Hospital and not at the Ministry of Health
Headquarters where other health services administration
are based (Mambwe 1983: 5). Emphasis is therefore placed
on the "uniqueness" of mental illness and the attendant
need to create "a professional environment" suitable for
handling these problems which are regarded as rather
special and therefore requiring professional skills;
whereas if patients were to be treated through the
"Community Care" style they contend, this would entail
that different agencies would be taking care of psychiatric
patients, thereby creating an aura of "professional
confusion", and muddling through approach etc. While at the
same time leading to wastage of limited public funds
(Friedman 1983: 90).

(b)   Community Care Style

In contrast, those researchers and practitioners who see
"Hospital Care" style as a major constraint in the delivery
of mental health services contend that the mystique of the
mental hospital was broken during the Second World War
when "Allies" army set up a psychiatric unit in Sinai Desert
(Myre 1974: 621). Here the army was able to admit and
treat every kind of mental illness occuring among diverse
nationalities, enemy and Allied, male and female, and ran it
efficiently. This Sinai experience convinced people that
similar experiments could be successful in civilian life.

It became apparent that there was nothing magical in the
physical structure or personnel arrangements of the
mental hospital that made the hospital care style unique.
All that was needed were adequately trained staff and
suitable accommodation. The work could be done
practically anywhere (Ibid: 621).

Recent experiences in some parts of the Third World
seem to support the Sinai experiment. In Nigeria for example,
the extensive involvement of four large villages with the
Aro psychiatric-hospital day patients and their relatives
and the success of the Nigerian experiment is an indication
that indeed the work can be done practically anywhere so
long as manpower was adequately trained and properly utilized.

Economic reasons further seemed to support the "Community
Care" style. Some writers such as Winkler (1982: 3-4) for
example, argue that community care style is cheaper than
hospital care because of reduced readmissions to mental
hospitals. This approach seems to be closer to the
prevailing Zambian practice.

According to statistics presented by Mambwe (1983:
op.cit.: 2) for out-patients throughout the country, 27406
patients were treated as out-patients as compared to only
7032 hospital care patients in 1982. This is an indication
that in Zambia, more emphasis is being put on community
care than on hospital care; partly because of economic
reasons partly as an indication that the style has its own
practical merits from the curative point of view.

Some writers have also claimed that community care style
is inherent in the socio-cultural beliefs of the African
extended family system. Thus, Castairs (1973: 5-6)
observed that,

"In developing countries, the extended family is still
the agent of social support."

This is especially true for most rural areas where
the extended family system is extremely tight and services
extremely scarce.

Another reason being given in support of community care
style is that recent advances in psychotropic drugs have
enabled patients to be treated in any environmental setting
other than mental institutions. Friedman (1983: op.cit: 89)
for example, posits that some forms of schizophrenia and
manic depressive disorders can actually be controlled
through regular drugs on an out-patient basis.
This view is shared by Harding and Crusciel (1975: 359) who
recommend that certain psychotropic drugs such as
Amitriptyline, Imipramine, Chlorpromazine, Trihexyphenidyl,
Diazepam and Phenobarbital should be available to health
centres and to general hospitals.

It is apparent that the proponents of the community
care style are of diverse background; some are from
industrialized countries such as Winkler, others such as
Mambwe are from developing countries. From the foregoing
discussion it can be concluded that one of the many
advantages of community care style is its emphasis on
manpower versatility to mental health problems so as to
reduce delivery costs by incorporating family support as
well as the services of Non-Government Organisations/NGOs
such as the Mental Health Association of Zambia, religious
bodies and other agencies. Nonetheless, the "Community Care"
style has as many antagonists with as much diverse background
as its proponents, especially those who advocate the integration
of mental health services with the general health services
as we shall see below.

(c)   Integration Style

Those who see both the "Hospital Care" style and the "Community Care" style as "Isolationism" argue that integration of health services is enshrined in the Alma-Ata Declaration of 1978, which established the concept of Primary Health Care (PHC), defined as "essential health care" made universally accessible to them through their full participation and at a cost that the community and country can afford (Zambia: 1981: 1).

Thus, manpower disintegration is seen as the major constraint in mental health administration. Lipton (1982) (1): 4) (1982(11): 2), for example has contended that it is essential to integrate mental health services because there is ample evidence to suggest that treatable psychiatric illness can at times masquerade as organic syndrome and vice verse; thus the need for training a polyvalent health worker.

In a country such as Zambia where mental health workers are numerically few as compared to general health workers on one hand and the dimension of mental health problems on the other, the myth of a professional mental health worker with policy influence over the running and direction of mental health services seems to be completely shattered by reality. For example, lack of policy influence by mental health professionals seems to manifest itself in poor state of facilities given to mental patients and workers alike as opposed to those given to general patients and workers. As Mambwe (1982: op.cit: 7) succinctly puts it:-

"Other serious constraints in mental health administration include the general dilapidation of all mental health units in the country".

This view is shared by McClelland (1983: 4-10) who contends that generally, the standard of maintenance of mental health services is inferior to that in the general field.

Integration of mental health services with the general health services would also help to end the discrimination against mental patients. For example, the New South Wales Association for mental health sub-committee in Australia (1981: 2) found that patients in state psychiatric hospitals were notcovered by health insurance, and they contend that such a situation could not be tolerated in general hospitals. Another study conducted to establish the public's hierarchy of acceptance of disability groups showed that of the 21 groups the mentally ill were in the last place, after the ex-convicts, the mentally retarded and the alcoholics (Lipton 1983 op.cit: 52). Thus, the need for professional advice and information to the general public by a well trained pool of manpower.

Limitations of The Three Styles

From the foregoing discussion it can be argued that all the three styles to mental health problems have their own merits. When examined against Zambia's mental health services administration however, the three styles do show some serious short-comings at the level of manpower training and utilization. For instance :-

(a)   Hospital Care Style

The "Hospital Care" style prefers the continuation of specialized mental health professionals as is the case now. These health professionals with their established medical facilities appreciate the need for psychiatric services but prefer to keep them separate from other services. In addition both administrators and these professionals feel

a threat to the existence and growth of their own
conventional psychiatric service. Although they are willing
to discuss preventive practices, while actually continuing
to train health professionals for hospital service, admissions
into hospital beds and units continue to be the symbol of
health care.

However, the prevailing economic difficulties in Zambia
have highlighted the importance of using the existing manpower
and facilities as efficiently as possible; and the immediate
need to remove administrative bottlenecks which hinder
officiency and minimize the impact of providing mental
health services to the community. The hospital care style
itself was only responsible for 20.5% of all psychiatric
patients seen in 1982 throughout Zambia (Mambwe, 1982, op.cit:
4-5). This was despite the fact that in-patient facilities
for short and long stay admissions were available at 92
hospitals and health centres throughout the country. According
to the 1986 statistical report, such facilities were
available in every province divided as follows; Lusaka
Province 20, Central Province 5, Copperbelt Province 17,
Eastern Province 8, North Western 11, Northern 8, Western 7,
Luapula 6 and Southern Province 10 (Zambia: 1986: 1-5).

Psychotropic drugs were also available in these hospitals
and health centres to facilitate patient's care. However,
provincial and district units constantly complained of
difficulties in obtaining the drugs because the medical
officers who are supposed to prescribe these drugs are not
available to the unit or are less competent with psychotropic
drugs (Zambia: 1981: 13).

Thus, the need for proper utilization of all health
workers in the country. This suggests that although drug
availability is on face value a major problem to effecting

mental health delivery service, yet it could be alleviated through effective planning and therefore through availability of qualified manpower. Hence the partial need for "Community Care" style.

(b)   Community Care Style

The training needs and models for this style are behavioural sciences which should equip the worker with three principles, namely: consciousness raising; desensitization; and the development of practical skills. Consciousness raising entails the need to recognize the psychosocial factors that were there all along, and also to admit a whole array of new ways of looking at situations. Desensitization means to become less afraid of and awkward about emotional behaviour, including severe mental illness. The development of practical skills is learning from experience about processing diverse information, problem-solving, counselling, community development and so forth. Thus, a person using "Community Care" style should make attempts in everyway possible to involve relatives, employers, co-workers, religious bodies and other agencies, as appropriate, in the treatment of each patient. To date however the kind of training provided to mental health workers cannot meet the foregoing challenges. Besides, the style seems to ignore the impact of the traditional healers on the receptivity of modern psychiatric services. Thus, according to Tumasi, (1984: 17).

> "There is in this day and age an increasing recognition
> of the place of traditional healers in healing social
> and psychological illnesses".

The "Hospital Care" style on the other hand is too limited in its scope and too specialized as well as too expensive to run in a country as poor as Zambia.

In order for "Community Care" style to succeed, there
ought to be community outreach which would require more
manpower training, retraining, and reorientation towards
intersectoral approach of both general and mental health
workers etc. ; all of which seems to be lacking in the
Zambian context. These measures when implemented should
be able to correct some of the cultural beliefs which have
proved to be stumbling blocks to the receptivity of mental
health services in Zambia. For example, one of the major
limitations in community care style is the persistent use
by the patient of traditional medicine and practices as
"cure" for the patient's condition. Since the medicine
so prescribed often lacks any scientific basis, and its
efficacy is not necessarily based on empirical evidence,
the patient's actual recovery may be delayed because of this
problem. Thus, in the Bemba tradition, it is claimed that
incipient "madness" can be cured by the patient eating part
of the heart of the python stuffed with other medicine
(Moore 1962: 4).

A similar observation is made by Gelfand (1964: 36) who
cites a case study of a man who suffered from epilepsy for a
period of nine years before deciding to seek medical help.
The man had consulted a diviner who told him that the spirit
of his late wife was annoyed with him for refusing to marry
her sister and thus brought on him epilepsy. However, when
the man married his sister-in-law, the epilepsy still
continued and that was when he decided to seek medical help.

Thus, although community care style may be a useful way of
ensuring community and family participation to health care,
social and cultural beliefs about illnesses may actually be
detrimental to the patient's well being and recovery programme.
This is especially true for most African countries where such
beliefs in traditional healers are still very high.

From the foregoing discussion we can conclude that
for the community care style to succeed there ought to be
a well trained pool of manpower to carry out social
education so as to eliminate the above short-comings in
Zambia's mental health services.

(c)   Integration Style

Although "Integration" style might appear to offer
better solution to manpower utilization in Zambia, yet it
tends to suffer from serious practical flaws. For example ,
although Zambia's psychiatric services were available at
37 of the 42 Government hospitals in 1982 throughout the
country; an indication that there was a high rate of
integration between mental health services and general
health services - while the psychiatric units in the
hospitals together were responsible for over 70% of all
the mental health activity in the country, (Mambwe 1982,
op.cit.:2), yet the quality of services provided through
integration style are lamentably deplorable. Thus, another
explanation is needed to account for the continuing exis-
tence of a chasm in Zambia's mental health services
administration.

The explanation can perhaps be found in manpower.
The major weakness inherent in all the above approaches
is that they tend to ignore the importance of manpower
training and utilization to the administration of mental
health services in general and in Zambia in particular.

(d)   Corrective Measures

Given the above shortcomings of the three styles
the best alternative perhaps would be to settle for
measures that lay emphasis on the importance of recogni-
zing the need to take stock of the existing manpower but
with

the view to making it more efficient through retraining, reorientation and deployment of qualified personnel to critical but relevant areas. Thus, Lenny (1974: 61); WHO (1982: 11) have, for example, strongly argued for the training and utilization of polyvalent health worker since mental health problems can masquerade as physical symptoms and vice versa. At the same time, the Sixteenth Report of the World Health Expert Committee on mental health (1975: 22) identifies the extreme scarcity of mental health professionals as the most important constraint in meeting mental health needs in developing countries.

The development of mental health professionals and their utilization exclusively on mental health work through basic training in mental health work is advocated by Haworth (1979: 23), Task Force Report (1982: 23) and Mambwe (1982: 23), while the conversion of general health workers into full time mental health professionals through retraining at the postbasic level is advanced by Price (1981: 41), Ad Hoc Committee on Post Basic Psychiatric Nurse Training (1982: 10-11) and Msoni (1985: 5).

Zambia, has since independence continued to experience an acute manpower shortage in all health services and in mental health field in particular. The Third National Development Plan (TNDP) for instance, points out that a paradox exists in the country: the existing health facilities in terms of number of institutions are by no means adequate in relation to the country's requirements. Yet, there is no adequate staff to man even the existing number of health institutions. (Zambia: 1979-1983: 367).

It was against this general manpower backcloth that we began addressing the issue of mental health administration as regards to training and utilization of mental health

workers in Zambia with the view to making the service
become more responsive to the needs of the community.   But
whether the present manpower makes psychiatric care an
integral part of the community and part of the culture
which is highly sensitive to the needs of mentally ill
patients and to mental health problems in general could
only be known through research such as this one.

However, it would appear that in view of the magnitude
of health problems in the country, a polyvalent health worker
would be suitable for the Zambian situation.   This would be
achieved through retraining of both mental and general health
workers.   In order for this plan to be realized there ought
to be career anchorages to motivate these workers to wish
to take up additional training.

Conclusion

Since all the three styles are invariably employed in the
Zambian case , then we have to go beyond the controversy of
identifying which of the three styles is "best" suited for
the Zambian situation.   Indeed, the three styles are , as
intimated above intertwined and can hardly exist totally in
isolation for reasons already advanced.   Instead, we need
to examine what constitutes the thread that binds all the
three styles and find ways and means of strengthening all
the three styles without necessarily incurring high costs.

What appears to be a major constraint affecting the
administration of mental health services in Zambia is manpower
utilization.   Thus , the understanding of the role and
training of each health worker in regard to mental and general
medical work will not only ensure a responsive administration
but will also promote "Hospital Care", "Community Care" styles
and "Integration" of mental health services into the general
health service delivery system in Zambia.

Thus, with an efficient, and effective mental health manpower reservoir, the three styles would achieve their parochial goals. However, there should be enough career anchorages in the profession to motivate and retain competent manpower in the field. This in itself requires an efficient and effective administration to control and coordinate mental health services in the country.

Rationale for the Study

Despite the efforts that have been made over the last 25 years since the present mental health services were established, no investigation had yet been undertaken to examine the manpower constraints affecting mental health services administration. This study tried to shade some light on some administrative issues which have a direct bearing on the present manpower situation in mental health services administration and on the future ; and advanced suggestions to improve the existing administrative framework within which mental health workers function. Once solutions to the manpower bottlenecks have been found, the three styles will then be able to operate within an atmosphere of interdependence , thereby ensuring the efficiency and effectiveness of mental health delivery system in Zambia through proper manpower training and utilization.

Methodology

Given the complexity of mental health services administration, therefore, we strongly felt that no one single methodology that we considered to be appropriate for data collection and analysis was adequate enough to explain the social dynamics of mental halth services administration. Consequently, this led us to adopting a combination of the following methodologies toward the research of the problem. First we employed the Historical approach. This approach is defined by Ackerman et al (1981: 88) as a

research method used to "study the pattern of events that
may appear to be repetitive". Therefore, by using this
approach we were attempting to trace the development of mental
health services administration in Zambia from the Colonial Era
to date and the various changes that have occured during this
period. Specifically, we were trying to trace whether or not
the social delivery system has responded to the growing need
of mental health services in the country in view of the ever-
growing population; and the attendant social complexity which
has largely led to psychological problems.

This approach had to be supplemented by the sociological
dimention. The sociological approach is defined by stewart,
(1981 : 8) as "a simplified picture of society that tries to
answer the question "What is Society like". This approach
therefore, enabled us to discover conflicts of interests between
general, mental health workers and administrators. It assisted
us also to find answers to the questions we posed on job
assignments, promotion to administrative positions and frequency
of visits by supervisors to mental health workers. In this
way, mental health delivery system was looked at as a sociological
system with its own set of organizational values but with the
different composite social groups - professional as they might
be - impinging themselves upon others and upon the delivery
system in general.

The sociological approach gave rise to serious Psychological
implications for those actors within the health delivery system
as a whole. For our study, however, it had serious psychological
implications for mental health workers as it proved to be
tangential to their perceptions for career archorages in the
system. This led us to employing the Psychological approach to
mental health services administration at this juncture. According
to Ernest et al. (1979); Psychological approach is a research

method employed by researchers to "study behaviour and mental processes. Thus, through this approach we were able to explore mental health workers' feelings about their supervisors and the Ministry's responsiveness to their needs. The purpose was to uncover whether the operatives have a high level of morale or not and draw some conclusions about their performance as a result.

From this foregoing cluster of approaches it becomes clear that the study was based upon the "Eclectic" approach. We employed the historical approach in order to trace the history of mental health services in Zambia. This was combined with the sociological approach because mental health delivery system was looked at as a sociological system with its own set of organizational values but with the distinct composite social groups-professional as they might be-impinging themselves upon others and upon the delivery system in general.

Finally we added the psychological approach because the other two approaches mentioned above give rise to serious psychological implications for the various actors within the health delivery system as a whole. For our study, however, it had serious psychological implications for mental health workers as it proved to be tangential to their perceptions for career archorages in the system.

Data was collected by means of structured interviews. Respondents were chosen to represent various types of health worker involved, directly or indirectly in mental health care. Zambia has, according to official statistics, 90 mental health facilities from which regular reports are submitted. For reasons of time and expense it was possible to visit only a proportion of these and therefore all mental health units were visited in Lusaka and Copperbelt Provinces and in Eastern Province, in order to adequately represent the distribution of staff in the mental health

service (not including Chainma Hills Hospital and Ndola Central
Hospital). Two mental health workers were selected according
to immediate availability, in each of 23 units - 46 workers in
all. A similar number of general health workers were interviewed,
working in the same hospitals and health centres as the mental
health workers. Whereever possible they were of the same sex and
had approvimately the same length of experience of their mental
health worker counterparts.

Supervision of mental health workers takes place at various
levels. An immediate supervisor was interviewed in each hospital
or health centre, the three Provincial Medical Officers and two
Deputy Directors of Medical Services - responsible for Development
and Planning and for Medical Care Administration respectively.
Questions appropriate for the responsibilities of each cadre were
prepared, focussing upon the topics previously outlined under
''Purpose of Study''.

In addition to primary data, a library and archives study
was also conducted for secondary data, referring both to Zambia
and in order to set the development of mental health services in
context, from neighbouring and other countries as well.

Analysis of responses was undertaken in order to determine
the comparative views of the different cadres and was based upon
the theoretical frame work already described.

Limitation of the Study

One of the major limitations of this study was that it was
confined only to three Provinces. This was primarily due to the
time factor as well as to financial constraints. The three
Provinces were however, representative enough to have given us
a strong clue as to the underlying constraints affecting the
administration of mental health services in Zambia: with special
reference to manpower training and utilization.

CHAPTER 2

HISTORICAL BACKGROUND AND CONTIGENCY FACTORS

Although the present Zambia's mental health services
are synonymous with the opening of Chainama Hills Hospital
in 1982, the actual idea was rooted long before that. For
example, as early as 1935, Sir Stewart Gore Brown, a
prominent member of the Northern Rhodesia (NR) Legislative
Council had this to say about the plight of the mentally
ill persons in the country;

>   "I wonder if Hon. Members realize, certainly the
>   country does not - that we still in this enlightened
>   country adopt the mediaval practice of putting
>   lunatics in prison and when necessary chaining them
>   up." (Haworth : 1987: 25).

This concern over the lack of administrative frame-
work governing the planning and running of mental health
services in Northern Rhodesia was however not immediately
taken up by the health authorities. As late as 1946, the
Ministry of Health reported;

>   "As for mental hospitals, Northern Rhodesia has
>   none and badly needs one and probably two" (Northern
>   Rhodesia: 1946: 22).

A year later (1947), the provision of a mental hospital
in Northern Rhodesia was said to be still under consideration.
But as a provisional measure a small mental annexe was being
constructed at Ndola. (Northern Rhodesia: 1947: 10-213).

The urgent need for a suitable accommodation for
mental patients was augumented by the increase in the
number of patients in the Territory. Thus, while in 1946
only 35 mental patients were recorded, in 1947 this figure
rose to 127 mental patients; a rise of 44% (Northern
Rhodesia (1946 (1) : 30), (1947) : (2) = 10-13).

It could be argued that the construction of a mental annexe
at Ndola could have facilitated the need for reporting mental
patients to authorities for either possible treatment or most
probably for custodial care.

Despite this large number of patients in the Territory, there
were still no mental health workers to care for them till 1948.
During this year, four Mental Nurses were recruited out of the
230 European staff establishment for the Department of Health.
(Northern Rhodesia : 1948: 10-13).

These nurses were to work at Livingstone where another
mental annexe had been built in 1948 in addition to a mental annexe
already existing at Ndola.

The building of these annexes in the Territory before
building an actual mental hospital was later to prove to be a
"blessing in disguise" as they became the corner-stones of the
present mental health services in Zambia (as we shall see later in
the text).

As the number of admissions of mental patients continued to
rise throughout the Territory, (206 in 1951, 257 in 1952 and 363
in 1953 - the start of the Federation) more and more of these
prison-like annexes (accommodation was in cells with high barred
windows) were opened at a number of other hospitals. (Figure 1).
(Northern Rhodesia 1951 (1) : 15-20), (1953(3) : 13-20).

This trend continued between 1953 and 1963 during the era
of the Federation of Rhodesia and Nyasaland. It accelerated
after Zambia's independence in 1964 as (Figure 2) illustrates.

After independence (1964) these mental annexes evolved
from their original role of being detention and observation centres
for emergency treatment in the Territory into treatment,

OKASAMA

CHIPATAO

OMANSA

OKABWE

LUSAKA

NDOLAO

CHILILABOMBWEO

OKABOMPO

OMONGU

LIVINGSTONE

1947 - 1985

200Km

0
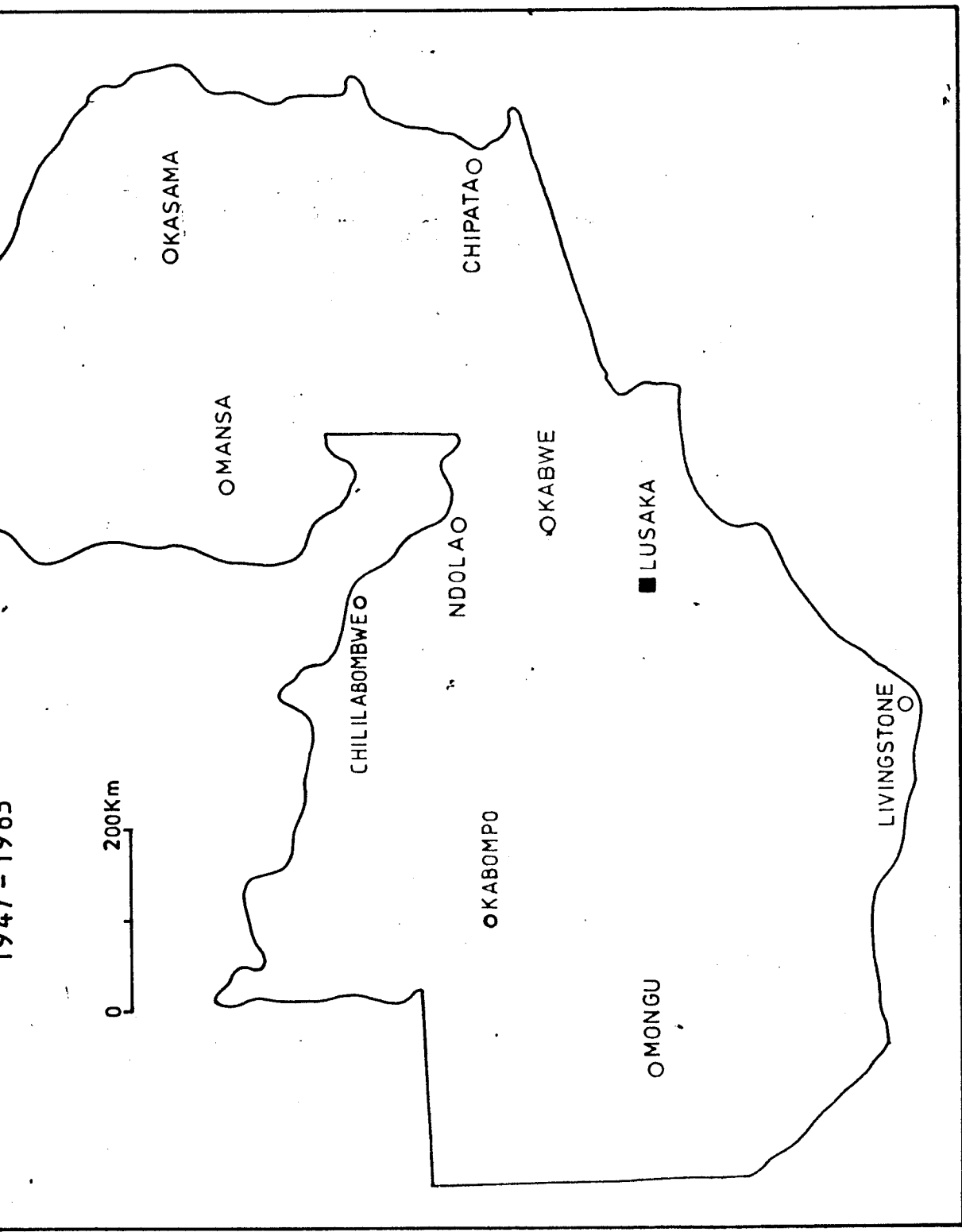
administrative and educational centres for the local
communities.

It was partly for the reasons given above that plans
were made by both the Northern Rhodesia and Federal Governments
to provide Northern Rhodesia with its own mental hospital to
accelerate this trend and for the hospital to provide
professional leadership to the administration of these units.

This view was emphasized by the Federal Government in
1960, when they pointed out in their Annual Public Health
Report that:

> "There is no doubt that mentally disordered persons should
> be treated as soon as possible, living in their own
> community... at observation centres near their home and
> family and many cases need never go further..."
> (Federation : 1960: 18).

However, the mental hospital to spearhead this extension
of community outreach through mental annexes in Northern Rhodesia
had not yet been constructed by the end of 1961.

The building of Chainama Hills Hospital in 1962, was
nonetheless left to the Federal Government when they took over
the responsibilities of all health services in the three colonies.
During this period and before Chainama Hills Hospital was opened
in Lusaka, Ingutsheni Hospital in Bulawayo was the main mental
hospital of the Federation. It should also be pointed out
however that although a mental hospital had been built at Zomba
(Nyasaland now Malawi) in 1954, there appears to be no evidence
to suggest that patients from Northern Rhodesia were ever sent
there. Instead, patients from Northern Rhodesia were sent to
Ingutsheni Hospital in Southern Rhodesia (Zimbabwe) for long
term treatment. (Federation 1959: 42).

1964 - 1984

200 Km
0

Mbala
Mporokoso
Kasama
Isoka
Chinsati
Chama
Lundazi
Chipata
Chadiza
Sinda
Nchelenge
Mbereshi
Kawambwa
Luwingu
Mpika
Katete
Kasama
Petauke
Mwense
Mansa
Samfya
Mkushi
Nyimba
Kabwe
Luangwa
LUSAKA
Lilayi
Kafue Gorge
Siavonga
Chilanga
Mazabuka
Sinazongwe
Mumbwa
Monze
Solwezi
Chililabambwe
Mufulira
Kitwe
Ndola
Kasempa
Chizera
Kaoma
Namwala
Choma
Livingstone
Mwinilunga
Zambezi
Kabompo
Lukulu
Senanga
Sesheke
Kalabo
Mongu

There were also other reasons for constructing a mental
hospital in Northern Rhodesia. For example, a rising population
in Northern Rhodesia meant a higher incidence of mental health
problems. This phenomenon was vividly revealed as early as
1956 when the Federal Government voiced concern over the number
of patients being transferred to Southern Rhodesia from
Northern Rhodesia. They had this to say:

> "The former practice of transferring all patients in
> Northern Rhodesia requiring hospital treatment to
> Ingutsheni continues and the upward trend in the number
> of patients admitted to this hospital has began again".
> (Federation 1956: 13).

Thus, the fear of over crowding Ingutsheni Hospital was
another reason for retaining mental patients in their own
territories by providing them with their own mental hospitals.
This fear of over crowding was justified in 1960 when the
Government further commented:

> "It is estimated that there are about 400 Africans from
> Northern Rhodesia presently under care at Ingutsheni,
> so it will be realized what a burden will be transferred
> when the Lusaka mental hospital comes into service..."
> '(Federation 1960: op.cit.)

Another reason which had been given for building a mental
hospital in Northern Rhodesia was that of "territorial boundaries".
The transferring of the mentally sick to Southern Rhodesia also
involved legal and political complexities. It meant that the two
governments had to reach agreements on immigration formalities
and had also to cultivate the political will especially on the
part of Southern Rhodesia to accept responsibility for looking
after sick citizens of another country. Thus, as early as 1959,
the Federal Government, frustrated by the non-start of
construction work for a mental hospital in Northern Rhodesia,
contended:

"Owing to a last minute alteration of the site for the
proposed Lusaka Mental Hospital, it was not possible for
building... to begin during this year. It is hoped that
this will now start in 1960, the first stage accommodating
African patients which should go some way towards relieving
the pressure on Ingutsheni Hospital and reduce the very
onerous legal complications in moving certified mentally
afflicted persons across territorial boundaries."
(Federation 1959: 16).

We may conclude therefore that the main reasons behind the
construction of a mental hospital in Northern Rhodesia were to treat
patients in their own communities and near their homes and
families, to relieve the pressure on Ingutsheni Hospital and to
avoid legal complications in transferring certified psychiatric
patients across territorial boundaries. Due to the foregoing
reasons, Chainama Hills Hospital came into the offing in June
1962.

This meant that Chainama Hills Hospital had not only to
be an administrative centre but would also bare the burden of
training in mental health. The later was to predicate on the
assumption that mental health administration had to be an on-going
concern requiring staffing as well as administration expansion.

However, in order for Chainama Hills Hospital to assume
this leadership role in the country, it had to be in a position
to formulate an elaborate administrative structure to fulfill
the goals and the need to establish a coordinative effort between
mental health and general health. Thus, there was a need for
clear mental health goals in the country both before and after
independence.

Goals of Mental Health Service

Etzioni, (1964 : 6) defines organizational goal as:

"A desired state of affairs which the organization
attempts to realize".

All organizations have got certain ends to which they drive
and therefore there should be certain means to fulfill this end.
Thus, organizations are by intent deliberative in that they are
contrived to achieve certain ends. Goals could be written or
unwritten, specific or general; whatever the situation, goals
are part and parcel of organizations.

For our purpose therefore, we shall try to establish the
goals of mental health services administration both before and
after Zambia's independence and try to show how the two
governments attempted to meet these goals.

During the pre-independence period, the main feature about
mental health goals is that they were not written nor were they
specific. Nonetheless we shall try to extract the organizational
goals through observing the activities of the Ministry of Health
during that particular period. As Simon (1964: 21-22) posits:

"Organizational goal may be ascertained through observing
the decision-making process, because they indicate the
various constraints that are present".

We will therefore begin by discovering mental health goals
of the Federal Government which took over the responsibility of
Health in the three Territories on 1st July, 1954.

Mental Health Goals During the Colonial Era

Mental health service goals during the Federation came as
a response to the increase in the number of cases of mental health
problems in the Federation which required treatment (Figure 3).

Fig. 3 Admission of Psychiatric patients, 1955-1959

Adapted from Appendix J.43."Mental Health in the Federation:1959 Annual Report on the
Public Health of the Federation of Rhodesia and Nyasaland."

Many theories were propounded to explain this increase in
mental illness. According to the Federal Government (1959:
42-43) for example, the causes included "environmental factors
such as malnutrition, either as a primary condition or secondary
to parasitic infection which may cause brain damage or interfere
with its functioning; intermarriage in closed and isolated
tribal communities causing cultural dissonance; birth injuries
due to the crude midwifery practiced in the villages, epilepsy is
one of the commonest concommitants of mental derangement; the
very real factor of the fears/anxieties and mental conflict arising
therefrom; a loosening of tribal and family ties which has the
effect of increasing the willingness of relatives to conceal and
narture the simple minded and mentally deranged in the family
circle; an increased awareness of the possibilities of treatment
of the mentally disordered, resulting in more patients being
brought to hospitals and clinics.

As a response to these identified problems the Federal
Government planned to adopt the following strategies to combat
them.

First, mental hospital treatment by certification of
patients by magistrate in order to ensure that "Human
Rights" were observed (Federation 1959: 42).

Secondly, treatment of certain types of mental patients
at general hospitals in order to foster the spirit of
integration between mental and general health services.
(Ibid: 44).

Thirdly, expansion of the mental observation Block systems
i.e. expansion of mental annexes to all Provinces to
facilitate decentralisation of the service.

Fourthly, identification and treatment of psychiatric
problems at out-patients by incorporating mental health
into the curriculi of general health workers so that
graduates could be able to manage mental health problems
presented to them at the clinics. (Ibid: 44).

Fifth, the training of "African doctors" and nursing staff
to replace the Europeans who were "hampered by language
difficulties and imperfect knowledge of the social and
traditional background in establishing a strong bond of
sympathy with their patients" (Ibid: 44).

We may therefore conclude from the above strategies that the
goals of the Federal Government in regard to mental health services
administration were first to establish a social "Institutional/
Hospital Care" style through the construction of Chainama Hills
Hospital and the expansion of Mental annexes for patients requiring
long-term treatment. Secondly, to institute a "Community Care"
style by encouraging community and family participation in the
treatment of their sick relative and the "Integration" of mental
health with the general health services through the treatment of
certain type of patients at general hospitals and out-patients
'departments.'

For the first time, there was also an emphasis on the
training of local mental health workers to look after their own
people and to run the service.

In sum we can argue that despite these "noble" ideals, the
implementation of those goals under the Federal authorities remained
obscure. For example, in the Institutional Care style while
admitting that some patients were able to recover and be
discharged as (Figure 4) shows, locked doors and mixing with
strangers was contrary to the:

"Tribe life of the country, where misfortune is shared by
the community or, if not possible, is given a simple satisfying
supernatural explaination". (Federation 1959: 43).

This is particularly true for the rural communities where
cultural ties play a very important role in the management of
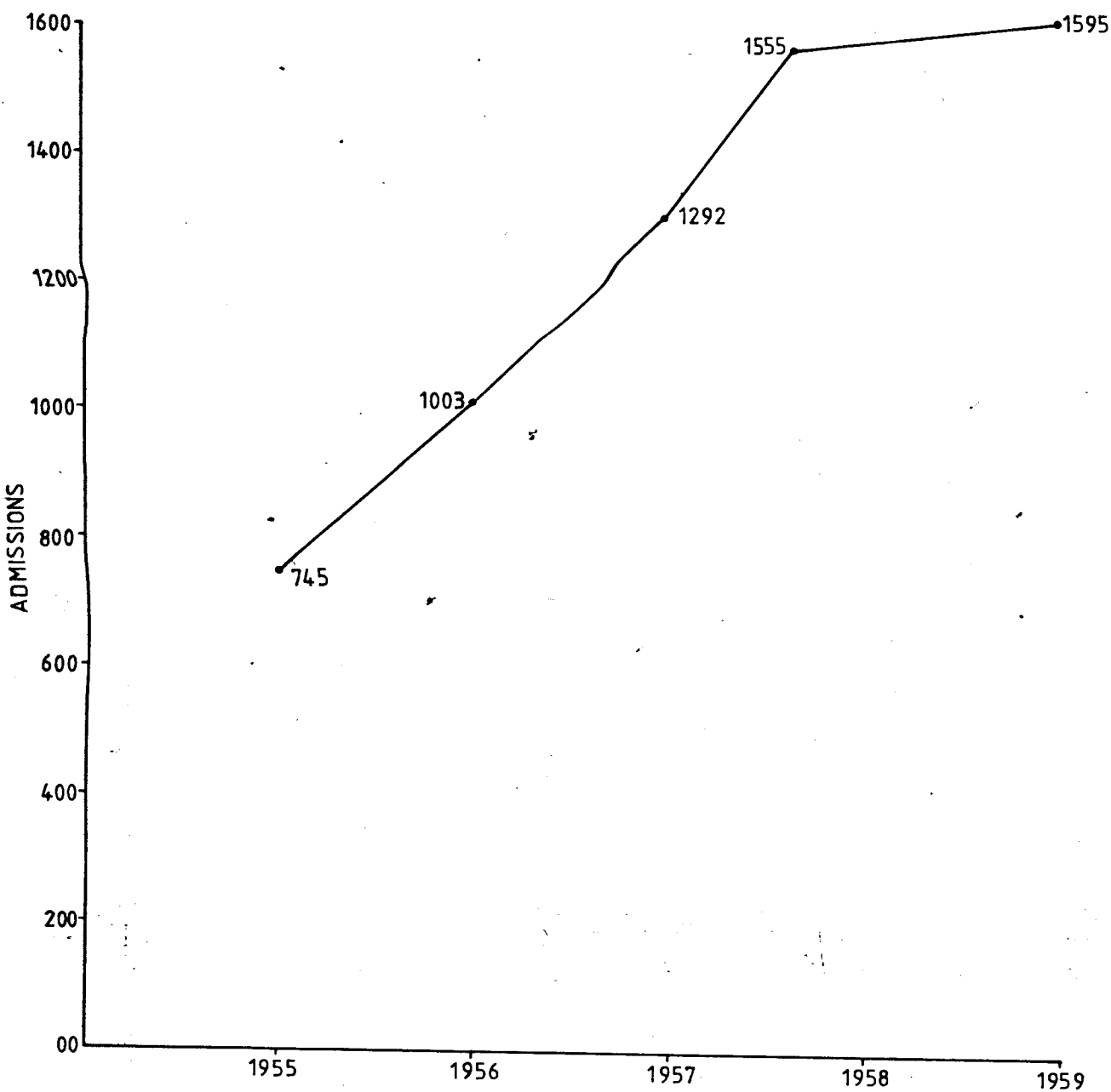illness and the recovery of the patient.
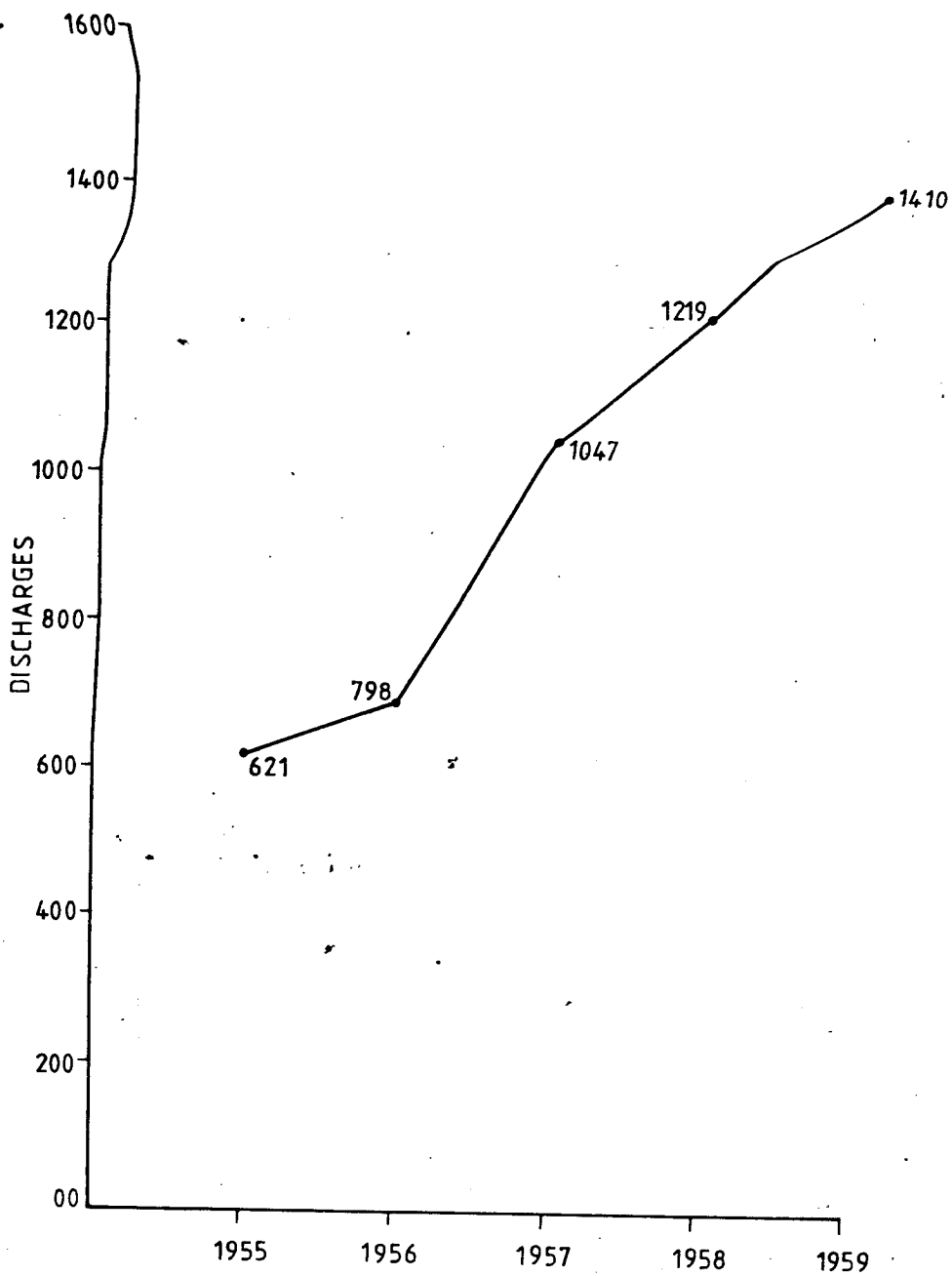
Fig 4 Discharge of Psychiatric patients, 1955-59

Adapted from Appendix J.4.3."Mental Health in the Federation: 1959 Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland."

In addition, the certification of the patient by the
magistrate treated a patient as though he was a criminal - thereby
defeating the concept of treating mental illness as any other
illness. Besides, the hospitals were divided on racial grounds
with the African having the poorest facilities. Thus, the
"Hospital Care" style goal during the Federation only encouraged
the detention of patients and their custodial care in a strange
environment.

The goal concerning the expansion of mental annexes in the
country although a viable one, could not be taken seriously because
in Northern Rhodesia only five such annexes had been built before
and during the Federation. These were built at Ndola, Livingstone,
Kasama, Fort Jameson (Chipata) and Broken Hill (Kabwe) Hospitals.
(Ibid: 42).

The same applies to the goal aimed at integrating mental
health services with the general health services where such
integration was limited to hospitals with mental annexes as
intimated above.

The involvement of the community and family in the care of
patients was in line with modern mental health practice. During
the Colonial days however, this important goal was adulterated
by racial prejudice.

Lastly, as Figure 5 indicates, the training of local
personnel who would speak the patient's language and understand
his culture did not start until two years before Zambia's
independence. The first group of graduates from this programme
came out in December, 1964. In addition, there was no School built
for training purposes. The training of these early mental health
workers was taking place in the wards of Chainama Hills Hospital.
It was left to the Zambian Government to build a training school
and to expand the training programme after 1964.
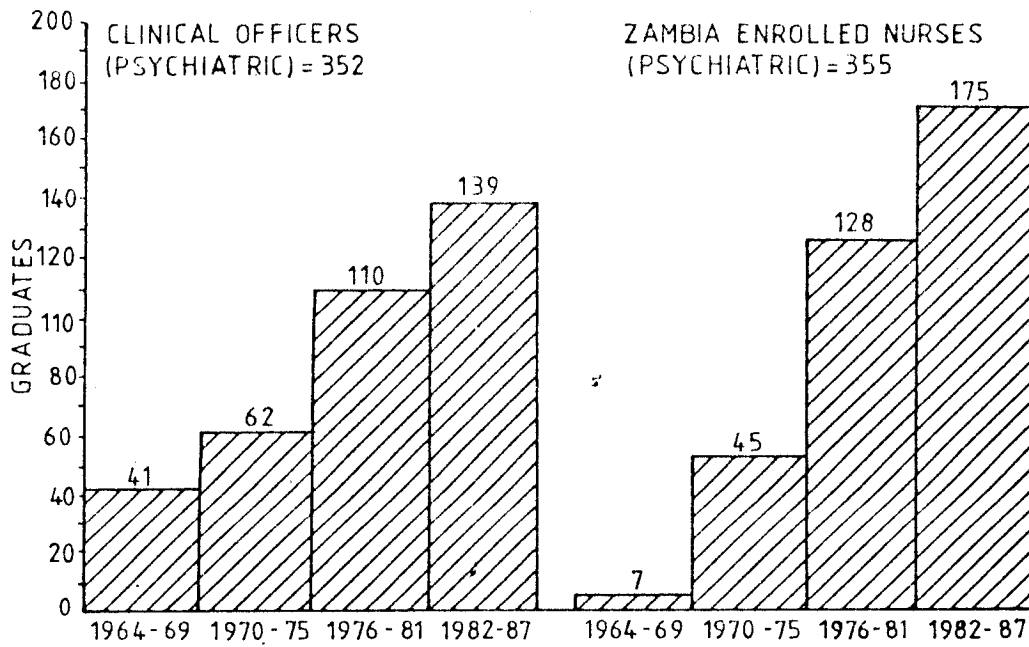
Fig. 5 Number of Mental Health Workers Graduates
from 1964 - 1987.

In conclusion, we may argue from the above observations that although the Federal authorities acknowledged the existence of mental health problems in the three Territories, in Northern Rhodesia there were no goals written down to cope with these increasing problems. The strategies the administrators adopted to grapple with such problems although having made the foundations for our present mental health services in Zambia, were riddled with problems particularly in the fields of race relations, language and cultural biases. As such new goals and new strategies had to be found after the country's attainment of independence in 1964.

Post-Independence Mental Health Goals

After independence, the new Government embarked upon a policy of developing an integrated national health service which was to become part of the overall socio-economic development of the country. Thus, in the Ten Year National Health Plan (1972-1981), the Party and Government's major objective was outlined as:

> "The provision of an integrated curative and preventive health services, so that medical care could be within easy reach of every citizen" (Zambia 1973-1977).

From this major objective of the Party and its Government, Mambwe (1983: 2) isolated five objectives of Zambia's mental health services. These were:

(i)   To provide promotive, therapeutic, preventive and rehabilitation service in accordance with modern practice.

(ii) To cover/reach as a wide population as possible while being responsive to the needs of special high risk groups.

(iii) To train relevant personnel to man the service.

(iv) To develop the service as an integral part of the national health programme.

(v) To achieve various targets of the service within
     realistic time scale with constant evaluation.

     We could say at least that the country had observable goals
against which the effectiveness and efficiency of mental health
services administration could be crudely measured. However, in
terms of the control and coordination of their implementation,
the big question was, whose goals were they: the Ministry of
Health as the Central Administration of all Government health
services in the country including mental health on one hand or
Chainama Hills Hospital as a professional institution primarily
concerned with mental health service administration in Zambia
on the other.

     If the goals were to be perceived as the Ministry's, then
the responsibility for ensuring their implementation would follow
under general medical administration headquartered there; while
if they were to be considered as Chainama Hills Hospital goals
the control and coordinating of their implementation would be
the responsibility of mental health professionals themselves.
This perception would have serious implications on the way mental
health workers in the country evaluate mental health services
administration generallyparticularly in regard to career
anchorages and responsiveness to their professional needs.

     Despite this apparent confusion in perception, the goals
outlined by Mambwe were a positive development in the approach
toward the administration of mental health services in the country.

     Although they may not differ significantly from those of
the Federal Government, the goals adopted by Zambia were much
broader than those of the Federation. They were intended to
transform the "custodial, prison-like" pre-independence service
for the mentally ill to a therapeutic one with increasing community
character and orientation.

Thus, from only a few psychiatric units based at
Lusaka, Livingstone, Ndola, Chipata, Kasama and Kabwe at
independence, the country now has over 200 mental health
facilities throughout the Provinces. That is, eight new
mental health facilities every year. In addition, there
are also over 1290 psychiatric beds in the country,
constituting 6.2 per cent of all the beds in Zambia
(Mambwe 1982 (1) :2), (1987 (2 : 7).

In the area of integration, great advances have
also been made. For example, mental health facilities
are now available at 37 of the 42 Government hospitals
in the country. Some mission hospitals also, such as
St. Francis Hospital in Katete have started having mental
health facilities as an integral part of their general
medical services. In addition, liaison mental health
services are also being provided to a large number of
"general" hospitals such as the University Teaching
Hospital, Ndola Central Hospital and Chipata General
Hospital among others.

However, the successful implementation of these goals
meant further changes in the training programmes in order
to cater for the added responsibilities assumed by the
new Government. More trained cadres in mental health work
such as Clinical Officers (Psychiatry) and Zambia Enrolled
Psychiatric Nurses had to be developed (Figure 5). These
workers who now number over 600, (from 12 at independence
including this author) had to be the "corner-stone" of
the new mental health programme in the country. Indeed
the general public has since been fully recognized. As
Mambwe (1987:9) contends:

> "Without the training of these cadres of staff, there
> would have been very little mental health service to
> talk about in this country. Indeed, our pioneering
> work in this area is now being copied by our
> neighbouring countries."

In sum, we may argue that both "traditional" and "modern" methods of implementing organizational goals co-existed in mental health services administration in Zambia - a feature we shall fully discuss in the next section.

Post-Independence Mental Health Services Administration:
Continuity and Change.

In the post independence period, the Zambian Government virtually maintained the organizational framework of the colonial era. Mental health services administration continued to be under the Ministry of Health with Chainama Hills Hospital as the advisory centre for mental health services in the country.

However, because of the broader approach to health problems and therefore the need to take mental health to the rural and urban communities, the Zambian Government infused the "Community Care" style into the old framework. Mental health workers were required to visit prisons and police cells to provide treatment to patient prisoners and to pick up patients who might have been detained in police custody. In addition, mental health workers were also required to make regular visits to patients' homes particularly to high-risk patients and discuss mental health problems with their families. Public lectures and talks came to constitute another aspect of the community approach to mental health, with mental health workers paying visits to schools, colleges, community leaders and to voluntary and specialized agencies such as the Lions' Club and the Jaycees and Nutrition Commission and Cheshire Homes for the physically handicapped children etc.

The organization of such public lectures and visits to institutions and charitable organizations were however, left to the Community Mental Health Coordinators. To enable this

community outreach not only to mental health but also to general health service to take place, the overall budget was increased from K4 million (£2 million) in 1963-1964 to K20 million in 1968. This represents a 500% increase over the Northern Rhodesia budget for health services. (Northern Rhodesia 1964: 47), (Zambia 1968: 2)[1].

Similarly, staff establishment for mental health workers in the country increased from a bare twelve psychiatric nurses at independence to forty-one clinical officers (psychiatry) and seven enrolled psychiatric nurses in 1969 - constituting an overall increase of 400% over the colonial period. (Zambia 1964; 1969).

We can posit that this increase was largely attributed to the training of local cadres (clinical officers psychiatry) which had started in 1962 and expanded by the Zambian Government after independence and included the training of Zambia Enrolled Psychiatric Nurses from 1967. (Figure 5).

Continuity was, nonetheless; registered at the level of mental health administration which remained the domain of the Ministry of Health. The formal bureaucratic arrangement for transmitting instructions and for control purposes continued to reflect the hierarchical structure of the colonial era as shown in Figure 6.

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1.   NOTES: Hospitals did not have individual budget during the colonial period. This trend appears to be the Zambian Government's creation.

FIG. 6 ORGANIZATIONAL CHART OF THE MINISTRY OF HEALTH

FIG. 6 ORGANIZATIONAL CHART OF THE MINISTRY OF HEALTH
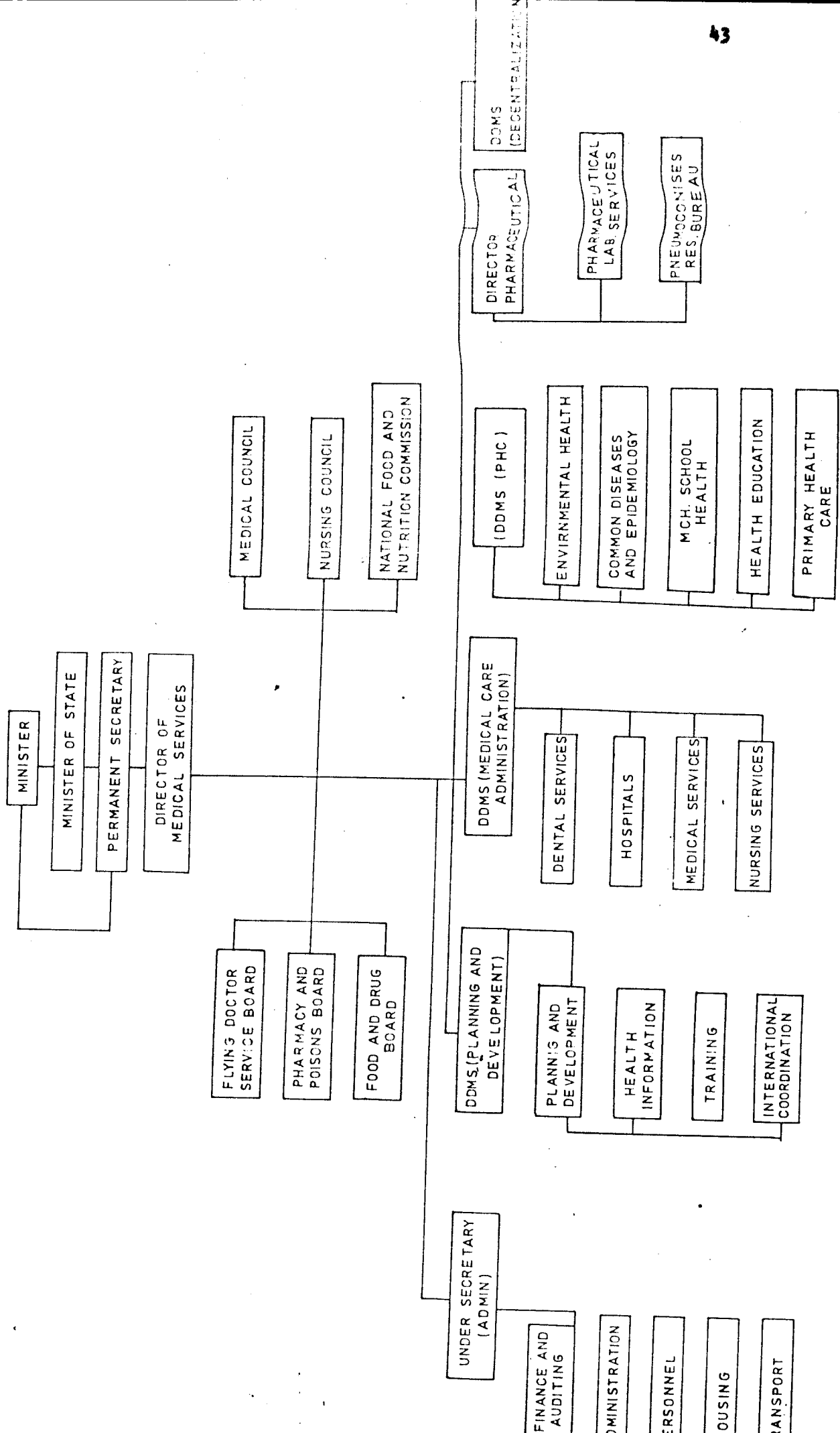
As can be noted in the organogram, the institutional frame-
work of the Ministry of Health administration continued to be
professionally organized along functional lines. This was to
ensure effective control and coordination of the services. The
Director of Medical Services (DMS) heads the professional side
of the Ministry of Health administration assisted by five Deputy
Directors of Medical Services (DDMS).

The five DDMS are in turn assisted by the Senior Training
Officer, Chief Nursing and Clinical Officers, Chief Health
Inspector and Chief Para-Medical Officer respectively. These
Officers have their deputies too who operate along functional
lines as the DDMS. For example, the Chief Nursing Officer who
functionally falls under Medical Care Administration has three
deputies who separately deal with training, administration and
Primary Health Care.

Nevertheless, the direction of the Ministry's health policies
to the lower enchelons of health workers throughout the country is
exercised mainly by the five DDMS who form the "dominant coalition."
The functions and line of authority of this "coalition" is depicted
in the organigram shown in Figure 6 and comprises five professional
domains as follows:

Planning And Development

The Planning and Development section is responsible for
planning and ensuring that the development of new health facilities
in the country such as training institutions, hospitals and
health centres are realized. It is further responsible for
disseminating information and coordinating international related
activities in the Ministry of Health. Thus, Heads of Training
Institutions such as Chainama College of Health Sciences are
answerable to the DDMS. Resource allocations for new developments,
teaching staff appointments, promotions, transfers and discipline
are some of the DDMS's responsibilities.

Medical Care Administration

The area's responsibilities are to ensure that curative medical services are available to the general public in accordance with the Party and Government's Health policies. Thus, dental, hospital, medical and nursing services are some of the responsibilities carried out by this section. At a lower level, officers such as the Provincial Medical Officers and Senior Medical Superintendents of large general hospitals and special hospitals such as Ndola Central Hospital and Chainama Psychiatric Hospital respectively are answerable to the DDMS. The allocation of resources, staff appointments, promotions, transfers and discipline in the service are controlled by the DDMS.

Primary Health Care (PHC)

This part is responsible for developing, implementing and evaluating Primary Health Care in Zambia following the country's adoption of the Alma Ata Declaration of 1978 which established the concept of PHC. It is concerned with making essential health care nationally accessible to individuals and families in the community in an acceptable and affordable way and with their participation.

The section therefore controls and coordinates such health programmes as Maternal-child health including child spacing, school health, health education, promotion of adequate nutrition and food supply, promotion and maintenance of a safe water supply and basic sanitation, immunisation, prevention and control of locally endemic diseases such as malaria, bilharzia, and sleeping sickness and the treatment of common diseases and injuries.

Pharmaceutical Services

In addition to these three sections of Central Administration, a new and fourth section is concerned with pharmaceutical

the functional lines and falls under the five functional divisions
forming the central administration of the Ministry of Health,
namely Planning and Development, whereby mental health workers
are expected to be trained under the auspices of the DDMS (Planning
and Development). Similarly, issues of physical expansion of
mental health care facilities and institutions also fall under
Planning and Development.

At the sametime the supply of psychotropic drugs for a
psychiatric patients is the functional responsibility of the
Pharmaceutical services. It corresponds with the community out-
reach approach in that drugs are not supplied to Chainama Hills
Hospital and then redistributed below but are given to each mental
health unit through the hospital under which it is attached.

Similarly, Medical Care Administration, that is, the overall
policy issues of how mental health institutions i.e. mental health
units in Central and General Hospitals and Chainama Hills Hospital
should be run, is the monopoly of the Medical Care Administration
headquartered at the Ministry's main office.

The preventive aspects of mental health, that is the community
outreach whose main concern is to prevent psychosocial problems
such as self-injury caused by excessive risk - taking behaviour,
alcohol and drug abuse and attempted suicide fall under the umbrella
of the Primary Health Care section. In addition, the Primary Health
Care section also controls and coordinates such essential health
care programmes as maternal child health, immunization, prevention
and control of locally endemic diseases such as malaria, bilharzia
and sleeping sickness etc., whose acceptance by the community is
significantly influenced by changes in their behaviour.

Decentralization in the field of mental health implies that
mental health care should be made available at the community,
district, and provincial levels, through psychiatric inpatient and

outpatient units linked to the general medical facilities. The
creation of large mental hospitals is discouraged because of their
isolation from the community and the stigma people attach to them.
Where such hospitals already exist as is the case with Chainama
Hills Hospital, the primary consideration of the "Decentralization"
section of the Ministry of Health is to ensure that the staff/
patient ratio allows adequate treatment, care and rehabilitation,
and that the hospital is supported by a network of other services
as described above. Thus, the position of Chainama Hills Hospital
administration within the organizational structure of the Ministry
of Health is important in regard to the control and coordination
of mental health services in the country.

Chainama Hills Hospital is the administrative centre of
mental health services in Zambia. It is:

> The brain behind the development of mental health services
> in the country. Even at the Provincial level, mental health
> units appear as extensions of Chainama Hills Hospital"
> (Mambwe 1982: 6, 1987: 7).

However, as Figure 7 indicates, Chainama Hills Hospital
Administration is accountable to the Medical Care Administration
under the DDMS for implementation of psychiatric care programmes.
In addition, other sectors of Central Administration control the
activities of Chainama Hills Hospital Administration through
functional allocations to various mental health programmes.
For example, the budget for inservice training programmes conducted
at the hospital are controlled by the Planning and Development
section, the provision of psychotropic drugs and equipment for
use in the hospital are controlled by the Pharmaceutical services
under the Director of Pharmaceutical services etc. This type of
administrative arrangement creates a serious problem for Chainama
Hills Hospital administration in terms of staff and resource
control and coordination by being answerable to different functional
areas for its mental health service activities as shown in the diagram.

49

Fig. 7 Chainama Hills Hospital and the Administration of Mental Health Services


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                    ┌─────────────────┐
                    │    DIRECTOR     │
                    │ OF MEDICAL SERVICES │
                    └─────────────────┘
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DDMS (Planning and development) — 2

DDMS (Medical Care Administration) — 3

Pharmaceutical Services — 1

DDMS Primary (Health Care) — 4

DDMS (Decentralization) — 5

SENIOR MEDICAL SUPERINTENDENT OF CHAINAMA HILLS HOSPITAL
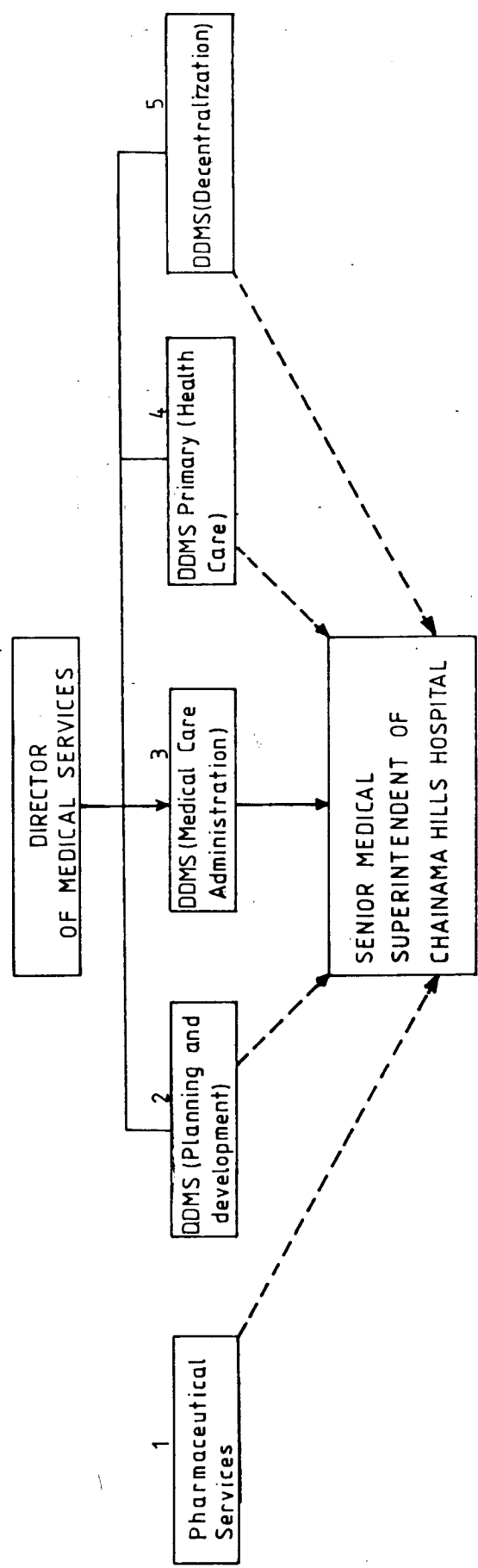
NOTES:

—————— Direct supervion and functional allocation

– – – – – Functional allocation in regard to:

1 Provision of drugs and equipment to mental health facilities.

2 Trainining and in-service courses budget

3 Provision of mental health care budgets and staff.

4 Integration of mental health into PHC budget and staff allocation.

5 Decentralization of mental health services

Similarly, the problems of control and coordination of mental health services administration in the country also exists at the level of mental health units. Figure 8 shows that mental health unit administration is under the umbrella of the particular hospital administration to which the unit is attached. Thus, weakening the line between Chainama Hills Hospital as the centre of mental health services administration and its apparent appendages - the mental health units.

It can be argued that an organizational structure such as the one now existing in the Ministry of Health has serious implications on the overall control and coordination of mental health services in the country as we shall see below.

Implications Of The Organization Of Mental Health Services Administration

It is clear from the organizational structure of the Ministry of Health that in order to have an effective mental health administrative system, there is need for a high degree of coordination among the five functional areas of Central Administration. For example, the Senior Medical Superintendent of Chainama Hills Hospital has to liaise with the DDMS (Planning and Development) for training budget, and DDMS (Medical Care Administration) for staff promotions and discipline etc. Thus, the question of accountability and control among the role occupants within mental health services administration is a serious problem since they are accountable to different DDMS for various mental health programmes.

In addition, Chainama Hills Hospital being the centre for mental health training programme for various groups of health workers in the country, the Senior Medical Superintendent has also to liaise with the Medical Council of Zambia for Clinical Officers (General and Psychiatry) training programmes and the General Nursing Council

FIG. 8 MENTAL HEALTH UNIT AND THE ADMINISTRATION OF MH SERVICES.
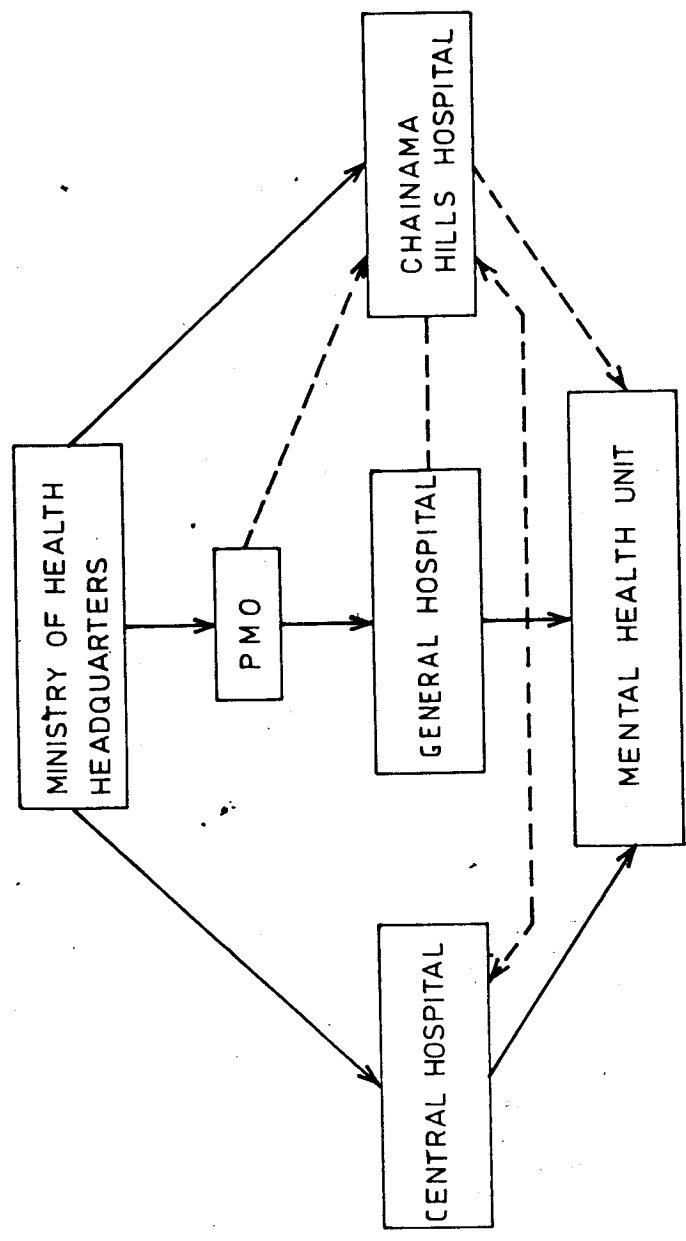
NOTES:

——— Functional Allocation: resources, staff appointments, promotions, transfers, training and discipline

- - - - Advisory functions only

Boxes: MINISTRY OF HEALTH HEADQUARTERS, PMO, CHAINAMA HILLS HOSPITAL, GENERAL HOSPITAL, CENTRAL HOSPITAL, MENTAL HEALTH UNIT

Enrolled Psychiatric Nurses (ZEPN) were analyzed in terms of
training environs and the actual nature and scope of the
programme.

In this chapter we will examine the training programmes of
both general and mental health workers in order to determine the
scope and nature of training they receive in fields other than
their own specialization.   There are several facets of curriculum
evaluation, but for our study we only selected two of these methods
i.e., scope and nature of training; "scope" so as to assess whether
the training programme provides a range of subjects wide enough
to prepare the student for his/her future role in the field.
"Nature" that is quality of the training programme, in order to
determine whether mental health workers are prepared to undertake
the polyvalent roles in the field.   These two aspects of training,
to us, constitute two important areas of mental health training
and are therefore key to our investigation.   This is so because
job assignments and career anchorages are to a large extent
dependant upon scope and nature of training.

Scope And Nature Of The Mental Health Training Programmes

Chainama College of Health Sciences provides basic and in-service
training programmes for clinical officers (General) and both categories
of mental health workers i.e. Clinical Officers (Psychiatry) and
Zambia Enrolled Psychiatric Nurses.   The only exception is the
training of Zambia Enrolled Nurses (General) which takes place in
hospital-based schools of nursing which are scattered throughout
the country.

The college graduates around 40 Clinical Officers (General),
15 Clinical Officers (Psychiatry) and 20 Zambia Enrolled Psychiatric
Nurses twice a year in January and July. This means a total of
80 Clinical Officers (General), 30 Clinical Officers (Psychiatry)
and 40 Zambia Enrolled Psychiatric Nurses annually. (College
Prospectus 1982).

Similarly, the 17 Zambia Enrolled Nurse Training Schools, together turn out an average of 250 graduates twice a year in January and July. This means an average of 500 graduates a year (General Nursing Council 1983).

These numbers appear to be insufficient to meet the population's health needs because between 1977-1983 during the Third National Development Plan (TNDP), the country had a shortfall of 515 Zambia Enrolled Nurses (General) and 675 Clinical Officers (General). (Zambia 1979: 372 op.cit).

Similarly, in the context of mental health workers; in 1982 the annual nominal consulation rate was 107 psychiatric patients per-Clinical Officer (Psychiatry) and the nurse to bed-ratio was one psychiatric nurse to 6.4 beds with an average annual nurse-to-patient ratio of one nurse per 50 patients (Mambwe 1982: 11 op.cit). With the annual admission rate in 1982 standing at 117.2 per 100,000 population and the out-patient attendance rate of 456.8 per 100,000 population, we may argue that the number of mental health workers graduating each year is insufficient to cope with this ever increasing demand for mental health services. As Mambwe (1982: 11) contended:

> "Basing on the World Health Organization's modest estimate of psychiatric morbidity that 1% of the general population are mentally ill in need of treatment, it can be said that all the "New" patients that the service managed to reach this year constituted only 13.8% of those in need of psychiatric treatment in Zambia".

It may be posited that this will not only require more mental health workers to be trained and remain in their field but general health workers too will have to be more involved in mental health work than is the case now.

Data on training programmes also revealed that entry qualifications to both Clinical Officers' training programmes are determined by the Medical Council of Zambia. The academic qualifications required for one to enter Clinical Officers' courses are a "Full Cambridge School Certificate", with credits in three of the following subjects: English Language, Mathematics, Biology and Physical Sciences. (Medical Council, 1984).

Conversely, entry qualifications to both nursing courses are controlled by the General Nursing Council of Zambia. The academic qualifications required are a "Full Junior Secondary School Certificate" with the English Language, Mathematics and a Science subject (but not Agriculture Science) as compulsory subjects. (General Nursing Council 1985.)

Table 1 shows that only three per cent of the Clinical Officers' (General) training programme is devoted to mental health work. This is despite the fact that three year training programme for Clinical Officers prepares students to diagnose, treat and control diseases and conditions common in Zambia, particulary in the rural areas of the country, under the supervision of Registered Medical Officers.

In the context of training in mental health, the major objective of a Clinical Officer (General) is to identify and manage - including referral and follow-up basic mental health problems in the country. Specifically the COG must demonstrate a clear understanding of a host of mental illnesses and basic psychiatry. He learns the basic precedure of history taking, that is, eliciting of psychiatric symptoms before making a diagnosis, and the simple classification of mental disorders etc.

In addition, the COG is expected to know the management of mental illnesses adapted to the local resources and constraints including simple drug prescription, referral and follow-up.
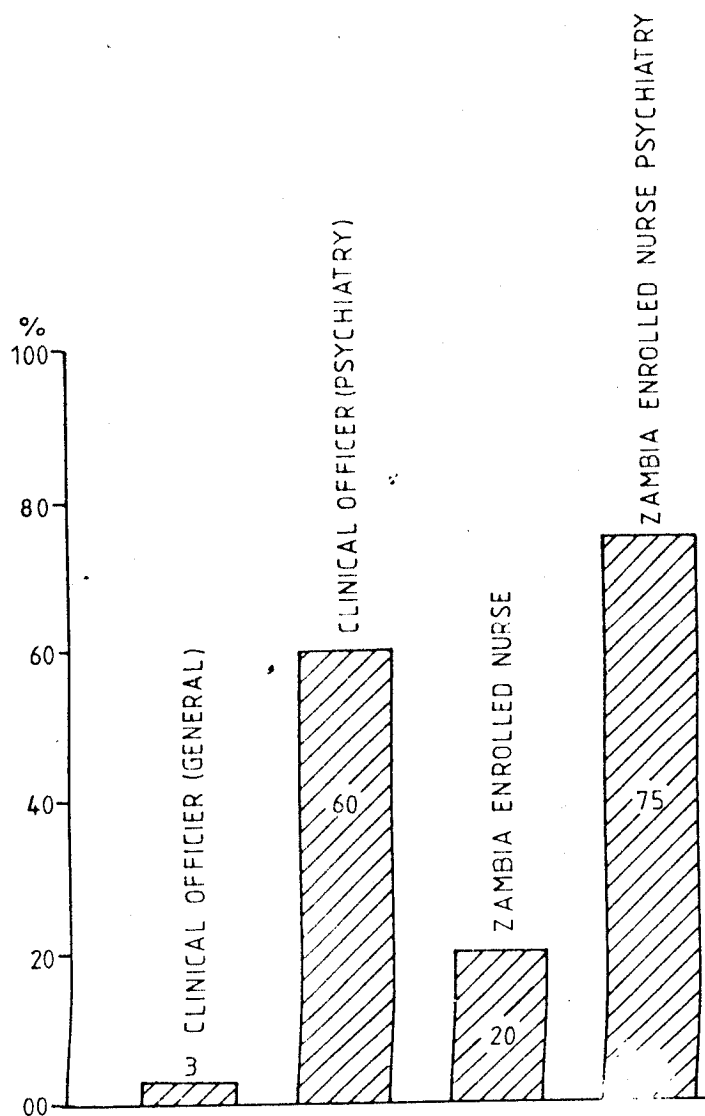
Table.1: Mental health in the Training
Programmes of health workers.

The number of hours devoted to mental health is 142 comprising 62 hours of theory and another 80 of field work. This number of hours forms about 3% of total hours for the overall three-year training programme. (Implementation Programme: 1987).

In view of the comprehensive nature of mental health problems, it can be argued that this amount of mental health lectures given at Chainama College of Health Sciences and the two weeks field work done at Chainama Hills Hospital are insufficient to allow any really practical learning to take place. Besides, the programme seems to suffer from poor linkage between the experience COGs gain at Chainama Hills Hospital with its emphasis on the "Hospital Care style and the generality of mental health problems presenting at the Health Centre where a COG works. The later environ requires "Community Care" and "Integration" styles. Thus, even though official instructions/ assignments may tend to determine to a large extent whether to be involved in mental health work or not, the limited nature of mental health training on the part of general health workers could also contribute to their apparent little involvement in mental health work. In addition general health workers may not have enough time to develop interest in mental health work and may have to do so in the field.

Likewise, only twenty per cent of the Zambia Enrolled Nurses (General) training programme is devoted to mental health work. But unlike the three-year training programme for Clinical Officers which prepares the graduates to function as "Mini-doctors of Medicine", this two-year training programme prepares students to provide health services and nursing care in the community and in the hospital setting under the supervision of Registered Nurses or Clinical Officers. The course deals with the concepts of "Normality" and "Abnormality" in the Zambian context in particular. The course content comprises introductory lectures in psychology, covering such topics as psychological development, learning, thinking, remembering, sensation and perception. It also covers, defence mechanisms, stress, frustration, conflict, psychological effects of being a patient, psychosomatic disorders and a therapeutic Nurse/ Patient relationship or the "Caring Nurse".

In addition, students are also given introductory lectures in the causes, features and management of common mental health problems in Zambia such as, violence, delusions, hallucinations, anxiety, hysteria, depression, abnormalities of speech such as acceleration and retardation of behaviour including withdrawal.[1]

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1. Throughout this Chapter the number of hours for both theory and field experience will be calculated on the basis of 08.00 - 16.00 hours daily from Monday to Friday.

Lectures are also given on drug and alcohol-related problems, *psychiatric disorders in child birth and their related health* education.

The students are given 2-4 weeks (optional) field experience at the nearest mental health unit. (Enrolled Nurse 1985).[1]

We may argue that by putting field experience "optional" for students, the training agencies are indirectly discouraging students from practicing psychiatric nursing after their graduation, thus creating a gap in the application of the acquired knowledge in the field. However, the 20% or 172 out of 844 hours allocated to mental health is better than those allocated to Clinical Officers (General) who are supposed to be supervisors of Enrolled Nurses, both psychiatric and general.

It can further be contended that these differences in the scope of mental health training may create a crisis of confidence at the level of supervision for both the COG and the enrolled nurses. A COG may not be interested in supervising mental health work and the nurses may lack the expert and professional guidance because of the COG's little experience in mental health work.

Conversely, we wanted to find out how much general medical work was done by mental health workers during their training. We wanted to know whether there was any correlation between level of involvement and the scope of training in general medical work by mental health workers. Table 2 reveals that 40 per cent of Clinical Officers' (Psychiatry) training programme and 31 per ce cent of the Zambia Enrolled Psychiatric Nurse training programme are both devoted to general medical work. This is to enhance their roles as mental health workers in the field.

1. Comprehensive rosters of psychiatric procedures for the COG and ZEN are determined by the Tutors.
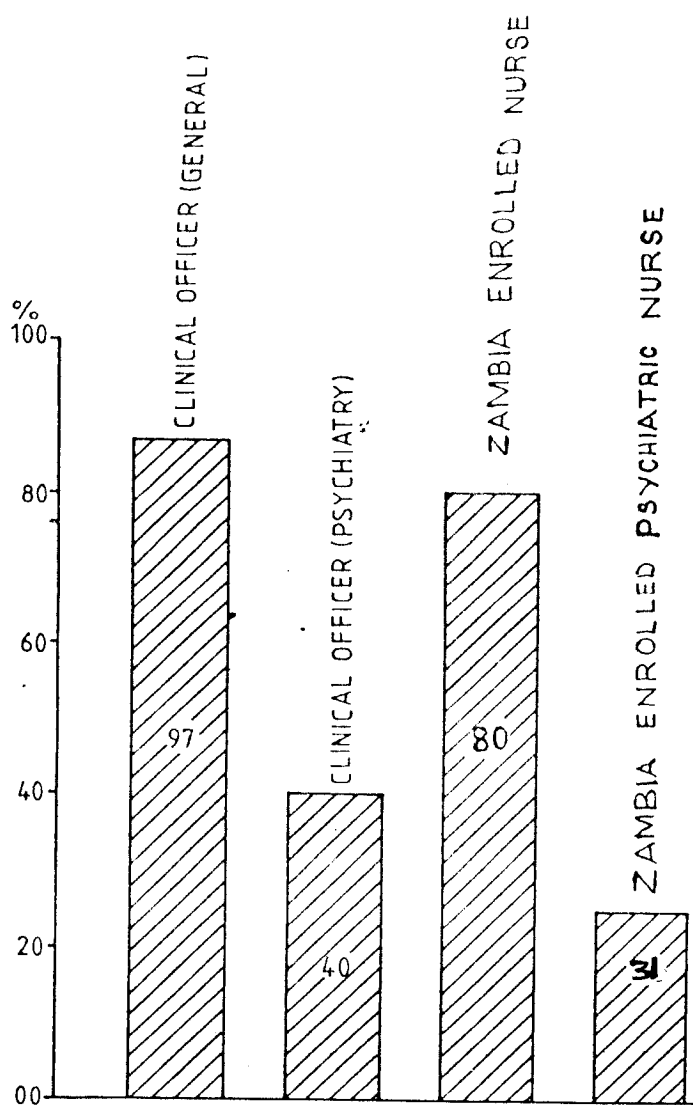
Table.2 : General medical work in the Training
Programmes of health workers.

Thus, the Clinical Officer (Psychiatry) three-year training programme is intended to prepare students to work as Clinical Officers (Psychiatry) in mental health units, hospitals, health centres and the community under the supervision of Government Medical Officers.

The programme content and structure for the first one-and-half years (19 months) is identical with the corresponding parts of the Clinical Officers (General) training programme. However, in the remaining training period of another eighteen months, greater emphasis is placed upon mental health subjects and the practical management of common mental health problems at Chainama Hills Hospital, mental health units and in the Community throughout the country.

In terms of general medical trining, the Clinical Officer Psychiatry is trained to carry out First Aid, and to diagnose and treat the common communicable and other diseases treated in the general hospital and health centres in the area where he works.

Specifically, the Clinical Officers (Psychiatry) are given lectures in therapeutics, medical history-taking, diagnosis and treatment of medical/Surgical diseases, and the related health education. In addition, they are also given basic knowledge in human pathology, and laboratory procedures etc. (Prospectus: 1982: 22-24), Syllabus 1982: 21-52).

The number of hours devoted to the general medical training is 2741, consisting of 501 theory given at the college and 560 hours field work taken at Health Centres in Lusaka. Thus, the general medical work takes 1619 out of 4550 total hours or 40 per cent of Clinical Officer's (Psychiatry) training programme.

Inlike manner, Zambia Enrolled Psychiatric Nurses' two-year training programme prepares students to work as Enrolled Nurses in

psychiatric hospitals, units, health centres and community under
the supervision of Registered Nurses. The course content
introduces the trainees into the practice of psychiatric nursing
as part of the overall patient care which lays stress on the
interaction of patient/disease and socio-cultural environment.

    As regards to the general medical work training, the trainees
are given lectures in several subjects such as medicine and medical
nursing and tropical diseases in which the trainees are expected
to describe common medical conditions in Zambia, identify the
needs of the patient with common medical conditions, explain the
diagnostic tools and therapeutic procedures used and plan and
implement nursing management of the patients with those conditions
as well as give related Health Education. In addition, the
student is also given lectures in surgery and surgical nursing
where a trainee nurse is taught how to outline the principles
of general surgery and surgical nursing, identify the patient's
basic needs associated with common surgical conditions, explain
the different types of diagnostic and therapeutic procedures and
tools, plan and implement nursing management of common surgical
conditions identified above and give related Health Education.
(Psychiatric Nurse 1985: 17-19).

    In terms of number of hours devoted to the general medical
work this is put at 1020 with 460 going to theory and 560 going
to field experience in various general hospitals throughout the
country. The total percentage of general medical work in the
overall training programme is 31% per cent or 1020 out of
3310 hours.

    In sum, this seemingly integrated type of training has the
flexibility elements which enable both type of trainees to
respond to the social dynamics of development in a country as
poor as Zambia with its lack of skilled manpower in the face of

a multitude of health problems. However, mental health workers receive a little more general medical training than it is true for their colleagues in mental health work.

The next section therefore attempts to assess how the health worker looks at both the nature of the training programmes he/she receives, the assignment given to him/her and whether there is a correlation between the two from his/her view point as well as the likely consequences arising from the inter-play between training background and perception of the nature of the field assignment given to the health worker.

Worker Evaluation of Training Programmes

Mintzberg (1979: 96) contends that training is a key design parameter in all work we call professional. He defines training as:

> "The process by which job-oriented skills and knowledge are taught...."

This definition amounts to the "internalization" of accepted (i.e., standardized) patterns of behaviour in the worker. A similar view is advanced by Flippo (1980: 181) who posits that "planned development programmes will return values to the organization in terms of increased productivity, heightened morale, reduced costs, and greater organizational stability and flexibility to adapt to changing external requirements". One might also add that such programmes will help meet the needs of individuals in their search for career advancements and anchorages which are consonant with their training programme. Thus, the essence of any training programme in terms of its content is skills transfer.

It was, therefore, necessary to explore the views of the graduates from the general and psychiatric training programmes

working in the same health care institution on their skills transfer. As mentioned elsewhere in this text, the study was conducted in general hospitals and Health Centres with mental health facilities. The respondents were 23 Clinical Officers (Psychiatry), 23 Zambia Enrolled Psychiatric Nurses, 22 Clinical Officers (General) trained at Chainama College of Health Sciences, and 22 Zambia Enrolled Nurses (general) trained from the various schools of nursing scattered throughout the country.

Data derived from the question on the scope and nature of training each cadre received in their minor field of work are shown in Table 3 below. The table reveals that generally, mental health workers feel that they receive enough training in general medical work. Only 10 out of 46 mental health workers felt that they did very little general medical work during training.

Conversely, 20 out of 44 general health workers feel that very little mental health work was done during training.

From the above responses, it is clear that although more mental health workers felt that they were trained in general medical work than their counterparts felt about mental health training, both groups felt that they did receive training in fields other than their areas of specialization. One could therefore expect them to be given equal treatment while in the field in order to foster the aims of "Integration style" to health care problems.

Conclusion

Generally, the foregoing training programmes appear comprehensive for both mental health and general health workers to undertake their professional responsibilities in

TABLE 3:   An Assessment By Health Workers Of The Nature And
Scope Of Training Given To Health Workers

CATEGORIES	MHWs (46)		GHWs (44)			
	Count	PCT of Responses	Count	PCT of Responses	TOTAL Count	TOTAL PCT
During training very little mental health work was done	2	4	20	45	22	24
During training very little general health work was done	10	22	2	5	12	13
During training a lot of mental health work was done	30	65	6	14	36	40
During training a lot of general health work was done	4	9	16	36	20	22
TOTAL RESPONSES	46	100	44	100	90	

their respective fields. Similarly, the training programmes'
content seem to offer sufficient room for both categories
of health workers to train as versatile workers in general
and mental health. Nonetheless, a closer look at the
duration of the training programmes reveal an inbuilt bias
against mental health work on the training given to general
health workers. For example, Zambia Enrolled Nurses are
given optional field pacticals and yet they are expected to
manage mental health problems in the fields. Similarly,
the duration of the training programme for COGs in mental
health is not only too short to permit adequate internalization
of mental health skills but also the practical aspect is
undertaken in a highly professionalized atmosphere which does
not present itself in the field where the treatment of mental
illnesses is highly simplified and basic.

Nevertheless, the training programmes of both categories
of health workers appear to foster the effective implementation
of Community Care, Hospital Care and Integration styles
described earlier in this study. This has been confirmed
by health workers' own positive assessment of their training
programmes.

But given the above training programmes for both mental
health and general health workers, what we would like to know
in the next Chapter is whether there is a strong correlation
between their training background and their field assignments.
This question is significant in that unless field assignments
correspond with the training background of the health worker
in the light of the three "styles" we have discussed, he/she
is bound to be misplaced, leading to possible frustrations
and inefficiency.

CHAPTER 4

FIELD ASSIGNMENT AND OFFICIAL RESPONSIVENESS: AN ASSESSMENT BY
THE HEALTH WORKERS

In order that the collected data may be more readily understood,
it is intended that only the findings pertaining to the responses
on the assessment of career anchorages such as professional autonomy,
state of existing mental health facilities, mental health workers
perception of how administrators evaluate their status, career
opportunities and an assessment of responsiveness of Central
Administration to the needs of mental health workers will be presented
and analyzed. Responses to the questions on personal data will be
included within this framwork.

The tables are arranged according to the questions in the
questionnaire (Appendix A). They compare responses of mental health
workers, general health workers and administrators to the research
questions.

It was further recognized that responses to questions 8 and 9
(professional autonomy-workload) 15 and 16 (Assessment of Central
Administration's responsiveness) would form the basis for our conclusion.
Therefore, it was decided to have a comprehensive treatment of the
data obtained through these questions by including more parameters
within the questionnaire for analysis with a view to identifying the
main administrative constraints affecting mental health services in
Zambia as seen by mental health workers.

Before examining the responses to the questions on career
anchorages, in the last chapter we explored the nature and scope
of the various training programmes and assessed how health workers
in general and MHWs in particular evaluate their training background
to determine whether or not the training programmes are seen as

adequate (enough) to equip the health worker with the necessary skills required to perform his/her polyvariant nature of his/her field work.

In this chapter therefore, we will proceed to scanning the various career anchorages from a theoretical perspective. This has been necessitated by the strong link that exists between employee perception of organizational anchorages and his/her career as well as performance within the organization.

Career Anchorage

According to Flippo (1980: 226-239); "career anchors of every employee in any organization include, managerial competence-the desire to bear administrative responsibility in his work, technical-functional competence - to be primarily interested in the functional work performed, security in the job rather than interest in work alone, to be creative in his job and to have the feeling of freedom and independence in exercising his professional skills."

In other words, these anchorages provide the nexus around which employee morale and performance can be built. As such, therefore, career anchorages are significant for employee self actualization and organizational growth.

The study findings below are expressions of health workers' and administrators' assessment of the way the Ministry of Health controls and coordinates mental health services in general and the way it responds to the needs of mental health workers in particular, and as such, the responses are an attempt to assess the availability of "career anchors" to mental health workers.

We first began by looking at professional autonomy as a career anchorage and how mental health workers perceive their professional autonomy within the Ministry of Health.

Professional Autonomy As Career Anchorage: Health
Workers Assessment Of The Workload

According to Flippo, (op.cit) professional autonomy entails
that an employee has the feeling of freedom and independence in
exercising his professional skills; i.e. he has some control over
his own work. He achieves this independence through standardization
of skills and its main design parameter of training as intimated
earlier in the text. There is a feeling of freedom and independence
in exercising professional skills. Thus, in this section the amount
of workload done by the various workers was assessed by asking
different questions pertaining to the extent to which mental health
workers are involved in general medical work and the extent to
which general health workers are involved in mental health work.

The respondents were further differentiated along age and sex
lines so as to determine whether age and sex had influence on
workload done or not. Age because the young generally have high
expectations than the old, thus, in a situation where career
archorages are loosely provided or non existent, then we can expect
a high level of dissatisfaction among young employees.

Similarly, men are generally more expectant of career
archorages than women that the abscence of these might lead to
a high level of frustration among the male employees.

Age

As Table 4 shows, all 18 mental health workers aged between
19-29 years were involved in general medical work regularly,
while 22 out of 26 mental health workers aged between 30-39 years
were also involved in general medical work on a regular basis.

TABLE 4: MHWs Assessment Of Degree Of Involvement In
General Health Work By Age Category

CATEGORIES	MENTAL HEALTH WORKERS					
Age	19-29	30-39	40-49	Over 50	Total Count	PCT
Involved in general medical work daily	15	19	2	0	36	78
Involved in general medical work weekly	3	3	0	0	6	13
Involved in general medical work monthly	0	2	0	0	2	4
Involved in general medical work every few months	0	1	0	0	1	2
Not involved in general medical work at all	0	1	0	0	1	2
TOTAL:	18	26	2	0	46	99

In contrast, Table 5 tells us that a large number of general health workers are rarely involved in mental health work. For example, 11 out of 18 general health workers aged between 19-29 years are rarely involved in mental health work. Similarly, ten out of eighteen health workers aged 30-39 are rarely involved in mental health work.

The above findings are similar to those of Najjar et al (1986) who found that in Lusaka Urban, "all Clinical Officers (Psychiatry) were treating general patients... The officers in-charge all said that Clinical Officers (Psychiatry) (COPs) were treating general patients in 45 per cent of health centres, COPs were treating patients often and in 54 per cent sometimes", (ibid: 19-20).

It can be argued therefore that mental health workers have to combine their mental health work with their general medical work on day-to-day basis. The consequences of this are enormous, assuming that there is enough mental health work around and that the general health workers are rarely involved in mental health work.

It becomes apparent that the majority of mental health workers are over-burdened since there are only few of them (mental health workers) left to do mental health work per se.

Sex

Next, we wanted to establish whether gender has any impact on the amount of workload among health workers in general and mental health workers in particular. That is, we wanted to know whether females are given the same workload as males.

TABLE 5: GHWs Assessment Of Degree Of Involvement In
Mental Health Work By Age Category

C A T E G O R I E S   G E N E R A L   H E A L T H   W O R K E R S

Age Range	19-29	30-39	40-45	Over 50	Total	PCT
Involved in mental health work daily	6	6	2	0	14	32
Involved in mental health work weekly	1	2	0	1	4	9
Involved in mental health work every few months	4	7	0	0	11	25
Not involved in mental health work at all	7	3	2	3	15	34
TOTAL:	18	18	4	4	44	100

Table 6 reveals that 24 out of 29 males and 12 out of 17 females are involved in general medical work daily. These responses show that there is little correlation between sex and level of involvement in general medical work on the part of mental health workers. Female workers are nearly as much burdened as their male counterparts. For married women this could have serious implications in terms of coping with the workload on one hand, as well as managing their family responsibilities on the other. It is doubtful therefore that married women could do their mental health work as efficiently as their single counterparts. These shortcomings notwithstanding, is evident that MHWs as a whole are heavily involved in general medical work regardless of marital status.

Reasons For Involvement

Next, we wanted to find out whether involvement in general medical work is "voluntary" or "involuntary", that is, we wanted to establish whether mental health workers and general health workers undertake general medical work and mental health work respectively on their own initiative. If the first case obtained "voluntary involvement", then we could posit that involvement was may be due to the type of training received by mental health workers and general health workers, as polyvalent trainees or due to personal interest.

TABLE 6:   MHWs Assessment Of Degree Of Involvement In General
           Medical Work By Sex Category

CATEGORIES	MENTAL	HEALTH	WORKERS	
Sex	M	F	Total Responses	PCT of Total
Involved in general medical work daily	24	12	36	78
Involved in general medical work weekly	5	1	6	13
Involved in general medical work monthly	0	2	2	4
Involved in general medical work every few months	0	1	1	2
TOTAL RESPONSES	29	17	46	99

Table 7 below reveals that 32 out of 46 (70%) MHWs identified official allocation of duties as the primary cause of involvement, and only 5 out of 46 (11%) cited preference for general medical work to mental health work, and another 5 out of 46 (11%) mentioned polyvalent nature of their training as the major factor.

In contrast Table 8 shows that 20 out of 44 GHWs mentioned preference of mental health work as the major reason for involvement, 11 out of 44 cited type of mental health training received and only 5 out of 44 identified official allocation as the primary factor for their involvement in mental health work.

Thus, for MHWs, allocation from above is the major factor. Given the superior - subordinate relationship in the Ministry, this means, inter alia, that MHWs have very little choice over whether to do general medical work before undertaking their tasks as mental health workers or vice-versa.

Conversely, degree of involvement of general health workers in mental health work is dependent upon individual preference (voluntary involvement) and the need to gain more knowledge in this area rather than on official allocation.

This obvious bias in the allocation of mental health workers to general medical work by the incharges of health institutions is a serious limitation to the effective implementation of the "integration" style discussed earlier in this study.

TABLE 7: Assessment Of Reasons For Involvement By Type
Of Work

CATEGORIES	Mental Health Workers	
	Count	PCT of Responses
Involved in general medical work because of being allocated by administrators	32	70
Involved in general medical work because of preferring it to MH work	5	11
Involved in general medical work because of adequate training in this area	5	11
Involved in general medical work because of very little mental health work to be done in this area	3	6
Involved in general medical work because of inadequate training in this field	1	2
TOTAL RESPONSES	46	100

The same bias may be shown if a mental health worker was to
be put in-charge of general health workers in the hospitals/
units. Thus, the need for professional autonomy among the
contending actors within the Ministry of Health.

Managerial Competence As Career Anchorage

Flippo (1980: 226) isolated managerial competence as one
of the fundamentals of career anchorage. Similarly among the
basic needs identified by Maslow (ibid: 328) is that of
recognition i.e. one needs to be recognized in his work in order
for him to become effective. But determination of managerial
competence is somehow subjective in that it depends in the main
on who is assessing such competence. Subordinates in particular
play a key role in evaluating managerial competence since such
competence has a strong bearing on their performance.

In this section, our efforts were directed toward assessing
how mental health workers evaluate official responsiveness
toward their needs. We isolated visits to mental health units
as well as the extent to which officials respond to what mental
health workers think to be their needs as well as whether they
think they are given equality of attention as their counterparts
in general medical field and to assess their attitudes towards
their superiors.

In addition, we served the same questionnaire to general
health workers with a view to establishing whether general health

TABLE 8:   Assessment Of Reasons For Involvement By Type Of Work

CATEGORIES	General Health Workers	
	Count	PCT of Responses
Involved in mental health work because of being allocated by administrators	5	11
Involved in mental health work because of preferring it to general medical work	20	45
Involved in mental health work because of adequate training in this area	6	14
Involved in mental health work because of very little general medical work to be done in this area	2	5
Involved in mental health work because of inadequate training in this field	11	25
TOTAL RESPONSES	44	100

workers think mental health workers are not given equal treatment as they receive.

Table 9 shows that 21 out of 46 (46%) mental health workers said that administrators in their area do not visit mental health units and 13 out of the 46 (28%) reported annual visits.

In contrast, 23 out of 44 (52%) general health workers reported that administrators visit mental health units in their area every week. Only 15 out of 44 (34%) said that administrators do not visit mental health units in their area.

The above findings highlight the negative responses on the part of mental health workers who are the people directly involved in the interaction with the administrators in their units. Mental health workers generally think that they are not given sufficient attention through visits by their superiors at the unit and that, on the whole, mental health workers do not think that they do

enjoy such attention at all. It can further be concluded that on the whole supervisors might not be paying sufficient visits to their field staff, leading to possible despondency among mental health workers.

Conversely, their counterparts in general medical work reflected a more positive picture indicating the remoteness from the real situation.

TABLE 9:   Evaluation By HWs Of Visits To MHWs By
            Administrators

CATEGORIES	MHWs (46)		GHWs (44)			
	Count	PCT of Responses	Count	PCT of Responses	TOTAL Count	TOTAL PCT
Knowledge of Administrators making weekly visits to mental health unit in their area	5	11	23	52	29	31
Knowledge of Administrators making monthly visits to mental health unit in their area	7	15	3	7	10	11
Knowledge of Administrators making yearly visits to mental health unit in their area	13	28	33	7	16	18
knowledge of Administrators not visiting mental health unit in their area	21	43	15	34	36	40
TOTAL RESPONSES	46	100	44	100	90	

Mental Health Facilities: As Career Anchorages

Aside from being a major component of anchorage, quality of facilities constitutes a major facade of any system of incentives in a firm or organization. Consequently, the way in which employees perceive the quality of such facilities has overriding implications on morale. This is no exception in mental health.

We therefore recognized that mental health workers' perception of their existing facilities will have serious implications on their performance. Consequently, we wanted to know how mental health workers and general health workers evaluate the existing mental health facilities in order to assess how they evaluate the quality of service; we therefore asked a question pertaining to the quality of facilities rendered by administrators to mental health workers. We ranked quality of facilities on the following scale; "excellent", "good", "faily good", "poor". Table 10 reveals that only 7 out of 46 mental health workers consider their facilities to be either "good" or "excellent". The majority (39 out of 46) consider the facilities to be either "fairly good" or "poor".

Conversely, 15 out of 44 general health workers consider the facilities given to mental health workers to be either "good" or "excellent". The remaining 29 consider the facilities given to their colleagues to be either "fairly good" or "poor".

TABLE 10:   HWs Assessment Of Type Of Mental Health
             Facilities

CATEGORIES	MHWs (46)		GHWs (44)			
	Count	PCT of Responses	Count	PCT of Responses	TOTAL Count	TOTAL PCT
Facilities given to mental health workers are excellent	1	2	5	11	6	7
Facilities given to mental health workers are good	6	13	10	23	16	18
Facilities given to mental health workers are fairly good	14	30	12	27	26	29
Facilities given to mental health workers are poor	25	54	17	39	42	47
TOTAL RESPONSES	46	99	44	100	90	

This again shows the negative assessment of mental health workers' conditions at place of work in contrast to the positive evaluation of the same conditions by their counterparts.

However, it is generally agreed by both groups of respondents that facilities given to mental health workers by the administrators tend to be poor. This observation could have serious implications on mental health workers' morale towards their work in general and their profession in particular in that the service delivery often appears to be glaringly discriminatory in favour of general health workers. This trend has serious implication on "Community style" and "Hospital Care Style" in particular.

Recognition as Career Archorage

Recognition, as we intimated earlier, is one of the basic needs of every employee in any organization. It contributes to a feeling of self-confidence, worth, and capability. Thus, in this question we wanted to establish how mental health workers think administrators evaluate mental health workers. Did they think that administrators have great respect for them or not? Table 11 shows that 18 out of 46 mental health workers felt that administrators in health institutions have great respect for mental health workers and 28 out of 46 felt that administ⁺ in health institutions have no knowledge of what m⁻ workers are supposed to do or have indiffereʳ toward the existence of mental health work

TABLE 11:   MHWs Perception Of How Administrators Evaluate
            The Status Of Mental Health Workers

CATEGORIES	MHWs (46)		GHWs (44)		TOTAL	TOTAL
	Count	PCT of Responses	Count	PCT of Responses	TOTAL Count	TOTAL PCT
Administrators in health institutions have great respect for mental health workers	18	39	32	73	50	56
Administrators in health institutions have indifferent attitude to the existence of mental health workers in their institutions	9	20	2	5	11	12
Administrators in health institutions have no knowledge of what mental health workers are supposed to do	13	28	8	18	21	23
Administrators in health institutions have hostile attitude to the existence of mental health workers in their institutions	6	13	2	5	8	9
TOTAL RESPONSES	46	100	44	100	90	

Positive responses are found among general health workers where 32 out of 44 of them felt that administrators in their institution have great respect for mental health workers and only 12 out of 44 felt that administrators in health institutions have no knowledge of what mental health workers are supposed to do or are indifferent to the presence of mental health workers in their institutions.

The above findings seem to tally with the overall negative evaluation of mental health workers towards services rendered to the sector and toward them. We can conclude that if the administrators are seen not to know the functions of mental health workers or are seen to be indifferent or hostile to their careers, then the consequences of this apparent benign neglect is possible indifference on the part of mental health workers toward their clientele, with the at-risk population facing the greatest danger. A person who is neglected or feels so is bound to transfer the same image onto those with whom he interacts; thus, creating a chasm between the three styles which up to now have been applied universally throughout the country.

Career Opportunities As Anchorage

The other area we tried to explore concerned the assessment of mental health workers' views toward their chances for

professional advancement. We wanted to establish how mental

health workers assess the extent to which the principle of

egalitarianism is being effected at the level of promotion.

This area was examined by asking various questions pertaining

to promotion and the role played by the Ministry of Health

in rewarding mental health workers.

In order to obtain a complete picture of the assessment,

it was decided to employ and extra parameter, that of marital

status, in addition to age and sex. We wanted to discover whether

or not there was any correlation between promotion or expectation

of it and the employed parameters. Married employees are

expected to be more stable at work, but given their family

financial and material needs, one could expect them to be less

satisfied in a situation where material rewards are low. The

following results seem to have unfolded.

Marital Status

A total of 32 mental health workers were found to be married

and only two of them did not feel that mental health workers have

either little chances of promotion than general health workers

or are *deliberately discriminated against when it* comes to

promotion. In addition, 13 out of 44 single mental health workers

gave corresponding response (Table 12 shows). Similarly, 22 out

of 24 parent mental health workers felt that mental health

workers have either little chances of promotion than general

TABLE 12:   Assessing Chances of Promotion By Marital
            Status

C A T E G O R I E S	MHWs	(46)	GHWs		(44)	TOTAL RESPONSE COMBINED	
Marital Status	Mar-ried	Sin-gle	Par-ents	Mar-ried	Sin-gle	Par-ent	Count Not Parents	PCT
Mental health workers have better chances of promotion than general health workers	0	0	0	2	1	3	3	3
Mental health workers have same chances of promotion as general health workers	2	1	2	17	3	14	23	26
Mental health workers have little chances of promotion as general health workers	17	7	14	10	4	9	38	42
Mental health workers are deliberately discriminated against when it come to promotion	13	6	8	6	1	6	6	29
TOTAL RESPONSES	32	14	24	35	9	32	90	

health workers   are deliberately discriminated against when
it comes to promotion.

In contrast, 19 out of 36 married general health workers
stated that mental health workers have either better chances of
promotion as general health workers or have same chances of
promotion as general health workers. But only 4 out of 9 single
general health workers gave similar response. 17 out of 32
parent general health workers reported that mental health workers
have either better chances of promotion than general health
workers or have same chances of promotion as general health
workers.

These responses show that there is no correlation between
marital status and the expectation for promotion among mental
health workers. Mental health workers (single or married) see
themselves as having little chances of promotion altogether.
The positive assessment of general health workers (single or
married) of their colleagues' chances for promotion could be
said to apply only at institutional levels where, for example
the chances of promotion to the ranks of Senior or Principal
Clinical/Nursing Officer are equitable to both General and
Psychiatric Clinical Officers/Nurses. However, at the Provincial
Medical Officer or Ministry levels no mental health worker has
yet been promoted to any administrative position of "Provincial"
or "Chief Clinical/Nursing Officers; including their deputies.

Nevertheless, mental health workers' negative assessment of

their chances of promotion can have serious consequences on their performance in the field, resulting in frustration, apathy toward their work or a high turnover in mental health services, to which we have not fully addressed ourselves.

Age

To examine the impact of age on how mental health workers see their chances of promotion, Table 13 shows that 16 out of 18 mental health workers aged between 19 and 29 years felt that mental health workers have little chances of promotion than general health workers or are discriminated against when it comes to promotion. Likewise, 26 mental health workers aged between 30 and 39 years gave similar response.

Conversely, 12 out of 18 general health workers aged between 30 and 39 years felt that mental health workers have either better chances of promotion than general health workers or have same chances of promotion as general health workers. Corresponding response were also obtained from 9 out of 18 general health workers aged between 19 and 29 years.

Again, these responses show that there is little correlation between age and the evaluation of chances of promotion of mental health workers.

TABLE 13:   Assessing Chances Of Promotion By Age

CATEGORIES	MHWs (46)					GHWs (44)					
Age Range	19-29	30-39	40-49	Over 50	To-tal	19-29	30-39	40-49	Over 50	To-tal	
Mental health workers have better chances of promotion than general health workers	0	0	0		0	1	1	0	1	3	
Mental health workers have same chances of promotion as general health workers	2	0	1	0	3	8	11	2	0	21	24
Mental health workers have little chances of promotion than general health workers	10	14	0	0	24	5	5	1	2	13	37
Mental health workers are deliberately discriminated agaisnt when it comes to promotion	6	12	1	0	19	4	1	1	1	7	26
TOTAL RESPONSES	18	26	2	0	46	18	18	4	4	44	90

We can conclude that there is a general feeling among all age groups *that mental health workers have little chances of promotion than general health workers or are deliberately discriminated against* when it comes to promotion. This has serious negative implications on their morale. The young mental health worker is bound to grow up in his/her career believing that his/her lot at work is poor both in terms of general conditions of services and chances of promotion in particular and that he/she is not likely to get out of the "pit".

Sex

Table 14 examines correlation between sex and chances of promotion. Data derived from this section reveal that 27 out of 29 male mental health workers felt that mental health workers have little chances of promotion than their counterparts the general health workers or are discriminated against when it comes to promotion. Similar responses were obtained from 14 out of 17 female mental health workers.

Again, 15 out of 26 male general health workers reported that mental health workers have either little chances of promotion as general health workers or are discriminated against when it comes to promotion. Contrasting replies were obtained from 11 out of 18 female general health workers who believed that MHWs have either

TABLE 14:   Assessing Chances Of Promotion By Sex

CATEGORIES	MHWs (46)		GHWs (44)		TOTAL RESPONSES COMBINED (90)	
	M	F	M	F	Count	PCT
Mental health workers have better chances of promotion than general health workers	0	0	1	1	2	2
Mental health worker have little chances of promotion than general health workers	13	8	8	4	33	37
Mental health workers have same chances of promotion as general health workers	2	3	10	10	25	28
Mental health workers are deliberately discriminated against when it comes to promotion	14	6	7	3	30	33
TOTAL:	29	17	26	18	90	

same or better chances of promotion. This contrast reveals the
remoteness of female GHWs from the real situation.

Thus, a major conclusion to be drawn from Tables 12, 13 and
14 are that generally mental health workers seem to be discriminated
against as a category at least from their perception. Mental Health
workers see themselves as having little chances of promotion than
their counterparts the general health workers regardless of marital
status, age or sex. Some of the underlying consequences of this is
that since promotion is the prerogative of administrators who happen
to be general health workers, mental health workers are willing to
do general medical work even though they may not have the feeling of
doing so.

Superior "Responsiveness" As Career Anchorage.

Lastly, in the next question we tried to find out how health
workers generally evaluate the responsiveness of the Central
Administration at the Ministry of Health Headquarters to the needs
of mental health workers in the country. This question was designed
to be a summary of the preceeding questions in the questionnaire.
It was hoped that data derived from this question would sum up the
overall picture about mental health workers' perception of mental
health services administration from the point of view of manpower

training and utilization. In order to get a complete picture of the situation, it was found necessary to use four parameters for our investigation so that we could see whether or not a strong relationship exists between evaluation of the Ministry's responsiveness to the needs of mental health workers and the parameters so selected. Thus, age, sex, marital status and parenthood were used to examine the responses of both categories of health workers participating in the study.

Whence Table 15 reveals that all the 18 mental health respondents aged between 19 and 29 years felt that the Central Administration at the Ministry of Health Headquarters favours general health workers and is indifferent to the needs of mental health workers. Similar responses were obtained among 25 out of 26 mental health workers aged between 30 and 39.

In contrast, a more positive evaluation (12 out of 18 respondents) of Central Administration's responsiveness to the needs of mental health workers is given by general health workers aged between 19 and 29 years who apparently are less experienced in the field.

Less positive evaluation is given by the 30 age group of general health workers (9 out of 18)who seem to have had short experience with the plight of mental health workers in the field.

TABLE 15: Assessment of Central Administration's Responsiveness to the Needs of MHWs by work Category.

CATEGORIES	MHWs (46)				GHWs (44)				TOTAL RESPONSES COMBINED (90)	
Age	19-29	30-39	40-49	Over 50	19-29	30-39	40-49	Over 50	Count	PCT
The Central Administration at the Ministry of Health Head-quarters is responsive to the needs of mental health workers	0	1	0	0	12	9	2	3	27	30
The Central Administration at the Ministry of Health Head-quarters favours the general health workers.	10	11	1	0	3	3	2	1	31	34
The Central Administration at the Ministry of Health Head-quarters is indifferent to the needs of mental health workers	8	14	1	0	3	6	0	0	32	36
TOTAL RESPONSES	18	26	2	0	18	18	4	4	90	90

Generally, however, data still show the constant negative

evaluation by mental health workers of their situation and the

positive evaluation of general health workers of their colleagues'

situation regardless of age.

Sex

Next we wanted to determine the impact of gender on the

evaluation of the Ministry's responsiveness to the needs of mental

health workers.

Table 16 below shows that 27 out of 29 male mental health workers

felt that the Central Administration favours general health

workers and is indifferent to the needs of mental health workers.

A corresponding response was made among 15 out of 17 female mental

health workers.

Conversely; barely half (13 out of 26) male general health

workers and slightly more than half (10 out of 18) female general

health workers felt that the Central Administration is responsive

to the needs of mental health workers. Thus, although both male

and female mental health workers seem to be more negatively

evaluative of Central Administration than their counterparts, one

thing appears to be clear, namely, that in both cases there is

virtually no correlation between sex and evaluation of the

Ministry's responsiveness to the needs of mental health workers in

TABLE 16: Assessment of Central Administration's
Responsiveness To The Needs Of MHWs By Sex
Category

CATEGORIES	MHWs (46)		GHWs (44)		TOTAL RESPONSES COMBINED (90)	
	M	F	M	F	Count	PCT
The Central Administration at the Ministry of Health Head-quarters is responsive to needs of mental health workers	2	2	13	10	27	30
The Central Administration at the Ministry of Health Head-quarters favours the general health workers	11	10	6	4	31	34
The Central Administration at the Ministry of Health Head-quarters is indifferent to the needs of mental health workers	16	5	7	4	32	36
TOTAL RESPONSES	29	17	26	18	90	

Zambia. At the same time, the general picture is that Central Administrators are regarded as generally less responsive to mental health workers needs by both categories of health workers.

Marital Status and Parenthood

We also wanted to know whether marital status or parenthood have any effect on how Central Administration is evaluated in regard to its responsiveness to the needs of mental health workers. Table 17 shows that 27 out of 32 married mental workers all 14 single mental health workers and 22 out of 24 parent mental health workers felt that the Central Administration at the Ministry of Health Headquarters favours general health workers and is indifferent to the needs of mental health workers.

In contrast, 17 out of 35 married general health workers, 5 out of 9 single general health workers and 17 out cf 32 parent general health workers felt that the Central Administration at the Ministry of Health Headquarters is responsive to the needs of mental health workers. Thus, there is no change from the previous responses except that there is a lower negative evaluation of Central Administration by general health workers as a whole.

It can be argued that there is a general consensus among the respondents that the Central Administration at the Ministry of

TABLE 17: Assessment of Central Administration's Responsiveness to the needs of MHWs by Marital Status.

CATEGORIES	MHWs (46)			GHWs (44)			TOTAL RESPONSES COMBINED (90)	
Marital Status	mar-ried	sin-gle	par-ents	mar-ried	sin-gle	par-ents	Count Not parents	PCT
The Central Administration at the Ministry of Health Head-quarters is responsive to the needs of mental health workers.	5	0	2	17	5	17	27	30
The Central Administration at the Ministry of Health Head-quarters favours the general health workers.	11	8	9	8	4	7	31	34
The Central Administration at the Ministry of Health Head-quarters is indifferent to the needs of mental health workers.	16	6	13	10	0	8	32	36
TOTAL RESPONSES	32	14	24	35	9	32	90	

Health Headquarters is not responsive to the needs of mental health workers in Zambia. Instead, it tends to favour general health workers and pays little attention to the needs of mental health workers generally. This may be due to the fact that the administrators of health services at the Ministry, Provincial, District and Health Centre levels are all general health workers and have therefore tended to favour their field of specialization rather than mental health.

We can further conclude that since self perception and the way we think others think about us have something to do with morale, the performance of mental health workers in their field will be negatively affected by their poor self-image. This is bound to have serious repercusions on the delivery of mental health services in the country by limiting the effectiveness of mental health personnel due to poor morale. Such a situation is bound to have serious consequences on the three styles discussed earlier in the study which have to continue operating effectively together.

Administrators' Responses.

Our last section is addressed to administrators themselves. The aim was to countcheck the information presented by both mental and general health workers on the status of mental health workers

in the Ministry. To what extent are the views of the former shared by their supervisors? If the views seem to crystallise toward a common consensus, then we can safely conclude that there is need to change the present organizational framework or to re-orient administrators in such a way as to have a more positive attitude toward the plight of mental health workers as the latter see them. If the two sets of opinions are asymmetrical, then we need to look elsewhere to account for the disparity.

We therefore asked the supervisors first to assess the extent to which mental health workers are involved in general medical work. The responses are tabulated below. Table 18 shows that 15 out of 18 supervisors reported that mental health workers are involved in general medical work daily, while only 3 out of 18 reported that MHWs are involved in general medical work every few months.

These responses confirm the earlier assessment of mental health workers' own situation (Tables 4 and 6 that MHWs are **regularly** involved in general medical work in addition to their mental health work - a feature which may lead to the partial neg- lect of community mental health work.

TABLE 18:   An Assessment By Supervisors Of MHWs Involvement
In General Medical Work

C A T E G O R I E S	Count	PCT
Mental health workers are involved in general medical work daily	15	83
Mental health workers are involved in general medical work weekly	0	0
Mental health workers are involved in general medical work monthly	0	0
Mental health workers are involved in general medical work every few months	3	17
Mental health workers are not involved in general medical work at all	0	0
TOTAL RESPONSES	18	100

Secondly, for the same reasons advanced above, we wanted to
find out whether health workers too are involved in mental health
work as much as their counterparts do on general medical work, Table
19 reveals that, the majority of supervisors (11 out of 18) see
general health workers as not getting involved in mental health work.
Only 3 out of 18 said that GHWs are involved in mental health work
on a daily basis. This again fortifies the earlier findings of this
study, namely that GHWs are rarely involved in mental health work
(see Table 5).

Thirdly, we also wanted to explore the views of the supervisors
as to why MHWs are involved in general medical work on a regular
basis while GHWs are rarely involved in mental health work. We
especially wanted to find out whether MHWs' involvement in general
medical work was a result of official job assignment by the super-
visors or was due to preference for general medical work. Table
20 reveals that exactly half of the supervisors (9 out of 18)
mentioned "too much general medical work" in their institutions
as the main reason for MHWs' regular involvement in general medical
work. Another 5 out of 18 mentioned the polyvariant nature and
scope of mental health workers' training programme which enables
them to work with confidence in general medical work as well as in mental
health work as justification for their involvement.

These responses are in contrast to MHWs' own claim (32 out
of 40) that their involvement is mainly due to allocation by

TABLE 19 : An Assessment by supervisors of GHWs
Involvement in Mental Health Work.

CATEGORIES	COUNT	PCT
General health workers are involved in mental health work daily in this institution.	3	17
General health workers are involved in mental health work weekly in this institution.	1	6
General health workers are involved in mental health work monthly in this institution.	0	0
General health workers are involved in mental health work every few months in this institution	3	17
General health workers are not involved in mental health work at all in this institution.	11	62
TOTAL RESPONSES	18	100

supervisors (see Table 7). However, we may conclude that if the
supervisors believe that there is "too much general medical
work" to be done in their institutions and also feel that MHWs
are adequately trained to handle both mental and general health
problems, the allocating of MHWs to general medical work
should therefore be expected. Too much general medical work in
health institutions could also account for the little involve-
ment of general health workers in mental health work - a question
we have partially addressed during our evaluation of the training
programme.

In our next question, we wanted to establish from the
supervisors the frequency with which supervisors visit MHWs in
their institutions. We did this in order to evaluate the
degree of attention the supervisors give to MHWs in their
institutions. It was reported in Table 21 below by 10 out of 18
supervisors that they never visit MHWs, while 4 out of 18 said
they visit every month and only 3 out of 18 reported weekly
visits to their MHWs.

In other words, the supervisors seem to be in agreement
with their MHWs over the infrequency of visits by supervisors
34 out of 46 MHWs reported " annual" or "no" visits at all from
their supervisors. (see Table 9). From this, it becomes

TABLE 20: Reasons Given By Supervisors for MHWs
Involvement in General Medical Work.

CATEGORIES	COUNT	PCT
Mental health workers are involved in general medical work in this institution because they are allocated by the supervisors.	1	6
Mental health workers are involved in general medical work in this institution because they prefer it to mental health work.	1	6
Mental health workers in this institution are involved in general medical work because their training prepared them adequately to work with confidence in general medical work.	5	28
Mental health workers in this institution are involved in general medical work because there is very little mental health work for them to do.	2	11
Mental health workers in this institution are involved in general medical work because there is too much general medical work for them to do.	9	51
TOTAL RESPONSES	18	101

obvious that MHWs are indeed isolated by lack of visits from their supervisors - a situation which could lead to frustration as has been amply demonstrated in the responses of mental health workers.

The next question addresses the supervisors' assessment of facilities given to MHWs in their institutions. The purpose was to evaluate how supervisors feel about the quality of facilities given to MHWs and whether or not there is a symmentry between their evaluation and that of MHWs. The findings are summed up in Table 22 below. Thus:only one out of 18 supervisors said the facilities given to MHWs are "excellent", 7 out of 18 reported that the facilities were "good", 3 out of 18 believed that the facilities were "fairly good" and 7 out of 18 supervisors reported that the facilities given to MHWs were actually "poor".

The assessment of supervisors of facilities given to MHWs corresponds with MHWs' own evaluation where only 7 out of 46 MHWs consider their facilities to be either "good" or "excellent". The majority (36 out of 46) consider the facilities to be either "fairly good" or "poor" (see Table 10).

We can sum up by saying that there is a general feeling in both circles that the facilities given to MHWs are somehow lacking.

The perception of the managerial grid about their juniors

TABLE 21 : Supervisors Responses To The Assessment Of
Their Visits to MHWs.

CATEGORIES	COUNT	PCT
Supervisors visit mental health workers in their unit weekly	3	17
Supervisors visit mental health workers in their unit monthly	4	22
Supervisors visit mental health workers in their unit annualy	1	6
Supervisors do not visit mental health workers in their unit at all	10	56
TOTAL RESPONSES	18	100

performances as well as their professional status can be a source
of positive or negative self image. In this following question,
therefore, we tried to establish how supervisors rate the status
of MHWs in their institutions. Did they hold them in high esteem
or not? Table 23 below shows that a large number of supervisors
(12 out of 18) had great respect for MHWs.

We may argue that supervisors generally have high respect
for the status of MHWs than it is true for MHWs' own assessment.
For example, only 18 out of 46 MHWsfelt that supervisors in health
institutions have great respect for MHWs. However, supervisors'
positive evaluation tallies with those of GHWs where 32 out of 44
of them felt that supervisors in their institutions have great
respect for mental health workers (see Table 11).

We also wanted to compare the degree of supervisors' aware-
ness of what MHWs in their institutions are supposed to do. Did
the supervisors know what MHWs in their institutions are supposed
to do? In our earlier findings, 28 out of 46 MHWs felt that
supervisors in health institutions are not aware of what MHWs are
supposed to do (see Table 11). However, Table 23 presents a
different picture. Only 5 out of 18 supervisors reported that
they did not know what MHWs in their institutions are supposed to
do. Thus, we can posit that although MHWs reported that their
supervisors rarely visit them and that the supervisor themselves
confirmed this, yet the latter generally felt that they know
what MHWs are supposed to do.

TABLE 22 : Supervisors Evaluation of Facilities Given
To MHWs.

CAA T E G O R I E S	COUNT	PCT
The Facilities given to mental health workers in this institution are excellent.	1	6
The facilities given to mental health workers in this institution are good.	7	39
The facilities given to mental health workers in this institution are fairly good	3	17
The facilities given to mental health workers in this institution are poor.	7	39
TOTAL RESPONSES	18	101

We may further conclude that supervisors may be trying to protect
their own situation. So we have to look to the responses of GHWs
to give us a balanced view. Only 8 out of 44 GHWs (Table II)
felt that supervisors in health institutions did not know what
MHWs are supposed to do. This response is closer to that presented
by the supervisors.

On balance, therefore, we could argue that MHWs are somehow
harsh in assessing their own plight. What appears from the
responses fromboth supervisors and GHWs is that the former do
understand and know what MHWs are supposed to be doing.

Lastly, we wanted to know the supervisors' assessment of
Central Administration responsiveness to the needs of MHWs
visa-a-vis, promotion to administrative positions within the
Ministry of Health. In other words,do the supervisors feel that the
principle of egalitarianism is being applied to MHWs? Table 24
reveals that 8 out of 18 respondents believe that MHWs have little
chances of promotion to administrative positions than general
health workers. 3 out of 18 said MHWs are deliberately discrimi-
nated against when it comes to promotions. In other words,
the majority (11 out of 18) feel that MHWs are discriminated against
when it comes to promotion. This is so inspite of the fact that
the majority of them felt that MHWs have equal access to opportuniti-
es in the Ministry. This could be attributed to the fact that
supervisors were evaluating not their own responses to the plight of

TABLE 23 : Supervisors Evaluation of MHWs Status.

CATEGORIES	COUNT	PCT
Supervisors in this institution have great respect for mental health workers	12	67
Supervisors in this institution have indifferent attitude to the presence of mental health workers.	1	6
Supervisors in this institution have hostile attitude to the presence of mental health workers.	0	0
Supervisors in this institution do not know what mental health workers are supposed to do.	5	29
TOTAL RESPONSES	18	101

of MHWs but those of Central Administration, leading to a more critical view of the conditions confronting mental health workers.

Conclusion.

We may conclude that the majority of supervisors assess the situation of mental health services administration in the country negatively. Mental health workers are regularly involved in other fields in addition to their own field. This inevitably lead to the over-burdening of mental health workers and to the partial neglect of community mental health work resulting in the service apparently achieving only 15% coverage of the at-risk population in the country. The problem is perhaps further compounded by the almost non involvement of general health workers in mental health work-as reported by both the supervisors and health workers themselves.

The other negative aspects about mental health services administration as perceived by supervisors are poor facilities given to mental health workers, lack of visits, and little chance of promotion to administrative positions within the Ministry of Health for mental health workers. Thus, we may further argue that, despite the over-burdening of mental health workers in the field, MHWs are not given rewards to boost their morale as health professionals - a situation which could have serious implications

TABLE 24 : Supervisors' Assessment of MHWs Chances Of Promotion.

C A T E G O R I E S	COUNT	PCT
Mental health workers have better chances of promotion than general health workers	0	0
Mental health workers have same chances of promotion as general health workers.	7	39
Mental health workers have little chances of promotion than general health workers.	8	44
Mental health workers are deliberately discriminated against when it comes to promotion.	3	17
TOTAL RESPONSES	18	100

on career anchorages and employee turn-over within mental health delivery system.

Nevertheless, mental health workers appear to enjoy a great deal of respect from their supervisors - a psychosocial reward which may be interpreted as a compensatory mechanism for poor facilities, lack of visits and little chances of promotions for MHWs - as assessed by health workers as well as by their supervisors. However, the efficiency of this reward system is strongly compromised by the fact that MHWs themselves do not actually recognise the reward system as present.

Next, we also wanted to find out the views of policy - makers at the provincial and Central Administration levels about the state of mental health services administration in the country particularly in regard to the level of involvement of MHWs on general medical work, visits to and quality of mental health facilities and chances of promotions for mental health workers.

In order to ensure comprehensive and spontaneous responses from the officials, we decided to use an open-ended interview.

First, we put these questions to the three Provincial Medical Officers of the provinces we visited. The following scenario seems to have emerged. All three reported that they know that mental

health workers are regularly involved in general medical work in their provinces. Two of them gave "very little mental health work" for mental health workers to do in their provinces as the reason for MHWs' regular involvement in general medical work, while one said there is too much general medical work for MHWs to do in his province. To put it in another way, officials at the provincial level generally feel that while there is too much general medical work to do, there is very little mental health work in their provinces to justify the deployment of MHWs exclusively on mental health work.

These responses therefore, appear to confirm the earlier findings reported in this study. Thus, if the PMOs believe that their provinces have very little mental health work for MHWs to do and that there is instead too much general medical work for MHWs to do, we can expect the continuation of "official assignment" of MHWs to general medical work by their supervisors, with the implicit encouragement from the provincial administrators – a situation which could have serious consequences on community mental health delivery system in the country.

As regards to the quality of facilities given to MHWs, the three Provincial Medical Officers agreed that the facilities were generaly poor. The reasons being advanced for this state of affairs were that mental health workers as a category

do not justify their requests through well laid out programmes.
Another reason being given is that poor facilities are not
only confined to mental health services alore; other services
such as physiotherapy, laboratory etc. have poor facilities too.

Evidently, the provincial administrators are aware of the
poor state of mental health facilities in their provinces, but
this situation should be seen in the context of mental health
services as part and parcel of health services which are poorly
funded and also in the light of the manner in which MHWs present
their plight before the officials at the provincial level. It
is clear that the Provincial Medical Officers do not wish to
compare facilities given to mental health services with those of
the general medical services, but rather with the other specia-
list services in their provinces . This type of perception has
serious implications on power among the contending actors within
the Ministry of Health as the allocation of resources is the
responsibility of administrators who are in the main GHWs.

On the visits to mental health units, all the three
Provincial Medical Officers said they visit all health institu-
tions in their provinces including mental health units at least
once a year.

It is apparent from the foregoing response that the visits

by administrators at the provincial level are very infrequent.
Annual visits are not enough for one to fully assess the plight
of MHWs or that of GHWs adequately. In essence, therefore, the
response of administrators clearly coincides with the sentiments
expressed by general and mental health workers who felt that
administrators do not visit them frequently. Similarly, the
feeling of isolation on the part of MHWs is vindicated by the
response of administrators as to the frequency of their visits to
their respective health institutions.

Lastly, we wanted to know how the Provincial Medical
Officers assess MHWs chances for promotion to administrative
posts within the Provincial Medical Offices. Did they think that
MHWs' have equal chances of promotion as their counterparts the
general health workers or not? Two Provincial Medical Officers
said that since mental health service is a specialist area, and
that there are no such posts at their provincial headquarters
MHWs have little chances of promotion to administrative posts at
the provincial level. Only one Provincial Medical Officer
believed that MHWs have $s_a$me chances of promotion as general health
workers in his province.

In sum, we can argue that MHWs perception of their chances
of promotion as being very little is shared not only by their

supervisors, but also by the majority of provincial
medical officers. Thus, mental health workers may see
their chances of professional advancement as being limited
by their mental health training. This situation could
have severe implications on future mental health training
programmes in the country. Fewer applicants are likely
to enter the field Caeteribus-Paribus, for fear of poor
professional opportunities.

We have established beyond doubt that there is a
general consensus that the range of opportunities for
promotion for MHWs is very contricted. This is shared by
Provincial Medical Officers and MHWs. If the former are
aware of the prevailing situation, the question we need
to ask ourselves is why has the situation been allowed
to continue ?

In order to get answers to this question, we deci-
ded to interview those officials at the Ministry level
who are responsible for planning and development (incl-
uding training) of health services in the country and
those responsible for medical care administration i.e.
the actual delivery of medical services (including
mental health services). Another reason for interviewing
these officials was that the Provincial Medical Officers
are answerable to the Deputy Directors of Medical services
stationed at the Ministry of Health Headquarters in Lusaka.
Thus, we put the same questions we had presented to the
Provincial

Medical Officers to the Deputy Director of Medical Services
(Planning and Development) and to the Deputy Director of Medical
Services (Medical Care Administration).

We wanted to find out from the DDMSs to what extent the
Central Administration was aware of MHWs' problems in the country
and what they were doing about them. The following answers
emerged from the two DDMSs: On poor facilities given to MHWs, the
two DDMSs gave similar responses to the Provincial Medical Officers,
namely that facilities given to MHWs can only be judged as being
poor if MHWs' amenities are compared to those allocated to GHWs.
However, they contended, in the face of many priorities and very
little funding, the Ministry has to provide facilities first to
the sector that will be utilized by the majority of the people.
Mental health facilities are only utilized by a small number of
the population. MHWs were also blamed for not putting up justi-
fications for their requests for facilities.

Thus, Central Administration sees facilities given to
MHWs in the country as being adequate because they do not bene-
fit the majority of the population. However, although this just-
ification is tenable along democratic lines in that health faci-
lities should first and foremost benefit the majority of the
populace, yet the working formula effectively forecloses chances

of boosting up morale among those health workers in the "elite"
sections of the health delivery system. In this case, therefore,
MHWs are victims of professional bias based on the overall
ideology of the Ministry of Health.

The two DDMS were also fully aware of the fact that MHWs
are involved in general medical work on a regualar basis. They
blamed the present system of training MHWs at a basic level
instead of the post-basic level for this controversy. They
contend that the present training programme does not take into
account the multiplicity of health problems with which any health
worker in the field has to grapple with. Besides, the majority
of people coming for treatment at any health institution would
not understand the distinction between general and mental health
workers. The consequences for this is that MHWs are involved in
general medical work as well as in mental health work. They
added that if MHWs were left to do mental health work alone, they
may only be occupied for one to two hours a day. The rest of the
day they would be doing nothing.

It is evident from the above discussion that the Central
Administration therefore believes that there is very little
mental health work in the country to justify the deployment of
MHWs exclusively on mental health work. This notioncan partly
account for the constant assignment of MHWs on general Medical

work, a feature that seems to permeate the health
delivery system at the field level.

This practice of assigning MHWs to general medical
work is not only known to the Central Administration
but is actually approved directly or indirectly by
them.

Concerning chances of promotion to administrative
positions within the Ministry of Health for MHWs, the
responses from the two DDMS were that the Ministry has
no official policy on the promotion of MHWs to admini-
strative positions within the Ministry of Health other
than those at Chainama Hills Hospital. However, they
added that suggestions have been made in the past to
make, for example, MHWs be Deputy Chief Clinical
Officer and Chief Nursing Officer respectively. The
top positions could remain as they are-for general
health workers. The above excuses notwithstanding,
the suggestions have not been followed up because there
has been no one to push them.

The Central Administration believes that MHWs have
have little chances of promotion to administrative
positions within the Ministry of Health than their
counterparts the general health workers. Thus, a young
mental health worker will grow up believing that his
chances of promotion to an administrative position
within the Ministry of Health are quite limited indeed-
a situation which could have severe implications on
morale and the way MHWs

apply themselves to their work.

Finally, we wanted to assess the views of the two DDMS
on the factors that have prevented the establishment of a mental
health unit at the Ministry level. We wanted to know why
mental health is not treated as a professional unit rather than
as a functional unit falling as it does under various DDMSs.
The two DDMSs contended that mental health is like any other
specialist service such as midwifery or medical laboratory
services; giving mental health service its own unit at the
Ministry would invite others to demand similar status. Secondly,
many policy makers are beginning to question the wisdom of
turning the scarce specialists into administrators thereby
preventing them from performing the work for which they were
originally trained. This present practice, therefore, could
have adverse effect particularly in a service such as mental
health where specialists are even fewer than in other sectors.
Finally, financial constraints and the Government's policy of
reducing the civil service was also mentioned as another contri-
buting factor which has prevented the establishment of a mental
health unit at the Ministry level.

In other words, the factors which the DDMSs believe have
prevented the establishment of a mental health unit at the
Ministry level are that mental health services are adequately

catered for by the present structural arrangement, the few
specialists in the country should not be wasted on administ-
rative work as the country has enough administrat ors to do the
work and the financial problems which have put a limit to
farther expansions in the public service. However, much as we
might appareciate the official position of letting general
health workers run the affairs of mental health workers, we
cannot totally exclude the possiblity of maintaining the exis-
ting monopoly of power by general health administrators and the
possibility that introducing a mental health unit at the centre
would entail diluting the existing monopolistic status by
ushering in alternative power centres at the level of DDMSs.
Consequently, the administrators would rather maintain the
existing colonial set up in which their interests are fully
entrenched.

CHAPTER 5

SUMMARY AND RECOMMENDATIONS

Summary

The purpose of this study was to investigate how the utilization of the available manpower in mental health delivery system could have accounted for the lack of coverage of the at-risk population in Zambia. A review of related literature to the stated variables, objectives or sub-problems was made in order to cristalize the problem and make it researchable.

The findings on conditions of training and service reveal that these are the same for both general and mental health workers. However, a large part (33%) of mental health workers' training programmes are devoted to general medical work, while only 12% of general health workers' training programmes are devoted to mental health work. But generally 69% of health workers felt that they receive adequate training in fields other than their own specialization.

In terms of career anchorages, there was a wide-spread dissatisfaction among mental health workers regardless of age, sex, marital status and parenthood with the present administrative structure which controls and co-ordinates mental health services in the country. For example, 91% of mental health workers felt that they were involved in general medical work regularly as compared to only 41% of general health workers getting involved in mental health work.

70% of MHWs respondents gave "official allocation" as
the main reason for their frequent involvement in general
medical work.

80% felt that facilities given to mental health workers
by the administrators were generally poor compared to those
of the general health workers.

61% felt that administrators in general health
institutions have no knowledge of what mental health workers
are supposed to do or they harbour indifference and hostile
attitude toward the presence of mental health workers in
their institutions.

92% believed that they have fewer career anchorages
than their counterparts the general health workers.

Finally, 94% of mental health workers regardless
of age, sex, marital status and parenthood felt that the
Central Administration (dominant coalition) at the Ministry
of Health Headquarters was not responsive to the needs of
mental health workers in the country.

In terms of administrators' responses to open-ended
questions, the following answers were advanced.

The majority of administrators (15 out of 18 supervisors,
all the three Provincial Medical Officers and both DDMSs)
believed that MHWs were regularly involved in general
medical work.

9 out of 18 supervisors gave "too much general medical work" as the reason for MHWs" frequent involvement in general medical work.

2 out 3 Provincial Medical Officers and both DDMs gave "very little mental health work" as the reason for MHWs' regular involvement in general medical work.

10 out of 18 supervisors reported that they never visit MHWs.

All three Provincial Medical Officers stated that they visit MHWs at least once a year.

10 out of 18 supervisors rated mental health facilities to be either "fairly good" or "poor" while only 8 out of 18 rated the facilities either "excellent" or "good".

All the three Provincial Medical Officers stated that mental health facilities in their provinces were generally "poor".

Both DDMSs argued that mental health facilities can only be judged as being "poor" if MHWs' amenities are compared to those allocated to GHWs.

11 out of 18 supervisors contended that MHWs have either little chances of promotion to administrative positions within the Ministry of Health or are deliberately discriminated against when it comes to promotions.

2 out of 3 Provincial Medical Officers believed that MHWs have little chances of promotion to administrative positions within the Ministry of Health.

Both DDMSs stated that the Ministry had no official policy on the promotion of MHWs to administrative positions within the Ministry of Health.

The study further discovered that mental health workers are highly utilized in general medical work than it is true for their counterparts, the general health workers on mental health work. This appears to have led to the feelings of being over-burdened among mental health workers and the apparent partial abandoning of "Hospital" and "Community" Care styles in the units as well as mental health clinics where mental health workers are expected to be fully utilized.

The high involvement of mental health workers in general medical work is mainly due to "Official" work assignment by the administrators in health institutions. In view of the superior - subordinate relationship which exists in the Ministry of Health, mental health workers have no choice but to comply with the assignments.

Mental health workers generally feel isolated from the main stream of decision-making process by lack of visits to their units by the health administrators. This seems to have contributed to the sector being supplied with poor facilities as reported by MHWs themselves resulting in apparent neglect on the part of mental health workers toward their work.

The training of mental health workers in the prevention and management of psychiatric diseases is primarily geared toward "Community" and "Hospital" care styles, while their partial general health training could be intended to cater for "Integration" style to health problems. Similarly the general health workers' training in preventive and curative medicine and the inclusion of mental health courses in their training programmes could be seen to be serving the same purpose.

Thus, the significance of training as a pointer to community,
hospital and intergration styles in Zambia has been
revealed in the partial integrative nature and scope of
health workers' training programme.

However, as regard to mental health workers, this
appears to have encouraged their continued utilization on
general medical work to the detriment of mental health
work.

The major constraints affecting the administration
of mental health services in Zambia particularly in regard
to manpower training and utilization therefore appears to
be lack of control and co-ordination of the service. As
revealed in this study, mental health services are
controlled by the various sectors under the DDMSs rather than
being treated as a professional problem needing an independent
mental health unit under the DDMS (Mental Health). The
present administrative structure of the Ministry of Health
at the institutional, district, Provincial and Headquarters
levels is as such characterized by an aura of various
authority claims in the person of general health workers
who appear to show some bias towards their own professional
domain.

Thus, although each province has a mental health unit, its effectiveness is not only dependent upon training but also on manpower utilization especially in terms of job assignments; since general health workers are the administrators of these units and therefore tend to be biased towards their field when utilizing mental health workers in their institution, the same bias could also occur if you put a mental health worker as incharge of general health workers. This in effect is a major limitation of intergration style.

Since data derived from the questionnaire responses in this study show that mental health workers are discriminated against as a category and their sector too is equally neglected, the under mentioned recommendations are made in the light of these perceptions.

Recommendations

As a result of this study on manpower constraints affecting the administration of mental health services in Zambia, it is recommended that:

The Ministry of Health should create a mental health unit at its Headquarters headed by the DDMSs (MH) or mental Health Co-ordinator. Such a professional unit should be given powers for budget allocations to mental health delivery system in order to enhance the operations of the three "styles" discussed in this text. The unit should also control funds for mental health training both for producing mental health workers and conducting inservice training programmes in mental health for other professionals.

In the context of promoting career anchorages in the field of mental health, the unit should plan and control career structures for mental health workers both in the service and training areas thereby partly relieving Chainama Hills Hospital, Chainama College of Health Sciences and indeed the various functional units at the Ministry of Health Headquarters of some of their planning and controlling responsibilities in mental health sector.

At the Ministry level for example, mental health planning, training and development which now come under the auspices of the DDMS (Planning and Development), mental health administration which is under the DDMS (Medical Care Administration), mental health in Primary Health Care and mental health education which are controlled by the DDMS (Primary Health Care) etc., could all be the responsibility of DDMS (Mental Health) in the new organizational structure.

In other words, the DDMS (MH) would control and
coordinate mental health services through mental health
training programmes, dissermination of information, provision
of psychiatric hospital and unit services, recruitment and
allocation to provinces and promotion of mental health workers,
budget allocation to the service and educational areas in the
field of mental health. He/she also would be responsible
for coordinating research activities in mental health, ensure
the integration of mental health into Primary Health Care and
to see that there is both national and international
cooperation in all areas of mental health activities.

The relationship between the proposed administrative
structure and the current functional areas of the
Central Administration would be similar to the one now
existing among the various functional domains. As it has
already been shown in the chart, the structure requires a
high degree of inter-dependence among the functional areas
of the Ministry of Health. Thus, although mental health would
be professionally represented, its functional responsibilities
would have to be coordinated with other health services depicted
in the organogram. For example the DDMS (MH) would have to
coordinate with the Director Pharmaceuticals for psychotropic

drugs, DDMS (Planning and Development) for health information, training and international coordination etc.

Since the problem emanates from the Provincial, District, and institutional levels of our mental health services administration, it is important that administrative changes do take place here too. For example, there could be a Provincial Mental Health Worker (PMHW) at the Provincial level to ensure that the interests of mental health workers are taken care of and to provide a link between Central Administration at the Ministry Headquarters and the Provinces. The PMHW could also act as a conduit for transmitting information about the state of mental health services and also to act as a channel for communicating complaints from mental health workers in the province. The administrative chain of these proposals is depicted in Figure 9.

In this way, there would for the first time be some accountability at every level of the Ministry of Health of what goes on in the field of mental health. It is expected that with such accountability, the nature and scope of training in mental health and the proper utilization of mental health staff in the field would be greatly enhanced. Only then can we expect the problems of mental health workers to

National level (HQ)

```
┌─────────────────────────────────────┐
│   DIRECTOR OF MEDICAL SERVICES       │
└─────────────────────────────────────┘
                  │
                  ▼
       ┌────────────────────────┐
       │   DDMS MENTAL HEALTH    │
       └────────────────────────┘
```

Provincial level

```
       ┌────────────────────────────────────┐
       │  PROVINCIAL  MENTAL HEALTH  WORKER  │
       └────────────────────────────────────┘
                      │
                      ▼
```

District level

```
       ┌────────────────────────────────────┐
       │   DISTRICT MENTAL HEALTH WORKER     │
       └────────────────────────────────────┘
                      │
                      ▼
```

Hospital/MH Unit· level

```
       ┌────────────────────────────────────┐
       │  PRINCIPAL MENTAL HEALTH WORKER     │
       └────────────────────────────────────┘
                      │
                      ▼
```

Community level

```
       ┌────────────────────────────────────┐
       │ COMMUNITY MENTAL HEALTH WORKER      │
       └────────────────────────────────────┘
```
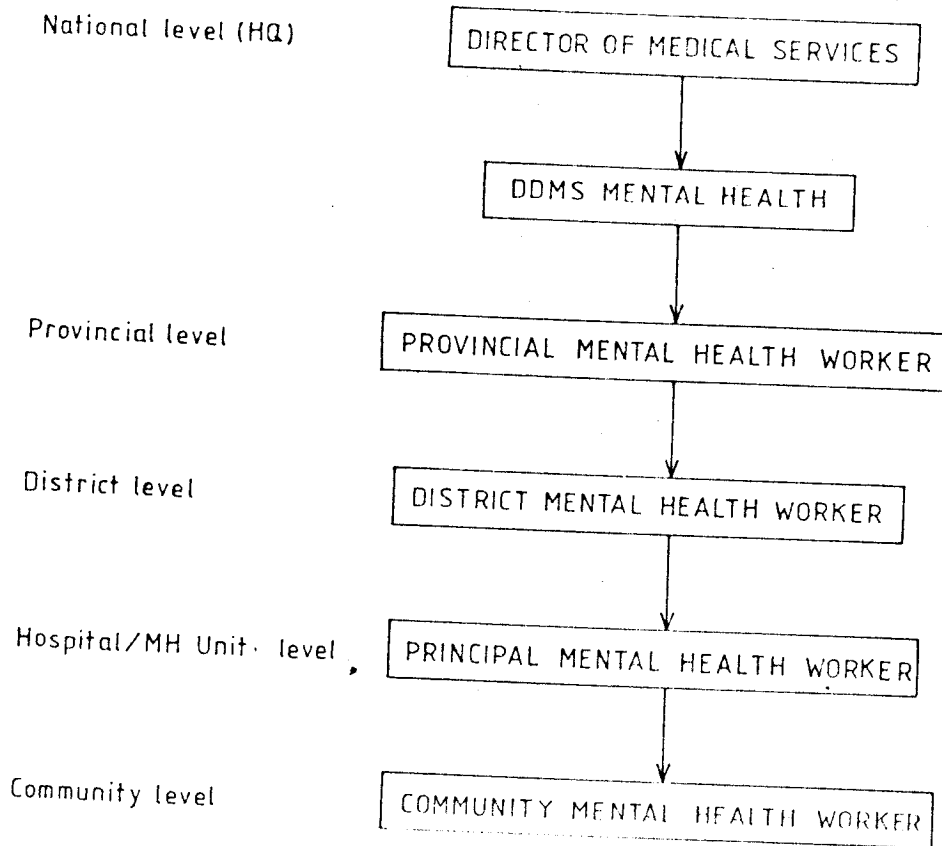
Fig. 9 Proposed administrative structure of mental health services in Zambia.

be taken seriously by the Ministry as a whole.

A polyvalent health worker should be developed in view of the magnitude of health problems in the country. This could be achieved through retraining of both mental and general health workers. In order for this plan to be realized there ought to be career anchorages to motivate these workers to wish to take up additional training.

Before these proposals could be implemented, however, there is a need to undertake a serious study of the controliability of the organizational changes to the administrative structure of the Ministry of Health in order to work out the details.

Some critics of the proposed changes might argue that this would lead to additional costs through the creation of extra posts and power structures.

However, given the gravity of mental health problems in Zambia and their growth potential, such organizational changes are justifiable from the cost-effective position and professional autonomy.

Another weakness established in this research revolved around the apparent low morale among MHWs due to what they perceive as lack of sufficient superior supportiveness toward their work. This problem is certainly critical to the success of the organizational changes advanced above. Morale is central to whatever we do, whether in a formal or informal capacity but since we are more concerned with the former, we shall restrict our proposals for change accordingly.

To enchance the morale of MHWs as well as that of their counterparts engaged in general health work, there is need not only to regularise official visits from central office and related middle level officials to hospitals but also to make such visits more frequent. This is imperative for building supportive roles among the rank and file in the health services. The tour and visit system (TAV) has a two pronged advantage as well. Aside from the above role, the system has the inherent functional advantage of acting as a critical source of information from below to the officials above. Through the T&V system, the policy makers will inadvertently have before them sufficient and badly needed data for policy decisions. This, say, they will be better able to adopt appropriate policy measures to steer the health services in general and MH services in particular along the right course. The present arrangement does not provide adequate feedback for both administrators and field workers. More especially T&V should provide a rostrum upon which MHWs and GHWs could air their views and develop meaningful dialogue with their superiors.

APPENDIX A

QUESTIONNAIRE

CONSTRAINTS AFFECTING THE ADMINISTRATION OF MENTAL HEALTH
SERVICES IN ZAMBIA: WITH SPECIAL REFERENCE TO MANPOWER
TRAINING AND UTILIZATION.

Instructions:

Manpower training and utilization have often been held
responsible for the poor delivery of mental health service to
the general public in Zambia. In the light of the above, I
would like to find out the extent to which mental health
workers are involved in general medical work and vice versa.
As such these research questions are meant to assist me
arrive at a better conclusion on the manpower constraints
affecting the administration of mental health services in
this country through your perception.

The information you give will be strictly confidential
and as such your identity should not be reflected in any part
of the questionnaire.

Thank you very much for participating.

W.W. Banda.

QUESTIONS (TO BE FILLED IN OR TICKED BY HEALTH WORKERS AND SUPERVISORS).

Part A: Personal Data

1. Place of Interview...

2. Date:..

3. Professional qualification of Interviewee-.

    ....

4. Position:....................Length of Service:

    ....

5. Sex.................Age..................................

    Marital Status:...

    Number of Children:.....................................

    Part B: Assessment of the Workload

6. Number of mental health workers in the Department/Section:

    ....

    (i)   Clinical Officers (Psychiatric):

    ....

    (ii)   Registered Psychiatric Nurses:

    ....

    (iii) Enrolled Psychiatric Nurses:

    ....

           TOTAL:..

7. Number of General Health Workers in the Department/ section:

  (i)   Clinical Officers (General)

          ....

  (ii)   Registered Nurses:

          ....

  (iii)   Enrolled Nurses:

          ....

          TOTAL:................................

8. To what extent are you involved in general medical work apart from mental health work.

  (a) Every day

  (b) Every week

  (c) Every month

  (d) Every few months

  (e) None at all

9. What reasons do you give for your involvement in general medical work apart from mental health work.

  (a) Allocated by administrators

  (b) I prefer it to mental health work

  (c) My training prepared me to work with confi-
       dence in general medical work

  (d) There is very little mental health work for
       me to do

  (e) My training did not prepare me to work with
       confidence in general medical work apart
       from mental health work.

(a) Excellent

(b) Good

(c) Fairly good

(d) Poor

13. Administratiors in this institution have:

(a) Great respect for mental health workers

(b) Indifferent attitude to the presence of mental health workers

(c) Hostile attitude to the presence of mental health workers

(d) No knowledge of what mental health workers are supposed to do

14. During my training:

(a) Very little mental health work was done

(b) Very little general health work hwas done

(c) A lot of mental health work was done

(d) A lot of general health work was done

Part D: Assessment of the Ministry's Responsiveness

15. The Central Administration at the Ministry of Health Headquarters:

(a) Is responsive to the needs of mental health workers

(b) Favours the general health workers

(c)   Is indifferent to the problems of mental health workers

16.   Mental health workers:

(a)   Have better chances of promotion than general health

workers

(b)   Have same chances of promotion as general health

workers

(c)   Have little chances of promotion than general health

workers

(d)   Are deliberately discriminated against when it comes to

promotion.

To be answered by Provincial Medical Officers and

Deputy Directors of Medical Services

17.   To what extent are you aware of the problems mentioned by

MHWs in this study? (Identified problems to be mentioned)

18.   If you are;how are you responding to them?

NOTE: Supplementary questions will be added during the interview

if necessary.

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