PROFILE OF PAEDIATRIC PSYCHOSOCIAL DISORDERS IN FRERE HOSPITAL AND ANALYSIS OF ASSOCIATED PATTERNS OF REFERRALS

THESIS

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by

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ABSTRACT

The profile of psychosocial disorders in children and the attendant patterns of referrals and health communication, were investigated within the context of a tertiary referral centre in the Eastern Cape Province. Literature on childhood disorders points to a high level of functional and substance related disorders in technologically developed countries of Europe and North America, in contrast to the developing countries of Asia and Africa, where the burden of infectious diseases and disorders of deprivation and lack still predominate in the profile of psychosocial disorders in children. In South Africa however, there is almost non-existent research on clinical psychosocial disorders profile and the research sets out to be an exploratory study in this area.

A combination design was employed in which interviews and observations complemented a primarily quantitative descriptive cross sectional analysis of hospital case records. A pilot study was performed using an information gathering questionnaire and interviews, with findings subsequently explored in the main study. The International Classification of Diseases (ICD-10) (WHO, 1992) diagnostic categories were used to create a profile of all ailments in the paediatric unit. Psychosocial disorders both in terms of aetiology and illness course, can be viewed from the perspective of social adjustment and functioning (in which there is a potential role of social factors as provoking, causal or modifying factors) (Williams & Clare, 1979); and the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) (American Psychiatric Association,1994) criteria was used to create the profile of these disorders in the paediatric unit at Frere Hospital which accounted for 45% of the ailments managed in one year.

The derived profile is a picture in between the profile found in technologically advanced countries, and developing countries. While the infection burden and malnutrition appear to be readily contained or curtailed, there appears to be a serious problem with access to health care services which manifest especially at the level of perinatal events, with resultant high level of hypoxic brain damage and consequently mental retardation and varying levels of impairment or disability. These medical consequences in turn are fundamentally psychosocial, requiring psychosocial care with heavy reliance

on strategic communication and referrals.

The referrals in respect of psychosocial disorders are mainly at primary care level revolving around local health care clinics, private clinics, special schools and rehabilitation centres.

ACKNOWLEDGEMENTS

DEDICATION

To Agnes and Egodi - in evergreen memory.

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PREFACE

The vital role of an efficient communication network within the health system in South Africa is only matched by the ever-rising need for adequate information in all health districts. At the national level, the White Paper for the Transformation of the Health Systems (RSA, 1997) states that the lack of reliable health information is one of the major obstacles to the effective planning of health services in South Africa and even where information collection systems do exist within the health sector, they have been found to be fragmented, uncoordinated, and not comprehensive. The various levels of health care provision, and the district health system around which primary health care is pivoted are therefore bedevilled by continuing territorial divides. Cook (1995) working in the Border-Kei area of Eastern Cape specifically noted that lack of adequate referrals was a major obstacle to development in general and health care in particular.

Communication in the health system falls into two main sections. The first relates to transport and other logistics necessary for moving from one section to another. But even more important is that people within the service should be able to talk to each other (interpersonal communication) and both make up effective referral (Kibel & Wagstaff, 1999). The implication of a sound communication system for adequate health delivery in the Eastern Cape was well articulated by Thomas (1996, p.i):

> "Collapsing hospitals, inhuman and overcrowded places of detention for children,
> absence of clinics and shortage of drugs on the shelves of those which do exist, and
> disgruntled staff are all clear indications of services in trouble and go hand in hand with
> poor or absent information systems which, though less obvious to an outsider, are at
> least as serious. Conversely, an accurate, comprehensive, current information system
> is a sensitive indicator that all is well in the rest of the service"

This study explores two key areas in child health where sound communication plays a central role, namely psychosocial disorders, and their attendant referrals.

Arguably, every illness in a child has to some extent social and psychological dimensions. But psychosocial disorders are viewed here from the realm of social adjustment and functioning, in which there is a potential role of social factors as provoking, causal or modifying factors.

In his acceptance speech in being awarded the Nobel prize, Nelson Mandela noted that children are at once the most vulnerable citizens in any society, the greatest of our treasures; and that the foundations of adult and psychological functioning are laid during childhood and adolescence. But while tremendous studies have been done on various aspects of ill health in children, very little has been done on psychosocial aspects of child health in South Africa (Moodley & Pillay, 1993); and more so in the Eastern Cape Province. This is in spite of the adoption of the primary health care concept by South Africa which guides current health reforms. The primary health care perspective recognises good health as both a prerequisite for socioeconomic development, as well as an outcome of that process. Good health is a product of many determinants, many of which lie outside the health sector. The most dynamic application of the primary health care's most fundamental tenet is a recognition that health is a responsibility not just of the medical and health profession, but of society as a whole; and which relies on strategic communication to be achieved.

This research is a study of the patterns of diagnosis and referral of psychosocial illnesses in children within the context of an Eastern Cape tertiary hospital department which is dedicated to the care of children. It is concerned to map the profile of psychosocial disorders within this health facility, their management and referral, and to develop an appreciation of the perceived role of psychologists within that context. It is hoped that it will be a useful document in the hands of those who render daily care to the children. In addition, the study will hopefully assist health planning and health service reform in South Africa, as well as general health promotion by providing practical suggestions for better procedures.

While it was interesting to research the entire course of an illness beginning with its identification, and to understand the ways in which different idioms of disorders and explanatory models bring the patient

into the health system in the first place (Kleinman, 1995; Manson, 1994), this study has more limited ambitions, concerned with the objective stated in the paragraph above.

<u>CHAPTER OUTLINE</u>

Chapter 1 explores the fundamental child's right as a basis for the child's health, and reviews relevant literature on the historical legacies of health. It locates the Primary Health Care (P.H.C.) approach as a comprehensive health perspective which relies upon strategic communication and referral to achieve its goals. It also highlights the importance of qualitative methods in health system research.

Chapter 2 espouses the context in which the research occurred by way of highlighting basic health parameters such as demographic indicators, nutritional indicators, indicators of progress, and health indicators.

Chapter 3 provides an outline of the methodology by which the study was conducted including: research goals and basic assumptions; design, sampling, tools and procedures; data analysis; and the pilot study.

Chapter 4 is the presentation as well as interpretation of the findings.

Chapter 5 highlights the most salient features of this study by way of drawing conclusions as well as proffering some recommendations.

CHAPTER 1 - REVIEW OF THE LITERATURE

1.1   PSYCHOSOCIAL DISORDERS AS CONSEQUENCES OF BREECH OF THE RIGHTS OF THE CHILD.

1.1.1   The child and child health

The United Nations Convention on the Child defined a child as any human being to the age of 18 years unless under the law he or she has reached her age of maturity earlier. Paediatrics is the study of growth and development of the child from the moment of conception through to adolescence which embraces the science and art of prevention, diagnosis and treatment of the diseases of childhood whether physical, mental or emotional (Coovadia & Wittenberg, 1999, p.3). Children differ from adults in that:

a.   Often we communicate with them indirectly through their parents or care-givers.

b.   The impact of genetic, environmental, and social factors are often more pronounced in children.

c.   The predominant impact of disease may be on the growth and development status of children.

d.   The growth and development of children may influence the expression of disease.

The famous British paediatrician Donald Winnicott came close to explaining the interaction and dependence of the child on adults and the environment when he proclaimed that there is no such thing as a baby (Winnicott, 1965). A baby is not an element apart, but rather dependent on care-givers and the community. A child's health may be defined as a state of well-being and effective functioning satisfactory to the child and his or her environment (Kibel & Wagstaff, 1997, p.123). The discipline of child health is concerned with the realisation of this optimal state of well-being and effective functioning. It embraces the health of children in the various developmental phases from conception

to delivery (the prenatal and perinatal periods), infancy, the preschool years (two to six years), later childhood, adolescence, and young adulthood.

1.1.2 Fundamental rights of children and their abuse

The basic rights of children can be classified into three main areas, namely a. survival, b. development, and c. protection. Erosion and denial of these fundamental necessities, usually by adults, result in illness (both physical and psychosocial) and even death.

UNICEF (1998) reported that 200 million children under the age of five are malnourished and that malnutrition contributes to more than half of the nearly 12 million under-five deaths in developing countries each year. Raging wars, natural disasters, and societal tensions have threatened most families, leaving most children without the much-needed stimulation for their development. According to Pappas (1983) children throughout the world and in all jurisdictions have been neglected, abandoned, abused, sold into slavery, mutilated, and even killed with impunity. Infanticide is increasingly reported as a phenomenon. In certain instances the law even provides positive reinforcement for parental authority in the form of severe sanctions by the state for filial recalcitrance, including the death penalty. Children the world over number over two billion (UNICEF, 1997, p.99), and consist of at least twenty five percent of most populations (Van Rensburg, Fourie & Pretorius, 1992), thereby constituting the single largest minority in every society, and hence need representation. Though valued by adults as a source of happiness, companionship, pride, and personal development, quite frequently they are valued more for their economic value and as a source of security in the later lives of their parents. Or they could be seen as a short-term drain on their family and societal resources since they consume approximately twenty percent of the gross national product. Hence the much needed secure environment for survival, development and protection of children is often lacking as they fall prey to various forms of abuse and neglect.

The age model of definition of childhood is complicated by differing ages for marriage, criminal responsibility, military service, and employment across borders and across cultures. There is also a lack of agreement on when the child should have a say regarding vital legislation concerning him or her; for instance in relation to adoption. In Africa today, children aged ten years or even less are arms bearers, and may inhabit prison as prisoners. The increasing need to safeguard the rights of the child led to the Declaration on the Rights of the Child by the United Nations Organisation (UNO) in 1959; the Convention on the Rights of the Child in 1989, and several such other statutes by United Nations, International Labour Organisation (ILO), the International Child Rights Monitor; the World Health Organisation, and UNICEF.

1.1.3 Declaration on rights of the child

Eglante Jebb pioneered the Save the Children Fund, with initial focus on children devastated by the first world war in Europe and was one of those who laid the foundations for the Declaration on the Rights of the Child (Minority Rights Group, 1985). This was adopted by the General Assembly of the League of Nations in 1924, with the revised version being adopted by the United Nations General Assembly in 1959 as follows:

> "Whereas mankind owes to the child the best it has to give, now, therefore, the General Assembly proclaims this Declaration of the Rights of the Child to the end that he may have a happy childhood and enjoy for his own good and for the good of society the rights and freedoms herein set forth, and calls upon parents, upon men and women as individuals and upon voluntary organisations, local authorities and national governments to recognise these rights and strive for their observance by legislature and other measures progressively taken in accordance with the following principles" (Lawson, 1991, pp.340-341) -
>
> The Right to affection, love and understanding

The Right to adequate nutrition and medical care

The Right to full opportunity for play and recreation

The Right to a name and nationality

The Right to special care if handicapped

The Right to be among the first to receive relief in times of disaster

The Right to learn to be useful members of society and to develop individual abilities

The Right to be brought up in a spirit of peace and universal brotherhood

The Right to enjoy these rights, regardless of race, colour, sex, religion, national or social origin

These resolutions were not binding on nations, and their application had to adapt to peculiar situations and cultures. Grant (1983) remarked that the Declaration on the Child was among the most essential principles etched in the statutes of humanity, as well as the most frequently disregarded.

1.1.4   Convention on the right of the child

The children of the world are innocent, vulnerable, and dependent. They are also curious, active, and full of hope. Their time should be one of joy and peace, and of playing, learning, and growing. Their future should be shaped in harmony and cooperation. Their lives should mature as they broaden their perspective and gain new experiences (UNICEF, 1991). This was the preamble, and underscores the fundamental tenet of the Convention on Rights of Children. The UNICEF (United Nations Childrens Fund) was born in December 1946 to heed the needs of children following the devastation of the second world war, and was later enlarged to cater for children in developing nations. The conviction that children have not only special needs, but a full spectrum of rights as adults - civil, political, social, cultural and economic - is at the core of a revolutionary shift in the world's approach to children. This conviction has been expressed as the Convention on the Rights of the Child (UNICEF, 1997) which

was enacted in 1989.

In what till then was the greatest gathering, seventy- one presidents and prime ministers came together for the world summit for children, in September 1990, and the New York Times (1990) noted that this largest global summit in history had pledged to better the lot of children, making the greatest promise to the children of the nineties. Their promises were eloquent and their goals ambitious, but given that children cannot survive or thrive on promises, they had to commit themselves to find the political will and resources necessary to translate hope into reality. The convention was subsequently adopted by the U.N. General Assembly and entered into international law and almost all nations on the globe have ratified the convention which became legally binding on them. Article 1 defined children as people below the age of 18 years whose interest must be promoted at all times. It further states that children have the right to survive and to develop to full potential and to the highest attainable standard of health care, to express their views and receive information. They must be registered immediately after birth, must have a name, nationality, the right to play, and protection from all forms of exploitation and abuse.

Taking cognisance of limitations of certain governments in terms of resources to meet all economic, social, and cultural rights of children immediately, the Convention nevertheless commits them to make these rights a priority and to ensure them to the maximum extent of available resources. The Committee on the Rights of the Child in every nation is the official monitor of the tenets of the Convention, to which the government reports within two years of ratifying the convention, and every five years subsequently, specifying steps taken to change national laws and formulate policies and actions for the children. UNICEF (1996) in the Progress of Nations has noted that the Convention on Rights of Children has yielded dividends, as many nations built the Convention into curricula or courses to teach children about their rights. In some countries, the Convention was etched into the constitution and yet in others, the law was amended to conform to the Convention.

Inspired by the Convention, Sierra Leone demobilized child soldiers, while children held in adult prisons for alleged war genocides, were freed in Rwanda. The campaigning to rid the earth of landmines, eminently galvanized by the late Princess Diana; the World Congress against commercial sexual exploitation of children, held in Stockholm in August 1996; the International Conference on Child Labour of 1997 in Oslo, all derived their impetus from the convention, and aim at highlighting these problems, and then eliminating them. The realisation of the ethos of the Convention requires massive education; especially through the media, non- governmental organisations (NGOs), international organisations; and international co-operation (UNICEF, 1997).

1.1.5   **Socioeconomic threat to the rights of children**

According to UNDP (1996) the global economy is valued at 28 trillion US dollars and technology and knowledge are available and easy to share. Per capita income has tripled in the past quarter of a century. Adequate resources therefore exist to plan for all children on earth. Yet the condition of the poorest in technologically advanced societies and in developing and underdeveloped societies continue to worsen. UNICEF (1994) stressed that an additional 40 billion US dollars yearly could ensure access for all the world's people to basic social services such as health care, education and safe water. Thirty billion dollars of this amount could readily be found from developing countries if only they could re-align and curtail their defence budgets of one hundred and twenty five billion dollars yearly by a mere 25%. And the developed world could readily furnish the rest if they re-aligned their aid from armaments, to the most basic needs of developing nations (UNDP, 1994).

Blair (1999) remarked that the international community has tried on a number of fronts to tackle these daunting socio-economic problems and to move the world forward in the new millennium: the Earth Conference of Rio which addressed major environmental issues; the Convention on the Rights of the Child; the battle to protect human rights globally; better family planning and support; the elimination of gender inequality and other forms of discrimination, are all steps in this direction. But these intentions need to be backed by political will on the part of nations, and supported by effective communication

for the goals to be realised and sustained.

1.1.6   Sophistication as an impediment to optimal health - Health care today.

Today's health care system is multinational, industrial and complex (Berliner,1985). The major conglomerates take on the role of drug manufacturing and medical technology on a multinational scale. As in a business atmosphere, the industrial epithet has engulfed cure and treatment protocols, which are increasingly standardised, technologised, fragmented and highly processed. There is an ever growing number of medical specialists, and Moon (1996) suggests that even social problems have been "medicalised". Depression which stems much more from social isolation than from any fundamental biomedical base is increasingly treated by anti-depressant pills (Conrad & Schneider, 1980; Moon, 1996). The consequences of the emergent medico-industrial complex includes reconstruction and empirical operationalisation of social problems in the health field so that they may receive scientific remedy.

From the foregoing it seems obvious that erosion of the fundamental childrens' rights; the prevalent economic order which neglects the most fundamental needs of the child (UNICEF, 1987) and rather pursues huge military expansionism; as well as the medico-industrial complex prevalent in most settings that de-emphasizes primary care, are at the root of the paediatric psychosocial disorders. These daunting problems need to be redressed if a state of optimal child health is to be achieved.

1.2   THE LEGACIES OF HEALTH AND ILLNESS

1.2.1   Historical legacies.

According to Moon and Gillespie (1996) the mediaeval theological or paternalistic perspective saw

sickness as a verdict of God upon lifestyles of individuals. Prayers, pilgrimages, priesthood, oracles and divinations were employed for healing. Naturalists who propounded naturalistic causation were seen as heretics and were seen to be subverting God's will, and were sometimes charged with witchcraft and sorcery. The naturalist medical concept follows a Graeco-Roman tradition and herbal legacy. Herbs and potions were used to address sickness, often with women as the specialists. This concept held health to lie in the balance of four humours - blood, black bile, yellow bile, and phlegm, with imbalance in any resulting in disease. Current practices such as homeostatic concepts of modern medicine; and Indian and Chinese medicine still bear these naturalist vestiges.

Traditions emanating from the naturalist legacy include the Asclepian (Greek god of healing) tradition which emphasised surgical intervention to root out offending body parts and use of herbal remedies to rescue the humouric balance.

In addition to Asclepianism, the Hygiean tradition (Hygiene) stressed cleanliness, harmony and a sensible lifestyle in order to produce cure. With the fall of Rome to the Arab world, the naturalist viewpoint was lost, but resurfaced during the renaissance of the fifteenth and sixteenth centuries to challenge every dogma of the church in mediaeval society. This perennial anarchy on the origins of illness between naturalists and the church however gave a positive boost to knowledge about illness as Rene Descartes (1590-1650) emerged on the scene. The Cartesians (after Descartes) held that the body with its series of parts was clearly physical. This physical whole could be conceptually separated from the mind, which was conceived as a metaphysical and immortal element. The mortal body with its many parts akin to component parts of a machine, coupled with a growing knowledge of its internal structure, could safely be the realm of human physicians. The religious and the church could concentrate on the mind. The reductionist, mechanistic view to health was thus born. The body therefore came to be viewed simply as a machine driven by the heart; and the patient was viewed as a faulty machine which could be repaired by a body mechanic, adequately knowledgeable about the machine (the physician). Health care consequently began to focus on issues which were measurable, observable, and open to description. Such abstract phenomena like fear, feelings and attitudes, began

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to disappear from the realm of health care. Moon and Gillespie (1996) came close to explaining how the Cartesians replaced the paternalistic theory with a parallel viewpoint - the theological perspective was replaced by mechanistic theory based on the scientific agency of the physician.

1.2.2   **Biomedical model of illness**

Engel (1981) stressed that the dominant standard for diagnosis and treatment of disease today is the biomedical model derived from molecular biology which assumed disease to be fully accounted for by deviations from the norm of measurable biological variables, and treatment hence aim at rational and specific outcomes. The goal of medicine seems to be merely to defend the person against the embodied threat (disease), to attack and destroy, or at least neutralise disease thereby curing or restoring the person (Jennings, Callahan, & Caplan, 1988).

The biomedical model has an acute care bias and has been criticised for lacking in adequate psychological, social, emotive, and spiritual dimensions, and a new kind of health system which emphasises continuing care rather than cure has been increasingly advocated. This new health ethos goes beyond merely improving health system coverage, efficiency, equity, and accessibility, but envisages a holistic approach to illness whereby the psychosocial dynamics of illness and treatment are more fully addressed (Callahan, 1990).

Disenchantment with the biomedical model is noticed not only among philosophers. Feminists have noted that the rise of science and scientific medicine coincided with male domination of the society as medical practice became the exclusive preserve of select "noblemen", with transformation of this humble trade into a "noble" profession. However, women had always been healers. They were the unlicenced doctors and anatomists in Western history; the pharmacists who cultivated healing herbs and exchanged the secrets of their uses; and the counsellors and midwives who travelled from home to

home and from village to village. The biomedical model de-emphasised such health care traditions. However, health care today is beyond acute care and hospitals (Ehrenreich & English, 1976; Oakley, 1993) since the psychosocial illnesses can not get effective hospital remedy.

The phenomenologist Oakley (1980) argued that science has a hidden agenda and curriculum of moral evaluation that masquerades as facts, and goes on to advocate a phenomenological understanding in medicine, which examines everyday accounts and understandings by people involved in the subject of study. Collectivists and Populists have their own critiques of foundationalism in medicine and health care policy, arguing rather that people should act together to pursue shared health interests, or goals, to the benefit of the community, as against the individualism very prominent in biomedicine and psychotherapy. The American Marxist, Navarro (1976) argued that the intention of biomedicine was to set the tree (health sector) within the setting of the forest (economic and political structure). Hence the health sector has become individualised, industrialised, scientised, and out of reach. For Illich (1976), biomedicine reinforced a morbid society in which social control of the population by the medical system turned into a principal economic activity. Thus speaking, the medical establishment has become a major threat to health, on the scale of an epidemic and iatrogenesis not only implies pain, sickness and death, deduceable from medical intervention, but includes medicalisation of social and spiritual problems. According to him, suffering, healing, and dying, which are essentially intransitive activities that culture taught each person, are now claimed by technology as new areas of policy making, and treated as malfunctions from which populations ought to be institutionally relieved (Illich, 1976).

1.2.3 Cure and caring in health care

The never-ending oscillation between two different points of view in medicine according to Dubos (1960) is well born out in the dichotomy between ideas of cure and care. Today it is recognised that diseases generally have many causes and that care is at least the equal of cure because though biomedical ideas continue to dominate modern notions of health care, social and psychological approaches are increasingly recognised. As a case in point, care for mentally retarded children and

those with learning disorders pose difficulties of immense proportions for the biomedical, hospital-industry mode of patient management. It reveals the limits of medicine, and poignantly points out the difficulty of making a division between health and social care. The traditional mode of management for this group of people has been the family, the neighbourhood, church, and society. The cure aspect emphasises the determination to intervene directly in the process of disease while caring is concerned with the need to achieve a balance between the body, mind, and environment. Evidence from Europe and America, and most developing countries since the sixties showed that biomedical model and services may sometimes fail to meet health needs and even encourage damaging approaches to health. For Dubos, the doctrine of specific aetiology is only a partial explanation of the cause of disease since it cannot explain the condition under which this aetiology may be found. To illustrate, the cure for tuberculosis has long been found, but the incidence and prevalence of this disease is rising in many places. Cochrane (1972) has noted that cure is rare while the need for care is widespread, and that pursuit of cure at all costs may restrict the supply of care. This led McKeown (1979, 1988) to observe that contrary to what is generally believed, the most fundamental issue confronting medical science is not the solution of one or more of the unsolved biomedical problems, but the evaluation of two approaches to the control of diseases, one through understanding of mechanisms and the other through a knowledge of origins.

1.3   A PSYCHOSOCIAL MODEL

1.3.1   Psychosocial disorder and therapy

Usage of the terms psychosocial disorder, psychosocial theory and psychosocial therapy, is becoming increasingly common in both literature and practice. Originally the term "psychosocial" was used as a bridging gap between psychological and sociological concepts, but has progressively taken a distinctive orientation in the psychological field. Frank Hankin of Smith College, for instance, used the term in 1931 to underscore the crucial need for social workers to understand man, in both psychological and sociological frameworks (Hankin, 1931). Hollis (1964) in her work - "Case work:

A Psychosocial Therapy" - firstly placed the skills and knowledge of the social worker within the psychotherapeutic arena, while at the same time arguing for an autonomous role for the social worker. Psychosocial theory and therapy originally drew from psychoanalytic theory and later from reformation of ego psychology, and is committed to a broader and more diverse understanding of man than was provided by earlier thinking (i.e. from a purely biophysical or psychogenic realm).

According to Turner (1978) the central concept of psychosocial theory started from the premise that a proper understanding of man would lead to a responsible and a demonstrably effective intervention requiring that a balanced position be taken between man as a psychological entity and man as a social entity, where people are understood as products of interaction between their biogenetic endowment, the effect of significant relationships, the impact of life experiences, and their participation in societal, cultural, and current events. It had a strong leaning towards understanding and utilising a broad range of thought systems, treatment methods, and environmentally oriented skills. It is used in a broad range of helping professions including psychiatry, psychology, education, and hence places the clinical social worker in an interdisciplinary role.

For Williams and Clare (1979) and Rutter and Smith (1995) the psychosocial disorders are the conditions which can be viewed from the realm of social adjustment and functioning, in which societal factors have a potential role as provoking, causal or modifying factors.

Psychosocial therapy is that form in which: a. the biopsychological knowledge of human and societal behaviour; b. skills in relating to individuals, families, groups and communities; and c. competence in mobilising available resources, are combined in the medium of individual, group, and familial relationships to help persons to alter their personality, behaviour, or situation in a manner that will contribute to the attainment of satisfying, fulfilling human functioning within the framework of their own values and goals and available resources of the society (Turner, 1978). Psychosocial therapy can be applied to a group such as a community, or family, or to a person in both normal and abnormal forms, in whom it aims at cognitive change; emotive, behavioural, and material change; as well as relief from

such suffering as depression, frustration, anxiety, and deteriorating personality.

Stierling, Wynne & Wirsching (1983) added their voice to the rising interest in psychosocial intervention especially in the Western world. Using schizophrenia as the case in point, they noted that biologically oriented research and refined technologies which permitted study of the intricate neurophysiological and pharmacological processes that seem to underly this disease (including the discovery of endorphins and massive use of neuroleptic drugs), do not produce cure. Indeed biochemical therapy has serious, sometimes irreversible toxicities which may impair recovery, with little if any long term positive psychosocial adjustments. At the same time there is overwhelming evidence that relational style and communication style patterns existing in certain families, and the power of social milieu, can foster or counteract the development of schizophrenic disturbance. Contributing to the discussion, Turner and Williams (1986) advocated inclusion of alternative forms of management in conjunction with (or without) pharmacotherapy in treating psychosocial conditions. These included a general openness to and awareness of psychological mechanisms, and use of psychotherapeutic techniques; an awareness of behavioural mechanisms and use of behavioural techniques whereby symptom and problems are considered with special reference to the role of learning in their aetiology and maintenance, especially reinforced behaviour; using relaxation techniques and cognitive therapy to modify thinking; social management using local support organisations like Samaritans, self-help groups, toddler groups, and using the services of social workers. Primary Health Care must form the pivot of health care delivery, with provision of health centre premises by local authorities so that coming together and working together of a variety of professionals could be facilitated.

1.3.2   **A biopsychosocial model of illness**

Tyrer and Steinberg (1987) enunciated four main approaches by which disease and illness (especially mental illness) could be analysed, namely a. physical model; b. psychodynamic model; c. behavioural model; and d. social model. The main claim of the physical model was the assumption that even mental disorders are dependent on biophysiological changes. This implied physical attribute makes it a useful

working hypothesis, and in line with the main advances of biological treatment as in psychiatry.

However, in arguing for a psychodynamic model, Tyrer and Steinberg cited Foucault (1967) who remarked that Freud did not make a major addition to the list of psychological treatments for madness but merely restored in medical thought, the possibility of a dialogue with unreason. Contributions of the psychodynamic model to understanding mental illness included: i. the fact that symptoms are not to be taken at their face value (symptom deceit); ii. the clinical features of mental illness have particular meaning (symbolism); iii. earlier life experiences are significant in determining mental illness (reactivation); iv. non conscious mechanisms play a major part in presentation of mental illness (unconscious motivation); v. the relationship between therapists and patient (transference) is important in elucidating the nature and reasons for mental illness.

According to Eysenck and Rachman (1965) on the other hand, while Freudian theory regards neurotic symptoms as the visible upshot of unconscious causes, Learning theory does not postulate any such unconscious causes, but regards neurotic symptoms as simply learned habits. There is no neurosis underlying the symptoms, but merely the symptom itself. Get rid of the symptom and you have eliminated the neurosis. He therefore postulated that symptoms and problems must be understood with special reference to the role of learning in their aetiology and maintenance, especially in reinforced behaviour.

The social model of behaviour and illness was linked to the environment, and Bronfenbrenner (1986) in his ecological theory of development listed five environmental systems that influence the biological being, especially the child, namely i. the microsystem, involving families, schools, peers, health services, church groups, neighbourhood play area, etc. These are areas of most direct interaction; ii. the mesosystem involving interaction between microsystems or between contexts e.g. relating family experiences to school experiences; iii. the exosystem comprising extended family, friends of family, the mass media, social welfare, legal services, and neighbours; iv. macrosystem which involves attitude and ideologies of the culture, and v. chronosystem, implying sociohistoric conditions. A holistic

(biopsychosocial) approach is the metaphor which most adequately addresses most illness conditions. It is important to understand the biopsychosocial reverberations of illness. In understanding these however, there is a tendency to segregate aspects of human existence. Cassel (1991) warned that drawing sharp distinctions between physical, psychological, and social factors prevents understanding. This is because all social behaviours involve body motions, whether shaking hands, kissing, eating, or sitting. All interference with functions at the whole body level has psychological consequences. All body functions have social meanings and ramifications.

1.3.3 A new paediatric agenda

Paediatrics is the branch of medicine concerned with diseases of children and child health. Writing on a new paediatric agenda, Green (1985) remarked that the perspective of child health and child health professionals has become both biologic and psychosocial, cross sectional and longitudinal, preventive and therapeutic, group and individual, and centres on growth and development of the child, the family, and the community. Commonly encountered paediatric psychosocial disorders are quite numerous, including malnutrition, HIV/AIDS, psychosis, child-abuse and neglect, epilepsy, juvenile delinquency, mental retardation, physical and sensory disability, unwanted teenage pregnancy, substance abuse, accidents and poisoning. The new paediatric agenda is that of adaptation, in that therapists, the children and their families, are enabled to constructively adapt to crucial life events and psychosocial stressors with which they are so frequently confronted. For Prugh (1983) and Cohen and Lazarus (1983), the extent to which practitioners and health systems adapt to psychosocial realities in the near future will not only depend on advances in paediatric psychoendocrinology, psychoimmunolgy, developmental neuroanatomy and psychopharmacology (biology), but eminently on developmental, behavioural, and social psychology, sociology, epidemiology, and cultural anthropology. The emergence of institutes of child health in most tertiary paediatric units to specifically address the psychosocial problems of children attests to this claim. The interaction and linking pathways between social and biologic factors in behaviour and aetiogenesis of disease (psychobiology) was addressed by Reisser (1980). On the one hand psychological stimuli initiated by life experiences are translated in the brain to produce

physiological changes, and alterations in the body may be transduced through endocrine and neurotransmitter channels in the brain to cause psychological effects. Biological and psychosocial factors are hence inseparably intertwined in health and illness, and no part of the human being can be changed without changing in some way and in some measure all the others.

1.3.4 Implications of psychobiology for child health

Part of health promotion includes evaluation of the biomedical and psychosocial status of the child and family, physical and developmental assessments, anticipatory guidance and containment of vulnerabilities, and promotion through physical activity, sufficient sleep, adequate nutrition, and avoidance of smoking, and substances of abuse (Green, 1983). He summarised the major implications of psychobiology for child health as follows:

a. Adaptation: the traditional interest of paediatrics in growth and development is now being extended to include adaptation and coping with daily stressors.

b. An increased pursuit of, and application of clinically useful methods for increasing activities which promote better functioning, comfort, and realisation of full potential, in children with pain, chronic disorders, or psychological discomfort.

c. To foster integrative research which pulls together observations at all levels of organisation from molecular to behavioural characteristics of living organisms.

d. Transformation in child health care aimed at meeting the needs in rapidly changing society creates new opportunities for fruitful collaboration between paediatrics and the behavioural and biologic sciences (interprofessional collaboration).

e. Treatment: Psychoneuropharmacology has contributed to disorders like ADHS (attention deficit hyperactivity syndrome), depression and anxiety, while physiological effects of biofeedback, relaxation therapy, and hypnotherapy, are currently being investigated.

f.   Prevention and health promotion in paediatrics: biological and psychological markers can be used to identify at risk individuals and vulnerable children, and thus deleterious situations or modifying behaviour patterns and adequate support services could be instituted.

The field of psychobiology in essence represents a good application of the biophysical, psychological and social interactive mechanisms in the area of child health.

1.3.5   Psychosocial disorders in children: changing trends

It seems obvious that children nowadays smoke at earlier ages, experiment with dangerous drugs, and involve in dangerous driving and violent crime than they did thirty to fifty years ago. Rutter and Smith (1995) provided reasons for changing trends in psychosocial disorders, especially as they affect children. These included the changing pattern of adolescence, the onset of which occurs much earlier these days in both boys and girls with concomitant biological, psychological and social consequences; the contextual changes in moral concepts and values; fluctuations in international migration; and growth of mass media. In addition, there is increasing instability of family units and changes in family structure and functioning. Levels of leisure have substantially increased for children. Increase in female employment, in particular employment of mothers with young children has reduced the level of attention paid to children. Other contributory factors include fluctuations in the level of unemployment, the long term reduction in the proportion of young people within most populations (old or elderly populations) (Van Rensburg et al., 1992), economic growth and improvement in the standard of living in most societies especially between 1950 and 1973 (the post war boom), and the increase in life expectancy. The implication of the changing trend is that the profile of psychosocial disorders will vary not only over time periods but will also vary with cultural and geographical differences.

1.3.6   Psychosocial research and the future

According to Hibbs and Jensen (1996), the field of psychosocial treatment and research for children

and adolescents is still in its own childhood. However, in the past two decades, research has been burgeoning, methodologies have improved and public awareness has been raised, but the level of achievement in the field is still far from the level reached in other areas of study such as biological, pharmacological, and treatment research within adult populations. In the USA for instance, the National Plan for Research on Child and Adolescent Disorders (Hibbs & Jensen, 1996), has as a primary mandate the research on psychosocial disorders in children, with emphasis in expansion of the entire spectrum of research related to these disorders and the development of optimal approaches to defining, assessing, diagnosing, and treating young peoples problems. In addition the Plan also calls for the development of clinical services research, and services systems research to evaluate and improve the efficiency, organisation, delivery, and accessibility of treatment and prevention services to young people.

1.4   A COMPREHENSIVE APPROACH

1.4.1   The Primary Health Care perspective

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination. It forms an integral part of both the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process (World Health Organisation (WHO), 1978; Lawson, 1991, pp.349-350). It is important to emphasize that the primary health care approach has gone beyond being a mere perspective, but rather forms the main plan or stratagem for bringing health and development to developing nations and has been institutionalised (Ransome-Kuti, 1995).

The greatest social policy of primary health care, long adopted by South Africa as the path to health was that health came to be seen as a dimension of development itself and not a matter of health service delivery. Disease and illness patterns and philosophies for combatting them were tied in with patterns of social and economic change. The national political, economic, and social structures as well as goals and objectives of general development form the horizon of focus of health service provision and planning. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace, and people have the right and duty to participate individually and collectively in the planning and implementation of their health care (WHO, 1993, 1998).

Kothari (1984) observed that neat transfer of resources and technology does not necessarily bring us any closer to the realisation of a desired state. Unless one builds the human rights dimension into the development paradigm, this (development) will not happen. Nowadays, technology appears to define goals rather than serving as a tool only for development. It appears that patterns of development and people's involvement with their own health are led by imperatives of technology. Illich (1977) cautioned that though we visit the hospital to seek health, what we often get is medical attention and more medical attention may result in diminishing health. Yet health and medical care have been positioned as synonymous. Hence Shaul (1993) remarked that our advanced technological society is rapidly making objects of most of us and subsequently programming us into conformity to the logic of its system, and to the degree that this happens, we are also becoming submerged in a culture of silence. But no amount of technological intervention can combat increasing landlessness. Improved technology may worsen the lot of the poorest in any nation, even the most advanced. The shift from local food production to export drives could impoverish developing communities and is rather counter-productive. The way forward rests not in sophisticated technology but through short, medium, and long term in-depth planning, and changes in socioeconomic and political conditions. We have to think of human survival as the main aim of the development paradigm. We have also to see it as an essential condition of human creativity. And we must think of survival - like a subsistence economy - as not a negative, minimal goal, but as a dynamic force projecting a positive alternative to the theory of progress and the goal of

affluence, one that finds dignity in genuine equity and in diverse cultures working out their own strategies in local movements for democracy and autonomy. Hence the central focus of development is the realisation of the potential of human personality, by embodying notions of desirable social and economic progress, and concern for the human condition.

Primary health care thus reflects and evolves from the economic conditions, sociocultural and political characteristics of the country and its communities. It involves in addition to the health sector all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works and communications, and demands the coordinated efforts of all these sectors. It requires and promotes maximum community and individual self-reliance and participation in planning, organisation, operation and control, and primary care. It attempts to integrate promotional, preventive, and curative health, employing low-level health personnel with heavy reliance on community participation and paying special attention to improving the health conditions of the poorest (WHO, 1978).

1.4.2   **Participatory policies. Rapid rural appraisal and participatory research approach.**

The Alma Atta declaration (WHO, 1978) noted that primary health care requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of health care, making fullest use of local, national, and other available resources; and to this end develops through appropriate education the ability to participate. Van Vlaenderen (1995) listed several factors as giving impetus to the emergence of the rapid rural appraisal method in research and service delivery in the seventies:-

a.   The first was an anti poverty bias. Urban based professionalism due to spatial bias (visit of only favourable spots in a village), person bias (speaking only to elite or to particular gender), seasonal bias (only going in the dry cool season, for instance), and diplomatic bias (avoiding asking ugly questions) generally resulted in the worst poverty. The biggest problems that were

supposed to be uncovered remained unrecognised.

b.   Increasingly, there was rising complexity of the interaction between ecological and socioeconomic processes, which required a multi disciplinary approach.

c.   Disillusionment with conventional methods in rural development which often involved over-bloated, and often fixed, top-down approach. These were very expensive, consumed much time, and alienated people.

d.   The growing recognition that rural people were themselves knowledgeable on many subjects that touched their lives. It would be cost-effective to use that knowledge.

Rapid rural appraisal is a collection of techniques for conducting action oriented research in developing countries, developed as quick, relatively cheap, insightful and multidisciplinary method of data gathering and analysis in response to rural development and agricultural challenges. Its uses include assessing development needs of a community through identification of priorities for action and further research, assessment of feasibility of planned intervention, the implementation of development actions as well as monitoring of development action. Rapid rural appraisal utilises the principles of "appropriate imprecision" and "optimal ignorance" by aiming at finding only what needs to be known and not measuring more accurately than is necessary. It attempts to learn from, and with the rural people, gaining from indigenous physical, technical, and social knowledge.

The techniques of rapid rural appraisal include secondary data review (by reviewing and summarising secondary data); direct observation; semi-structured interviews; use of diagrams such as maps, transects, seasonal calender, historical profiles, stories and portraits, as well as analytic games and workshops.

1.4.3 **Participatory research**

Participatory rural appraisal (PRA) is an attempt to use the above methods and principles of rapid rural appraisal within a participatory research approach, since according to Eckman (1986) knowledge of one subject by another is progressive. A lot of emphasis in the research process is laid on discovering and tapping the capabilities of the local people. The people themselves are motivated to choose the methods relevant for the issue at hand, thereby enabling their capabilities to be expressed, which has both an educative and an empowering effect.

Participatory research therefore can be defined as a process involving social investigation with the full and active participation of all participants in the entire process; an educational process of mobilisation for development; and a means of taking action for development (Van Vlaenderen, 1995). The participatory research process typically commences with a collective identification and description of the research problem, ensuring a full understanding of and commitment to the research problem at hand by all involved. This helps to demystify the research process, which traditionally remained unexplained and incomprehensible to the research subjects, which resulted in lack of interest and commitment to the process. It assumes that deprived communities and individuals have traditional, well established, systems and carefully developed techniques which, over many years allowed them to survive in very harsh conditions. An analysis of the local community history forms the basis for any intervention. The researcher plays a catalytic role in the process of tapping local knowledge, indigenous technologies, survival strategies and resources which will serve as a foundation for the development of an appropriate action plan. It is believed that the building on indigenous knowledge and resources will reduce the likelihood that a programme intervention will de-skill the local people and increase their dependence on external supplies and experts. It combines data gathering with learning and action as an integral part of the overall process, relying on, and building upon the capacity and legitimacy of local community organisations. These participatory processes are very important in respect of the psychosocial disorders given that these disorders have their origins in the community, and their management can only take place with active community participation.

1.5   CHALLENGES OF COMMUNICATION DYNAMICS IN HEALTH FIELD

1.5.1   Communication as a participatory process

Communication is a process in which the participants create and share information with one another in order to reach a mutual understanding (Rogers & Kincaid, 1981). Mutual understanding builds the foundation for mutual agreement, which in turn makes collective action possible. In other words, communication can be visualised as an interactive process involving two or more individuals or groups in which all participants both encode (create and share) and decode (perceive and interpret) information until the goals of each are adequately achieved. The emphasis shifts from monologue to dialogue; from top down or bottom up policies to a participatory polity.

In the Alma Atta Declaration of 1978, the World Health Organisation (WHO) enunciated three basic principles of a primary care approach namely: a. An attack on socio-economic causes of ill health, through intersectorial development and redistribution of power and wealth; b. A series of changes in the nature and delivery of health system; and c. Genuine community participation (WHO, 1978).

The important and serious challenges posed by strategic communication in the health field is underscored by the fact that none of the three basic pivots of primary health care could be achieved without adequate communication.

According to Rogers (1996) communication as a scientific discipline has developed from sociology, social psychology, and political science, and has been applied to schools of journalism and speech. The last fifty years have seen communication studies applied to become a powerful force for public education and behaviour change, especially in countries of Africa, Asia, and Latin America. Unfortunately however, there is a greater gap than ever before in history between what has been discovered and what is being applied, between what is known to health professionals and what is being made known to patients and parents, between what could be done and what is being done (UNICEF,

1988). Today in all nations, organised social resources have reached the level of development at which it is possible to inform and support the great majority of families in taking advantage of today's knowledge, but that new capacity has to be consciously mobilised, and effective communication is a pre-requisite. From social mobilisation for development purposes through family planning and child survival stratagems, to "green revolution" and environmental programs, the need for communication can be felt.

1.5.2   **Scope of the communication challenge**

.The need for communication permeates all aspects of the health field, both at the individual level and groups (such as the family, community, health systems and facilities) and at inter-professional level. Personal health related behaviour may be influenced by Knowledge, Attitude, Belief, and Practice. (KABP) (Katzenellenbogen, Joubert & Yach, 1997). Individual knowledge (facts), combined with their attitudes and beliefs (positive or negative feelings and opinions), may influence health behaviour, including predisposition to such illnesses like cancer, HIV/AIDS, heart disease, and injury. Basic advances in knowledge, allied to today's new capacity for communication and support could play key roles in public health, but profoundly in family and child health. The present potential is based upon the fact that new and vital pieces of health information have emerged from relatively recent scientific research, and the ensuing information would enable parents the world over to protect their children, at a cost they can afford, against many causes of disease and malnutrition. This information is the scientific core of what is now possible, but because its power depends entirely on its being known and understood not only by all levels of health services but by politicians, planners, press, public, and above all by parents, it is necessary to persist in making that information available in non-specialist languages (UNICEF, 1987). Commenting specifically on aspects of family knowledge, UNICEF (1988) noted: so far the most significant examples of social mobilisation for development objectives have been the spread of family planning and the spread of the "green revolution". In both cases many millions of families have been empowered to improve their own lives through the dissemination of available knowledge and affordable technologies. That same strategy has been used to put two of the most

powerful of all health technologies, immunisation (EPI) and oral rehydration therapy (ORT), at the disposal of a significant percentage of the world's parents. An effort to use today's communications capacity to empower people with today's knowledge cannot be limited to half measures or short term campaigns. Social mobilisation could also empower people with knowledge of improvements in housing and water supply, food security, and education, economic productivity and income earning opportunities. As important as any of these, it could promote today's knowledge and low-cost technologies for lightening the work load of women. In all these areas, new and vital knowledge is now available. And in all these areas, that knowledge could be put at the disposal of the majority by mobilising already existing communication resources.

The greatest of all gains could be made in the area of child health. A solid scientific consensus stands behind a body of knowledge, traditional as well as modern, discovered or rediscovered, which could enable most families to prevent and treat almost all of the major causes of child death and child malnutrition by methods which they can understand and at a cost which they can afford. Putting that body of information at the disposal of all families is a task as enormous as the rewards it offers. It is the great health challenge of our time. And to meet that challenge, it will be necessary to forge a new public health alliance, to stimulate a new and permanent mobilisation of a wide range of conventional and unconventional resources in the cause of health (UNICEF, 1988).

The WHO/UNICEF "Facts for Life" campaign insisted that every family has a right to know about timing of births and child spacing; breast feeding which is a major defence against child malnutrition in the developing countries; and immunisation, because millions of children die each year from measles, tetanus, whooping cough, tuberculosis, polio, which are all vaccine preventable. Basic home hygiene, safe motherhood, promoting child growth, respiratory infections, and malaria were all targets in the Facts for Life campaign. All families in both industrialised and developing nations have a right to know about AIDS, the risks of tobacco smoking and alcohol abuse (UNICEF, 1988, p.37). Their profound effects on children are now daily reality in most nations. Tobacco smoking affects children by polluting their environment and exposing them to higher than necessary risks of both respiratory infection and

cancer. Incidence of childhood asthma is higher in such environments. Alcohol abuse is closely associated with accidents, violence, neglect, and increasing poverty - events and processes to which young children are always the most exposed. Smoking and alcohol indirectly mean that family resources are diverted at the expense of meeting the basic needs of the child. Alcohol and tobacco can affect the unborn child and increase the risk of low birth weight, premature birth, fetal alcohol syndrome, spread and transmission of HIV/AIDS to the unborn. Only by empowering all families with the basic facts of health risks of alcohol and tobacco can prevailing trends be reversed. The threat of AIDS, with its striking rapid spread in Africa is creating children who have been orphaned. On the horizon is the additional worry of its treatment cost, which could threaten essential services for children. Public education is the best defence against the AIDS threat. Hence the information about safer sex must be added to the lexicon of what every family should know about in the Facts for Life.

1.5.3 Need for communication in the district health system

In 1986, the WHO Global Programme Committee in defining the district health system noted that it is a health system based on Primary Health Care which is more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographic area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private, or traditional. A district health system therefore consists of a large variety of inter-related elements that contribute to health in homes, schools, workplaces, and communities, through the health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first referral level and the appropriate laboratories, other diagnostic and logistic support services. Its component elements need to be well coordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative, and rehabilitation health activities (World Health Organisation, 1996, p.20). In addition to emphasis on equity, promotive and preventive aspects of health services, the district health system envisages accessibility, intersectorial action, community

involvement, decentralisation and integration of health programmes, as well as coordination of separate health activities. These attributes are all communication driven. If adequate communication is lacking in the district health system, there will be confusion, and clarity will be lacking in the minds of district planners or in practice. For effective functioning, a referral network must be created throughout the district with supporting network of communication facilities to enable it to provide for stepwise progression of interaction, counter referrals and continuity of care. Provision of adequate referral systems within health districts often pose formidable challenges (WHO, 1997).

1.5.4 **Flawed methods**

Certain methods and procedures for communicative action in health field may be flawed and are bound to be met with resistance and failure. Many health topics could be very controversial including reproductive functioning, family size, child spacing, contraception, sterilisation and abortion, practice and use of pills, smoking and drug use. A whole range of stakeholders may be equally involved in a communicative action in research including churches, the community at large, local leaders, project health workers, outside professionals or consultants, local authorities, or government bodies, commercial companies, universities and research councils, the research subjects and target groups, researchers, funders and project staff, and each has to be carried along appropriately if intended messages have to make headway and desired impact.

A proper understanding of the socio-cultural context and individual variables is hence a *sine qua non* for proper communicative action. Pilot and pretesting of basic ideas, questionnaires, and field strategy, is essential for achieving desired goals, and it is important to involve individuals from local communities in all stages of communication planning. In a review of family planning communication for instance, the following were identified as being associated with ineffective communication (Piotrow, Kincaid, Rimon & Rinehart, 1998):

a.   Lack of coherent communication planning and strategic design to achieve specific objectives.

b.   Lack of integration between multimedia communication campaigns with other programme components such as service delivery systems.

c.   An erroneous assumption that awareness and knowledge automatically lead to persuasion and adoption, thereby over emphasising awareness.

d.   Attempts to communicate same messages to everyone rather then segmenting audiences according to their varying needs for information and service.

e.   Lack of systematic pretesting of messages with members of intended audiences.

f.   Lack of rigorous evaluation research to determine what effect communication was having, why, and with whom.

g.   Lack of systematic applications of scientific theories regarding how communication changes behaviour.

The challenges faced in understanding communication dynamics in the health field are readily linked with above points. There is therefore need for regular communication needs assessments, training in communication skills and management, development of national communication strategies and campaigns, technical assistance to various types of communication and community mobilisation projects, workshops, seminars and conferences, and evaluation of communication interventions.

1.5.5   Achieving desired goals - conceptual framework for strategic communication

Social psychological theories are very important in addressing how behaviour is determined, how communication is internalised and how reciprocal action is effected. Three prominent theories applied to health behaviour include the Health Belief Model of Janz and Becker (1984), Attribution Theory (Hewstone, 1983), and Bandura's Social Learning Theory (Bandura, 1992).

According to Health Belief Theory, the core factors that influence a person's actions are

a.   The person's perceived vulnerability to a particular condition of illness;

b.   The person's perception of the severity or effects of the condition or illness;

c.   Their perception of the efficacy, costs, and benefits of any proposed actions.

Attribution Theory as applied to the health field emphasised two key concepts - locus of control and locus of causality - both concerning the individual's perception of events as being under personal control, or as being determined by external influences. People with limited locus of control may feel powerless to change their lifestyles or behaviour because they feel that influences outside themselves control their lives; e.g., witchcraft.

Bandura's Social Learning Theory implied that those who want to change their behaviour may need training to enable them to behave in a health promoting manner. It stressed the need for personal, social and behavioural skill development to enable individuals to put into practice their convictions regarding health-maintaining or health-promoting behaviour. For instance, suddenly stopping a drug addict from using drugs may result in catastrophic rebound phenomenon and withdrawal symptoms, but time management skills, assertiveness training, and so on, achieve better results.

Many theories have also been put forward to explain how communication impacts on behaviour. The Mass Media Theory emphasised cultivation of mass media, whereby repeated, intense exposure to deviant definitions of "reality" in mass media leads to perception of that "reality" as normal. The result is the social legitimisation of the "reality" depicted in the mass media, which can influence behaviour (Gerbner, 1977; Gerbner, Gross, Morgan & Signorelli, 1980).

Emotional Response Theory postulates that emotional response precedes and conditions cognitive and attitudinal effects. In effect highly emotional messages in entertainment are probably more likely to influence behaviour than messages poor in emotional content (Clark, 1992).

The Theory of Reasoned Action (Cognitive Theory) implies that adoption of behaviour is a function of intent, determined by a person's belief and expected values, towards performing the behaviour and by perceived social norms (Fishbein & Ajzen, 1975). The psychologists Prochaska, Di Clemente and Norcross (1992) proposed the Steps of Change Theory which identified the psychological processes which people undergo and the steps they reached as they adopt new behaviour. Changes in behaviour hence result when the psyche moves through spiralling processes of iteration from pre-contemplation through contemplation, preparation, and action, and finally the maintenance of new behaviour. The Input-Output Persuasion model (McGuire, 1989) emphasised the hierarchy of communication effect and considered how various aspects of communication, such as message design, source, channels, as well as audience characteristics influenced the behavioural outcome of communication. The Diffusion of Innovation Theory traced the process by which a new idea or practice was communicated through certain channels over time among members of a social system. It described the factors that influenced people's thoughts and actions and the process of adopting a new belief or idea. The Convergence Theory underscored the close ties and similarities between communication theories developed across different disciplines of enquiry. The original Diffusion of Innovation Theory developed from rural sociology outlined five stages: knowledge, persuasion, decision, implementation, and confirmation (Ryan & Gross, 1943), and in its revised form (Kincaid, 1987; Rogers & Kincaid, 1981) it listed five individual steps in the process of communicative change namely: perception, interpretation, understanding, agreement, and action, plus three social outcomes: mutual understanding, mutual agreement, and collective action.

The Social Marketing Theory equally has a place in health behaviour change. It can be defined as the design, implementation, and control of programmes calculated to influence the acceptability of social ideas and involving consideration of product, planning, pricing, communication, distribution, and marketing research (Kotler and Zaltman, 1971); using the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programmes designed to influence the voluntary behaviour of target audiences in order to improve their welfare and that of their society (Anderson, 1995). Social marketing has been used extensively to sell ideas about AIDS, oral

rehydration salts, mosquito nets, and so on.

The above concepts on health behaviour change have special relevance in participatory research, as well as in health communication. Firstly communicative action must be seen as a process of change. Dialogue and participation must replace one way transmission monologue. The "large volume" approach whereby the recipient is over flooded with information, with hope of imbibing at least bits has been replaced by a consultative approach. The technicality and quantity of material do not matter as quality and social context.

1.5.6 Strategic communication

The strategic development and use of communication is a major contribution to health communication. Strategic thinking lies at the heart of effective communication, helping to change communication programmes from a "spare wheel" called upon when other approaches fail, to a "steering wheel" that can provide direction for programme activities (Piotrow et al., 1998). Strategic programmes are designed on the basis of scientifically collected data to achieve measurable objectives that reach and involve specific audiences and that position health practises persuasively as a benefit in the minds of the intended audience. They are also designed to leave behind trained practitioners and effective institutions to continue the programme in the future. The key elements include:

a.   A science based approach to communication, applying conceptual models in behavioural sciences, social learning, persuasion theory, and social marketing to achieve realistic objectives.

b.   Emphasis on audience involvement and participation throughout the project planning, implementation and evaluation - by use of focus groups, pretesting surveys, exit interviews, interactive counselling approaches, participating mass media formats, iterative feedback.

c.   Recognising that behaviour change is both societal and individual process, to aim at reaching multiple audiences including family members, old and young, patients and health professionals,

policy makers, news and entertainment media etc.

d.   The application of multimedia and mass media channels to produce awareness as well as legitimisation, cues to action for individual behaviour, and specific information, by the use of electronic mail and the Internet.

e.   Appreciation of crucial role of entertainment, through mass media at the community level, to capture the attention, interest, and above all emotions of audience, thereby making learning the liveliest pleasure.

f.   An increasing focus on sustainability for communication activities and evaluation.

Hence development and implementation of effective communication stratagems must be systematic and should include the following:

i.   Analysis: of communication needs, potential audiences, existing programmes on ground, policies, resources, strengths and weaknesses of information gathering , including review of literature.

ii.   Strategic design - of the audience, of behaviour change model, action plan, evaluation plan, etc.

iii.   Development of message, pretesting and revision, and production.

iv.   Management, implementation, and monitoring.

v.   Impact Evaluation.

vi.   Planning for continuity and self-sufficiency.

Psychosocial disorders are often complex and difficult conditions, and hence management plans for dealing with them including mass media campaigns need to be strategically designed, using the above principles in order to achieve desired goals.

1.5.7   **Partners in the alliance for communication**

With particular reference to psychosocial disorders, the area of child health offers a good example of how vital alliances can be forged with various groups and organisations to achieve desired goals. The core of basic information on child health addresses major child health problems in almost all nations, on which almost all scientists are now agreed, and upon which all parents could now act. Centres of medical expertise in each country need to become involved in "customising", without complicating this basic information, for although the knowledge is universally relevant, the priority varies from region to region. For example, information about the advantages of breast feeding and dangers of bottle feeding is more acute for urban Latin America than rural Africa where prolonged breast feeding is a norm (UNICEF, 1988). The nature of the social alliance needed to promote health information, and the communication techniques employed, will also vary with the contours of each nation's culture. The constant element is the dynamic application of the primary health care's most fundamental tenet - that health is a responsibility not just of the medical and health profession but of society as a whole. In the "Grand Alliance For children", the following bodies play a crucial role in communication (UNICEF, 1988) namely:

a.   Educators: There are more than five times as many teachers in the developing world as there are health workers. The formal education system constitutes the developing world's broadest and deepest channel for putting information at the disposal of its citizens. Children ought to be acquainted with today's knowledge about protecting their lives and the normal mental and physical growth of children before leaving school.

b.   Business and labour: Since employers and trade unions, the retail service, and advertising profession, are in regular contact with hundreds of millions of parents, the business world could and should make crucial contributions to the empowering of parents with today's knowledge.

c.   Organised religion: The voice of organised religion still regularly reaches out to hundreds of millions in developing nations, both direct and via the print and electronic media. The respect

in which the voice of religion is heard in the developing world gives it a special place in the propagation of information.

d.   Health services: With over 2 million doctors and 6 million trained nurses and midwives in developing nations, and an almost equal number of community health workers trained since the Alma Atta Primary Health Conference in 1978, the sheer number of clinics and contact of people with them, the scale of outreach by health visitors and their status, there is no doubt that the medical services have a major role to play in health communication.

e.   The public role: In both industrialised and developing nations, members of the public can play great roles by influencing the policies of government, by influencing newspaper, magazine and radio editorials, by supporting voluntary organisations, and by direct action to communicate child health.

f.   Mass media: Those who run the television networks, radio stations, cinemas and videos, and newspapers and magazines, know how to communicate with their audiences, and can use that power to promote child health. There is therefore a great need for collaboration between the health services and the media organisations.

g.   Voluntary agencies: They number over 3000 organisations in all countries of the world. Their role is invaluable, including pioneering child health and health communication, and the health officials must aim at building lasting relationships with them.

1.5.8 **Future challenges.**

The preceding section has traced the major challenges encountered in communication within the health field, using psychosocial disorders and child health as point of reference. The challenges faced and goals aimed for are exactly in keeping with dictates of the primary health care and 'New Paradigm' research (Reason & Rowan, 1981).

Piotrow et al. (1998) enumerated various factors that are sure to influence global interaction and health communication in the present millennium. These include the changing values and ensuing mandates of communication in various societies, as well as the changing behavioural science theory and research need to cope with the rapidly changing world; the expected continued rise in world population and changing character in the audience of communication; changing organisational structures, changing political environments and resources and the changing channels of communication, whereby use of electronic communication is continually making the world smaller. The explosion in communication channels has set the world on an ever changing course. However by vigorously adapting to the tenets of strategic communication, each of these anticipated changes in the new millennium can be adequately handled. Each challenge in addition creates an opportunity for effective intervention. Effective communication will in turn make adequate knowledge available to mankind which will foster optimal health, environmental health, social stability, and world peace.

1.6   LINKING THE HEALTH SYSTEM

1.6.1   Effective referral in the health field

The social work dictionary defines the verb "to refer" as to send or direct a client to an agency, resource or professional known to be able to provide needed service (Baker, 1987.) Referral is not an isolated act. It is a process which requires time, skill, and sensitivity. Accomplishing a successful referral can be almost as complicated as doing good psychotherapy or diagnosing a complex illness condition, and in light of this it is surprising that the subject is given only very brief attention in most textbooks and training programmes (Charry, 1981). Primary health care should be sustained by integrated, functional, and mutually supportive referral systems, leading to the progressive improvement of comprehensive health for all, and giving priority to those most in need, through reliance at local and referral levels, and on health workers. The physicians, nurses, midwives, auxiliaries, and community workers as applicable, as well as traditional practitioners as needed, suitably trained, (socially and technically) should be linked to work as a house team and to respond to the expressed health needs of the community (WHO,

1978).

At the core of the referral concept is an efficient interactive process which provides for stepwise progression and continuity of care. All health-related facilities within a district need to be linked. Most commonly, a sub-district system will consist of a combination that includes a reference health centre, clinics, sub-centres, dispensaries, village health posts, and social service agencies. These should form a network so that the centres with more comprehensive service can support the others. The objective is to create a referral network throughout the district. In this way each centre will have its own catchment population but the subdistrict will provide a coherent range of health services. Such a network depends on adequate transport links and communication which will bring the services closer to people's homes, thereby responding more rapidly and effectively to local needs. The prerequisites for success are support from the district health office and an ongoing programme of continuing education for health centre staff (WHO, 1997). A referral network can function only if the skills and services available are markedly better at a higher step within the district health system than in the step below. Too often this is not the case, i.e. the referral step is not seen by the client as offering a satisfactory level of care. The client then rejects the referral system and proceeds to an already overfull hospital outpatients department where she or he is more confident of seeing a doctor and receiving treatment. In planning the district referral system it is necessary to take into account the intended route for referrals and the combination of services available at each step (Pearson, 1995). A major investment in skill (clinical competence, preventive and promotive expertise) at each successive step will ensure that the referral system offers a progression of facilities and care. The variety of health facilities which are available, especially in large urban centres, can be confusing, hence every effort must be made to simplify them into groups such as private practitioners; specialised agencies; and health centres; and adequate information made readily available to staff and parents. The majority of people who consult a health worker are people with problems in living, with anxieties and fears, with mild depression and with personality traits which get them into difficult situations. Some have overt organic physical or mental disease. Yet others are those with psychosis, severe depression, suicidal tendencies, or cases of drug addiction and abuse.

Continuity of care essentially describes a lasting relationship between the health workers and the people. It is a means of building confidence, obtaining a better understanding of local conditions, and of getting to know individuals, families, and the whole community. In turn, health workers gradually become part of the life and experience of the local people. It is better therefore to organize team work around families or places where they live instead of around different technical disciplines (WHO, 1997).

Referral is difficult to accomplish because it calls for a significant shift in thinking by both the client and health worker. The expectation of the patient was that their needs would be met at the point of call but they have to give up this expectation and accept the idea of going to another person for help. On the part of the therapist the act of referral demands the recognition and admission of limitations. He must shift from the role of the competent expert to the role of the facilitator who helps the patient to get to the expert. Making this shift gracefully requires considerable openness, a clear perception of one's abilities, and a secure sense of self-esteem (Charry, 1981). Kaeser and Cooper (1971) enumerated reasons why practitioners may make a referral which include a. failure to respond to therapy; b. referral made at the request of the patient and their family; c. to seek specialist opinion or advice; d. the need for special form of treatment; e. behavioural disturbance or social difficulties; f. assessment of suicidal risk.

1.6.2   **The referral chain**

The whole referral chain requires both transport (e.g. an ambulance) and some form of verbal or written communication (telephone, radio, facsimile or hand-carried note). Lack of these basic communication resources will not only adversely affect referral of patients, but will make it impossible for nurses to obtain verbal advice on the management of emergency cases (Mahlalela, Rohde and Bennet, 1997). Contact and advice of patients in their homes will also be an impossible task. The availability of emergency transport is an important element of basic health services. Hospitals which receive calls for ambulances must have these communication resources if they are to support the clinic and communities in their catchment area. The referral process should be followed by a back-referral which is a form of

letter received from a referral centre to the institution which initially referred the patient. It provides not only for continuity of care, but also serves as a vital form of continued learning and morale-boosting for clinic staff. It represents one aspect of the role of hospitals in primary health care, that of support for peripheral staff to ensure continuity of clinical management and of patient follow-up (WHO, 1997). When sufficiently articulated and effectively carried out, a good communication network provides many benefits which improve the district health system (Ramduny, McCoy & Boulle, 1998): a. the management system is supported through a free flow of information; b. fragmentation is minimised in the various subsectors; c. isolation and frustration on the part of frontline health workers working in rural districts is averted; d. an efficient communication system supports training and further education of health workers, thereby empowering them; e. it supports the development of the district health information system which improves service delivery in the community; f. most importantly, it ensures quick referral of sick patients and back-referrals.

1.6.3 Levels of care and interaction

All child health professionals in Southern Africa share the desire to promote growth, development, and overall well-being of children. At the present however, the majority of these professionals pursue this goal by attending to established disease in individual children within relatively sophisticated, and usually urban, health service settings. The African National Congress (1994) National Health Plan however envisaged active community participation and democratically elected community structures integrated with representatives of the different sectors. Stakeholders are to be involved in health and community development, with power to decide on health issues at district level based on a Primary Health Care (PHC) approach.

Primary level of care (Kibel & Wagstaff, 1997, pp.67-74) refers to health service facilities staffed by generalists that are open to self-referral and through which a patient makes first contact with the health care system. This level of care may be provided at primary health care clinics, at the offices of general practitioners, and also at outpatient departments (OPD) in level one, level two, and level three hospitals.

Secondary level of care refers to health service facilities staffed by either generalists or specialists to which patients, seen at primary level are referred for more sophisticated management. This level of care can be provided at level one hospitals but is more frequently available at level two and level three hospitals. The tertiary level of care refers to health service facilities staffed by either specialists or superspecialists (in more confined aspects of a discipline) to which patients seen at the secondary level, are referred for more sophisticated management and is invariably offered at level three hospitals, and may be affiliated to universities. Level one facilities include health posts and clinics, community health centres, community based organisations or district or non-specialist hospitals, as well as independent providers, staffed by medical generalists with access to basic diagnostic and therapeutic facilities, which provide 24 hour patient management. Level two (base) hospitals are regional, usually located in larger towns, staffed by general specialists like paediatricians, obstetricians, physicians, general surgeons, radiologists and anaesthetists, and providing specialist care for referred patients. They invariably also function as level one hospitals for patients within their own catchment area. Level three hospitals are superspecialist or teaching hospitals located in metropolitan areas, staffed by both general specialists and super specialists, providing sophisticated care for less common, but more complex health problems, like heart surgery. This entire network is linked through district and provincial health authorities to the national ministry of health, to form a national health system, with each still maintaining some measure of autonomy (Kibel & Wagstaff, 1997, pp.67-74; Pearson, 1995).

A whole range of helping professions support the health system from the primary level through the tertiary level including doctors, social workers, physiotherapists, occupational therapists, psychologists, nurses, speech therapists etc. Overall, relationship between these professionals could be poor (Len Rattof & Carole, 1979; WHO, 1988). Differences in approach, perceptions of the role, working situation and the organisation of the various professions may differ and create difficulties. Conflicts of statutory role, authority and accountability, record keeping and confidentiality all produce problems. Subjective factors which go unrecognised can also interfere with co-operation. Len Ratoff and Carole (1979) and Conrad (1997) highlighted basic areas of fundamental difficulties namely:

a. Differences in approach (training, knowledge, expertise): the various helping professions are concerned with different aspects of human functioning. General medical practice for instance is mainly concerned with physical health of the family, while the social worker focusses on relationships within the family, community and society. The social worker places little emphasis on biology while the GP has little training in behavioural sciences, psychological functioning, and emotional responses to stress and illness.

b. Limited perception of respective responsibilities and roles: a physician for instance may not refer a patient to a social worker, except to provide financial and practical help.

c. The work situation (differences in method and tempo): doctors are trained to be decisive, to provide as quickly as possible diagnosis and treatment. Intervention time in emergency and trauma unit could be as short as five to ten minutes, and an interview must be incorporated within this period. Assessment for the social worker may take a very long period to establish a relationship with the client, to diagnose and then to treat.

d. Authority and accountability: doctors wield great power and authority allowed by society but are accountable to society, their professional council, and often a court of law. But the social worker is answerable mainly to an employer.

e. Statutory awareness: doctors are often unaware of the legal status under which paramedicals such as social workers operate in such areas as statutory responsibilities for children, physically and mentally handicapped, the aged and mentally ill. The social worker, on the other hand, may not appreciate the medical implications of certain functions they perform.

f. Organisation: Levels of autonomy, as against hierarchical corporate bureaucracy, vary for the various helping professions. Hence one group (in a hospital setting for instance) may be dismayed when emergency services do not arrive or arrived late from another helping profession.

g. Records and confidentiality: This has been a recurring area of conflict as each group of

professionals jealously guard their records from others.

Interprofessional hostility, based on misunderstanding and feelings of mutual frustration and impatience interfere with constructive collaboration, and to redress these problems, they recommended regular interdisciplinary, interprofessional seminars and workshops which facilitate better understanding and education, and shared educational programmes at post graduate and undergraduate levels.

1.7   **CONCLUSION**

1.7.1   **The health systems research**

According to WHO (1996) health system research is used to look at influences of socioeconomic and cultural factors in health care delivery in the district and to use these influences to readjust and strengthen support systems such as planning, information, training and supervision. It is required to improve district management and technical capacity through operational and action research with communities, and to establish a health monitoring system to support integrated care delivery. The resources to support this research and the subsequent modification of planning systems may need to be sought outside the district, from the national level or from donors.

Health system research is applied research which aims to support the decision making process at all levels by providing information to improve operation, leading to an improvement in the impact of health care, which in turn leads to an improvement in the health of the population. It encourages collaboration between researchers, health care users, communities, health care providers, managers , and politicians in the design and conduct of research. Collaborative research can help different stakeholders to reach a common understanding of problems, their causes and solutions (WHO, 1991).

The present research consists of a study of the patterns of diagnosis and referral of children with psychosocial disorders in the context of an Eastern Cape tertiary hospital department which is

dedicated to the care of children, and is concerned with mapping the profile of psychosocial disorders within this health facility; to understand the patterns of referral of paediatric patients with psychosocial disorders to and from the facility; and to develop an appreciation of perceived role of psychologists within a referral context. Allwood (1997), speaking of the South African context, observed that those with psychosocial disorders often received less than optimal treatment and in addition may be stigmatised, and are often required to see a confusing array of health practitioners, suggesting that models for caring for those with psychosocial disorders including children, have not yet been established. This is exacerbated by lack of personnel, facilities and knowledge of the needs of those with psychosocial disorders, which leads to neglect of psychosocial needs and perhaps medicalisation of psychosocial problems. It is expected that through studying patterns of referral relating to different diagnosed psychosocial conditions, inadequacies in the system of care will be revealed.

The fundamental changes in health care structure presently under way in South Africa (Ramduny et al., 1998) are largely driven by a primary health care vision, and the attempt to integrate mental health services into primary health care (Jones, 1998) make studies of particular sites important, both for monitoring change and dealing with transformation problems. Within this context there is a need for understanding the communicative systems involved in health delivery, and amongst these are referral networks (Mahlalela et al., 1997). This study will play key role in planning and health service provision. It will also aid in understanding key health delivery issues to be addressed in dealing with psychosocial disorders.

1.7.2 **Qualitative approach and triangulation in health research**

Underlying the qualitative approach is a philosophical concept concerning how behaviours and social processes are determined. Attempts to explain the social world in terms of overt behaviour misses the most vital part of it, which is that each behaviour or action carries meaning which needs to be explored.

When scant information exists on a topic, when variables are unknown, and when a relevant theory base is inadequate, incomplete or missing, a qualitative study can help define what is important to be studied. Conducting qualitative descriptive research is a prerequisite to all types of experimental research. Unless the important dimensions and concepts of a field have been identified, explicit cause and effect relationships cannot be tested in true or quasi experimental research and the medical field, as one example, has made extensive use of qualitative methods as unique or puzzling cases are investigated (Ertmer, 1997). According to Strauss and Corbin (1990), one might use qualitative data to illustrate or clarify quantitatively derived data or use some form of quantitative data to partially validate one's qualitative analysis (triangulation). The present study thus has employed both qualitative and quantitative approaches in exploring psychosocial disorders.

CHAPTER 2 - THE RESEARCH SETTING

2.1   FRERE HOSPITAL AND THE CITY OF EAST LONDON

East London is South Africa's only river port which has grown to be a major industrial centre. The towns economy is based around the motor assembly plants, textile and electronics industries. It is popular with tourists, with its three main beaches - Orient, Eastern and Nahoon being crowded during holiday seasons as they offer seaside family entertainment. The town centre is a modern, busy place. The major influence on the climate is the topography and the surrounding ocean. Annual rainfall may be as high as 1,000mm. total, while temperatures range between 20C and 5C.

Frere, a 900 bed hospital, serving an estimated population of 2.5 million children in Eastern Cape Province is classified as a central hospital. It is structured and operated on the basis of a tertiary centre, though offering primary and secondary level services to the immediate surrounding population. It is also a major training centre in the province for medical registrars, interns, staff nurses (including a nursing school), and various other cadres of community health workers. The East London Health Resource Centre, a joint venture of the provincial government, Rhodes University and Frere is attached to the hospital, and holds some of the most current medical journals.

The dynamics of communication (referrals) which this study aimed at exploring are played out between Frere and approximately 100 district, provincial, and regional hospitals within the province. A constant interaction by way of referrals and counter referrals also takes place between Frere and private doctors' surgeries. With respect to the more social paediatric ailments (psychosocial disorders), it relates with over a hundred caring agencies within the province such as schools and special schools, genetic counselling clinics, vocational and rehabilitation centres. It also interacts with other major health institutions within South Africa such as the Medical Research Institute, the Red Cross Children's Hospital, and other teaching hospitals.

2.2   **EXISTING NEEDS**

Frere hospital is committed to rendering qualitative health care service to all its patients. To this end it actively solicits comments from the general public on how to better its services. The interest of the researcher arose primarily from a board poster within the hospital advocating for comments on services within the hospital and how these services could be improved. However inadequacies of service in respect of psychosocial disorders and referrals have been highlighted quite extensively by researchers and authors, including Allwood (1997), Cook (1995), Dick et al. (1978), Mauer (1987), and Van der Burgh (1983). An interview of selected doctors and nurses further convinced the present researcher of problems and needs in the following areas:

a.   A low level of awareness and sensitization regarding diagnosed paediatric psychosocial disorders on the part of health workers, with concomitant low level sensitization of the parents in these regards.

b.   A remarkably low level of communication tools such as telephones among the populace, making any indirect form of communication with health facilities impossible, except by visiting.

c.   An acute shortage of ambulances within the district which turns emergency referrals and medical attention into nightmares.

d.   Some measure of difficulty both on the part of health care givers and parents in identifying and using available information regarding psychosocial disorders.

The broad aim of this research therefore is to raise awareness on the psychosocial basis of most disorders diagnosed within the paediatric unit, and the associated need for psychosocial therapy, which lies mainly outside the hospital setting, while taking cognisance however, of the basic limitations of the study.

2.3   **THE STATE OF THE CHILDREN OF SOUTH AFRICA**

If development is to assume a more human face, there arises the need for a means of measuring both human as well as economic progress, and UNICEF (1998) stressed that the under-five mortality rate (U5MR) is the principal indicator of such progress for the following reasons:

a.   It is a measure of the end result of a development process rather than an "input" such as school enrollment level, number of doctors per thousand population, per capita calorie availability. These inputs are rather means to an end.

b.   U5MR is known to be the result of a wide variety of inputs and as such a more comprehensive measure of such inputs as child environmental safety, availability of clean water and sanitation, family income and food availability, nutritional health and health knowledge of mothers, level of immunization and ORT use, availability of maternal and child health services.

c.   The U5MR is less susceptible to the "fallacy of averages" which is rampant with such indicators as Per Capita Gross National Product, (GNP). This is because the national scale does not allow the children of the rich for example to be one thousand times more likely to survive a disease, even though the man made scale does permit them to have one thousand times as much income. It is hence much more difficult for a poor or rich minority to affect a national average.

UNICEF ranks South Africa as the 69th. highest in the world in terms of under-5 mortality. The basic indicators which point to the state of the children of South Africa are presented as follows: demographic indicators; basic indicators of progress; nutritional indicators; health indicators.

2.3.1 **Demographic indicators**

i.   National population (1998):-   42.4 million (United Nations Population Division).

ii.   Total population under 18 years: 18.4 million (1996 census)

iii.   Total population under 5 years: 5.8 million

iv.   Urban population (percentage of population living in urban areas): 50% (UN Population Division)

v.   Annual population growth rate (1980-1996): 2.3%

vi.   Life expectancy at birth (the number of years newborn children would live if subject to the mortality risks prevailing for the cross-section of the population at the time of their birth): 65 years (UN Population Division, 1996)

vii.   Crude birth rate (annual number of births per 1000 population): 30 (UN Population Division)

viii.   Crude death rate (annual number of deaths per 1000 population): 8 (UN Population Division, 1996)

ix.   Total fertility rate (the number of children that would be born per woman if she were to live to the end of her child bearing years, bearing children in accordance with prevailing age specific rates): 3.9 (UN Population Division).

2.3.2 Basic indicators of progress

i.   Under 5 mortality rate (U5MR) (Probability of dying between birth and exactly five years of age expressed per 1000 live births): 126 (1990); 66 (1996) - UNICEF; UN Population Division; UN Statistics Division.

ii.   U5MR Ranking: South Africa is ranked 69th. highest in the world (UNICEF, 1998)

iii.   Infant mortality rate (probability of dying between birth and exactly one year of age expressed per 1000 live births): 50 per thousand (1996) - (UNICEF; UN Population Division; UN Statistics Division)

iv.   Adult literacy rate (percentage of persons aged 15 years and above who can read and write): 82% (1995) - UNESCO (United Nations Educational, Scientific, and Cultural Organisation)

v.   Gross primary school enrolment ratio (the number of children enrolled in primary school regardless of age, divided by the population of the age group that efficiently correspond to schooling): 117 (1990 - 1995) - UNESCO

vi.   Gross National Product (GNP) per capita (gross output value, including net receipts of primary income in US dollars, divided by mid year population): $3160 (1995). USA $26,980 (1995) - World Bank.

2.3.3 Nutrition indicators

i.   Percentage of underweight among under-5s (weight below minus two standard deviations from median weight for age of reference population): 10%

ii.   Wasting among under-5s (weight below minus two standard deviations from median weight for height of reference population): 3%

iii.   Stunting among under-5s (height below minus two standard deviations for median height for age of reference population): 23%   (underweight, wasting, stunting (1990 - 1997)Source: Demographic and Health Surveys, Multiple Indicator Cluster Surveys (MICS); and WHO).

iv.   Total goitre rate (percentage of children aged 6-11 years with palpable or visible goitre - an indication of iodine deficiency which causes brain damage and mental retardation): 2% (1985-1994) - WHO.

v.   Percentage low birth weight among infants (birth weight less than 2500 grams) - South African national figures not available.

2.3.4 Health indicators

i.   Percentage of population with access to safe water: rural areas 53%; urban areas 99%

ii.   Percentage of population with access to adequate sanitation: rural areas 53%; urban 85%.

          i.& ii. (1990 - 1996) - UNICEF; WHO; and Multiple Indicator Cluster Surveys (MICS).

iii.   Percentage EPI (Extended Programme on Immunization) funded by government (1995 - 1996): 100% - UNICEF

iv.   ORT use rate (percentage of all cases of diarrhoea in children under 5 years treated with oral rehydration salts and/or recommended home fluids): absent data.

v.   TB vaccination coverage in 1 year olds (1995/96): 95%; DPT (Diphtheria, pertusis and tetanus): 73%; polio: 72%; measles: 76%; pregnant women tetanus: 26%

Source (Demographic indicators, basic indicators of progress, nutritional indicators and health indicators): UNICEF (1998).

In respect of psychosocial disorders, these basic indicators are very valuable by assisting in research, by aiding service delivery, in the identification of needs area, in health planning and monitoring progress.

CHAPTER 3 - METHODOLOGY

3.1   AIM OF STUDY

3.1.1 General aim

To create the profile of paediatric psychosocial disorders in Frere Hospital and to analyse the ensuing referral patterns.

3.1.2 Specific goals

i.   To understand the pattern of psychosocial disorders in the paediatric unit of Frere over a one year period (July 1998 to June 1999).

ii.   To ascertain level of awareness and perception of psychosocial disorders by care givers and how this mediates their approach to management of these diseases.

iii.   To ascertain level of communication, including referrals both within the paediatric setting and with the outside environment.

iv.   To understand how the various helping professions (especially psychologists) are perceived by the others.

3.1.3 Design

The conceptual framework within which to realise the stated goals comprised of a combination research technique consisting of a retrospective cross sectional study using hospital records; and a prospective study by way of interviews and observations.

Use of a combination of research techniques to explore a particular topic has the potential of maximising the quality of data collected and reducing the chance of bias (Varkevisser, Pathmanathan & Brownlee, 1993). The quantitative study aims at quantifying size, distribution and association of variables, while in complementing this, the qualitative technique aims at gaining insight into the nature and causes of the problem, and the consequences for those affected. The combination design clarifies the subject of study better, and one can partially validate the findings of one method through the other.

3.2 **THE PILOT STUDY**

3.2.1 **Aim of pilot study**

The pilot study sought to ascertain the feasibility of the main study, and possible scope through:

i.   Ascertaining the level of clerkmanship and documentation (i.e the quality of patient records) for individual patients attending various hospitals.

ii.   Ascertaining the structuring and functioning of the referral network.

iii.   Ascertaining the distribution of hospitals within the province.

iv.   To identify themes which could be further explored in the main study.

3.2.2 **Method; procedure**

The pilot utilized the dipstick method of information gathering through interviews and observation and use of a questionnaire. Sampling was by a mixture of convenience sampling (eg. proximity to Grahamstown) as well as by quota and ad-hoc (Questionnaire).

The purpose of the pilot was thus not to get an unbiased picture but to have a feel of the prevailing

situation in the area of study. The researcher approached key organisations which in his judgement will contribute to key information on psychosocial disorders and referrals. Usually, doctors or nurses in the organisation were interviewed, but in instances, the head of an organisation was interviewed. In the course of an interview a quick census of the staff in the organisation revealing their specialities was obtained, and questionnaires proportionally allocated to the different specialities. In a few instances however, the researcher sought to obtain information just as the opportunity called (for example, interviewing an ambulance driver in the emergency room, or administering a questionnaire to a speech therapist during a session with the patients) on an ad hoc basis.

Themes explored in the questionnaire included the perception, prevalence and management of psychosocial disorders; the availability of basic health information and level of communication within the health system; the efficiency of the ambulance services; as well as interprofessional relations (see appendix 2).

Two doctors and a nurse were interviewed in Settlers Hospital, Grahamstown; 2 nurses in Fort England Hospital; 2 auxiliary nurses in a private surgery in King Williams Town; as well as making contact with the Head of Paediatrics, Frere Hospital and the Hospital Superintendent. Valuable information on localisation and gradation of hospitals and caring agencies in the Eastern Cape was received from the Health Department in Bisho. Finally, of 50 questionnaires distributed, half were recovered by the time of the main study, with a variety of respondents including doctors, nurses, psychologists, social workers, occupational therapists, physiotherapists, speech therapists and nutritionists. The outcome was forged into an interviewing schedule (see appendix 3) that was utilised in semi-structured interviews during the main study.

3.2.3 Results and implications for main study

a. Most of the health facilities sampled were inadequate for the study, either from under-representation of paediatric psychosocial illnesses (e.g. Fort England Psychiatric Hospital); or

because there was an inadequate level of documentation.

b.   Frere Hospital was identified as a major referral and training centre within the province. The Eastern Cape Health Resource Centre attached to it was also a major stimulus for undertaking research there. It also maintains a high level of documentation in the case files.

c.   Most caring agencies for children with psychosocial disorders; e.g. Red Cross, Downs Syndrome Association and Association for Disabled Children, are concentrated in East London, with the implication that logistics problems would be minimised by carrying out the study there.

d.   Most questionnaire/interview respondents thought that HIV/AIDS was the greatest social disease among children in South Africa today; that the ambulance service is fair to poor; that availability and dissemination of basic health information is fair; and many felt that poverty is at the root of all psychosocial problems.

The researcher subsequently assumed the role of a participant observer for a 60 day period in Frere Hospital in the course of which he explored these and other themes further through interviews, observations and checking records.

3.3 **THE MAIN STUDY**

3.3.1 **Basic assumptions**

The main study which took place mainly in Frere Hospital was premised on the following key assumptions:

i.   That patients' diagnoses were clearly recorded in the case files in accordance with ICD-10 (International Classification of Diseases) (WHO, 1992) categories.

ii.   It was assumed that in instances where recorded diagnoses do not exactly accord with ICD-10 categories, enough information would have been presented in the case files to enable one assign ICD-10 diagnosis, given that this diagnostic system was developed to be usable throughout the world.

iii.   It was assumed that the referral notes were enclosed, or at least recorded within the patients records.

iv.   It was assumed that the majority of the hospital staff who worked in the paediatric unit were permanently in their jobs during the study period. This was confirmed in the course of the study.

3.3.2   **Delimitations**

The study was limited only to:

a.   In-patients

      i.   Patients who were admitted into the paediatric unit

      ii.   Patients who were referred to the paediatric unit.

It hence excluded all paediatric patients seen only in out-patient departments and discharged, as their case records were very scanty and lacking in substantive referrals.

b.   Surgical paediatric patients managed in the surgery unit were excluded.

c.   The cross-sectional case file study covered only a one-year span (July 1998 to June 1999).

d.   As interesting as it would be to adopt a multicentre approach which expands the scope of this study; or to monitor the dynamics of certain referral processes (e.g. ambulance response time), logistical problems and other contingencies strictly limited the scope of this enquiry. Hence this study is only concerned with mapping out the profile of psychosocial disorders and referrals in the paediatric unit of Frere through use of patient's

case files and hospital records; as well as by interviews and observation.

3.4   **QUANTITATIVE STUDY**

3.4.1   **Aims**

i.   To create a profile of all illnesses managed in the paediatric unit during the study period.

ii.   To isolate the psychosocial disorders and analyse their referrals.

3.4.2 **Sampling**

A multistage sampling technique was used whereby the 12 months under study were first stratified into quarters and one month randomly chosen from each quarter. Ten days in turn were selected randomly from each chosen month using a table of random numbers. A 25% systematic selection of case files from chosen days formed the definitive sample.

3.4.3 **Tools, procedures**

A recording pro-forma (see appendix 4) was used to encode relevant information from case files, namely biodata (age at first diagnosis, gender); relevant biographical data including home language and address; referral sources and destination; key diagnoses and management type (chemotherapy, surgery, physiotherapy, social work intervention, occupational therapy, psychotherapy etc.) as well as presence or absence of contact telephone numbers. Diagnosis was assigned according to ICD-10 categories. The psychosocial disorders were subsequently isolated from general medical conditions using DSM-4 (Diagnostic and Statistical Manual of Mental Disorders) (American Psychiatric Association, 1994) criteria.

3.4.4 **Data analysis**

Basic statistical analysis on the encoded variables were performed on a computer. The summaries were presented in tabulated forms, as well as graphs and frequency distributions generated by the computer.

3.5   QUALITATIVE STUDY (INTERVIEWS, OBSERVATION, CHECKING RECORDS)

3.5.1 Aim

The qualitative study was concerned with exploring the information generated in the course of the pilot and quantitative studies further. Its specific aims included:

i.   To develop a better appreciation of the referral system in the paediatric unit of Frere Hospital as they relate to psychosocial disorders.

ii.   To develop an understanding of the perceived nature and management of psychosocial disorders by health workers.

iii.   To ascertain the level of communication both among staff and with outside agencies.

iv.   To understand the conceptions of the psychologist within a referral context.

3.5.2 Method

The method was through combination of unstructured participant observation, use of semi-structured and unstructured interviews, and checking records. Observations and interviews were recorded in field notes. Transcription of the field notes took place immediately afterwards.

3.5.3 Sampling (Theoretical sampling)

Qualitative researchers typically begin a study with general research questions and interests but usually do not predefine the nature and number of cases, settings or informants. Researchers rather typically define their sample on an ongoing basis as the study progresses. According to Patton (1989), where random sampling is not an option, the best way to select participants for interviewing, who will facilitate the ability of others to connect the meaning is by purposive sampling which includes enlisting typical

cases, extreme cases, critical or sensitive cases, and maximum variation sampling. Theoretical Sampling (Glaser & Strauss, 1967) is sampling on the basis of concepts that have proven theoretical relevance to an evolving theory.

Hence consciously, additional cases are selected to be studied according to their potential for developing new insights or expanding and refining those already gained. The researcher maximises variation in additional cases selected in order to broaden the applicability of theoretical insights. Consequently the following were interviewed:

i.   Head of Department, Paediatrics, Frere Hospital: This interview took place in Frere Hospital and emphasised the areas of need in meeting the needs of children with psychosocial disorders. It took the form of a semistructured interview and set the pace for identifying other participants and records necessary for the study. The interview was prescheduled.

ii.   Interview with a "patient group": The group consisted of a sick child and his parents and took place in the corridors of the Paediatric Outpatient Unit of Frere Hospital. It was unscheduled and unstructured. The interview was guided by questions relating to the experience of being an emergency patient. It was executed in two sessions, before and after treatment. Surrounding contextual events were also observed and recorded in the field notes.

iii.   Interview with a staff nurse, Frere Hospital. This took place in the doctors' common room, was in-depth and prescheduled. It was concerned with understanding the communication dynamics within the hospital, the respective interprofessional relationships, the ambulance system and general hospital functioning.

       In addition to interviews within the hospital, the researcher had very numerous exchanges and discussions with hospital staff - doctors, nurses, records officers and statisticians on the nature of psychosocial disorders. The evolving interactions during the course of duty were also observed and documented.

iv.   Interview with a shopper at the Spar, Southernwood, East London, and observation: This

interview took place following a medical emergency at the Spar. The participant at the interview was one of those who helped with calling the ambulance. Two ambulance drivers were subsequently interviewed by the researcher in Frere Hospital.

v.   Interview with the Director, Rehab. Centre, East London: The interview was semistructured and took place in the office of the director. It was very helpful in gaining insight into the psychosocial management of children with psychosocial disorders.

vi.   Interview with staff of Khayalethu Special School, East London: Two staff of this school were interviewed on a prescheduled basis, using a semistructured interview. The interview took place in the school and threw light on understanding referrals in respect of mentally retarded children.

3.5.4 **Analysis (Thematizing)**

According to Kvale (1996), in the practice of social research, qualitative and quantitative approaches interact, and in the more open approaches to interview texts, qualitative and quantitative analyses intermingle. Not just the analysis phase, but the whole research process involves the interaction of the qualitative and quantitative approaches. An investigation starts with a qualitative analysis of the existing knowledge about a phenomenon and the development of qualitative concepts and hypotheses for the specific study. The phases of data collection and data analysis that follow can be mainly qualitative or quantitative, often with an interaction. The major focus of qualitative research however, is on the context, seeking to identify how it influences the observed events (Holman, 1993).

Thematizing refers to a conceptual clarification and a theoretical analysis of the theme investigated, and the formulation of research questions. This implies that the "why" and "what" of the investigation should have been clarified before the question of method is posed. The context of this research was psychosocial diagnosis, referral and care, with the interviews being guided by theoretical review, observations, the pilot and the quantitative study. The thematic understanding of these "contents" of the study was through analytic integration of the interview findings into sections of the study, which corresponded to the aims of the study, and their further interpretation in the discussion section. Hence

the themes of the qualitative findings were integrated into other findings of the research.

CHAPTER 4. DATA ANALYSIS AND DISCUSSION

Table 4.1 Summary frequency table of ailments in the paediatric unit (ICD-10 diagnostic categories)

		Sex		Age Distribution of Illness						Key Therapeutic Measures								Associated pathologies						
MAJOR DIAGNOSIS	TOTAL	M	F	0-6 m.	7-12 m	1-5 y	6-10 y	11-15 y	15+ y	As detailed below								As detailed below						
Certain infectious/parasitic diseases Tuberculosis: pulmonary 　　　　meningitic 　　　　**TOTAL**	3 1 **4** (2.29%)	1 1 **2**	2 **2**	1 **1**		2 1* **3**				Medic. 3 1 **4**														
HIV/AIDS	**4** (2.29%)	**2**	**2**			**4**				**4**														
Malignancies (Neoplasms): Leukaemia Lymphoma Wilms tumour (nephroblastoma) Neuroblastoma Rhabdomyosarcoma **TOTAL**	 1 1 2 1 1 **6** (3.34%)	 1 1 1 1 1 **5**	 1 **1**			 2 1 1 **4**		 1 1 **2**		Medic. 1 1 2 1 1 **6**	Surg. 1 2 1 1 **5**													

		Sex		Age Distribution of Illness						Key Therapeutic Measures							Associated pathologies					
MAJOR DIAGNOSIS	TOTAL	M	F	0-6 m.	7-12 m	1-5 y	6-10 y	11-15 y	15+ y	As detailed below							As detailed below					
Endocrine, nutritional & metabolic										Medic.	Feeding											
Marasmus			1	1	1					1	1											
Marasmic kwashiokor			1	1		1				1	1											
Kwashiokor		1		1		1*				1												
Rickets			1	1		1				1												
Congenital adrenal hyperplasia			1	1			1			1												
TOTAL		**1**	**4**	**5** (2.8%)	**1**	**3**	**1**			**5**	**2**											
Mental & behavioural diseases										Medic.	Speech	Occ.	school				Speech	Hearing	School			
Mental retardation	8	6	2			2	5	1		1	1	1	4				2	1	3			
ADHS (Attention deficit hyperactivity syndrome)	1	1					1															
TOTAL	**9** (5%)	**7**	**2**			**2**	**6**	**1**		**1**	**1**	**1**	**4**				**2**	**1**	**3**			
Diseases of the nervous system										Medic.	Surgery	Physio	Ortho	Social	Sch	Occ.	Retard	Seiz.	CP	Spch/Hear/Sight	Hydro	Men.
Epilepsy	8	3	5				4	4		8			1	1	1		6		2	1	2	2
Other seizure disorder	6	4	2			5	1			2	1	1	3	-	2	3	6	1	2	-	2	-
Cerebral palsy (movement and coordination disorder)	18	10	8			16	2			6	2	4	-		1	-	-	-	-	1	-	
Meningitis	4	3	1 2	1 1	1	1	1			2	-	-		-	-		2	1		-	2	
Hydroencephalus: Acquired	3	1	2 1	1		2				1	1	2		1			2			2	1	
Congenital	2	1	1			2					1				1		2		2			
Spinal muscualar atrophy	1	1				1					1				1							
TOTAL	**42** (23%)	**23**	**19**	**2**	**1**	**27**	**8**	**4**		**19**	**5**	**9**	**4**	**1**	**5**	**3**	**16**	**2**	**6**	**3**	**5**	**2**

| | TOTAL | Sex | | Age Distribution of Illness | | | | | | Key Therapeutic Measures | | Associated pathologies |
MAJOR DIAGNOSIS		M	F	0-6 m.	7-12 m	1-5 y	6-10 y	11-15 y	15+ y	As detailed below (Medic.)	(Surgery)	As detailed below
Diseases of the respiratory system										Medic.		
Otitis media	3	2	1	1		2				3		
Upper respiratory tract infection	2	1	1			2				2		
Tonsilitis	2		2			2				2		
Asthma	3	1	2			2		1		3		
Laryngotracheal bronchitis	2	1	1			2						
Bronchiolitis	9	5	4	6	1	2				9		
Pneumonia	17	12	5	4		9	4			17		
TOTAL	**38 (21.6%)**	**22**	**16**	**11**	**1**	**21**	**4**	**1**		**36**		
Diseases of the circulatory system										Medic	Surgery	
Cogenital heart diseases	3		3			1	1	1		2		
Tetralogy of Fallot (TOF)	4	2	2			3	1			3	3	
Ventricular septal defect (VSD)	1	1				1				1		
Atrial septal defect (ASD)	2	1	1	1			1			1		
Patent ductus arteriosna (PDA)	2		2			2				1		
Atrio-ventricular septal defect (AVSD)	1	1						1		1		
Mitral stenosis	4	3	1			1	1	1	1	4		
Acquired heart diseases	**17**	**8**	**9**	**1**		**8**	**4**	**3**	**1**	**13**		
Rheumatic heart disease											3	
TOTAL	(9.4%)											
Diseases of the digestive system Diarrhoea disease	17 (9.4%)	9	8	7	4	6				Medic 17		

		Sex		Age Distribution of Illness						Key Therapeutic Measures							Associated pathologies				
MAJOR DIAGNOSIS	TOTAL	M	F	0-6 m.	7-12 m	1-5 y	6-10 y	11-15 y	15+ y	As detailed below							As detailed below				
Diseases of the genitourinary system	3	2	1			1	1		1	Medic 3	Surgery										
Urinary tract infection	2	1	1				2														
Nephritis	2	2					2			1											
Renal stone	2	1	1				2			1	1										
Chronic renal failure									1	1	1										
TOTAL	**9** (5%)	**6**	**3**			**1**	**7**		**1**	**5**	**2**										
Congenital malformations, deformities & chromosonal										Medic	Surgery	Socia					Retard	Hirsch	VSD	AVSD	
Down syndrome	**6** (3.3%)	**3**	**3**				**5**		**1**	**3**	**1**	**1**					**6**	**1**	**1**	**1**	
Injuries, poisoning, etc.										Medic.											
Alcohol overdose	1	1					1			1											
Benylyn syrup overdose	1	1				1				1											
Tegretol poisoning	1		1			1				1											
Unidentified poisoning	3	1	2			3				3											
Paraffin poisoning	8	5	3			8				8											
Road traffic accident	1	1					1			1											
TOTAL	**15** (8%)	**9**	**6**			**13**	**2**			**15**											
Neglect & abuse										Medic.	Surgery	Socia	Police	Sch	Feeding	Phys	Occ.	Orth.			
Suicide attempt	2		2					1	1			2									
Near drowning by mother	1	1				1						1	1								
Phyical assault by bigger boys	1	1					1					1									
Sexual abuse	1		1			1						1	1								
Abandonment	1		1			1															
Abscondment	1		1			1															
TOTAL	**7** (4.2%)	**2**	**5**			**4**	**1**	**1**	**1**			**5**	**2**								

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		Sex		Age Distribution of Illness						Key Therapeutic Measures							Associated pathologies					
MAJOR DIAGNOSIS	TOTAL	M	F	0-6 m.	7-12 m	1-5 y	6-10 y	11-15 y	15+ y	As detailed below							As detailed below					
TOTAL	**179**	**99**	**80**	**22**	**7**	**96**	**37**	**13**	**4**	**128**	**16**	**7**	**2**	**9**	**2**	**9**	**5**	**4**				

Mean age: 4.03yrs. Modal age: 2.0yrs. Standard deviation: 4.08yrs. Youngest age: 3 weeks (0.06yrs). Oldest age: 18yrs. Range: 17.94yrs

Key

0-6m	0 to 6 months	Medic.	Medication	Phys.	Physiotherapy	Hydro.	Hydrocephalus
1-5y	1 to 5 years	Surg.	Surgical therapy	Ortho.	Orthopaedic therapy	Men.	Meningitis
* Fatal		Speech	Speech therapy / impairment	Social	Social work intervention	Hirsch	Hirschprung
		Hear	Hearing impairment	Retard	Mental retardation		disease
Police	Police intervention	Occ.	Occupational therapy	Seiz.	Seizure disorder	VSD	Ventricular
		Sch.	Special schooling/	CP	Cerebral palsey		septal defects
			difficultiy with schooling	Spch/Hear/Sight: (disorders)		AVSD	Atrioventricular

Figure 4.1 Diagnostic Distribution Of Patients
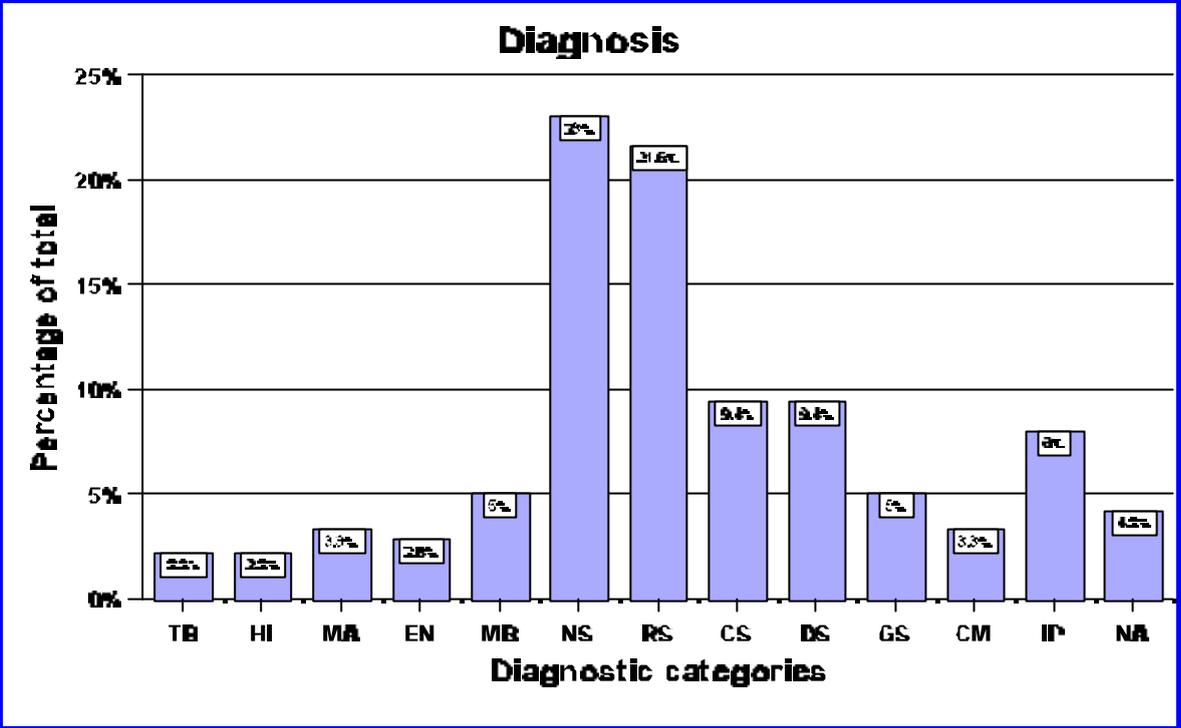
Key:

TB	Tuberculosis
HI	HIV/AIDS
MA	Malignancies
EN	Endocrine, nutritional and metabolic
MB	Mental & behavioural
NS	Diseases of the nervous system
RS	Diseases of the respiratory system
CS	Diseases of the circulatory system
DS	Diseases of the digestive system
GS	Diseases of the genitourinary system
CM	Congenital malformation, deformities, and chromosomal
IP	Injuries and poisoning
NA	Neglect & abuse

Figure 4.2 Age Distribution Of Patients

Figure 4.3 Age Profile Of Diagnostic Categories
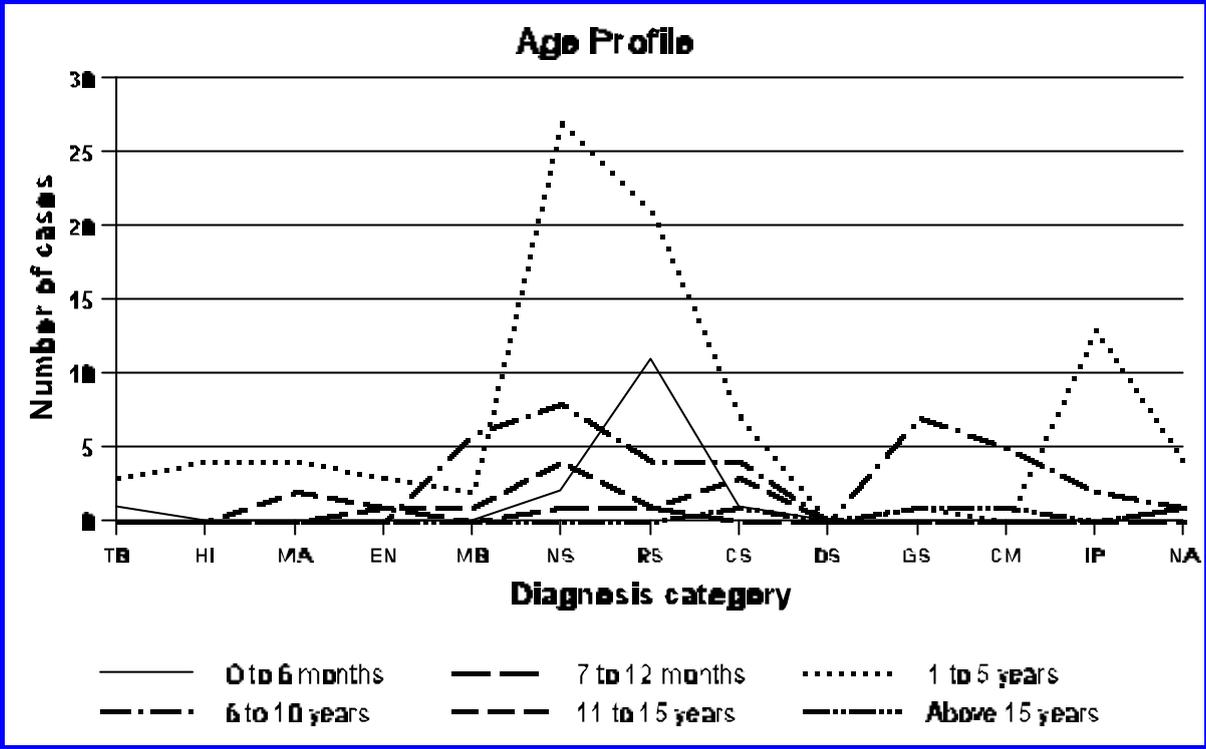
Key:

TB	Tuberculosis
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DS	Diseases of the digestive system
GS	Diseases of the genitourinary system
CM	Congenital malformation, deformities, and chromosomal
IP	Injuries and poisoning
NA	Neglect & abuse

Figure 4.4 Profile Of Interventional Measures (non-chemotherapeutic) Of Patients Seen In Frere
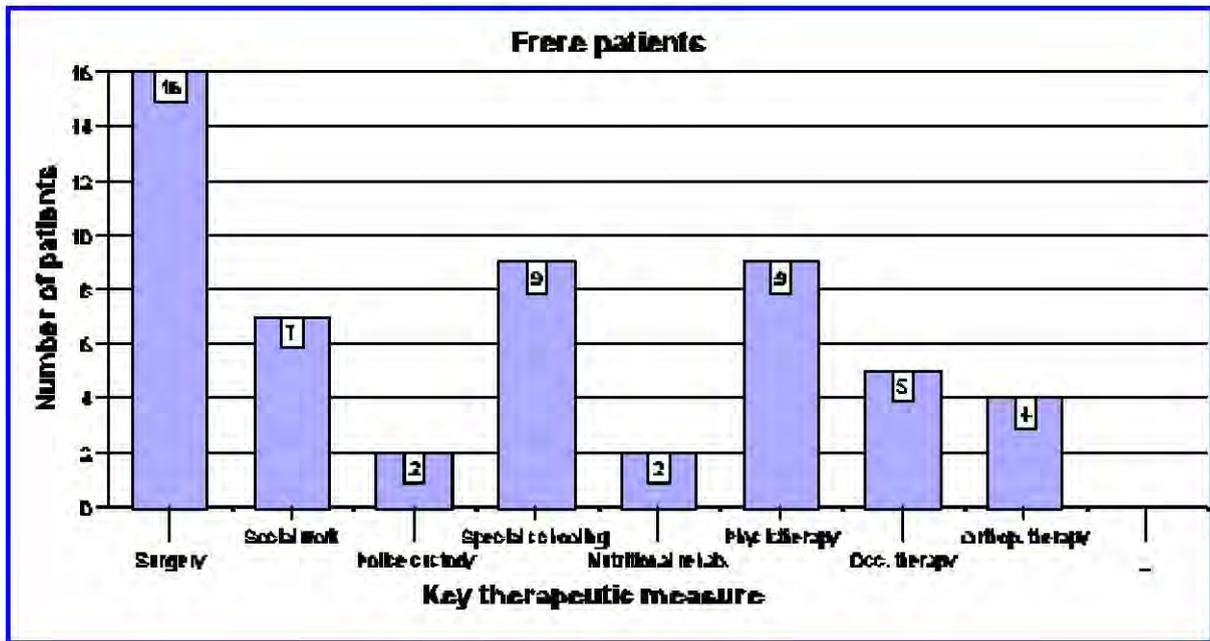
Figure 4.5 Relative application of chemotherapeutic remedy for different illness categories
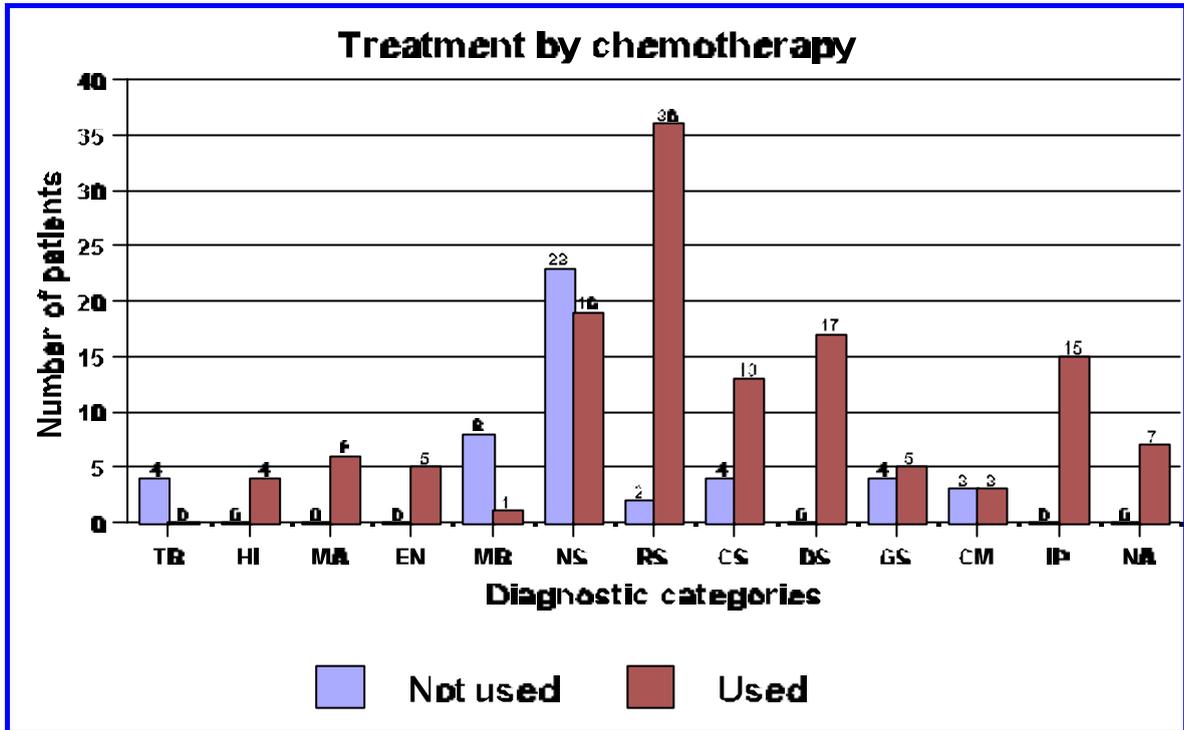
Key:

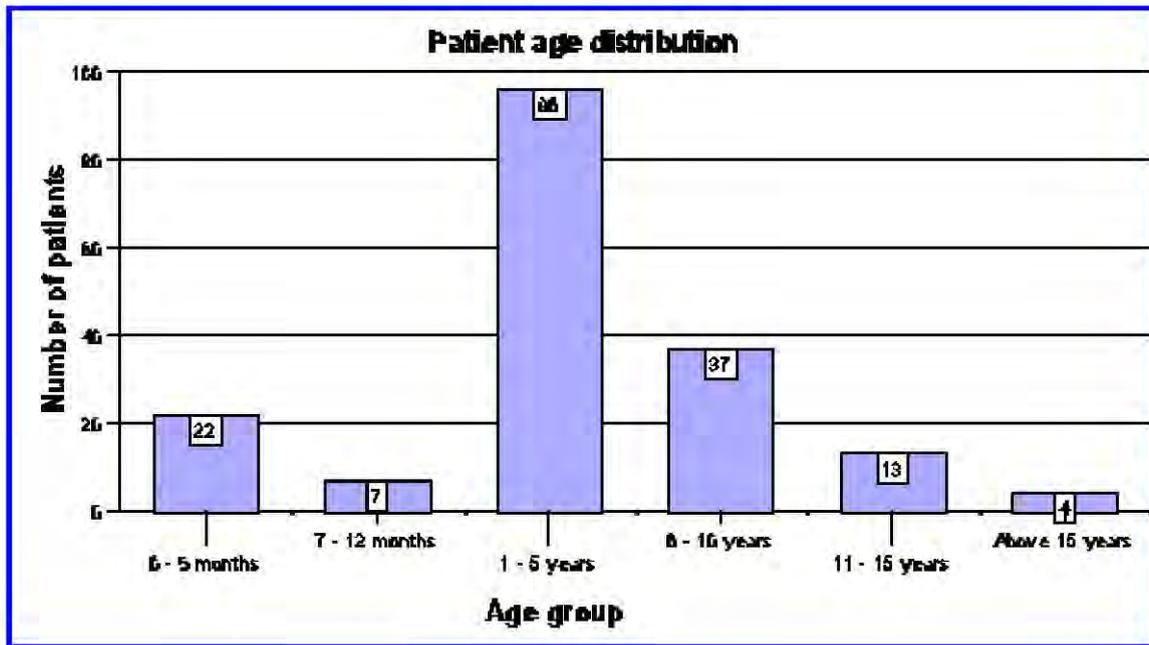|	
TB	Tuberculosis
HI	HIV/AIDS
MA	Malignancies
EN	Endocrine, nutritional and metabolic
MB	Mental & behavioural
NS	Diseases of the nervous system
RS	Diseases of the respiratory system
CS	Diseases of the circulatory system
DS	Diseases of the digestive system
GS	Diseases of the genitourinary system
CM	Congenital malformation, deformities, and chromosomal
IP	Injuries and poisoning
NA	Neglect & abuse

Figure 4.6 Key Therapeutic Intervention In Various Diagnostic Categories
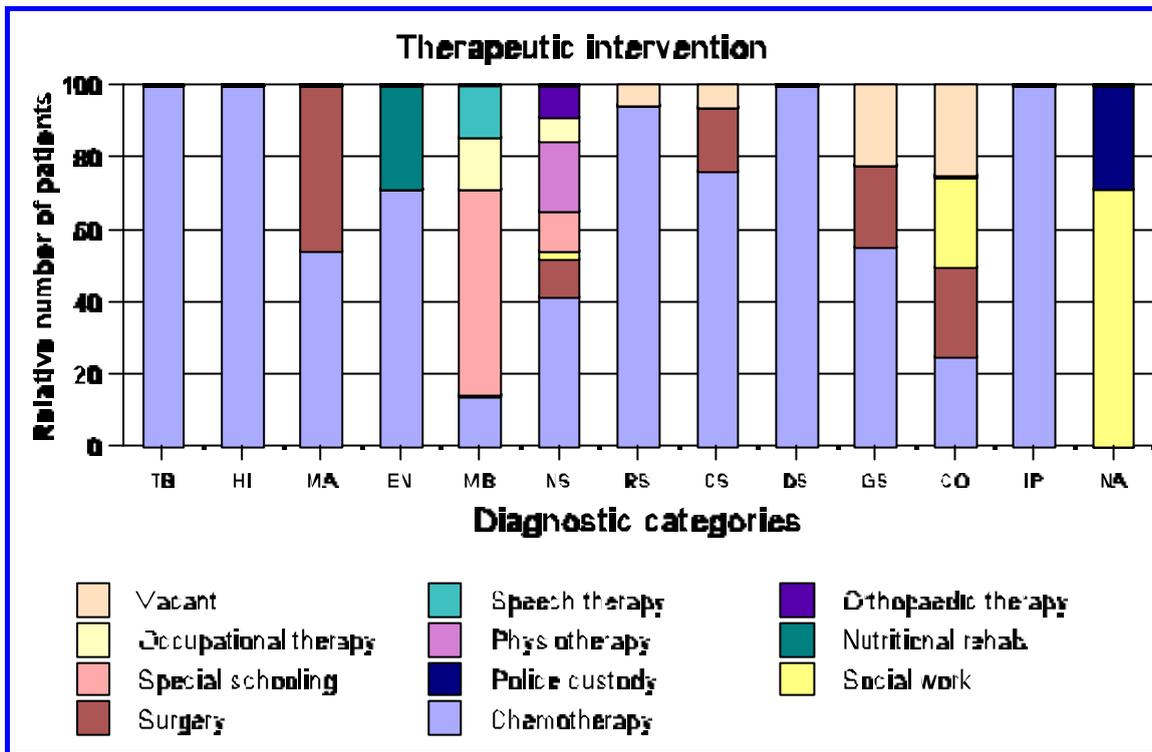
Key:

TB   Tuberculosis

HI   HIV/AIDS

MA   Malignancies

EN   Endocrine, nutritional and metabolic

MB   Mental & behavioural

NS   Diseases of the nervous system

RS   Diseases of the respiratory system

CS   Diseases of the circulatory system

DS   Diseases of the digestive system

GS   Diseases of the genitourinary system

CM   Congenital malformation, deformities, and chromosomal

IP   Injuries and poisoning

NA   Neglect & abuse

Table 4.2 Frequency table showing psychosocial disorders and their referral sources

Referral Source 6 Major diagnosis	Casualty	Doctor, health centre	Nurse, health centre	Private clinic	Hospital	Rehabilitation centre	Schools / special schools	Psychologist	General outpatient department	TOTAL
Tuberculosis	4									4
HIV/AIDS	4									4
Marasmus		1								1
Marasmus kwashiokor		1								1
Kwashiokor		1								1
Rickets	1									1
Mental retardation (isolated diagnosis)		2		2	1	1	1	1		8
ADHS - Attention deficit hyperactivity								1		1
Epilepsy	1	1		4			1		1	8
Cerebral palsy		5	4	4	3		1		1	18
Meningitis with mental retardation		1		1						2
Meningitis with speech, hearing, or				2						2
Hydroencephalus with mental				2						2
Down syndrome		1		1	1				3	6
Alcohol overdose	1									1
Benylin syrup overdose	1									1
Tepretol poisoning		1								1
Poisoning, unknown substances		2							1	3
Paraffin poisoning	5	1	2							8
Road traffic accident					1					1
Suicide attempt	1	1								2
Near drowning by mother				1						1
Physical assault	1									1
Sexual abuse		1								1
Abandonment									1	1
Abscondment									1	1
TOTAL	19	19	6	17	6	1	3	2	8	81

Figure 4.7. Referral sources of psychosocial disorders
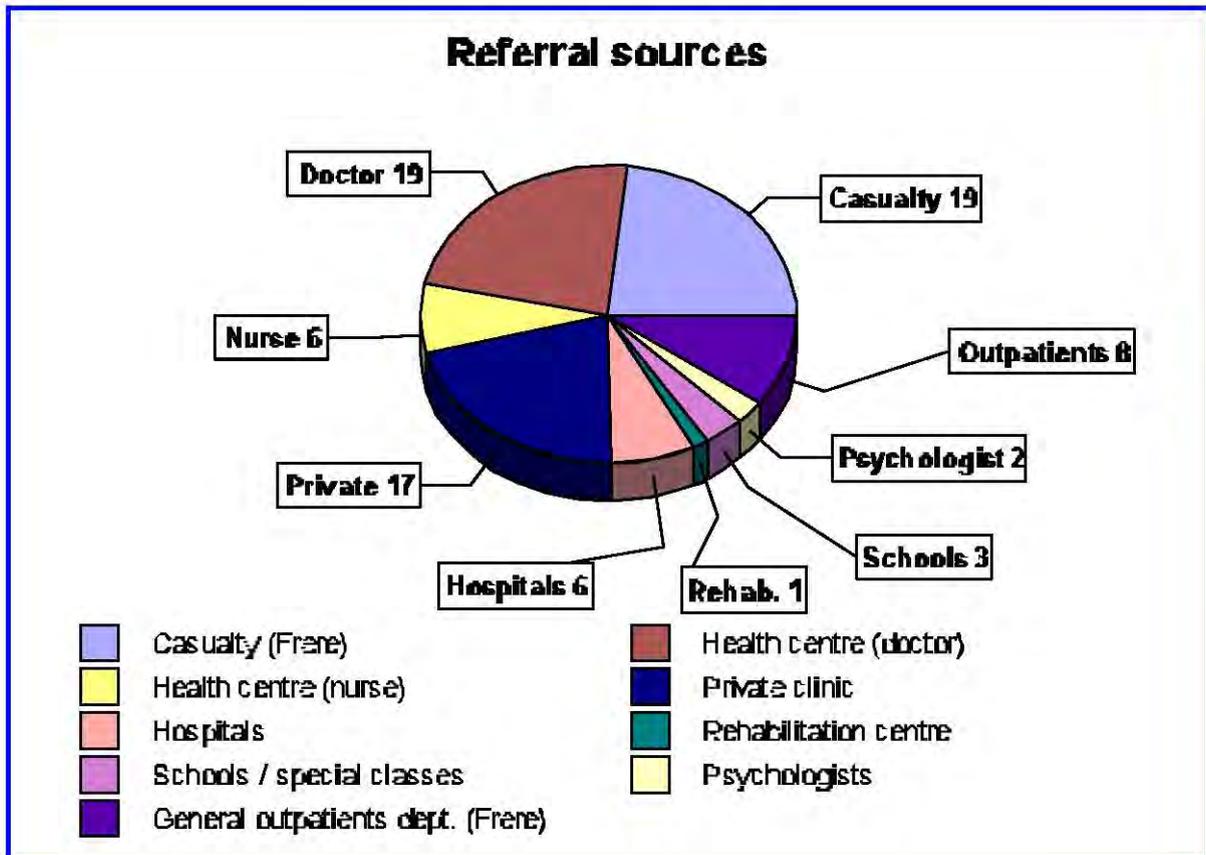
Table 4.3. Frequency Table Showing Types Of Referral Source (Medical) For Psychosocial Disorders

REFERRAL SOURCE (Outside Frere Hospital)	No of patients
EAST LONDON	
Private doctors	8
Duncan Village day hospital (clinic)	7
Municipal clinic, Beaconsfield	2
Empilweni health centre	5
Chris Hani clinic	1
City health centre	2
Gonubie clinic	2
KING WILLIAMS TOWN	
Private doctors	2
Health clinic, KWT	1
ALIWAL NORTH	
Private doctors	1
Aliwal North health clinic	2
BUTTERWORTH	
Private doctors	3
Butterworth hospital	2
STUTTERHEIM Private doctors	2
MACLEAR TOWN Private doctors	1
KAMBASHE Health clinic	1
KIDDS BEACH Kelega Trust clinic	1
GAUTENG Clinic	1
PEDDIE Hospital	1
COFIMVABA Hospital	1
KOMGA Hospital	1
BEDFORD Hospital	1

TOTAL   48

Table 4.4 Place of Domicile for Children with Psychosocial Disorders

Place of Domicile	No. of Patients
Abbotsford	1
Adelaide	1
Aliwal North	1
Amalinda	3
Buffalo Flats	3
Burgersdorp	1
Butterworth	4
Cambridge	4
Cofimvaba	1
Cookhouse	1
Duncan Village	12
Eziphunzana Location	2
Gompo Town	1
Gonubie	2
Gqweya	1
Idutywa	2
Igova	1
Kidd's Beach	1
King William's Town	4
Kwelega	2
Mdatsane	4
Macleartown	1
Mooitplaas	1
Msombovu	1
Nokhale Location	1
Nqamakwe Location	3
Parkside	2
Pefferville	1
Queenstown	1
Scenery Park	2
Southernwood	2
Stutterheim	2
Tsomo	1
Unspecified (East London)	10
Vergendeg	1
TOTAL	81

Figure 4.8 Presence Or Absence Of Contact Telephone In Home Or Workplace

Table 4.5 Referrals from Frere Hospital

Major diagnosis / Referral destination 6	Social worker	Special school / class	Orthopaedic / prosthetic	Physiotherapist	Occupational therapist	Rehabilitation centre	Hospitals / health clinics	Psychologist / psychiatrist	Speech therapist	Audiologist	Down syndrome association	Police custody	Children's home, East London / Jhb.	Neurodevelopment clinic (reappointment)	Paediatric outpatient (re-appointment)	Multiple referral stages to Frere	Multiple referrals from Frere
Tuberculosis			1												3		
HIV/AIDS	3																
Marasmus															1		
Marasmic kwashiokor															1		
Kwashiokor															1		
Rickets							1										
Mental retardation (isolated diagnosis)	1	7	1	1		1										(2 stage) x 1	(2 stage) x 1
ADHS - Attention deficit hyperactivity syndrome								1									
Epilepsy	1	3												4	1		(2 stage) x
Cerebral palsy		1	2	4	1	4	1						1	5		(2 stage) x	(2 stage) x
Meningitis with mental														2			
Meningitis with speech,		2							1	2						(2 stage) x	(2 stage) x
Hydroencephalus with mental		2		1													
Down syndrome		1						1			2				3		(2 stage) x
Alcohol overdose															1		
Drug poisoning / overdose	1														4		
Paraffin poisoning															7		
Road traffic accident																	
Suicide attempt	2																
Near drowning by mother	1											1					(2 stage) x
Physical assault	1																
Sexual abuse	1											1					(2 stage) x
Abandonment													1				
Abscondment	1																
TOTAL	12	16	4	6	1	5	2	2	1	2	2	2	2	11	22		
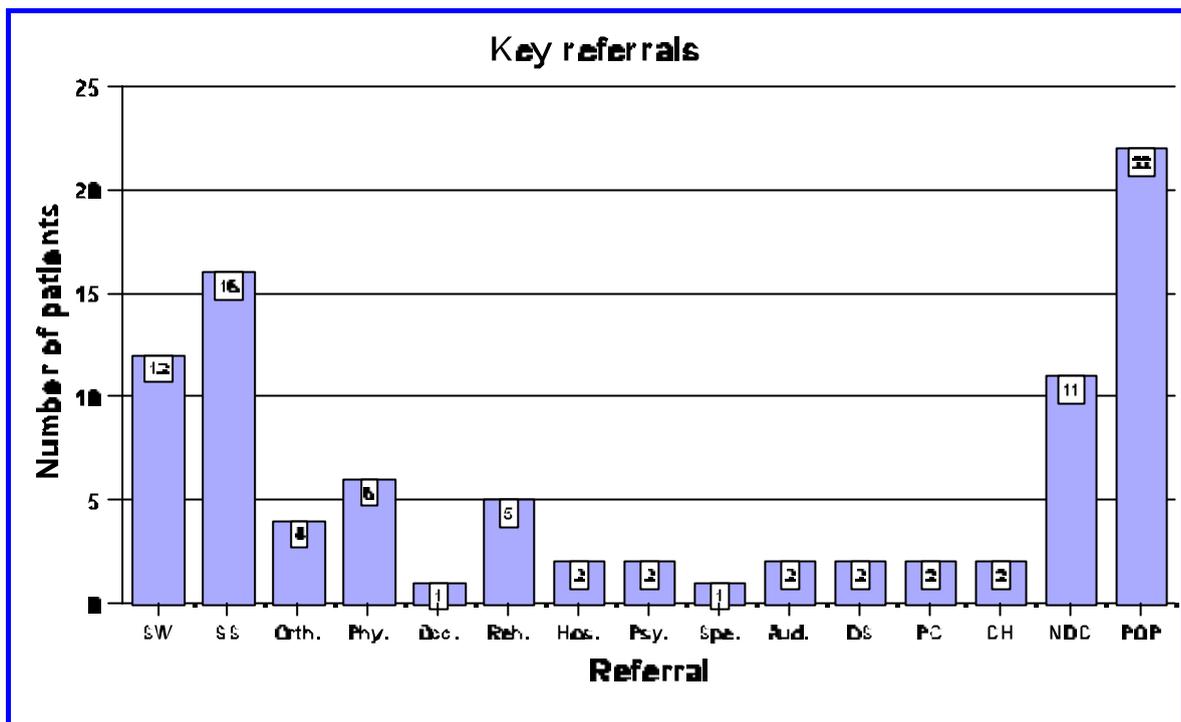
Figure 4.9 Referrals From Paediatric Unit To Therapists / Care Givers Outside Frere Hospital

Key

SW   Social work

SS   Special schooling

Orth.   Orthopaedic therapy

Phy.   Physiotherapy

Occ.   Occupational therapy

Reh.   Rehabilitation Centre

Hos.   Hospital / health clinics

Psy.   Psychologist

Spe.   Speech therapist

Aud.   Audiologist

DS   Down Syndrome Association

PC   Police custody

CH   Childrens' home

NDC   Neuro developmental clinic reappointment

POP   Paediatric outpatient reappointment

4.1 <u>ILLNESS PROFILE IN THE PAEDIATRIC UNIT</u>

4.1.1 The International Classification Of Diseases (ICD-10)

The (ICD-10) (WHO, 1992) was designed for classification of morbidity and mortality information for statistical purposes, for the indexing of hospital records (diseases and operations), for data storage and retrieval, and has a long historical background, having gone through several revisions. It was designed to be useable throughout the world. The ailments in the paediatric unit at Frere were classified according to ICD classification in this study (using the major diagnosis where there are more than one diagnoses).

4.1.2 Illness Summary

The quantitative sampling techniques yielded a total of 179 patients, comprising 99 males and 80 females. Diseases of the central nervous system, especially cerebral palsy and seizure disorders occurred most frequently, accounting for 23% of cases, followed by diseases of the respiratory system especially pneumonia and bronchiolitis. The chronic infectious diseases (tuberculosis and HIV/AIDS) accounted for 2.2% each while nutritional and metabolic diseases accounted for 2.8%. Malignancies (childhood cancer) accounted for 3.3% of cases. Mental retardation as an isolated key diagnosis was responsible for 4.4% of cases, but when considered also as a major complication of disorders like epilepsy, cerebral palsy, meningitis, hydrocephalus and Down syndrome, it constitutes the single largest disorder handled in the paediatric unit.

Injuries, poisoning, suicidal attempts as well as various kinds of abuse and neglect accounted for 22% of cases.

Salient features of the illness summary (Table 4.1) include:

i. A relatively low level of infectious diseases which altogether account for less than 30% of total ailment. This low prevalence could be accounted for by the absent to very low prevalence of malaria attack which in most African settings alone accounts for over 50% of total illness.

ii. Most infectious diseases in the paediatric ward are acute infections such as pneumonia, bronchiolitis and acute diarrhoeal diseases. They were readily treatable and often were discharged home within one

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week on drug therapy.

iii.The chronic infectious diseases of HIV/AIDS and tuberculosis pose a very serious threat, accounting for 4.4% of ailments (a relatively high value) and are often associated with nutritional disorders like kwashiokor, marasmus or marasmic kwashiokor.

iv.The chronic infectious diseases (tuberculosis and HIV/AIDS) as well as malnutrition accounted for 100% of all mortalities within the patient sample.

v.Mental retardation and cerebral palsy (motor/tone and movement coordination disorder) constitute the largest medical problems encountered in the paediatric unit. A limited number of mentally retarded cases derive from genetic/chromosomal disorders like Down syndrome or fragile X syndrome; epilepsy and neonatal infections (meningitis), but the bulk of cases go hand in hand with cerebral palsy and both are traceable to hypoxic brain injury to the developing brain at the perinatal period (during birth).

vi.While Road Traffic Accidents (RTA) occur fairly frequently (most are rather managed in surgical unit), the biggest accidental threat in the paediatric unit is paraffin ingestion. Accidental ingestion or overdose of medicinal agents is also frequent - e.g. benylyn syrup, Tepretol and local herbs.

vii.Suicidal attempts, physical and sexual abuse and neglect were fairly common, but cases of use of substances of abuse and other social ills among adolescents were virtually unrecorded. Few adolescents however were treated in the paediatric unit.

viii.Prevalence of various illness categories peak at various age ranges (Fig. 4.3). e.g. respiratory diseases peak at 0 to 6 months, the nervous system diseases peak at 1 - 5 years, injuries and poisoning peak at 1 - 5 years.

4.2   THE PSYCHOSOCIAL DISORDERS

4.2.1   The Scope

Williams and Clare (1979) identified psychosocial disorders as those cases which can be viewed from

the realm of social functioning, in which there is a potential role of social factors as either provoking, causal or modifying factors; and van der Burgh (1983) added that psychological illnesses pose not only far reaching health problems but also social problems.

However while psychopathology is a biomedical concept which denotes disorder of mental functioning, it differs significantly from other medical conditions in that there are usually no demonstrable, universally acceptable physical or physiological changes to account for the symptoms, thereby making classification not clear cut. Desjarlais, Eisenberg, Good and Kleinman (1995) noted that the formally defined neuropsychiatric disorders are responsible for only a portion of the overall burden of social and psychological morbidity such as alcoholism, drug addiction, suicide and suicide attempts, violence, child abuse and abandonment, crime and street violence, forced prostitution, ethnic and state violence, and dislocation of forced migration. These mental health problems are hardly reflected in published prevalence rates of psychiatric disorders. While information about the prevalence of specific disorders in Africa is sparse (Robertson & Berger, 1994; Giel et al., 1981), it has been estimated by Odejide, Oyewunmi and Ohaeri (1989) that 25-30% of all children attending primary health care facilities have some form of mental disorder but less than 20% of them are identified. These revelations on statistics and classification are compounded further by the fact that many children with psychopathology, present to and are managed, not by hospital professionals but appropriately by educationists, welfare and other professions e.g. children with autism may be managed in special school. But most publications may cite only hospital figures.

4.2.2 Towards a classification - the DSM multiaxial system

In the past the major hypothesis to account for mental illness were the psychogenic and somatogenic hypotheses which envisaged mutually exclusive, specific physical of physiological changes as underlying various mental disorders, with genetic factors and early childhood trauma as predisposers (vulnerability); age and gender as modulators (e.g. adolescence, mid age, old age, female sex (and heightened risk for depressive illness)); and environmental stressors as precipitating factors. However, except in psychopathology due to general medical conditions and in substance related disorders, this

model no longer holds but has been supplanted by an interactive, multifactorial, biopsychosocial aetiology model. The general systems theory which forms the basis of the biopsychosocial model implies that each system - biological, psychological and social, affects and is affected by every other system, thereby providing a comprehensive scientific framework within which health workers have a holistic approach to the treatment of patients. Some primary biological deficiencies affecting mental health include mental handicap, neurological damage as in cerebral palsy and epilepsy, congenital chromosomal anomalies like Down syndrom and the fragile X syndrome. Psychological risk factors include poorly developed coping mechanisms, low self esteem, and maladaptive personality. Social risk factors include community and environmental influences such as high density urban suburbs with easy access to drugs and alcohol by children with attendant delinquency; urbanisation with increased risk to homelessness, stress, school maladjustment, sexually transmitted diseases, and rapid disease spread; as well as familial influences and risks like unmarried mothers under 20, abandonment, rejection or overprotection, inconsistent discipline, marital discord, divorce or remarriage, poverty, unemployment, isolation, dysfunctional family and pathological communication. To these must be added the general risk factors such as malnutrition, chronic illness, communication and motor skill disorders.

While the psychiatric classification systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 1994) are based on the categorical, biomedical approach, assuming clear cut types of psychopathology or disorders (with underlying disorder-specific physical or physiological changes) which are either present or absent, and mutually exclusive, it is noteworthy that even psychiatry has broadened the biomedical concept into a biopsychosocial approach. This is to highlight the significance to mental functioning of psychological and social influences, in addition to physical and physiological factors (Robertson, 1996). The DSM-IV (fourth edition) hence uses the biopsychosocial model in its multiaxial system of diagnosis by integrating the various levels of dysfunction that describe the behaviour of the individual based on five axes.

The multiaxial system promotes the application of the biopsychosocial model in clinical, educational and research settings (American Psychiatric Association, 1994, p.25). Axis I covers the clinical psychiatric disorder and other conditions that may be the focus of clinical attention, excluding mental retardation

that is covered in axis II, in addition to personality disorders. Axis III covers general medical conditions (on ICD basis) which may cause or help in understanding of a mental condition. Axis IV specifically deals with psychosocial and environmental problems namely:

i.   Problem with primary support group

ii.   Problems related to environment

iii.   Educational problems

iv.   Occupational problems

v.   Housing problems

vi.   Economic problems

vii.   Problems with access to health care services

viii.   Problems related to interaction with legal system / crime.

Axis V is used for reporting an individual's overall level of psychological and social functioning and hence is particularly useful in charting progress. It is noteworthy that in the multiaxial system, the various axes are not mutually exclusive.

4.2.3   **Key features of the paediatric psychosocial profile**

Using the axis IV (psychosocial criteria) and the multiaxial system of DSM-IV, it becomes possible to isolate the paediatric ailments into two broad groups - the organic (physical) ailments with little or no psychosocial components; and the psychosocial disorders. Even though some paediatric physical organic diseases may manifest considerable psychological and social features such as cancer, asthma, congenital heart lesions, the key element setting them apart from psychosocial ailments is that focus of attention and intervention is usually on the individual level. The key manifestations of the psychosocial disorders from this study include:

a. Psychosocial disorder as chronic illnesses: the bulk of the psychosocial disorders exhibit manifest chronicity, with some of them such as cerebral palsy and mental retardation resulting in lasting debilitations. They may not be immediately fatal as most organic acute diseases, but their effects linger for long.

b. Psychosocial disorders are multi-pathological: This study proved the psychosocial disorders as multi-pathological conditions. 75% of mental retardation cases for instance (Table 1) in addition manifested with speech, hearing, or schooling difficulties. All epileptic children in addition had cerebral palsy or were mentally retarded. This attribute makes psychosocial disorders very complex.

c. Psychosocial disorders as multi-referral conditions: Most psychosocial disorders because of their multi pathological nature and chronicity often warrant that patients seek multiple remedies, implying that numerous referrals had to be made (see Table 4.5).

d. Psychosocial disorders need care and not cure: The goal of management in physical, organic illnesses, including even such ailments as cancer is to eliminate the ailment which otherwise may kill the individual. In respect of psychosocial disorders however, the patients situation may not immediately change, but the chronicity lingers on and the care givers, therapists, the patient group (i.e. inclusive of their family) need to adapt to the new realities and psychosocial stressors which they are daily confronted with. The psychosocial disorders are beyond acute care. Figure 4.4 reveals a high reliance on caring agencies such as social workers, special schools, police and occupational therapists in managing the psychosocial disorders. According to a care giver (interviewed), ... "the greatest motivation I have in continuing this work is the feeling that I am helping someone who is handicapped to learn to do things for himself. This kind of work is definitely not the kind of thing hospitals can cope with. Some will outgrow their problems, but for others it is for life."

e. Psychosocial disorders need psychosocial therapy. The use of drug therapy and other physical remedies such as surgeries were remarkably lower with the psychosocial disorders (Figures

4.5; 4.6). Even in situations where drug therapy was a major mode of treatment, other measures such as social work intervention, and special schooling often were employed. Hence a holistic approach to management of psychosocial disorders is always called for which goes beyond mere physical remedies.

f.   Psychosocial disorders are very expensive illnesses: the overriding evidence from this study is that psychosocial disorders are very expensive to manage which derives from the multiple referrals needed, multiple pathology and multi-therapeutic regimen, the chronicity and overwhelming handicap. The cost of institutional and psychosocial care, as well as loss of productive human resources are also staggering. In most instances, the available medical resources and personnel are stretched to the full. Most interview respondents felt that the remarkable chronicity associated with certain psychosocial ailments was mainly responsible for the high management costs.

4.2.4   **Aetiogenesis of psychosocial disorders**

The key psychosocial disorders in this study can be traced to

i.   problems with primary support group, namely physical and sexual abuse, abscondment, abandonment, and other forms of neglect and abuse. Tables 4.1, 4.2, reveal that there are 7 cases of abuse and neglect, or attempted suicide.

ii.   High level housing and economic problems, and at times educational problems resulting in inadequate housing, homelessness, and unsafe neighbourhood. These encourage home injuries and poisoning such as accidental paraffin ingestion, road traffic accidents, and social diseases such as tuberculosis and HIV/AIDS, as well as the nutritional disorders like kwashiokor, marasmic kwashiokor and rickets. Home accidents / poisoning accounted for 18% of the psychosocial disorders. (Table 4.2).

iii.   Problems with access to health care services are particularly prevalent with respect to leading psychosocial disorders (mental retardation and cerebral palsy), resulting from insufficient or

inadequate health information, poor communication with health centres, and difficulties with the ambulance. Maternal illiteracy and lack of awareness usually limit utilization of obstetrical and ante-natal services resulting in very high levels of anoxic brain damage in the peri-natal period with concomitant very high levels of cerebral palsy and mental retardation. Cerebral palsy and mental retardation (isolated diagnosis) account for a third of all cases of the psychosocial disorders (Table 4.2). Examination of the case files linked almost all to hypoxic brain injuries (hypoxic ischaemic encephelopathy). The mothers were often uneducated, and used obstetrical facilities very sparingly.

4.3 **PSYCHOSOCIAL REFERRAL PROFILE**

4.3.1 **Referral sources**

Table 4.2 shows that 19 out of 81 cases presented via the casualty unit of Frere Hospital and subsequently referred to the paediatric unit. These were mainly cases of paraffin ingestion and complications of the chronic infectious diseases (tuberculosis and HIV/AIDS). 8 also presented via the general out patient department and subsequently referred to the unit. Of the 64 patients referred from other centres to Frere, 72% were from hospital sources and 28% from non-hospital sources. The ratio of private clinic sources to government hospital clinics is approximately 1:2. Primary level (medical centre / clinics) referrals outnumber secondary level (hospitals) referrals by 6:1.

The picture from referral sources reveal certain facts:

i.   The psychosocial referrals are mainly primary referrals from doctors and nurses at primary care level, as well as from teachers in schools / special schools, psychologists, and from the Rehabilitation Centre (Rehab.), East London.

ii.   The private medical setup (private surgeries) have a crucial role to play in the psychosocial management of patients. Over one third of patients at the primary health care level are handled by them.

iii.   Despite the fact that the psychosocial disorders are fundamentally psychological and social in origin, there is remarkably low input from psychologists in the interactions involving these patients. Only two referrals involved trained psychologists.

4.3.2 Referrals from Frere Hospital

Table 4.5 reveals that 11 and 22 patients were respectively rebooked to visit the neurodevelopmental clinic and the paediatric outpatient clinic for follow up. The highest number of referrals were made to special schools or special classes in normal school (16 patients), 12 to social worker, 4 for orthopaedic / prosthetic care (mainly children with cerebral palsy), 6 referred to the physiotherapist, and 5 to the Rehabilitation Centre (Rehab.), East London. Again referrals made to the psychologist was one of the least (merely 2 patients).

4.3.3 Multiple referrals

Cases of cerebral palsy (Table 4.5) recorded the highest number of multiple / multistage referrals to or from Frere, followed by cases of speech / hearing impairment, mental retardation, epilepsy, abuse and neglect. Multiple referrals derive from the fact that psychosocial disorders are often complex, multidimensional problems, requiring many resources to manage. Often referrals are made to wrong sources meaning that a confusing array of doctors have to be seen before an appropriate destination is found to adequately handle a particular case. According to a respondent: "A child once had to go through two health centres and a private surgery before we finally found out that she simply had hearing impairment." The provision of adequate information to care givers and parents, coupled with formal and informal on the job training through continuing education will arguably greatly uplift the standard of referrals and psychosocial care by care givers. The most revealing picture of the referrals from Frere is that only two cases went back to hospital sources (mainly by way of back referrals) while the majority of cases were destined for non-hospital care. This further emphasises that psychosocial care is essentially community care.

4.4 <u>OBSTACLES TO PSYCHOSOCIAL CARE AND REFERRALS</u>

4.4.1 Lack of knowledge

Some health workers take considerable time to appreciate the psychosocial nature of paediatric problems they are daily confronted with, and in many instances simply equated psychosocial problems

with poverty, thereby adopting an attitude of 'fatal helplessness' since it is assumed very little can be done to immediately alter the patients' economic situation. However the greatest threat to psychosocial care is insufficient knowledge and awareness. The most rampant disorders encountered in the paediatric unit, both physical and psychosocial e.g. acute diarrhoeal diseases, HIV/AIDS, tuberculosis, marasmus and kwashiokor, abandonment, abuse and neglect all depend very little on economic power, but very much on adequate knowledge for their prevention and management. The Head of Paediatrics at Frere revealed for instance that most treatment protocols for children are subsidized, and in instances such as tuberculosis, treatment is actually free. But many parents fail to take these advantages and often will not keep to clinic appointments or take the medications regularly. It has been realised however that the more knowledgeable the parents are (especially mothers), the more likely it is that they will utilize health information.

4.4.2   Information and communication gap

Agencies caring for children with psychosocial disorders are scattered through most parts of East London and the Eastern Cape Province including Association for Rehabilitation of Persons with Disability (REHAB), Child and Family Welfare Society, Down Syndrome Association, Society for the Deaf, Quadriplegic Association, Aid for the Blind, Attention Deficit Hyperactivity Disorder Association, Vocational training centres, sports groups, orthotic / prosthetic assistive devices, etc. But it is quite frequent for a care giver not to know of the availability of these societies within the Province, not to talk of their location. According to an interview respondent: "I know that these organisations caring for disabled children in Eastern Cape do exist. The problem is they are scattered everywhere, I don't know. I have not actually had any contact with any of the organisations caring for handicapped children." Similar views were expressed by others.

Only 14% (Figure 4.8) of patients attending the paediatric unit have any access to telephones in their home or workplace. The implication is that reminders for hospital appointments cannot be sent from hospital, neither can valuable health information be sought or passed on except through physically visiting the hospital or health centre. In the absence of ready transport, this could be quite difficult.

Indeed the worst aspects of being an emergency patient under these circumstances is getting to the hospital. Most interview respondents felt that the ambulance situation is critical. The number of available vehicles is simply inadequate and most emergency calls arrive late. The researcher actually witnessed an emergency scene in which the ambulance was invited but could not arrive even after one hour. Some ambulance drivers who were later interviewed noted that during peak hours (e.g. on Friday evenings) their resources are simply stretched to the limit and they couldn't cope.

4.4.3   Interprofessional harmony

Cohesion among staff in many instances seems to run along disciplinary lines but WHO (1997) envisages an interprofessional cohesion built around the patient. Interviews by the researcher revealed that relationships among different professionals within the organisation can be only fair to poor and ones allegiance is firstly to professional team mates. But medical care demands that in order to achieve the best for the patient, the various professionals need to work together as a team in a less formal atmosphere. This can be achieved by encouraging more joint sessions between the professions in health seminars, courses, meetings and functions. The relationship could become quite fractious with some staff (especially junior staff) taking off on a strike action with disruption of key services. Mutual understanding through negotiation and agreement, employing dialogue, can go a long way in achieving cohesion.

4.4.4   Inadequate psychological intervention

It is quite encouraging that the role of the social worker has been increasingly recognised as reflected in the referrals. Unfortunately a major complaint of most care givers is absence of trained psychologists within the management setup.

Psychologists are needed to offer not only individual psychotherapy but also group therapy. Assessment of level of functioning at admission phase to a care facility or special school requires sound psychological assessment so that progress could reliably be monitored. Equally important is that upon

improvement, adequate assessment is needed before discharging a child. Presence of a disabled child in a family automatically transforms the family into a patient group who need psychotherapy. Though various helping professions practice psychotherapy, they are nevertheless mostly immersed in other aspects of patient care leaving a large vacuum in psychological management. Interviews with staff across the range and observation of care givers revealed they are often stretched to the limits. The overall perception of the psychologist by care givers is first and foremost as an empathic professional, who has the patience to spend long hours listening to the patient and helping them to cope with disease stress; who has long experience handling psychological problems, and whose training has equipped with insight into the nature and dynamics of emotional and behavioural problems. The various perceptions and impressions of the psychologist appear however to be a function of the level of schooling of the respondent. For instance, social workers, speech therapists, audiologists and doctors who had been trained in psychology or psychiatry had no problems identifying their perceived roles of the psychologist; while most supporting staff on the other hand often equated the psychologist with someone trained to 'read people's minds'. All care givers are agreed on the fact that psychologists' input to psychosocial care at present is inadequate. Most would prefer sending children without tangible physical disability to psychologists on a referral basis. Such patients include the mentally retarded, hyperactive, emotionally disturbed, and delinquent.

4.4.5 Training and continuing education

The present level of training and continuing education among care givers could be increased to reach more staff members. Most staff members are eager to increase their knowledge of psychosocial disorders and should be encouraged. In particular, increased emphasis should be placed on training more cadres of community health workers and health visitors, as well as instructing non-medical staff such as teachers on various aspects of psychosocial care.

4.5 KEY REFERRAL DESTINATIONS FROM FRERE HOSPITAL -INSTANCES OF PSYCHOSOCIAL CARE

Featuring very prominently in the referral destination of most Frere patients are the REHAB centre, and the special school for mentally retarded (Table 4.5). The researcher subsequently explored these centres by way of interviews and observing their activities.

4.5.1 REHAB centre, East London

The Association for Rehabilitation of Persons with Disability (REHAB Centre) was founded in 1988 with the financial aid of an individual donor. Its range of activities include running a day care centre for children, an outreach (outpatient) programme in places like Transkei, King Williams Town, Grahamstown and Port Alfred. It is staffed by various professionals including 6 assistants, a physiotherapist, occupational therapist, speech therapist, nursing sister, social worker, house keeper, and instructors on appropriate paper technology (APT). It takes in a whole range of children with varying levels of physical and mental disability including cerebral palsy and mental retardation. It receives a government subsidy of R5.80 per child per day, and hence relies on public donations. The children undergo necessary physiotherapy as part of management, and are involved in appropriate paper technology, making valuable equipment such as chairs and tables out of cardboard. Interviews with staff in this centre revealed that the problems are no different from the hospital setting: lack of staff hinder appropriate referrals. Funds are in short supply and the government subsidy is inadequate to cater for the children. Orthopaedic accessories and equipment for the physically disabled are lacking. Special schools are not adequately available to cater for the mentally retarded. A serious problem is that primary level care is not sufficiently allowed a free hand since certain bureaucratic rules and procedures must be followed to get things done resulting in unnecessary delays, frequently leading to counter productive outcomes.

4.5.2 **Khayalethu Special School, East London**

This school for mentally retarded children (especially the moderately retarded) was founded by government in 1982 with 9 children, but the children population has risen to 120. Qualified teachers, class aid, medical sister and professional nurse, as well as other technical staff cater for the children on a non-boarding basis. The government subsidy of R5.80 per child enables the children to be fed. The referral range to this centre is quite daunting: Some children are malnourished and have been referred here to be fed; some have alcoholic parents who cannot take care of them and for this reason they have been referred; some have serious emotional problems like loss of their parents and are socially withdrawn. Some have communication problems, and yet others have learning problems. Cases of sexual abuse also abound, and some parents being mentally retarded themselves abuse their children on a continual basis.

The staff engage themselves in vital functions such as socialisation exercises through games, songs and stories to stimulate the withdrawn children. Communication exercises including recitations are aimed at those with communication problems. Life skills such as sewing, carpentry, crutcheon, brick making, vegetable garden are taught. The children also participate actively in sports, winning international laurels.

But the school is limited in terms of funds to carry on its activities. Staff are in short supply, with no psychologist to assess the children. Some children in the centre do improve, outgrowing their handicap, and need to go back to normal schools but psychological assessment becomes a problem. Facilities for life skills training are lacking. It makes no sense treating an emotionally disturbed child in the daytime only to return him at night to retarded parents who inflict varying kinds of abuse and trauma all afresh. The school hence has a strong need for a hostel in which to board these children.

CHAPTER 5 - CONCLUSIONS, RECOMMENDATIONS

1. Psychosocial disorders are commonplace in the paediatric unit. These disorders have direct social causation and consequences, and constitute nearly half of the illness burden which the staff have to contend with. Their treatment is essentially psychosocial, with management residing mainly in the community, as well as on environmental resources. It becomes quite necessary therefore that health personnel should be fully aware of the nature of the psychosocial disorders and constantly transmit this information to the parents through communication and education, since prevention is the better cure. The major threats include cerebral palsy and mental retardation, HIV/AIDS and tuberculosis, accidental paraffin and drug poisoning, as well as neglect and abuse of children.

2. Problem with access to health care services is a very serious one, as ambulances and patients' contact telephone are lacking. The records showed that brain damage (hypoxic ischaemic encephalopathy) from non-optimal antenatal and obstetrical care account for most cases of cerebral palsy and mental retardation which are the leading psychosocial disorders. These deficiencies in antenatal and perinatal care do not result from lack of suitably qualified personnel to handle complications, but from lack of prompt access to health facilities (through telephone and ambulances), as well as deficient knowledge. The level of birth asphyxiation goes hand in hand with such problems as low birth weight and high infant mortality, which together constitute measures of health, as well as socio economic development of a community. As a first step in arresting the situation, there is need for massive campaign in the target population on need for regular antenatal care and safe delivery. Ambulance and other measures to improve emergency obstetric care also need acute improvement.

3. The psychosocial referrals are mainly primary level referrals, emanating from private clinics and health centres, from nurses and schools; with referrals from Frere proceeding mainly to schools and special schools, social worker, physiotherapist, orthopaedic / prosthetic centres, and the rehabilitation centre. It is the desire of the primary health care concept that these primary levels

of patient care be encouraged by district, provincial and national health administration, as well as by politicians, as they could form the focus of genuine community development through collaboration with other key sectors.

4.   It is not encouraging that input of trained psychologists is actually the least with respect to psychosocial management of children. Even police officers seem to have more impact than psychologists. Psychology has a primary objective of promoting human welfare (American Psychological Association, 1981; Canadian Psychological Association, 1986). And all staff interviewed at the various centres hold a consensus on the crucial role of psychologists, and actual need for them in patient care. It will require further observation to arrive at the root cause of deficient psychological input. Currently it does seem that most psychologists are concerned with mental health care. There is a need for health psychologists however to support other existing health needs and facilities.

5.   The health services for adolescents need improvement, since currently there is almost non-existent health programme targeted particularly at the adolescents. The proportion of children aged above 15 years from this study, for instance, represented a mere 2% of total, quite below the distribution of this age group in the general population; or even their expected illness rate. It was established that most adolescents and young adults are managed not in the paediatric unit, but in adult wards. However, the pubescent / adolescent stage is a period marked by increased physiological, emotional, behavioural and social problems. These young adults experiment with various phenomenon including alcohol and substance abuse. Serious psychosocial and medical disorders may be quite frequent such as accidents, unwanted teenage pregnancy and sexually transmitted diseases. Equally, the need to assert their independence brings them at conflict with their parents and society, leaving them often quite confused. Hence adolescents need not only adequate psychological counselling services, but also adequately targeted health programmes and medical attention. These facilities - formal adolescent medical services, counselling services, sports and recreational facilities, from the present enquiry are almost non existent. It will be a good policy if all patients aged below 18 years are managed

within the paediatric department, and if necessary steps are taken by health authorities to provide for the psychological and medical needs of adolescents.

6. The various rehabilitation organisations such as Rehabilitation Centre, Association for the Blind, Down Syndrome Association, and the special schools render invaluable services to the community, handling most cases which by their sheer chronicity will be impossible to manage in hospitals. These organisations represent an instance of primary health care action. Their key problems include insufficient funding, lack of accommodation, lack of equipment and life skill accessories, as well as bureaucracies of management which often could hamper their smooth running. In the spirit of primary health care, adequate powers to act in the best interest of children, in the shortest possible time and means need to be delegated to them, with only supervision coming from above.

7. Basic information on the existing rehabilitational and caring agencies are not readily available to health care workers. From interviewing health workers, it became obvious for instance that the average health worker could be quite confused on where to refer an unsupported teenager with unplanned pregnancy. Also while the Rhodes Psychology Clinic, East London, has been existing for a long time, some special schools nearby are unaware and did not make use of their services. Adequate psychosocial care can only thrive where there is adequate information, as very often inputs from such experts like psychologists, social workers, nurses, audiologists and speech therapists are needed. Every effort therefore must be made to articulate the existing information on caring agencies, which must be made available to care givers in very handy forms. Such institutions like Rhodes University and Frere Hospital can take the lead in this regard through organising lectures, seminars and tutorials for the professionals and care givers who stand to benefit.

8. Continuing health education is a prerequisite for adequate understanding and good management of psychosocial disorders. As a participant observer and through interviews, it was clear to the researcher that the ability of a health worker to effectively identify a psychosocial disorder and

their management, and even filling out a health questionnaire was a reflection of their level of training. It will therefore be a step in the right direction to encourage both formal and informal continuing education among staff which in addition serves as a morale booster. Substantial attention must be focussed on primary health care. Equally, multidisciplinary approach is essential, and staff from different disciplines should be encouraged to work together in keeping with primary health care objectives.

9. The literature base on most health care problems and psychosocial disorders in particular is still in the early development phase in the Eastern Cape Province. One of the greatest problems in doing health system related research within the province relates to a poor literature base, as such current references like International Classification of Diseases / DSM series may have to be sought elsewhere outside the province. While the Health Resource Centre, East London, is already doing a marvellous job regarding building a sound literature base, there is every need for expansion, as only very few copies of the vital resources currently exist.

10. The very high profile of cerebral palsy and mental retardation evident from this study may need further exploration, down to the community health post levels to precisely identify the key intervening variables and how the situation can be improved.

REFERENCES

African National Congress (1994). *The reconstruction and development programme - a policy framework.* Johannesburg: Umanyano Publications.

Allwood, C.W. (1997). Psychiatry, mental health and primary health care. In C.W. Allwood & C.A. Gagiano (Eds.), *Handbook of psychiatry for primary care* (pp.26-28). Cape Town: Oxford University Press.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders*, (DSM-IV). Washington: American Psychiatric Association

American Psychological Association (1981).   Ethical Principles for Psychologists. *American Psychologist, 36,* 633-638.

Anderson, A.R. (1995). *Marketing for social change. Changing behaviour to promote health, social development, and the environment.* San Francisco: Jossey-Bass.

Baker, R.L. (1987). *The social work dictionary* (p.137). Maryland: National Association of Social Workers.

Bandura, A. (1992). A social cognitive approach to the exercise of control over AIDS infection. In R. Di Clemente (Ed.), *Adolescents and AIDS: A generation in jeopardy* (pp.89-116). Newbury Park, California: Sage.

Berliner, H. (1985). *A system of scientific medicine.* New York: Tavistock.

Blair, T. (1999). Facing the modern challenge. Available: http://www.fco.gov.uk/news/speech text

Bronfenbrenner, U. (1986).   Ecology of family as context for Human Development: Research Perspective. *Developmental Psychology, 22,* 723-742.

Callahan, D. (1990). *What kind of life: The limits of medical progress* (p.13). New York. Simon & Schuster.

Canadian Psychological Association (1986). *A Canadian Code of Ethics for Psychologists.* Quebec: Canadian Psychological Association.

Cassel, E.J. (1991). *The nature of suffering* (pp.49-51). New York: Oxford University Press.

Charry, D. (1981). *Mental health skills for the clergy: Evaluation, intervention, referral* (p.13). Valley Forge: Judson Press.

Clark, M.S. (1992). *Emotion and social behaviour. Review of personality and social psychology 14*. Newbury Park: Sage.

Cochrane, A.L. (1972). *Effectiveness and Efficiency.* London: Nuffield Provincial Hospital Trust.

Cohen, F. & Lazarus, R. (1983). *Coping and Adaptation in health care and health profession.* New York: Free Press.

Conrad, P. (1997). *The sociology of health and illness: Critical perspectives* (pp.203-205). New York: St. Martins Press.

Conrad, P. & Schneider, J. (1980). *Deviance and medicalisation.* St Louis: Mosby.

Cook, J. (1995). *Psychiatric problems in the primary health care context. A study in the Border-Kei area.* Unpublished M.A. thesis, Rhodes University. Grahamstown.

Coovadia, H.M. & Wittenberg, D.F. (1999). *Paediatrics and child health: A manual for health professionals in the third world (p.3).* Cape Town. Oxford University Press.

Desjarlais, R., Eisenberg, L., Good, B. & Kleinman, A. (1995). *World mental health: Problems and priorities in low income countries.* New York: Oxford University Press.

Dick, B., Spenser, I.W.F., Watermeyer, G.S., Bourne, D.E., Wolfe, P.E. & Moyle, G.D. (1978). Chronic illnesses in non-institutionalised persons: Prevalence and epidemiology. *South African Medical Journal, 52,* 892-904.

Dubos, R. (1960). *Mirage of Health.* London: Allen & Unwin.

Eckman, B. (1986). *Jung, Hegel and the universe (p.95). Dallas: Spring Publications.*

Ehrenreich, B. & English, D. (1976). *Witches, midwives and nurses.* London: Writers and Publishers Press.

Engel, G.L. (1981). The need for a new medical model: A challenge for biomedicine. In A. Caplan, H.T. Englehardt & J.J. Mc Cartney (Eds)., *Concepts of health and disease* (p.591). Reading, Massachusetts: Addison-Wesley.

Ertmer, P.A. (1997). Common qualitative research designs. In P.D. Leedy, *Practical research. Planning and design* (pp.155-172). New Jersey: Prentice Hall.

Eysenck, H.J. & Rachman, S. (1965). *The causes and cure of neurosis* (pp.1-13). London: Routledge & Kegan Paul.

Fishbein, M. & Ajzen, I. (1975). *Belief, attitude, intention and behaviour: An introduction to theory and research.* Reading, MA: Addison-Wesley.

Foucault, M. (1967). *Madness and civilisation.* London: Tavistock.

Gerbner, G. (1977). *Mass media policies in changing cultures.* New York: Wiley.

Gerbner, G., Gross, L., Morgan, M. & Signorelli, N. (1980). The mainstreaming of America: Violence profile No.11. *Journal of Communication, 30*, 10-27.

Giel, R., De Arango, M., Climent, N., Harding, T., Ibrahim, H., Ladrido-Ignacio, L., Murphy, R.S., Salazar, M.C., Wig, N.N. & Younis, Y.O.A. (1981). Childhood mental disorders in primary health care: Results in four developing countries. *Paediatrics, 68*, 677-683.

Glaser, B. & Straus, A. (1967). *The discovery of Grounded Theory.* Chicago. Aldine Press.

Global Summit pledged to better the lot of children. (1990, September, 30). New York Times, p.1.

Green, M. (1983). Coming of age in general Paediatrics. *Paediatrics, 72,* 275.

Green, M. (1985). *The psychosocial aspects of the family* (p.12). Toronto Canada: Johnson & Johnson.

Grant, J. (1983). Foreword. In A. Pappas (Ed.), *Law and the status of the child* (pp. ix - x). New York: United Nations Institute for Training and Research.

Hankin, F. (1931). The Contributions of Sociology to the practice of social work. In *Proceedings of the National Conference of Social Work* (pp.528-535). Chicago: University of Chicago Press.

Hewstone, M. (1983). *Attribution theory: Social and functional extensions* (pp.170-186). Oxford: Blackwell.

Hibbs, E.D. & Jensen, P.S. (1996). *Psychosocial treatment for child and adolescent disorders* (pp.xix-xxi). Washington DC: American Psychological Association.

Hollis, F. (1964). *Casework: A Psychosocial therapy*. New York: Random House.

Holman, H.R. (1983). Qualitative inquiry in medical research. *Journal of Clinical Epidemiology, 46(1)*, 29-36.

Illich, I. (1976). *Limits to medicine*. London: Calder & Boyers.

Illich, I. (1977). *Medical nemesis. The expropriation of health.* New York: Bantam Books.

International Childrens' Rights Monitor. (1983). *Draft convention on the rights of the child* (8-9). New York. International Childrens' Rights Monitor.

Janz, N. & Becker, M. (1984). The health belief model: A decade later. *Health Education Quarterly, 11,* 1-47.

Jennings, B., Callahan, D. & Caplan, A.L. (1988). Ethical challenges of chronic illness. *Supplement to Hastings Centre Report, 18(3)*, 3.

Jones, L. (1998). *Mental health care in Mount Frere. A situational analysis of existing needs, services and resources*. Durban: Health Systems Trust.

Kaeser, A.C. & Cooper, B. (1971). The paediatric patient, the G.P. and outpatient clinic: An operational study. *Psychological medicine 1*, 213-325.

Katzenellenbogen, J.M., Joubert, G. & Yach, D. (1997). *Epidemiology. A manual for South Africa* (pp.169-175). Cape Town: Oxford University Press.

Kibel, M.A. & Wagstaff, C.A. (1997). *Child health for all. A manual for South Africa*. Cape Town: Oxford University Press.

Kincaid, D.L. (1987). *Communication Theory: Eastern and Western perspectives.* New York: Academic Press.

Kleinman, A. (1955). *Writing at the margin: Discourse between anthropology and medicine* (pp.147-172). Berkeley: University of California Press.

Kothari, R. (1984). Communications for alternative development: Towards a paradigm. *Development Dialogue, 1 (2)*, 22.

Kotler, P. & Zaltman, G. (1971). Social marketing: An approach to planned social change. *Journal of Marketing, 33*, 10-15.

Kvale, S. (1996). *Interviews* (pp.59-69). Thousand Oaks: Sage.

Lawson, E. (1991). *Encyclopaedia of human rights.* New York: Taylor & Francis.

Len Ratoff, A.R. & Carole, R.S. (1979). Psychosocial disorders in general practice. *Social Work Today, 5(16)*, 497-500.

Mahlalela, X., Rohde, J. & Bennet, J. (1997). *The status of primary health care services in the Eastern Cape Province*. Dimbaza: Khanyisa.

Manson, S.M. (1994). Culture and depression: Discovering variations in the experience of illness. In W.J. Lonner & R.S. Malpas (Eds.), *Psychology and culture* (pp.285-291). Boston: Allyne and Bacon.

Mauer, K.F. (1987). Leporello is on his knees. *South African Journal of Psychology, 17,* 83-92.

McGuire, W.J. (1989). Theoretical foundations of campaigns. In R.R. Rice & C.K. Atkins (Eds.), *Public communication campaigns.* Newbury Park, California: Sage.

McKeown, T. (1979). *The role of medicine*. Oxford: Blackwell.

McKeown, T. (1988). *The origins of human disease.* Oxford: Blackwell.

Minority Rights Group. (1985). *Children: Rights and Responsibilities.* London: Minority Rights Group.

Moodley, K.F. & Pillay, A. (1993). Two years of admissions to Natal's first in-patient child mental health centre. *South African Medical Journal, 83*, 209-211.

Moon, G. (1996). Health care and society. In G. Moon & R. Gillespie (Eds.), *Society and health* (pp.123-136). New York: Routledge.

Moon, G. & Gillespie, R. (1996). *Society and health.* New York: Routledge.

Navarro, V. (1976). *Medicine under capitalism.* New York: Prodist.

Oakley, A. (1980). *Women confined.* London: Martin Robertson.

Oakley, A. (1993). *Essays on women, medicine and health.* Edinburgh: Edinburgh University Press.

Odejide, A.O., Oyewunmi, L. & Ohaeri, J. (1989). Psychiatry in Africa: An overview. *American Journal of Psychiatry, 146,* 708 - 716.

Pappas, A. (1983). *Law and the status of a child* (p.xxviii). New York: United Nations Institute for Training and Research.

Patton, M.Q. (1989). *Qualitative evaluation methods* (pp.100-107). Beverly Hills: Sage.

Pearson, C.A. (1995). *Medical administration for frontline doctors.* Oxford: Oxford University Press.

Piotrow, P.T., Kincaid, D.L., Rimon, J.G. & Rinehart, W. (1998). *Health Communication* (pp.157-188). Westport, Connecticut: Praeger.

Prochaska, J.O., Di Clemente, C.C. & Norcross, J.C. (1992). In search of how people change: Applications to the addictive behaviours. *American Psychologist, 47(9)*, 1102-1112.

Prugh, D.C. (1983). *The psychosocial aspects of paediatrics*. Philadelphia: Lea & Febiger.

R.S.A. Government Gazette. (1997, April). White Paper for the Transformation of the Health System in South Africa, Vol.382, No.17910.

Ramduny, V., McCoy, D. & Boulle, A. (1998). *Guidelines for development of better communication in health districts.* Durban: Health Systems Trust.

Ransome-Kuti, O. (1995). Foreword. In C.A. Pearson, *Medical administration for frontline doctors*. Oxford: Oxford University Press.

Reason, P. & Rowan, J. (1981). *Human Enquiry. A source book of New Paradigm Research.* Chichester: Wiley & Sons.

Reisser, M.F. (1980). Implications of a biopsychosocial model of research in psychiatry. *Psychosomatic Medicine, 42*, 141.

Robertson, B.A. & Berger, S. (1994). Child psychopathology in South Africa. In A. Dawes & D. Donald (Eds.), *Childhood and adversity: Psychological perspectives from South African research*. Cape Town: David Philip.

Robertson, R. (1996). *Handbook of psychiatry for primary care* (p.13). Oxford University Press.

Rogers, E.M. (1996). The Field of Health Communication Today: An Up To Date Report. *Journal of Health Communications: International Perspectives, 1(1)*, 15-23.

Rogers, E.M. & Kincaid, D.L. (1981). *Communication networks: A paradigm for new research.* New York: Free Press.

Rutter, M. & Smith, D.J. (1995). *Psychosocial disorders in young people. Time trends and their causes* (p.3). Sussex: Wiley.

Ryan, B. & Gross, N.C. (1943). The diffusion of hybrid seed corn in two Iowa communities. *Rural Sociology, 8*, 15-24

Shaul, R. (1993). Foreword. In P. Freire, *Pedagogy of the oppressed* (p.15). Middlesex: Penguin.

Stierling, H., Wynne, L.C. & Wirsching, M. (1983). *Psychosocial intervention in schizophrenia. An international view*. New York: Springer-Verlag.

Straus, A. (1987). Health Policy and Chronic Illness. *Society Nov/Dec*, 34.

Straus, A. & Corbin, J.M.(1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park: Sage.

Thomas, T. (1996). Foreword. In Dept. of Health, *Health care in the Eastern Cape. Implications for planning* (p.i). Durban: Health Systems Trust / Dept. of Health & Welfare.

Turner, F.J. (1978). *Psychosocial therapy* (p.13). New York: Free Press.

Turner, R.M. & Williams, P. (1986). *Psychosocial disorders. Management of common diseases in the family*. Lancaster, England: MTP Press.

Tyrer, P. & Steinberg, D. (1987). *Models for mental disorders*. Chichester: John Wiley & Sons.

UNDP (1994). *Human Development Report* (p.58). New York: UNDP.

UNDP (1996). *Human Development Report* (p.12). New York: UNDP.

UNICEF (1987). *The State of the World's Children*. Oxford: Oxford University Press.

UNICEF (1988). *The State of the World's Children*. Oxford: Oxford University Press.

UNICEF (1991). *The State of the World's Children* (p.53). Oxford: Oxford University Press.

UNICEF (1994) *The 20/20 initiative: Achieving universal access to basic social services for sustainable human development* (p.5). New York. UNICEF.

UNICEF (1996). *The Progress of Nations* (pp.38-40). New York: UNICEF.

UNICEF (1997). *The State of the World's Children.* New York: UNICEF

UNICEF (1998). *The State of the World's Children*. New York: UNICEF.

Van der Burgh, C. (1983). *Views of White, Coloured and Indian South Africans on mental illness and the mentally ill.* Pretoria: HSRC.

Van Rensburg, H.C.J., Fourie, A. & Pretorius, E. (1992). *Health care in South Africa* (pp.95-124). Pretoria: Academia.

Van Vlaenderen, H. (1995). *Participating research for rural development: The use of rapid rural appraisal (RRA) and participatory research approach (PRA).* Unpublished manuscript, Rhodes University, Grahamstown.

Varkevisser, C.M., Pathmanathan, I. & Brownlee, A. (1993). Designing and conducting health systems research project. *HSR Training Series. Volume 2 Part 1: Proposal Development and Fieldwork.* Geneva. WHO.

Williams, P. & Clare, A.W. (1979). *Psychosocial disorders in general practice.* (pp.325-332). New York: Grune & Stratton.

Winnicott, D.W. (1965). *The maturational process and the facilitating environment*. London: Hogarth.

World Health Organisation (1978). *The Declaration of Alma Atta.* Geneva: WHO.

World Health Organisation (1988). *Learning together to work together for health. Report of a WHO study group on multi-professional education for health personnel: The team approach (Technical Report Series, No.769).* Geneva: WHO.

World Health Organisation (1991). *Programme on Health Systems Research and Development. From Research to Decision-making: Case studies on the use of health systems research.* Geneva: WHO.

World Health Organisation (1992). *ICD-10: International Statistical Classification of Diseases and Related Health Problems. Tenth Revision.* Geneva: WHO.

World Health Organisation (1993). *Implementation of the global strategy for health for all by the year 2000. Second evaluation and eighth report on the world health situation. Vol.1: Global review*. Geneva: WHO.

World Health Organisation (1996). *WHO Study Group on Improving Performance of Health Centres in District Health Systems. Technical Report Series 861.* Geneva: WHO.

World Health Organisation (1997). *WHO Study Group on Integration of Health Care Delivery*. Technical Report Series 869. Geneva: WHO.

World Health Organisation (1998). *Health for all in the Twenty first century. (Document A51/5)*. Geneva: WHO.

Appendix 1. Towns And Hospitals In Eastern Cape.

QUESTIONNAIRE : Psychosocial Disorders in Children

Dear Respondent, I am carrying out a study on the above topic in Frere Hospital. Please answer to the best of your ability by ticking T in the boxes provided. All information supplied is strictly for the above study and will be handled with utmost confidentiality.

1. What do you consider the greatest social disease among children in South Africa today.

a. HIV/AIDS	9	i. mental disability	9
b. psychotic disorders (e.g. schizophrenia)	9	j. speech impairment	9
c. malnutrition	9	k. hearing impairment	9
d. child abuse	9	l. sight disorders	9
e. accidents	9	m. drug abuse	9
f. poisoning	9	n. juvenile delinquency	9
g. epilepsy	9	o. unwanted teenage pregnancies	9
h. physical disability	9		

p. others (specify) ....

2. Please rank above disorders according to their frequency of occurrence starting from the commonest to the least frequent

(e.g. e, k, f, ...)   ....

3. In your opinion the psychosocial disorders in children are much more difficult to treat compared to physical ailments such as appendicitis, renal disease, pneumonia, etc.

Yes **9**   No **9**

---

4. Social illnesses consume much more time, personnel, hospital financial and material resources to treat compared to physical diseases.

a. strongly agree **9**

b. agree **9**

c. no difference exists **9**

d. disagree **9**

e. strongly disagree **9**

---

5. When confronted with a child with psychosocial illness, your basic philosophy in managing the patient is directed at providing

a. cure **9**

b. care **9**

c. others (specify) ....

---

6. Which among the following helping professions plays the most crucial role in managing the child with psychosocial disease

a. nurse **9**   f. educators **9**

b. psychologist   **9**   g. dietician/nutritionist   **9**

c. doctor   **9**   h. occupation therapist   **9**

d. social worker   **9**   i. physiotherapist   **9**

e. pastor   **9**

j. others (specify) ....

7. Please rank the above professionals according to their contribution in psychosocial management of children, from most important to least important

(e.g. a, f, g, ...).   ....

8. As a professional, to what extent do you understand the training program and curriculum of other helping professions (i.e. other than your own profession)

a. I have no knowledge of what their training entails   **9**

b. I have very little knowledge of what their training entails   **9**

c. I have good knowledge of their training program   **9**

d. I have detailed knowledge of what their training involves   **9**

e. I have excellent knowledge of their training , and actually   **9**

    trained together with some of them in some instances

9. To what extent do you understand the legal frame work within which the various helping professions (other than your profession) must operate

a. I have no knowledge of their legal frame work   **9**

b. I have a little knowledge of their legal frame work   **9**

c. I have good knowledge of their legal frame work   **9**

d. detailed knowledge   **9**

e. excellent knowledge of their legal frame work and have actually   **9**

   collaborated with them on specific legal issues.

---

10. Regarding the management of children with social ailments. (You may mark more than one box here).

a. doctors must be more involved   **9**

b. doctors must be less involved   **9**

c. greater responsibilities (more than at present) must be delegated   **9**

to professionals other than doctors e.g. nurses, psychologists, etc.   **9**

d. There is at present undue interference in the management of these   **9**

patients by non doctors

e. others (specify)

....

---

11. Generally the relationship between the various helping professions is

a. excellent   **9**

b. good   **9**

c. indeterminate   **9**

d. fair   **9**

e. poor and often marred by inter professional hostility and frustrations **9**

12. (For doctors only)

In my daily working schedule as a doctor I have enough time to adequately address the psychosocial needs of my patients

a. strongly agree	**9**		d. disagree	**9**
b. agree	**9**		e. strongly disagree	**9**
c. can't say	**9**			

13. The main reason why a patient is referred from one health facility to another , or from one professional to another in my experience is

a. failure to respond to treatment   **9**

b. request by patient /relatives to be transferred   **9**

c. need to seek special form of treatment   **9**

d. need to seek specialist opinion/advice   **9**

e. serious social or behavioral disturbances from the patient   **9**

f. others (specify)
....

14. Please rank the above reasons for referral according to their frequency (from most common to least common)

(e.g. b, c, a, ...) ....

15. The present level of communication within the health system (hospitals , special schools, homes for disabled, health boards, professionals etc) is

a. excellent   9   d. poor   9

b. good   9   e. very poor   9

c. fair   9

16. In terms of efficiency, the ambulance system within the Eastern Cape Province could be classified as

a. excellent   9   d. poor   9

b. good   9   e. very poor   9

c. fair   9

17. Basic information especially regarding non hospital institutions where children with social ailments are catered for within Eastern Cape Province could be said to be

a. very adequate   9   d. very poor   9

b. adequate   9   e. non existent 9

c. poor   9

18. Your profession ?

a. physician   9   e. educator   9

b. psychologist   9   f. physiotherapist   9

c. social worker   9   g. pastor   9

d. nurse   **9**   h. occupational therapist   **9**

i. others (specify)   ....

---

19. What types of patients would you definitely refer to the psychologist?

....

---

20. What types of patients would you definitely not refer to the psychologist?

 ....

---

21. What factors would make you think that a patient is a good candidate for referral to a psychologist?

 ....

---

22. What factors would make you think that a patient is not a good candidate for referral to a psychologist?

 ....

---

23. What special skills do you think that psychologists have for assisting in treatment of children with psychological disorders?

 ....

Appendix 3: Schedule for semi-structured interview

1.   When was your organisation founded? By whom?

2.   What range of activities are you involved with?

3.   What is the capacity of your organisation? (Both residential and non residential)

4.   Where is your catchment area?

5.   What is your staff strength and specialities?

6.   What types of cases do you attend to?

7.   How rampant are psychosocial disorders of children within your unit?

8.   What do you perceive to be psychosocial childhood problems?

9.   How do you think psychosocial problems should be managed?

10.   What are the greatest stimulations you have in continuing this work?

11.   What are the special problems and areas of need in your organisation?

12.   How is your organisation funded?

13.   How often do you make or receive referrals?

14.   What are the inter professional relations like both within your organisation and with other agencies?

15.   Is the communication level within the health sector adequate?

16.   Is health information readily available?

17.   Is your unit involved with any educational, training or mass campaign programme?

18.   Do you consider psychological practices central to your organisation?

19.   What types of patients do you refer to the psychologist?

20.   What special skills do you think psychologists have?

Appendix 4: Data Capture Proforma

Diagnosis ICD-10 category)	Ref.	Age at first diagnosis	Gender	Home language	Residential address	Referrals		Therapies	Tel. No.
						Source	Destination		