

A

GUIDE FOR

BACHELOR OF SCIENCE (NURSING)

LICENSING EXAMINATION

PAPER IV

- UNIT 1 : MENTAL HEALTH AND PSYCHIATRIC
NURSING**
- UNIT 2 : SOCIOLOGY AND ANTHROPOLOGY**
- UNIT 3 : RESEARCH IN NURSING**
- UNIT 4 : MANAGEMENT**
- UNIT 5 : TEACHING AND LEARNING
METHODOLOGIES**

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PAPER IV

TABLE OF CONTENTS

UNIT ONE: MENTAL HEALTH AND PSYCHIATRIC NURSING..... 3

UNIT TWO: SOCIOLOGY AND ANTHROPOLOGY 43

UNIT 3: RESEARCH IN NURSING..... 76

UNIT 4: MANAGEMENT 114

UNIT FIVE: TEACHING AND LEARNING METHODOLOGIES..... 150

UNIT ONE: MENTAL HEALTH AND PSYCHIATRIC NURSING

In this unit you will look at the basic concepts of mental health and illness, also covered is the process of admitting and discharging patients who are mentally ill. Additionally you will look at how mental health conditions are treated and managed, and community health services in the community.

This knowledge, and these skills and attitudes will help you to manage patients having psychosocial problems.

This unit is composed of five sections:

Section One: Concepts, Principles and Theories of Mental Health and Psychiatric Nursing.
Section Two: Admission and Discharge Procedures of Mentally Sick Patients.
Section Three: Treatment Used in the Management of Mentally Ill Patients.
Section Four: Management of Common Mental Health Conditions.
Section Five: Community Mental Health.

Unit Objectives

By the end of this unit you will be able to:

- Describe mental health and psychiatric nursing
- State the admission process for the mentally ill patient
- Describe the modes of treatment used in psychiatry
- Recognise and manage common mental health conditions
- Describe community mental health

SECTION 1: CONCEPTS, PRINCIPLES AND THEORIES OF MENTAL HEALTH AND PSYCHIATRIC NURSING

Introduction

This section looks at the basic concepts of mental health and mental illness.

Objectives

By the end of this section you will be able to:

- Describe the concepts of mental health and mental illness
- Describe at least two theories of personality development
- Explain aetiological factors for mental illness
- Classify mental illness

- State factors that influence attitude towards mental illness
- Explain principles of psychiatric nursing
- Describe trends in psychiatric nursing

Concepts of Mental Health and Mental Illness

What is meant by the term 'mental health'?

Mental health is defined as the simultaneous success at working, loving, and creating with the capacity for mature and flexible resolution of conflicts between instincts, conscience, other people and reality (Evelyn and Wasili, 1986).

According to the World Health Organisation (WHO), mental health is a state of emotional well-being which enables one to function comfortably within society and to be satisfied with one's

own achievements.

Mental health also refers to the ability of the individual to carry out their social role and to be able to adapt to their environment (Johnson, 1997).

What do you understand by the term 'mental illness'?

A mental illness is defined as a disorder with psychological or behavioural manifestations and/or impairment of functioning due to a social, psychological, genetic, physical, chemical or biological disturbance (Evelyn and Wasili, 1986). A mentally ill person may have at least one of the following characteristics:

- Being dissatisfied with one's abilities and accomplishments
- Having ineffective or unsatisfying interpersonal relationships
- Dissatisfaction with one's place in the world
- Having ineffective coping/adaptation mechanisms and lacking personal growth

According to world health organization (WHO) mental health is a state of emotional well-being which enables one to function comfortably within society and to be satisfied with one's own achievements. **True** or **False**

Theories of Personality Development

For one said to be healthy, normal growth and development must have taken place. To assist in looking at

growth and development, you are going to look at the two main theories of personality development.

These are:

- Psychoanalytic theory by Sigmund Freud
- Social learning theory by Erik Erickson

You will now look at each of these theories in turn.

Psychoanalytic Theory

This theory will help you understand psychopathology and stress related behaviour. It will also help you explore human behaviour instead of taking behaviour at face value. The psychoanalytic theory makes several assumptions.

The theory posits that all human behaviour is determined by earlier life events and that human behaviour is driven by energy known as libido. It is also argued that people function at three levels

of awareness:

- Conscious level where immediate events and perceptions are stored
- Pre-conscious level where thoughts and feelings are not accessible with ease
- Unconscious level where material is not accessible most of the time

According to the proponents of psychoanalysis, people develop through five stages:

Stage	Age	Focus or Interests
Oral	0 - 1	Focus on mouth, teeth and gums
Anal	1 - 3	Focus on control and self-control (primarily toilet training and defecation)
Phallic	3 - 6	Focus on genital stimulation and gender differentiation
Latency	7 - 11	Energy focused on non-sensual activity
Genital	12+	Development of mature sexual interests

One: Birth to 1 year

Oral phase, where sexual satisfaction is obtained through the mouth by actions of sucking or biting.

Two: 1 year to 3 years

Anal phase, where sexual satisfaction is obtained through the anus.

Three: 3 years to 6 years

Phallic phase, during which interest in the genitalia is developed and the individual acquires gender roles.

Four: 7 years to 11 years

Latent phase, where there is no sexual interest, this divides boys and girls into different groups.

Five: 12 years and onwards

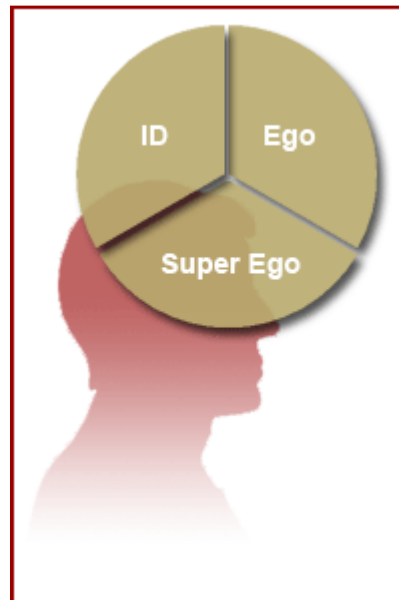
Genital phase, when the capacity for objective and mature sex is developed.

According to this theory, the human personality is made up of three hypothetical structures:

Id: The id is the most primitive and is driven by impulses. It demands immediate gratification of the needs.

Super Ego: The super ego, whose main function is to oppose the id. It contains values, legal, moral regulations, and social expectations.

Ego: The ego, which unlike the id, is in contact with reality. It is able to delay the satisfaction of a need until an appropriate time, place, or object is available. It mediates between the id and the super ego.



Social Learning Theory

Erikson postulated eight human developmental stages which one has to go through in normal life. He called them psychosocial stages. Each stage is characterised by tasks or ego qualities, which one has to develop in normal life. You will now examine one stage at a time.

Trust versus Mistrust

This is attained during infancy. Trust is developed when the mother breastfeeds the infant as well as meeting other needs of the infant such as changing wet diapers. The approximate age at which the individual goes through this stage is 0 - 18 months.

Autonomy versus Shame and Doubt

During this period the child wants some independence from the mother. This happens approximately at the age of 18 months to 3 years and this period is referred to as toddlerhood.

Initiative versus Guilt

This occurs at approximately 3 to 6 years, otherwise known as the pre-school years. The child is able to initiate action on its own in an effort to manipulate the environment.

Industry versus Inferiority

This takes place during school years between the ages of 6 to 12 years. The child is able to acquire skills in sports, calculate in figures and language skills are well developed.

Identity versus Role Confusion

This occurs around the age of 12 to 20 years and is referred to as adolescence. During this time an individual acquires an identity as a male or female corresponding to specific roles in the society.

Intimacy versus Isolation

This occurs at an approximate age of between 20 to 40 years. Here, one has productive work and has satisfactory sexual relations with an intimate member of the opposite sex.

Generativity versus Stagnation

This usually occurs between the ages of 45 to 65 years. During this period, one is involved in establishing and guiding the next generation. Productivity and creativity is at its peak.

Integrity versus Despair

This refers to the phase from around the age of 65 till death. During this time one develops new and different love for one's parents. One also develops emotional integration and is able to defend the dignity of one's own life-style against threat. The individual is capable of fellowship and will often take leadership responsibilities in the community.

It is worth noting that, it is only after satisfactory completion of one stage that one is ready to move to the next. Any person who is unable to go through one stage successfully would experience difficulties in subsequent stages of human development. For further details, please refer to psychology in module one.

Social Learning Theory

Using Erikson's theory, how would you counsel a couple whose only child has developmental problems during the adolescent period?

You should help the couple to assist their child to acquire acceptable social roles. You should also tell them how to guide their child to accept body changes and be able to socialise with age mates of both sexes. For more information, you can refer to your notes on the stage of identity versus role confusion.

Aetiological Factors of Mental Illness

You should now be familiar with the concepts of mental health. You will now look at the components of psychiatric nursing, starting with the factors of mental illness.

The causes of mental illness can be classified into three categories:

Predisposing Factors

These factors determine the likelihood of one getting a mental illness. Usually they are adverse experiences one undergoes in early life. They include physical, psychological and social factors in infancy and early childhood.

Precipitating Factors

These are events that take place shortly before the onset of a disorder. Physical precipitants include cerebral tumours, malaria or drug abuse. Social and psychological precipitants include misfortunes such as loss of a job, losing a loved person, or sudden change in routine activities.

Perpetuating Factors

Once the disorder has been triggered, these factors do prolong the course of the disease. They are secondary in nature since they may appear long after the original predisposing factors have been treated. Examples include secondary demoralisation and withdrawal from social activities.

Classification of Mental Disorders

There are two major classifications of mental disorders used internationally.

These are:

- International Classification of Diseases (ICD)
- Diagnostic and Statistical Manual (DSM)

The ICD is the WHO system of classification, currently in its 10th edition, commonly referred to as ICD 10. The DSM classification is the American Psychiatric Association system, currently in the 4th edition and commonly referred to as DSM IV. For our learning purposes here, this module will use the WHO classification.

The rationale and other details relating to these classifications are beyond the scope of this module. Please find a copy and refer for details to the ICD 10 and DSM IV manuals, which are easily available in WHO and medical training college libraries.

Introducing ICD 10

ICD10 is classified in the following manner.

F0	Organic, including symptomatic mental disorders.
F1	Mental and behaviour disorders due to psychoactive substance use.
F2	Schizophrenia, schizotypal and delusional disorders.
F3	Mood (affective) disorders.
F4	Neurotic, stress related and somatoform disorders.
F5	Behavioural syndromes associated with physiological disturbances and physical factors.
F6	Disorders of adult personality and behaviour.
F7	Mental retardation.
F8	Disorders of psychological development.
F9	Behavioural and emotional disorders with onset usually occurring in childhood or adolescence.

The main aims of the ICD 10 working party, when they drew up the classification system, were that they would create a system that:

- Was suitable for international communication on statistics of morbidity and mortality
- Provides a reference for national and other psychiatric classifications
- Is acceptable and useful in research and clinical work
- Contributes to education

To achieve these aims, the classification also had to be acceptable to a wide range of users in different cultures. It had to be practical in that it would be simple to use and easy to translate into different languages.

Factors that Influence Attitudes towards Mental Health and Mental Illness

Having outlined the classification of mental illness, you will now turn your attention to the factors that influence attitudes towards mental health and mental illness. In this section, you are going to look at just a few examples.

Culture

The way people think, behave or feel is shaped by their culture. Culture also determines the features of insanity, for example, who is labelled as insane and under what circumstances.

What is considered insane in one culture may be considered perfectly normal in another. Culture also gives guidelines on the nature of treatment and the identity of the helper.

Education

The level of education also influences attitudes towards mental health and mental illness.

An educated person has a better understanding of health and mental illness, thus making their attitude more positive.

Health Beliefs

These will determine whether the individual's attitude is positive or negative. It will depend on how the patient explains the illness to themselves, that is, whether they believe in germ theory, evil spirits or an imbalance of some kind.

Religion

A patient's reaction to mental illness will often depend on whether or not the patient believes in God or a particular religion, for example, some religions believe that ill health is caused by evil spirits. Usually, religion encourages the followers to be empathetic to sick people.

Principles and Qualities of Psychiatric Nursing

Having looked at the factors that influence attitudes towards mental health and mental illness, you will now look at the principles of psychiatric nursing and various ways of assisting the patient to overcome the prevailing problems.

Respect for the Patient

This is achieved by accepting the patient as they are.

The therapist should take time to listen to the patient and provide privacy for all conversations. Minimise situations and experiences that might humiliate the patient and be honest in providing information on medicines, privileges, length of management and stays in hospital if indicated.

Availability

The nurse must be constantly available to assist the patient to attain their basic needs and alleviate suffering.

Spontaneity

You should avoid being overly formal. Instead, you should be comfortable with yourself, be flexible and aware of the therapeutic goals.

Acceptance

Even if the patient behaves in a way that does not please the nurse, they should be accepted as they are, but taking care not to reinforce their behaviour.

Sensitivity

You should do your best to show genuine interest and concern. You should be persistent and patient even if no observable improvement is made.

Accountability

Since mentally ill patients are vulnerable due to their distorted thinking and behaviour, accountability is required more in a psychiatric setting than any other type of health care (Peplau, cited by Wilson and Kneisl, 1988). You are also accountable to yourself as well as professional colleagues and peers.

Empathy

This is the process of putting yourself in another's shoes and remaining emotionally detached. The nurse should strive to understand the patient's perspective, and work toward mutually developed goals.

The most important function of empathy is that it enables you to give the patient the feeling of being understood and cared about.

Self-understanding

This involves recognition and acceptance of your own behaviour and how it affects your relationship with other people.

This will inevitably help you, as a therapist, to understand other peoples' behaviour, needs and problems.

Permissiveness and Firmness

Although you have been told to accept the patient as they are, this does not mean that you are in a position to allow them to do whatever they like. The therapist is expected to set limits and to be firm in implementing them.

Skill in Observation

It is important for a psychiatric nurse to be alert and observant at all times of the patient's behaviour, attitudes and how they react to staff, relatives and fellow patients.

Historical Trends in Psychiatric Nursing

Psychiatric nursing, and the understanding of mental illness, with which it associates, has developed in several epochs through the centuries. You will now look at each of those epochs in more detail.

Demonological Period

The earliest records of a person believed to have suffered from mental illness relate to King Nebuchadnezzar, who ate grass believing that he was an ox. Another example is Ajax, who impaled himself on a sword believing that he was tormented by demons.

During that time people believed that the cause of mental illness was demons. The treatment was quite harsh, degrading and dehumanising and involved beating, chaining, locking the individual up in a dark room and throwing the individual into rivers and ponds.

Those patients who escaped this harsh treatment survived on stealing food or eating wild fruits. Wild animals ate up those who inadvertently wandered into the forest.

Political Period

This period is associated with King Edward II of England.

During that time, a law was passed in the parliament to protect the property of the mentally sick. In the year 1403, the Sisters of the Order of Saint Mary managed to start a facility to care for the mentally sick at Bedlam. The facility was able to accommodate six patients only. Thereafter, other hospitals followed the example.

The cause of mental illness, however, was still thought to be demons. The treatment, therefore, remained more or less as in the demonological period. Facilities were often dark, humid and infested with lice. They were also overcrowded, leading to mass deaths during outbreaks of disease such as the plague.

In the early 18th century, the first qualified nurse was appointed to look after the mentally ill by Edward Tyson. However, although qualified, the nurses appointed to look after the mentally sick were equally harsh to patients.

Men and women were housed together and members of the public used to visit these facilities as a form of entertainment. It was at St. Luke's hospital in London where this form of entertainment was eventually banned. In order to enforce the policy, members of the public were only allowed to see the mentally ill in the presence of an attendant after being issued with a ticket.

Humanitarian Period

During this period, reforms of the patient care system for the mentally ill began in France, followed by Britain and later America.

Reform in France started in 1793 at Bicetre Hospital in Paris. Dr. Philippe Pinel unchained a group of patients who had been in chains for 30 years. He advocated kindness for mentally sick persons, and as a result there was a marked improvement in mentally sick patients.

William Tuke started reforms in Britain in 1796. He advocated humane treatment of the mentally sick. In addition, he introduced what we today call 'occupational therapy'. Men were involved in gardening while women were involved in sewing. Both men and women assisted attendants in their daily work activities. It is worth noting that so far, members of staff were not specifically trained to deal with mental health issues. In 1808, a bill was passed to regulate the treatment of mental health patients.

In America, Dorothea Lynda Dix introduced reforms after visiting Britain and seeing how mentally sick persons were improving after getting reformed type of management. In 1841, she managed to have a bill passed in parliament to regulate the treatment of the mentally sick in America.

In 1853, Dr. W.A.F. Browne started giving informal mental health lectures to nurses so as to give quality care.

By 1882, formal training on mental health had begun in America at McLean Hospital, Boston.

In 1884, formal training in mental health was started in Germany and thereafter other countries followed that example.

The Scientific Period

The scientific period is associated with the 19th Century. During that period science was devoted to developing modern treatments that were based on scientific findings. Many forms of treatments were discovered and later abandoned like hydrotherapy, insulin therapy and leucotomy.

The current forms of treatments include physical treatment like chemotherapy and electroconvulsive therapy.

There are also various psychological treatments, which include:

- Individual/group psychotherapy
- Behaviour therapy
- Occupational therapy
- Rehabilitation
- Cognitive therapy
- Counselling

Some of these treatments will be covered in more detail in section two of this unit

The scientific period witnessed the integration of mental health services with other health services. Trained manpower was developed to care for the mentally sick.

Men and women were either managed separately or in the same wards, depending on the policy of the particular hospital.

Children were managed in special wards. Where resources were available, different mental health conditions were managed in different units

Development of Psychiatry and Mental Health Services in Kenya

The current Mathari hospital was started in July 1910 as a lunatic asylum. Before then, the facility served as a smallpox isolation centre. The asylum was renamed Mathari Mental Hospital in 1924. The care was mainly custodial, taking place in dark, gloomy and often damp conditions.

Europeans, Africans, and Asians were managed separately and the quality of mental health care provided depended on the individual's racial background.

Mathari was the only mental hospital until the 1962 Decentralisation of Mental Health Services Act. Other facilities began to spring up, including a 22 bed psychiatric unit in Nakuru in 1962, Machakos in 1963, Nyeri and Muranga in 1964 and Port Reitz and Kakamega in 1965.

Currently all provincial hospitals have operational psychiatric units. However, only some district hospitals have operational psychiatric units. Outpatient psychiatric clinics have been established in most of the district hospitals.

Mathari hospital is being redeveloped, and the future plan is to intensify community based psychiatric services all over the country. It is

worth noting that community psychiatric services were established in Nairobi in 1983.

Training of Mental Health Workers

The training of enrolled psychiatric nurses was started in 1961 and later changed to a post enrolled psychiatric nursing course. In 1963, the first two registered psychiatric nurses were trained overseas.

In 1979, a post basic diploma in psychiatric nursing was started in Kenya. Between 1972 and 1982 most psychiatrists received overseas training at the Institute of Psychiatry in England.

In 1982, the University of Nairobi started training psychiatrists.

SECTION 2: ADMISSION AND DISCHARGE PROCEDURES OF MENTALLY SICK PATIENTS

Introduction

In this section, you will need to use the knowledge you gained on the classification of mental disorders.

You will look closely at the admission and discharge procedure of mentally sick persons using the Mental Health Act.

Objectives

At the end of this section you will be able to:

- Apply the knowledge acquired on legal aspects in admission and discharge of patients
- Demonstrate skills in history taking

Mental Health Act (Cap 248) and Legal Application

The Mental Health Act is an act of parliament to amend and consolidate the law relating to the care of persons who are suffering from mental disorders, or mental sub-normality with mental disorder, for the custody of these persons, management of their properties, management and control of a mental hospital and for custodial purposes.

The act provides for the procedures to be followed for reception into a mental hospital. It also stipulates that no person shall be received or detained for treatment in a mental hospital, unless they have been received and detained under this act or under criminal procedure code.

Kenyan Board of Mental Health

The act also provides for the establishment of a board, that is, the Kenya board of mental health for

the purposes of administering this act.

The members of the Kenya board of mental health include:

- Chairman, who can be the Director of Medical Services (DMS) or the Deputy Director of Medical Services and is appointed by the minister.
- Psychiatrist (medical practitioner) appointed by the minister.
- One clinical officer with training and experience in mental health care appointed by the minister.

- One psychiatric nurse with experience in mental health care, appointed by the minister.
- The commissioner of social services or their nominee appointed by the minister.
- Director of education or their nominee appointed by the minister.
- A representative from each province in Kenya, being resident in the provinces, appointed by the minister.

The board may co-opt any person whose skills, knowledge or experience may be useful. It may also establish a committee for better function and regulate its own procedure.

The functions of the Board are under the control and direction of the minister for health.

They include:

- To coordinate mental health activities in Kenya.
- To advise the government on the state of mental health and mental health care facilities in Kenya.
- To inspect mental health care hospitals to ensure that they meet the prescribed standards.
- To approve the establishment of mental health care hospitals.
- To assist when necessary in the administration of mental health hospitals.
- To receive and investigate any matters referred to it by a patient or relative of a patient concerning the treatment of the patient at a mental health hospital and, where necessary, to take or recommend to the minister any remedial action.
- To advise the government on the care of the persons suffering from mental sub-normality without mental disorder.
- To initiate and organise community or family based programmes for the care of persons suffering from mental disorder, and to perform such other functions as may be placed upon it by this act or under the law.

Sections of the Mental Health Act

Part V - Voluntary Patients (Section 10)

Any person who has attained the apparent age of sixteen years, decides to voluntarily submit himself to treatment for mental disorder, and who makes to the 'person in charge' a written

application in duplicate in the form prescribed, may be perceived as a voluntary patient into a mental hospital.

The person fills in a form MOH 613, in duplicate provided for in the first schedule to these regulations before admitting them to the institution as an in-patient. This indicates that the admission is at their own request.

Any person who has not attained the apparent age of sixteen years and whose parent or guardian desires to submit them for treatment for mental disorder, may if the guardian or parent makes to the 'person in charge' of a mental institution, a written application in duplicate in the prescribed forms, be perceived as a voluntary patient. In such cases forms MOH 637 in duplicate should be filled and signed by the guardian or the parent.

Part VI - Involuntary Patients (Section 14 M.H.A)

Involuntary patients are those who are incapable of expressing themselves as willing or unwilling to receive treatment. They require the forms MOH 614 to be filled in duplicate by the husband, wife or relative of the patient, indicating the reasons why they are applying for admission.

Any person applying on behalf of another person should state the reasons why a relative could not make the application and specify their connection with the patient.

The patient is admitted for a period of not more than six months. The 'person in charge' can prolong this period by six more months provided the total period does not exceed twelve months. An MOH 615 form should be filled by the doctor indicating why he thinks that the patient can benefit from the treatment. They should write down their own name, qualifications, date and then sign the forms.

Both the MOH 614 and MOH 615 forms must reach the hospital within 14 days of the date they were signed, otherwise they become invalid.

Part VII - Emergency Admissions (Section 1b M.H.A)

A police officer, chief or assistant chief can arrest any person who is found to be dangerous to himself or others, and take them to a mental hospital for treatment within 24 hours or a reasonable time. The patient should be reviewed after 72 hours and can be discharged if found to be of sound mind. If found to be of unsound mind, the patient may be admitted for treatment

as an involuntary patient. For the purposes of admission, the form MOH 638 must be filled in by the police officer or an administrative officer.

Part VIII - Admission and Discharge of Members of the Armed Forces (Section 17 M.H.A)

Any member of the armed forces may be admitted into a mental hospital for observation, if a medical officer of the armed forces, by letter addressed to the 'person in charge', and certifies that:

- The member of the armed forces has been examined within a period of 48 hours before issuing the letter
- For reasons recorded in the letter, the member of the armed forces is a proper person to be admitted to a mental hospital for observation and treatment

A member of the armed forces may be admitted under section 17 for an initial period of 28 days from the date of admission, that period may be extended if, at or before the end of 28 days, two medical practitioners, one of whom shall be a psychiatrist, recommend the extension after re-examining the patient.

The said patient can be discharged if two medical practitioners, one of whom is a psychiatrist, by a letter addressed to the 'person in charge', certifying that they have examined the member of the armed forces within a period of 72 hours before issuing the letter.

Where any member of the armed forces suffers from mental illness whilst away from his armed forces unit and is under any circumstance, admitted into a mental hospital, the 'person in charge' shall inform the nearest armed forces unit directly, or through an administrative officer or gazetted police officer.

If a member of the armed forces is admitted to a mental hospital they cease to be a member of the armed forces, the 'person in charge' shall be informed of that fact and the patient shall be declared an involuntary patient under part VI (section 14) with effect from the date the information is received.

Part IX - Admission of a Patient from Foreign Countries (Section 18 M.H.A)

According to this section of the act:

- No person suffering from mental disorder shall be admitted into a mental hospital in Kenya from any state outside Kenya except under Part IX of M.H.A.
- This part will not apply to individuals ordinarily resident in Kenya.

- (Section 19 M.H.A) Where it is necessary to admit a person suffering from mental disorder from any foreign country into any mental hospital in Kenya for observation, the government or other relevant authority in that country shall apply in writing to the mental health board to approve the admission, no mental hospital shall receive a person suffering mental disorders from a foreign country without the board's written approval.
- The application for the board's approval under subsection (1) shall indicate that the person whom it relates to has been legally detained in the foreign country for a period not exceeding two months under the law in that country, relating to the detention and treatment of persons suffering from mental disorder, and their admission into mental hospital in Kenya has been found necessary.
- No person shall be admitted under this section unless they are accompanied by a warrant or other documents together with the board's approval under subsection (2) shall be sufficient authority for their conveyance to admission and treatment in the mental hospital to which the board's approval relates.

According to this section of the act:

- On the admission of a person into a mental hospital under this section, not being a person transferred to the mental hospital under section 23, the 'person in charge' shall within 72 hours or such longer period as the board may approve (i) Examine the person or cause the person to be examined to determine the extent of the mental disorder and the nature of treatment and (ii) Within that period forward to the Board a report on the findings, together with the warrant or other document from the foreign country concerned accompanying the patient/person.
- A person shall not be detained in a mental hospital under this section for a period longer than two months from the date of admission to the mental hospital unless the board, on application in the prescribed forms by the 'person in charge', approves.

Part X – Discharge and Transfer of Patients (Section 21 and 22 of M.H.A)

The 'person in charge' of a mental hospital may, by order in writing, and upon the recommendation of the medical practitioner in charge of any person's treatment in the mental hospital, recommend discharge and that person shall thereupon be discharged as having recovered from mental disorder, provided that:

- An order shall not be made under this section for a person who is detained under criminal procedure Cap 75.
- This section shall not prejudice the board's powers under section 15 of M.H.A.

Section 15 provides that:

Where any person has been received into a mental hospital under part V and part VI (voluntary and involuntary mode of admission), the board may at any time order that the person shall be discharged or otherwise dealt with under this act.

Section 22: Order for delivery of patient into care of relative of friend.

- If any relative or friend of a person admitted into any mental hospital under this act desires to take the person into their custody and care, they may apply to the 'person in charge' who may, subject to subsection (2), order that the person be delivered into the custody and care of the relative or friend upon such terms and conditions to be complied with by the relative or friend.
- In the exercise of their powers subsection (1) the person in charge shall consult with the medical practitioner in charge of the person's treatment in the mental hospital and the board on the relevant district mental health council, which is performing the board's functions under section 7, subsection (1).

Part XIV – Offences under MHA

Section 47:

It is an offence for a person other than medical practitioner to sign certificates.

Section 48:

Any medical practitioner who knowingly, wilfully or recklessly certifies anything in a certificate made under this act, which they know to be untrue, shall be guilty of an offence.

Section 49:

It is an offence for any person to assist the escape of any person suffering from mental disorder being conveyed to or from, or while under care and treatment in a mental hospital. It is also an offence to harbour any person suffering from mental disorder that they know have escaped from a mental hospital.

Section 50:

It is an offence for any person in charge of or any person employed at a mental hospital to unlawfully permit a patient to leave such a hospital.

Section 51:

Any person in charge of, or any person employed at a mental hospital that strikes, ill-treats, abuses or wilfully neglects any patient in the mental hospital, shall be guilty of an offence.

Section 52:

Any person who without the consent of a 'person in charge' gives, sells or barter any articles or commodities of any kind, to any patient in a mental hospital, whether inside or outside the grounds of the mental hospital, shall be guilty of an offence.

Section 53:

General Penalty: Any person who is guilty of an offence under this act, or who contravenes any of the provisions of this act or any regulations made under this act, shall where no other penalty is provided, be liable on conviction to a fine not exceeding Ksh 10,000. or to imprisonment not exceeding twelve months or both.

History Taking

History taking from a mentally ill person or their relatives will assist you to make a nursing diagnosis and to give holistic care to

the patient. You are now going to look at all the steps involved in history taking.

Personal Data

Here you ask for information pertaining to age, sex, marital status, occupation, residence and nationality.

Personal History

Ask the patient questions relating to their mode of delivery, as well as milestones in infancy and early childhood.

You may ask the patient when they started school and their educational performance as well as about possible incidents of traumatic experience like falling or losing a parent.

Social History

You should try to find out about the nature of the patient's occupation, how they relate to both sexes, whether they are outgoing or not, the number of friends the patient has of both sexes and whether or not the patient is involved in religious activities.

Sexual History

In taking down this information, you are aiming to check the degree of sexual satisfaction with the marriage partner, male or female friend, frequency of sexual relationships and the patient's attitude to sex.

Family History

Ask the patient about their parents, brothers and sisters. For each one of them you are trying to find out whether they are married, occupation etc.

in an attempt to identify possible family behavioural patterns.

If the patient is married, try and find out the sibling line up of the patient's spouse as well.

Past Medical and Psychiatric History

By taking down the patient's medical history, you are in a position to find out about any medical conditions the patient has suffered, which may have affected their mental health.

You should also try and find out if there have been any incidences of the patient being

admitted into a mental unit/hospital and the outcome of the treatment.

History of Presenting Illness

Ask the patient about the onset of the illness, duration, any allegations that brought them to the mental hospital and the patient's pre-morbid history, that is, how they presented before they became mentally ill.

Remember:

In an outpatient clinic, this information is better taken first, since the patient or the informant would like to talk about it straight away.

Mental Status Assessment

Check facial expressions to provide information about mood, orientation to time, place, person, concentration and perceptual disorder, where you should check for the following senses:

- Olfactory
- Auditory
- Tactile
- Visual
- Gustatory

Thought Content

When checking the thought content, you should be on the lookout for grandiose or persecutory delusions, delusions of worthlessness or of preference and thought insertion and thought broadcasting.

Memory

Pay attention to immediate memory (min/hrs), recent memory (days, weeks, months) and past or remote memory (10 years and above).

Mood

Try and evaluate whether the patient is manic, depressed, labile or flat.

You should also try and establish the patient's judgment, by checking for signs of logical thinking. In addition, you should look into whether or not the patient has 'insight', that is, whether or not they are aware of their mental illness.

Physical Examination

Conduct a general examination, checking for scars, deformity and number of teeth not in place.

Also check vital signs of temperature, pulse, respiration and blood pressure.

After conducting all these checks you should be able to make a provisional nursing diagnosis and draw up a plan of care using the nursing process.

SECTION 3: TREATMENT USED IN THE MANAGEMENT OF MENTALLY ILL PERSONS

Introduction

In this section you will look at indications, effects, side effects and contraindications of various drugs used in the management of mentally ill patients. These drugs fall under the categories of tranquillisers, antidepressants, anti-anxiety and antiparkinsonian drugs.

Also you will cover psychological treatment, psychotherapy, behaviour therapy and rehabilitation.

Objectives

At the end of this section you will be able to describe treatments under the following headings:

- Drugs and other physical treatments
- Psychological treatments

Drugs and Other Physical Treatments

There are various types of drugs and other physical treatments used to treat patients suffering from mental health illness.

These can be grouped together under the following categories:

- Antipsychotic Medication
- Antidepressant
- Anxiolytics or Anti-anxiety Drugs
- Antiparkinsonian Drugs
- Electroconvulsive Therapy (ECT)

You will now look at each of these categories in turn.

Antipsychotic Medication

Antipsychotic drugs are also called major tranquillisers or neuroleptics used in the treatment of psychoses like schizophrenia, bipolar disorders (manic phase) and alcohol withdrawal disorder.

Antipsychotic Drugs

Generic Name	Trade Name	Daily Doses (range)
Low Potency Drugs		
Chlorpromazine	Largactil	300-1000mgs
Sulpride	Domatil,Sulparex	200-2400mg
Thioridazine	Melleril	50-800mg
High Potency Drugs		
Haloperidol	Haldol,Serenace	1-20mg
Thiothixene	Navane	6-60mgs
Zoxapine	Loxitane	60-250mgs
Molindone	Lidone	50-400mgs
Flupenthixol	Depixol	6-18mg
Fluphenazine	Moditen	2.5-20mg
Trifluoperazine	Stelazine	5-30mg
Zuclopenthixol	Clopixol	20-150mg
Pimozide	Orap	2-10mg
Depot Injections		
Fluphenazine decanoate	Modecate	12.5-100mg(IM 2 Weekly)
Zuclopenthixol Acetate	Clopixol Acuphase	50-150mg every 2-3 days
Haloperidol decanoate	Haldol decanoate	50-300mg (IM 4 weekly)

Mechanisms of Action

The drugs are thought to work by blocking dopamine receptors causing a decrease in psychotic symptoms. The drug is metabolised in the liver and excreted by the kidneys. For one to get the desired effects, one must maintain the patient on the lowest dose possible and initial therapy should be on divided doses so that the patient can be monitored.

For acutely psychotic patients:

- Give intramuscular haloperidol, for example, 5mg every 30 to 60 minutes over a two to six hour period. Peak level is attained 20 to 40 minutes after injection.
- Monitor blood pressure before each dose and withhold if the systolic blood pressure is 90mm Hg or below.

- Sleep state should be monitored to ensure six to seven hours of sleep.
- Dystonia occurring 1 hour to 48 hours after starting treatment should be treated with an antiparkinsonism drug.
- To decrease the danger to the patient themselves and others, the patient needs to be monitored for possible adverse reactions to the medication.

Drugs should be given using the following time frame:

- Six months for first psychotic episode.
- One year period for second psychotic episode.
- Indefinite period for third and later psychotic episodes.

The drug should be discontinued through tapering the dosage to avoid dyskinesia.

Gertrude and MacFarland (1986) have identified the following expected responses to the treatment:

- Initially the patient is drowsy and co-operative within hours to a week.
- The patient becomes more sociable and less withdrawn for the next two months.
- The thought disorder generally disappears in six weeks or more.
- Improvement is generally noted in hallucinations, acute delusions, sleeping habits, appetite, tension, combativeness, hostility, negativism and personal grooming.

Remember:

Use of more than one phenothiazine is not recommended.

Geriatric patients should be given lower dosages to avoid hypertension due to prolonged half-life in people aged over 55 years.

Side Effects

There are several side effects that may be experienced by patients. These include drowsiness and orthostatic hypotension, especially after im injections. The patient may also experience extra pyramidal symptoms like:

- Dystonia, that is, spasms of muscles of face, neck, back, eye, arms and legs.
- Oculogyric crisis, presenting as fixed upward gaze from spasm of oculomotor muscles.

- Torticollis, that is, pulling of the head to the side from spasm of cervical muscles.
- Opisthotonus, which refers to the hyperextension of the back from spasm of back muscles.
- Akathisia or continuous motor restlessness.
- Akinesia or lack of body movement especially arms.
- Pseudoparkinsonism, which presents with a shuffling gait, mask-like facial expression, tremor, rigidity and akinesia.

The patient may also experience tardive dyskinesia, that is, a wormlike movement of the tongue, frequent blinking, and involuntary movement of tongue, lips and jaw. They may experience convulsive seizures or allergic or toxic effects (some of which are rare and serious).

These include:

- Aggranulosis
- Oral monoliasis
- Dermatitis
- Jaundice

The patient may also exhibit other side effects including endocrine or metabolic effects like weight gain or decreased libido, impotence, impaired ejaculation in males. They may also have decreased thermoregulatory ability and as a result might complain of being too cold or too hot.

Adjusting the dosage of antipsychotic drugs, and giving antiparkinsonian drugs can often be quite effective in treating side effects.

Contraindications

Comatose, glaucoma, prosthetic hyperplasic, acute myocardial infarction are contraindications to the use of these drugs (Gertrude and McFarland, 1986).

Antidepressants

These drugs are used to treat affective disorders.

Mechanisms of Action

They act by increasing epinephrine and serotonin. Both of them are metabolised in the liver and excreted in the urine.

Table showing some examples of antidepressant drugs.

Major Groups	Generic Name	Trade Name	Daily Dosage (range)
Tricyclic antidepressants	Amitriptyline	Elavil (laroxyl)	75-300mg
	Imipramine	Tofranil	100-300mg
Tetra cyclic anti-depressants	Maprotiline	Ludiomil	75-300mg
Monoamine Oxidase Inhibitors	Isocarboxamid	Marplan	10-60mg
	Phenelzine	Nardil	45-90mg
Selective Serotonin Reuptake Inhibitors	Fluoxetine	Prozac	20mg
	Citalopram	Cipramil	20-60mg
	Paroxetine	Seroxat	10-50mg

Mechanisms of Action

For the drugs to be effective:

- Dosage may be divided, but the total dose can be given at bed time due to the sedative effects.
- Minimum dose should be given then increased gradually.
- 5 to 21 days must be allowed before any mood change is observed.
- four to six weeks must be allowed to pass for therapeutic effects to be observed.
- Medication needs to be continued for 6 months after patient is free from depression.

The patient may respond to the treatment in several ways. They may exhibit drowsiness in early stages, which later subsides. Hypotension may be experienced initially, leading to feeling of fainting. Withdrawal symptoms may be experienced if the drug is not gradually stopped. As previously mentioned, lower dosages are indicated for geriatric patients since they are more sensitive to the drug and its side effects.

Side Effects

According to Gertrude and McFarland (1986), some of the side effects that might be experienced include mild anticholinergic effects from tricyclic and monoamine oxidase inhibitors, dry mouth, constipation, blurred vision, tachycardia, nausea, oedema, hypotension and urinary retention. Adjusting the dosage to a lower level will usually resolve the problem.

Side effects that are specific to tricyclics are:

- Allergic reactions manifested as skin rash and jaundice.
- Tachycardia.
- Tremors.
- Long term treatment may depress bone marrow, predispose to sore throat and aching, and fever.

Under such circumstances, stopping the use of the drug is the intervention of choice.

Meanwhile, specific side effects of monoamine oxidase

inhibitors include:

- Liver damage that is rare but fatal.
- Precipitation of manic episodes.
- Hypertension crisis characterised by severe headache, palpitation, neck stiffness, nausea, vomiting, increased Bp, chest pain and collapse. It occurs 30 minutes to 24 hours after eating food containing tyramine. These foods include cheese, wine, beer, sour cream, liver, chocolate, bananas, avocados, soy sauce, and beans.

The main form of treatment when side effects occur is to discontinue the drug and then give regitine to lower the blood pressure.

Contraindications

The use of antidepressants is contraindicated when the patient suffers from glaucoma, agitated states, urinary retention, cardiac disorders and seizure disorders.

Having looked at major tranquillisers and antidepressants, now you will look at minor tranquillisers.

Remember:

Anti-depressants should be discontinued prior to surgery.

Anxiolytics or Anti-anxiety Drugs

These drugs, when given to a patient having generalised anxiety disorder, are able to provide relief.

They are mainly recommended for acute anxiety states, which may present with palpitations, sweating, trembling, shortness of breath, chest pain, nausea, dizziness, a feeling of unreality, fear of losing control or dying, chills or numbness.

Examples of these drugs include buspirone, a novel anxiolytic, and benzodiazepines like diazepam and lorazepam.

For the purposes of your study, you are mainly interested in diazepam.

Effects

The main effects include sedation, muscle relaxation and elevation of seizure threshold.

Side Effects

Side effects include dizziness, headache, nervousness, insomnia, light headedness, dry mouth, nausea, vomiting, abdominal and gastric distress and diarrhoea.

When high doses of medication are used for more than four months, the patient is likely to develop drug dependence or withdrawal syndrome.

Contraindications

Benzodiazepines should not be used together with other central nervous system depressants. They should be given with caution to patients who are elderly, depressed or suicidal and those with a history of substance abuse.

It is worth noting that these drugs need to be combined with psychotherapy to ensure complete cure of the problem.

This implies that anxiolytics by themselves are not a cure for psychological problems. The most commonly used drug is diazepam. This is usually administered as a dose of 2-10mg bid/qid orally or 2-20mg i.m. or i.v. This can be repeated one hour after the initial dose.

Antiparkinsonian Drugs

These are drugs given to counteract the side effects of major tranquillisers.

An example of such a drug is benztropine (Cogentin) whose initial dose is 0.1-1mg daily,

the maintenance dose is 0.5-6mg daily divided into two or four times.

Side Effects

Side effects include dry mouth, nausea, constipation, urinary retention, blurred vision, disorientation and confusion.

Electroconvulsive Therapy (ECT)

Ugo Cerletti and Lucio Bini founded this method in 1938. It is given in doses ranging from 70 to 130 volts via electrodes placed on the temporal lobes from a machine constructed for treatment purposes.

Before ECT is administered, the following investigations are done:

- Physical examination like x-ray of the chest and spine
- Electrocardiogram (ECG) and electroencephalogram (EEG) may be done

At the same time, informed consent is obtained from the relatives after explaining the procedure. The night before ECT the patient is starved for six hours. Before taking the patient to the ECT department, all metallic objects are removed from the patient. Thereafter, premedication of atropine 0.6mg is given to dry body secretions. The patient is put under general anaesthesia, and then the doctor passes the current as explained earlier. The patient is secured on a theatre couch to prevent accidental fall.

The patient is then taken to the recovery room where vital signs are taken until the patient is fully awake. After that, the patient is given something to eat. In the ward, the patient should be closely observed, and later assessed to monitor the effect of ECT.

Treatments can be repeated if the patient does not improve. The frequency of treatment depends upon the severity of the patient's mental disorder. He may have two or three ECT treatments per week for a maximum of 8 to 12 treatments.

Nurses are responsible for setting up treatment and for the safety of the patient. Although deaths during treatments are rare, a supply of colamine to counteract barbiturates and the usual supply of emergency equipment must be at hand.

Psychological Treatments

Having completed your look at the physical treatment methods, you will now look at some of the psychological treatments used to treat patients suffering from mental health illness.

Psychotherapy

This is a form of treatment involving communication between the patient and the therapist, with the aim of modifying and alleviating illness.

A professional relationship is established, with the patient aimed at removing, modifying or mitigating the existing symptoms or disturbance patterns of behaviour or promotion of positive personality, growth and development.

There are two main types of psychotherapy:

- Individual psychotherapy
- Group psychotherapy

Individual Psychotherapy

Individual psychotherapy can be further subdivided into several categories.

Supportive

This deals with current problems and helps the patient to overcome their symptoms and cope with them satisfactorily in future.

Suggestive

This is a therapeutic method based on the belief that the patient has the ability to modify their abnormal emotional behaviour by applying their willpower and common sense.

Appeals are made to the patient's reason and intelligence. This is to help them abandon neurotic aims and symptoms and enable them to regain self respect.

Persuasive

This is the oldest form of psychotherapy. It is also widely used in advertising, propaganda, religious and political activities.

It revolves around a state of artificially induced suggestibility known as hypnosis. The technique is aimed at narrowing the patient's attention to the hypnotist alone.

Hypnosis ranges from a light hypnotic state to a deep trance. The main purpose of hypnosis is psychological investigation. This deals with current problems and helps the patient to overcome their symptoms and cope with them satisfactorily in future.

Group Psychotherapy

The treatment of the patient by psychotherapy in groups was first introduced as a time saving measure, but subsequent experience demonstrated that, the method had special therapeutic value, which did not occur in individual psychotherapy.

There are various styles of group therapy. One example of a group therapy setting, might involve a group size of six to eight patients. The therapy would have a time span of 1 to 1.5 hours and sessions would be held once or twice weekly. A relaxed, informal style might be adopted, with the patients sitting in a circle to denote equality.

There are several benefits associated with the group therapy method. These include:

- Re-education of the patient with a view towards altering attitudes and behaviour patterns
- Socialisation
- Improved adjustment and adaptation to reality
- Increased understanding of emotional problems and conflicts
- Modification of personality and character

Behaviour Therapy

This is defined as a therapeutic technique, which attempts to change the patient's behaviour directly rather than correct the basic cause of the undesirable behaviour.

The two main methods that are used are:

1. Changing the behaviour from inside using covert and cognitive therapies. Here, the priority is to help the patient modify their view of the world and themselves, by helping them change the things they say about themselves.
2. Changing the behaviour from outside. This is achieved through positive reinforcement of acceptable behaviour and negative reinforcement for unacceptable behaviour.

Activity Therapy

There are several forms of activity therapy.

Occupational Therapy

This involves the use of selected activities to improve general performance, to enable the

patient to learn the essential skills of day-to-day living and to assist in the reduction of symptoms. Activities may include painting, washing clothes and so on.

Recreation Therapy

This method uses activities like sports, games, hobbies to treat behaviour. It lays the emphasis on re-socialisation, reality orientation and involvement of mentally ill persons.

Dance Therapy

It uses body rhythmic movements and interaction to express emotions, thereby increasing awareness of the body and ego strength.

Rehabilitation

This is the process of restoring a person's ability to live and work as normally as possible after disabling injury or illness.

It is aimed at helping the patient achieve maximum possible physical and psychological fitness and regain the ability to care for themselves.

This aim is achieved through:

- Physical therapy
- Occupational therapy
- Vocational training
- Industrial/ work therapy
- Recreation or social therapy

SECTION 4: MANAGEMENT OF COMMON MENTAL HEALTH CONDITIONS

Introduction

In this section you will be required to reflect on the classification of mental illness. This knowledge will assist you to better understand any of the conditions that might come under discussion. For each condition, efforts will be made to include definition, causes, psychopathology, clinical features, methods of diagnosis and management.

To avoid repetition, the content of psychopathology will be treated as a separate topic at the beginning. You will then be expected to apply the knowledge in all relevant mental health conditions

Objectives

By the end of this section you will be able to:

- Define psychopathology
- Describe mental illness
- Describe some of the more frequent psychotic conditions

Psychopathology

Psychopathology is defined as the study of abnormal states of mind. There are many approaches to psychopathology but in this material, developmental psychopathology will be used. This approach examines different maladaptive behaviours displayed during childhood, adolescence and adulthood. Since personality development is a continuous process, behaviour in childhood and adolescence do overlap. It is important to note that emotional problems in childhood can surface later and plague a person in adulthood.

There are several vulnerability issues regarding children that you should always keep in mind.

Since children do not have realistic view of themselves and their world, they have less self-understanding and have not developed a stable sense of identity. Therefore, children have less developed coping mechanisms when it comes to dealing with stressful situations. Children tend to use unrealistic concepts to explain events since they have limited perspectives. For example, in an effort to join a dead parent, the child may commit suicide.

Children are protected against stress by parents since they are dependent on them. However, if

the parents ignore the child, they experience rejection, disappointment and failure. Since children lack experience in dealing with problems, ordinary hardships are magnified.

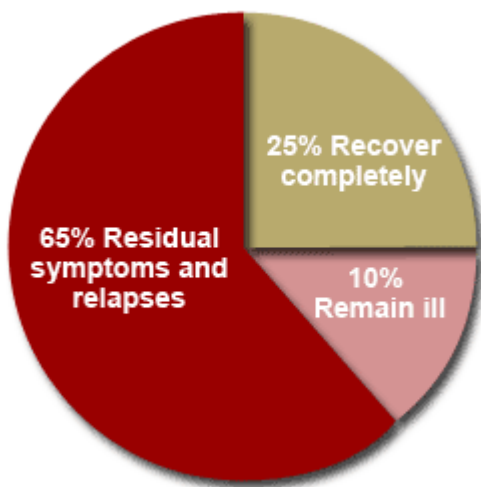
Problems that look minor to adults easily hurt children causing psychological trauma. These series of traumatic experiences may surface later in life in the form of mental illness.

Schizophrenia

Schizophrenia is a group of mental disorders that presents with varied symptoms of disordered thinking and bizarre social behaviour. It affects approximately 1% of the total population, including adolescents and young adults. There is increased incidence in the lower social class. Patients with this condition occupy 50% of beds in mental hospitals.

Generally:

- 25% of patients diagnosed with schizophrenia recover completely.
- 50 to 65% have residual symptoms and relapses.
- Approximately 10% remain ill.



There are several risk factors associated with the conditions. Schizophrenia is often witnessed in individuals with family members who have schizophrenia or in children who are:

- Highly individualistic in their thought processes.
- Overtly independent and obedient.
- Shy, withdrawn and loners.
- Unmanageable, prone to destructive, aggressive behaviour.
- Truant from school.

- Sensitive to separation.

There is no single cause but research studies indicate several possible factors. These include possible hereditary factors or disturbances in the neurotransmitter system. The condition can also be traced back to disturbed family interaction patterns, for example, family schism and faulty familial communication and environmental stresses such as major crisis or migration.

The condition manifests in several ways. Early signs include:

- Blocking or cutting off conversation with friends
- Expressing various body symptoms
- Forgetting or abandoning plans or life goals
- Disregarding social customs

As the condition progresses, the patient exhibits a tendency towards separation, rejection or substance abuse like alcohol.

In the acute phase, the patient will experience:

- Auditory and visual hallucinations.
- Illusions.
- Delusions of persecution, grandeur or impending distraction.
- Autistic thinking characterised by being highly personal.
- Speech characterised by incoherence, echolalia, neologisms and unwillingness to speak.
- Inappropriate behaviour, for example, grimacing, negativism, suggestibility and poor personal hygiene.
- Blunting ambivalence and inappropriateness of affect.

The next phase is known as the residual phase. At this stage, the patient usually exhibits symptoms of flat or blunt affect, rambling speech, poor hygiene and grooming and distortion of some perceptual experiences may persist.

Finally, in the chronic/relapse phase, the patient may point to feelings of boredom and apathy, impulsive suppression of feelings and psychotic disorganisation with increasing perceptual and cognitive dysfunction, loss of identity and loss of self-control.

There are several types of schizophrenia, which you will know look at in detail.

Catatonic Schizophrenia

This is a disorder characterised by a stuporous state in which the person is mute, negative or complains in response to a request. The

individual may be immobile, display waxy flexibility and may retain urine and faeces. It may alternatively be characterised by a highly excited state in which the person is abusive, aggressive, hyperactive or agitated (catatonic excitement).

Disorganised Schizophrenia

This is a disorder characterised by incoherence, foolishness and regressive behaviour.

Paranoid Schizophrenia

This is a disorder characterised by delusions of persecution or grandeur.

Undifferentiated Schizophrenia

This disorder is characterised by a variety of symptoms found in several of the types of schizophrenia that have previously been covered above, and are known as simple types.

Treatment

The nurse should arrange short-term, intermediate and long-term goals for the patient on drug treatment

Short-term Goals

These are goals that can be accomplished in the shortest time interval and must be done before the patient can move on to accomplish other types of goals. For example, to ensure that the patient establishes contact with the nurse.

Intermediate Goals

An intermediate goal might be for a patient to express their feelings in whatever mode they are able. This is not possible before the patient learns sufficient trust to share their painful and unacceptable thoughts. The patient must give up behaviours that hinder nurse-patient interaction in the working phase.

This goal involves certain behaviour on the part of the nurse that permits the patient to draw closer to them, including actual physical care of the patient.

Long-term Goals

To attain this objective, the patient needs to trust other people, and to communicate fully enough so that others become familiar with the patient's symbolic representations and characteristic modes of thought.

Another long-term goal would be to help the patient identify living situations that cause them great anxiety and help them to learn how to

reduce their own tension before their ego begins to shatter under the impact of the forces impinging on them.

A variety of therapies are available and include the following:

- Short hospitalisation to assist with the problem of being a danger to themselves or others, of deviant behaviour that is abrasive to the family and community and monitoring effects of drugs or other therapies.
- Outpatient treatment to provide aftercare, maintenance therapy, social support programs and medical clinics.
- Rehabilitation services to provide opportunities to increase skills in living such as vocational rehabilitation, foster home care and halfway houses.
- Drug therapy with antipsychotics to assist in alleviating symptoms and increasing patients availability for psychotherapy (refer to the section three on chemotherapy in treatments used in psychotherapy).
- Individual and group psychotherapy to assist patient in daily problems by exploring relationships, sources of anxiety and coping techniques. In group therapy support is offered on how to cope with problems encountered in everyday life.
- Family therapy to assist in defining the problem as one concerning the entire family rather than concerning the patient alone, to improve communication, to clarify roles within the family, to manage stress and to assist in problem solving.

It is also important to provide some basic health education to the patient. This would include the following steps:

- Teach patient and family various ways of obtaining help in improving work, educational and social skills.
- Stress the need for re-hospitalisation if the need arises.
- Teach the patient how to take medication and how to tolerate and/or adapt to side effects of the drugs.
- Patient and relatives should be taught how to identify stress early and then use problem solving skills.
- Family members should be taught how to supervise the patient's medication and how to respond to disturbing behaviour.

- Provide information on the nature of schizophrenia and the treatments available.
- Stress the importance of not using illicit drugs and alcohol.

Nursing diagnosis of schizophrenia should refer to:

- Poor or lack of insight.
- Non-compliance.
- Aggression.
- Impaired communication.
- Suspiciousness.
- Impulsiveness.
- Sensory/perceptual alteration: visual, auditory, gustatory, kinaesthetic, tactile.
- Self-care deficit: feeding/hygiene, dressing/grooming, toileting.
- Coping is ineffective.
- Suicidal tendencies.
- Alteration of thought process.
- Disturbance in self-concept, that is, disturbance in self-esteem, role performance and personal identity.

For an individual to be diagnosed as having schizophrenia, symptoms must persist for six months with one month of acute symptoms.

Affective Disorders

Affective disorders are a group of mental disorders that present mainly with symptoms of mood disturbance with associated changes in thinking and behaviour. In terms of their incidence, females outnumber males 2:1. An estimated 20%-50% of people over 65 years of age experience depression.

Bipolar disorders occur before the age of 30, while depression occurs at any age. Depression occurring for the first time after the age of 40 frequently indicates underlying physical illness. Depression is frequently associated with other medical disorders or treatment, for example, alcoholism, cancer and/or the side effects of some drugs used in the treatment of hypertension.

No single causal factor has been identified but hypotheses and research indicate several possible causes. These include:

- Genetic factors.
- Disturbance in the neurotransmitters system, involving norepinephrine, serotonin, dopamine, acetylcholine.
- Disturbance of steroid hormones.

- Stressful life events prior to onset of illness.
- Lack of social support.
- Depression is hostility turned against yourself, while mania is hostility projected at others.
- The individuals view themselves, the future and the current experiences in a negative way.
- Family interaction patterns in which a child experiences high expectations of achievement by parents and little approval for being themselves.

The conditions manifests in different ways depending on the type of disorder.

Major Depression

Symptoms include sadness, apathy, feelings of worthlessness, self-blame, thoughts of suicide, desire to escape, avoidance of simple problems, anorexia, weight loss, lessened interest in sex, sleeplessness, reduction in activity or ceaseless activity. In infants and older children, symptoms include a refusal to eat, listlessness, lack of activity, fear of death of a parent and fear of separation from parents. In adolescents, symptoms are social isolation, negative attitude, sulkiness, feeling of being unappreciated and acting out in antisocial ways.

Bipolar Disorder

This is a disorder in which there are alternating periods of depression and mania. Bipolar disorder manic episodes exhibit symptoms of hyperactivity, speech pressure, hyper sexuality, delusions, abusive and sleeplessness. Meanwhile, bipolar disorder depressive episodes exhibit symptoms similar to those of major depression.

There are several forms of treatment. You will now look at some of these in more detail.

Hospitalisation

This is used in acute mania and in depression when there is evidence of poor judgment, weight loss and a lack of emotional support.

Drug Therapy with Antidepressants or Antimanic Drugs

Examples of drug therapy treatments include antidepressants. As a hypothetical treatment, using tricyclic medication, for example, imipramine. Build up to the effective dose over 7-10 days. Start with 25-50mg each night and build up to 100-150mg. Withdraw the medication

slowly and monitor for withdrawal reaction and to ensure remission is stable.

You can also use antimanic drugs.

Drug Therapy with Antidepressants or Antimanic Drugs

If the patient displays excitement or disruptive behaviour, antipsychotic medication is needed initially, for example, haloperidol, at a dose of 1.5-4mg up to three times a day. In acute agitation, benzodiazepines may be used in the short term in conjunction with antipsychotic drugs, for example, diazepam 5-10mg up to four times a day.

Another drug that can be used is lithium. One usually commences or stops taking lithium with the advice of a specialist to help relieve mania and depression. It also prevents episodes from recurring. Levels of lithium in the blood must be measured frequently when adjusting the dose, and every three months in stable patients. Ten to fourteen hours post-dose the desired level is 0.4-0.8mmol/litre. Lithium should be stopped immediately if blood levels are more than 1.5mmol/litre or there is diarrhoea and vomiting.

Drug Therapy with Antidepressants or Antimanic Drugs

Other forms of treatment include:

- Electro Convulsive Therapy (ECT): used in severe depression or mania.
- Psychotherapy used to deal with issues of dependency and manipulation of loss experience and self-destructiveness.
- Behaviour therapy, which focuses on rewarding acceptable behaviour and providing social skills.
- Maintenance of social support by family members, workmates, etc.
- Assessment for suicide ideation particularly for the depressed patients and prompt intervention.
- Health education is necessary to provide the patient with information about affective disorders, major treatments and prognosis.
- Assist the patient and family in learning ways to manage stress.

Substance Use Disorders

Substance use disorders are a group of mental disorders manifested by impairments in social and occupational functions, which are related to

a regular use of specific substances that are intended to alter mood or behaviour.

Alcohol is one of the commonly used psychoactive substance. Alcoholism affects 7.5-10 million people worldwide, mainly those in early and middle adulthood. Substance abuse is more common in men than in women.

Presenting Complaints

Patients may be depressed, nervous or exhibit signs of insomnia. They may directly request a prescription for narcotics or other drugs, request help to withdraw, or help in stabilising their drug use.

They may present in a state of intoxication, withdrawal or physical complications of drug use, for example, abscess or thrombosis. They may also present with social or legal consequences of their drug use, for example, debt or prosecution. Occasionally, covert drug use may manifest itself as bizarre, unexplained behaviour.

Signs of drug withdrawal include:

- Opioids lead to nausea, sweating, hallucinations.
- Sedatives lead to anxiety, tremors, hallucinations.
- Stimulants lead to depression, moodiness.

The family may request help before the patient does, as often, the patient is irritable at home, or missing work. The aim is to assist the patient to remain healthy until, if motivated to do so, and with the necessary help and support, they can achieve a drug-free life.

Diagnostic Features

There are several diagnostic features associated with substance abuse. These include:

- Physical harm, for example, symptoms of mental disorder due to drug use or a harmful social life leading to loss of a job, severe family problems or criminality.
- Habitual or harmful drug use.
- Difficulty in controlling drug use.
- High tolerance, for example, the individual can use large amounts of drugs without appearing intoxicated.
- Withdrawal, for example, anxiety, tremors or other withdrawal symptoms after stopping use.

The diagnosis will be aided by:

- Taking the patient's personal history (especially drug use).
- Examination for needle tracts, complications, for example, thrombosis or viral illness.
- Investigations for haemoglobin, Liver Function Tests (LFTs), urine drug screen and hepatitis B and C.

Management

If the patient is not willing to stop or change drug use:

- Do not reject or blame the patient.
- Advise the patient on harm-reduction strategies, for example, on the dangers of needle sharing by intravenous drug users.
- Point out clearly the medical, psychological and social problems associated with drug use.
- Make a future appointment to reassess health and discuss drug use.

If the patient is willing to reduce the drug uses but not to quit completely:

- Negotiate a clear goal for decreased use, for example, not more than one marijuana or cigarette per day.
- Discuss strategies to avoid or cope with high-risk situations.
- Introduce self-monitoring procedures, for example, a diary of drug use.
- Consider options for counselling and/or rehabilitation.

If the patient opts to have a substitute drug:

- Negotiate a clear use of the prescribed substitute drug.
- Discuss ways of avoiding high risk situations, for example social situations or stressful events.
- Consider withdrawal symptoms and how to avoid or reduce them. Provide information and management of methadone toxicity.
- Consider options for counselling and/or rehabilitation.

For patients willing to stop drug use:

- Set a definite day to quit.
- Consider withdrawal symptoms and how to manage them.
- Discuss strategies of avoiding or coping with high risk situations.

- Make specific plans to avoid drug use, for example, how to respond to friends who still use drugs.
- Identify family or friends who will support stopping drug use.
- Consider options for counselling and/or rehabilitation.

In the case of patients who do not succeed or relapse:

- Identify and give credit for any success.
- Discuss situations that led to the relapse.
- Return to earlier steps.

The medication to be used varies according to the specific drug withdrawal. You should always make sure that you do not only give the patient the right medication, but that you are also able to help the patient deal with life problems, employment, social relationships, etc. This is a very important component of the treatment process.

Alcohol Abuse

Alcohol misuse is another common substance abuse problem. Patients may present with:

- Depressed mood.
- Nervousness.
- Insomnia.
- Physical complications of alcohol use, for example, gastrointestinal ulceration, gastritis, liver disease, and hypertension.
- Accidents or injuries due to alcohol use.
- Poor memory or concentration.
- Evidence of self-neglect.
- Poor compliance to management for depression.

The patient may also have experienced legal and social problems due to alcohol use, for example, marital problems, domestic violence, child abuse and neglect or missed work. The individual may show signs of alcohol withdrawal, which include sweating, tremors, morning sickness, hallucinations and seizures.

Patients may sometimes deny or are unaware of alcohol problems. Family members may request help before the patient does. The problem may also be identified during a routine health promotion screening.

Diagnostic Features of Alcohol Abuse

Harmful alcohol use refers to the consumption of over 28 units per week for men and over 21 units per week for women. This can result in physical harm, for example, liver disease,

gastrointestinal bleeding, psychological harm, for instance, depression or anxiety or social consequences, like the loss of a job.

Alcohol dependence is said to be present when any of the following factors are present:

- Strong desire or compulsion to use alcohol.
- Difficulty controlling alcohol use.
- Withdrawal symptoms, for example, anxiety, tremors, sweating, when drinking is ceased.

Tolerance refers to the individual who is able to drink large amounts of alcohol without appearing intoxicated. They continue alcohol use despite the harmful consequences.

Blood tests such as Gamma-Glutamyltransferase (GGT) and Mean Corpuscular Volume (MCV) can help identify heavy alcohol drinkers.

Management of Alcohol Abuse

There are many similarities in the management strategies used for patients who have substance abuse problems and those who have alcohol abuse problems. For patients with physical illness and/or dependency or failed attempts at controlled drinking, an abstinence programme is indicated.

If you have a patient who is willing to stop now:

- Set a definite day to quit.
- Consider withdrawal symptoms and how to manage them.
- Discuss strategies of avoiding drinking, for example, ways to respond to friends who still drink.
- Consider options for support after withdrawal.

For patients not willing to stop or reduce alcohol use immediately, a harm reduction programme may be indicated:

- Do not reject or blame the patient.
- Point out clearly medical, psychological and social problems caused by alcohol use.
- Consider thiamine preparations (150mg per day in divided doses should be given for one month).
- Make a future appointment to reassess health and alcohol use.

In the case of patients who do not succeed or have a relapse, you should identify the problem that caused the relapse and give the patient credit for any success. You should also discuss

situations that led to the relapse and return to earlier steps.

You may wish to recommend self-help organisations, for example, Alcoholics Anonymous. Most voluntary and non-statutory agencies are often very helpful.

Medication for Alcohol Abuse

For patients with mild withdrawal symptoms, frequent monitoring, support, reassurance, adequate hydration and nutrition are sufficient treatment without medication.

Patients with moderate withdrawal syndrome will also require benzodiazepines. Most can be detoxified as outpatients or at home. Only practitioners with appropriate training and supervision should do community detoxification.

Inpatient detoxification is indicated for:

- Patients at risk of complicated withdrawal syndrome, for example, with a history of fits or delirium, tremors, very heavy use and high tolerance.
- Significant polydrug use or severe morbid medical or psychiatric disorder who lack social support or are considered to have a significant suicide risk. In such cases, chlordiazepoxide (librium) at 10mg is recommended. The initial dose should be considered against withdrawal symptoms within a range of 5-40mg four times a day. This requires close and skilled supervision.

The regimen opposite can be used although the dose level and length of treatment will depend on the severity of alcohol dependence and individual patient factors, for example, weight, sex and liver function. Treatment should be dispensed daily. You may want to involve a family member to prevent the risk of misuse or overdose.

Thiamine (150mg per day in divided doses) should be given orally for one month. Parenteral thiamine is indicated for patients with ataxia, confusion, memory disturbances, delirium tremens, hypothermia and hypotension, ophthalmoplegia or unconsciousness.

Day 1 and 2	20-30mg	QDS
Day 3 and 4	15mg	QDS
Day 5	10mg	QDS
Day 6	10mg	QDS
Day 7	10mg	QDS

Daily Treatment

An expert should be involved in case monitoring for the first few days.

When depression concurs with alcohol misuse, Selective Serotonin Re-uptake Inhibitors (SSRI) may be used. These include fluoxetine, paroxetine and citalopram. Tricyclic antidepressants should be avoided because of tricyclic-alcohol interactions. For anxiety, benzodiazepines should be avoided because of high potential for abuse.

Referral

The patient should be referred for hospital detoxification, if they do not meet the criteria for community detoxification.

In addition, the patient should also be referred for targeted counselling, if available, to deal with the social causes or consequences of drinking, for example, relationship counselling.

Organic Disorders

Organic disorders represent a group of mental disorders that present a variety of symptoms, especially a disturbance of cognition. Delirium is common in general hospitals with an estimated 5%-15% of patients exhibiting the symptoms. Meanwhile, dementia impairs about 1,000,000 people. Alzheimer's disease is the most common type of organic disorder.

Delirium

Families may request help because the patient is confused or agitated. The patients may appear uncooperative or fearful. Occasionally, delirium may occur in patients hospitalised for physical conditions.

Diagnostic features include an acute onset, usually over hours or days, of confusion where the patient is disoriented and struggles to understand surroundings. This is evidenced by clouded thinking or awareness. This condition is often accompanied by:

- Poor memory.
- Agitation.
- Emotional upset.
- Loss of orientation.
- Wandering attention.
- Auditory hallucinations such as hearing voices.
- Visual hallucinations.
- Withdrawal from others.
- Illusions.

- Disturbed sleep (reversal of sleep patterns).
- Autonomic features, for example, sweating, tachycardia.

Some of the main causes of this condition have been identified as:

- Alcohol intoxication or withdrawal.
- Drug intoxication, overdose or withdrawal.
- Infection.
- Metabolic changes, for example, liver disease, dehydration, hypoglycaemia.
- Head trauma.
- Hypoxia.
- Epilepsy.

Medication for Delirium

When prescribing medication, you should avoid the use of sedatives or hypnotic medications, for example, benzodiazepines, except for the treatment of alcohol or sedative withdrawal. Antipsychotic medication in low doses may be needed to control agitation, psychotic symptoms or aggression.

Drugs with anticholinergic action and antiparkinsonian medication can exacerbate or cause delirium.

You should offer advice and support to the patient and their family. You should also prevent the patient from harming themselves or others, for example, by removing unsafe objects or restraining the patient if necessary. In addition, ensure that supportive contact with familiar people is maintained so as to reduce confusion. Keep in mind that hospitalisation may be required because of agitation or physical illness, which is causing the delirium.

Referral for Delirium

Referral to secondary mental health services is rarely indicated. However, referral to a physician is always necessary if the cause of the dementia is unclear or if the patient presents with drug, alcohol withdrawal, overdose or any other underlying condition that requires in-patient medical care.

Dementia

This is a slow deterioration in cognitive functioning, causing multiple changes. This condition is common in individuals of advanced age, that is, 65 years and above and quite rare in youth or middle age.

Presenting complaints for this condition include:

- Patients may complain of forgetfulness, decline in mental functioning or they may feel depressed but may be unaware of the memory loss.
- Families may ask for help initially because of failing memory, change in personality or behaviour and disorientation.
- Changes in behaviour and functioning, for example, poor personal hygiene or social integration.
- Decline in memory, thinking, judgment, orientation and language.
- Being apathetic or disinterested.
- Decline in every day functioning, for example, dressing, washing, cooking.

Senile Dementia

This is a disorder of unknown cause characterised by severe impairment of intellectual functioning. If it occurs before the age of 65 years it is called Alzheimer's disease.

The treatment of dementia is directed towards the elimination of the physical cause, however, there is no specific treatment in the majority of cases. Treatment may include continuous assessment for cause of symptoms and treatment as indicated, group and/or individual psychotherapy with focus on the management of anxiety, loss, impairment, impending death, reality orientation and changes in lifestyle.

Non-pharmacological methods are often tried first in dealing with difficult behaviour. Antipsychotic medication in very low doses may be needed occasionally to manage aggression or restlessness. If possible avoid using sedatives or hypnotics, for example, benzodiazepines. Aspirin in low doses may be prescribed in vascular dementia in order to slow deterioration.

Health education includes:

- Reduction of stress and introduction of healthy habits in daily living.
- Acceptance of a spouse as they deteriorate.
- Involvement of the family to avoid anxiety-provoking situations.
- Developing ways of combating disorientation, for example, appointment calendars, clocks, stable routines, set places for important items, etc.

Referral for Senile Dementia

The patient should be referred to a specialist to confirm diagnosis in complicated cases. They may also be referred to social services for practical help, for example, home help and day care. If there are behavioural problems, the patient should be referred to a psychiatrist. These usually involve complex family relationships and might be precursors to a depressive or psychotic episode

Psychoses Associated with Pregnancy and Childbirth

These are psychiatric illnesses that have been precipitated by either pregnancy or childbirth. They may occur during pregnancy or within six weeks after delivery. The peak is common within two weeks after delivery. In pregnancy, these disorders often occur during the first and third trimester.

Unwanted pregnancies are associated with anxiety and depression in the first trimester. In the third trimester, there may be fears related to the impending delivery or doubts about the normality of the foetus.

The condition is more frequent in:

- Primigravidas.
- Those who have suffered previous major psychiatric illness.
- Those with history of mental illness.
- Those with serious medical problems affecting the course of the pregnancy, for example, diabetes mellitus. (Obstetricians and midwives consider mothers with these conditions as mothers at risk.)

The causes of psychoses associated with pregnancy and childbirth are not conclusive. However, it has been proposed that there are several possible causal factors.

These include:

- Pre-existing predisposition. Some women have a hereditary or personality predisposition to develop mental illness. The women are asymptomatic until pregnancy or delivery which then acts as a stressor precipitating psychosis.
- Hormonal changes, that is, the early onset of puerperal psychosis has led to speculations that they may be caused by hormonal changes.
- Psychological factors, which refer to psychological stresses, especially

during the first and third trimester when the anxiety level is high.

- Social factors, that is, pre-existing marital constraints, for example, lack of social support from the husband.
- Biological factors usually associated with physical illness.

There are several psychiatric conditions that are precipitated by factors associated with pregnancy and childbirth.

Acute Organic Psychosis

This has declined with good obstetric care but can occur when care is inadequate, for instance, puerperal sepsis.

Functional Disorders

These can occur in the form of manic-depressive psychosis, depressive or manic phase. Depression is the most common form, and may result in suicidal ideation, guilt and/or negative feelings towards the baby. For example, the mother may think that the child has a serious ailment and for that reason she should kill it to save it from suffering.

Schizophrenia

This tends to develop sooner and is more acute than depression.

Schizoaffective Disorders

Schizoaffective disorders incorporate features of schizophrenia and affective disorder, which appear in the same person at the same time.

The clinical presentation will depend on the presenting condition.

Management

Medical treatment will depend on the form the illness has taken. Patients who are moderately to severely depressed, usually benefit from ECT. This enables the patient to recover quickly so that they can resume the care of the baby. If the patient is less depressed, antidepressants may be tried first.

In schizophrenic patients, phenothiazines are given. If improvements are delayed, phenothiazines may be combined with ECT. In puerperal sepsis, appropriate antibiotics must be given.

Great care must be taken in the use of psychotropic drugs because of the risk of foetal malformations, impaired growth and pre-natal problems.

Where possible, avoid using tricyclic antidepressants or neuroleptics unless there are compelling clinical indications. Where the illness is endangering the patient's life and no alternative treatment is available or favourable, then termination of pregnancy should be considered.

Nursing Management

Nursing management depends on the form the illness has taken. The patient should be nursed in a therapeutic environment. For example, a depressed patient may be contemplating suicide and should, therefore, be nursed on the ground floor to prevent her jumping to her death. Preventive precautions necessary for suicidal patients must be taken.

Where facilities are adequate, a separate nursery where the child can be nursed must be utilised.

In order to promote lactation, a well balanced diet rich in proteins and a lot of fluids must be provided.

As the patient improves, involve her in occupational therapy and psychotherapeutic group activities in order to rehabilitate and socialise her. You should also provide health education for the husband and other relatives on the causes, course and treatment of the illness.

The best way of preventing this condition is:

- Identification of risk groups.
- Good obstetrics care during antenatal, delivery and postnatal periods.
- Supportive psychotherapy.
- Health education on clinic follow-up and drug compliance.

Abnormalities of Sexual Preference (Paraphilias)

This concept has three dimensions. The first dimension is related to social life. The behaviour of the individual does not conform to what is generally regarded as normal behaviour. However, you should note that the accepted view of what is normal in one community does not necessarily apply to other communities. The second dimension is concerned with the harm that may be inflicted on the sex partner. The third dimension concerns itself with the suffering experienced by the persons themselves.

There are various ways through which sexual preference abnormalities may reach a medical practitioner. One way is through direct approach by the persons themselves. Another situation is where the patient will seek sexual help for the

spouse or other sexual partner. Sometimes the patients may present themselves as having sexual dysfunction and it is only with time that the doctor will discover the abnormality of sexual preference.

Abnormalities of Sexual Preference of Sexual Object

These abnormalities are usually divided into two groups. The first one is the abnormalities of the object of the person's sexual drives. The second one refers to the abnormalities in the preference of the sexual act. You will now take a look at a few abnormalities of sex object. This mainly involves preference for an object other than another adult in the achievement of sexual excitement.

Paedophilia

Sexual excitement is achieved through having sexual activity or through fantasy of such activity with pre-pubertal children.

Treatment involves behavioural therapy and group treatment, which have, unfortunately, had little success. General measures (to be found at the end of this section) can also be tried.

Fetishism

This involves the use of an inanimate object as a means of attaining sexual excitement. It could also involve parts of the human body that are not related with sex act. It is not uncommon for men to be sexually excited by a part or clothing of a female. However, the behaviour becomes abnormal when it takes the precedence over usual sexual intercourse.

Psychoanalysis and behaviour therapy are the recommended forms of treatment. The general measures at the end of the section can be applied as well.

Abnormalities in Preference of Sexual Act

This group of abnormalities involves a variation in the behaviour that is carried out so as to get sexual arousal. The behaviour is usually directed towards adults but occasionally children are involved. Exhibitionism is an example of such behaviour.

Exhibitionism

This is the repeated exposure of genitals to unprepared strangers in order to get sexual excitement but with no further effort to have sex with the stranger concerned. The average age is 20-40 years and the condition is usually found in men (Gayford, cited by Gelder et al., 2000).

The treatment approach that has been found to be most effective is a combination of counselling and behavioural techniques. Counselling deals with personal relationships while behaviour deals with self-monitoring. Self-monitoring involves the identification of circumstances that initiated the behaviour so as to avoid them.

Drugs that reduce sexual drive like cyproterone acetate have also been used, however, they are not generally recommended due to uncertain results and problems.

Abnormalities of Gender Identity

Transsexuals have been grouped under this category. People who are transsexual have a strong belief that they are of a gender opposite to that signified by their external genitalia. The person concerned has a strong urge to live like a member of the opposite sex. They feel strange in their bodies and want to change their body appearance to suit the desired gender.

Although transsexualism is a psychological problem, people often seek treatment that is aimed at the body and not the mind. Physical changes are not recommended. However, if a decision is made to undertake them, it should be made in stages, despite the radical demand by the patient, so as to give the patient time to adjust to the changes they are undergoing, as well as to evaluate the decisions that have been made.

The treatment that is most recommended is supportive psychotherapy. The therapist tries to convince the patient to accept the current status. Unfortunately, this is rarely successful.

General Assessment and Management of Abnormalities of Sexual Preference

The first step in the assessment is to exclude mental illness since abnormal sexual preference, is commonly secondary to dementia, alcoholism, depressive disorders or mania. These illnesses are thought to release previous fantasies that had not been acted upon. This is mainly true if the onset is middle age or later.

An inquiry should be made into sexual practices bearing in mind that one can have diverse sexual practices. Details of normal heterosexual vigour and interest are taken both in the present and in the past. If possible, an interview should be arranged with the patient's regular partner. The patient should be asked to explain what role the abnormal sexual preference is playing in their life. For example, it could be providing

comfort in addition to being a source of sexual excitement.

Patients seek treatment for paraphilias due to different motives. Some do it because their sexual partner, relative or police know about it. Though treatment is sought, the patient may have little desire to change since they are happy when told that nothing can be done. Occasionally, patients may seek treatment due to depression caused by guilt. During such moments, the urge to change is high but this often fades when normal mood is restored. The recommended form of treatment is psychotherapy, behaviour therapy and psychoanalysis.

Neurotic Disorders in Adolescents and Adults

Anxiety disorders are a group of mental disorders in which anxiety is the main concern.

The psychodynamic theory views anxiety as arising from conflicts that are usually sexual and aggressive. There are several types of anxiety:

- Superego anxiety, for example, fear of being found guilty.
- Castration anxiety, for example, fear of bodily mutilation.
- Separation anxiety, for example, fear of loss of significant relationship.
- Impulsive anxiety, for example, fear of the control of impulses.
- Obsessive-compulsive disorders arise during the developmental stage. The patient uses the defence mechanism of undoing, isolation and reaction formation.
- Phobic disorder is characterised by the use of the defence mechanism of displacement and avoidance to deal with castration anxiety and oedipal drives.
- Automatic learning of responses to situations that are anxiety provoking.

You will now move on to look at the clinical manifestation and management of selected types of anxiety disorders.

Generalised Anxiety Disorders

Generalised anxiety disorders usually present with tension-related physical symptoms, for example, headache, pounding heart, insomnia, and/or sweating.

Diagnostic Features of Anxiety Disorders

There are multiple symptoms of anxiety or tension, which include:

- Physical arousal, for example, dizziness, sweating, a fast pounding heart, a dry mouth, stomach pains or chest pains.
- Mental tension, for example, weariness, feeling tense or nervous, poor concentration, fear that something dangerous will happen and not being able to cope.
- Physical tension, for example, restlessness, headache, tremors or an inability to relax.

Symptoms may last for months and recur regularly. Often they are triggered by stressful events in those prone to worry.

Management of Anxiety Disorders

Medication is secondary to treatment in the management of general anxiety. If anxiety symptoms exist, anti-anxiety medication, for example, diazepam may be used. However, it should not be used for longer than two weeks so as to avoid dependence.

Antidepressants, for instance, imipramine or clomipramine may also be used, especially if symptoms of depression are present. These drugs do not cause dependence but can lead to withdrawal symptoms, therefore, they should be tapered gradually.

Other forms of management include:

- Psychotherapy, used in various forms, with focus on analysing unconscious conflicts, interpersonal conflicts, or providing supportive measures.
- Relaxation technique which helps the patient not to be tense and to relax.
- Teaching the patient ways of monitoring themselves for increasing anxiety and taking appropriate action. This is termed as self-care and is especially applicable in cases of milder anxiety.

Hospitalisation is used for short periods when symptoms become intense and family ability to give support at that time is limited.

Conversive and Dissociative Disorders

Patients present with unusual or dramatic physical symptoms, such as severe amnesia, trance, loss of sensation, visual disturbances, paralysis, aphasia, identity loss, confusion or possession states. The patients are not

malingering since they are not aware of their role in their symptoms.

Diagnostic features include physical symptoms that are unusual in presentation and not consistent with known disease. The onset may be sudden and related to psychological stress or difficult personal circumstances.

In acute cases, symptoms may be dramatic and unusual, may change from time to time and may be related to attention from others.

Differential Diagnosis

You should ensure that you have carefully considered physical conditions that may cause the same symptoms and rule them out through full history, physical examination and laboratory investigations.

Management

When medicating the patient, you should avoid anxiolytics or sedatives. In more chronic cases with depressive symptoms, antidepressants may be helpful.

The patient and the family should be informed that physical or neurological symptoms often have no clear cause. Symptoms can be brought about by stress. They should also be aware that symptoms usually resolve rapidly, from hours to a few weeks, leaving no permanent damage.

The following advice should be given to both the patient and their family:

- Encourage the patient to acknowledge recent stresses or difficulties.
- Advise the patient to take a brief rest and relief from stress, then return to usual activities.
- Advise against prolonged rest or withdrawal from activities.

Phobic and Anxiety Disorders

These are disorders having generalised anxiety only in particular circumstances - these people are free from anxiety most of the time. Another characteristic of phobic disorders is avoidance of the feared object.

Simple Phobia

This is a disorder characterised by inappropriate anxiety in the presence of the feared object or situation. For example:

- Arachnophobia, that is, fear of spiders.
- Acrophobia, that is, fear of heights.

- Others include phobia of dental treatment, phobia of flying, and phobia of illness.

Simple phobias usually start in childhood and persist until adulthood. Under stressful situations it can start in adulthood. Genetic vulnerability has also been proven through twin studies (Kendler et al cited by Gelder et al, 2000). Phobia that persists from childhood has poor prognosis as compared to one starting in adulthood. Treatment is through graded exposure to the feared objects or situation. This can reduce the intensity of fear but rarely is phobia cleared completely.

Social Phobia

This refers to inappropriate anxiety experienced in situations where one is observed and criticised. Such places include restaurants, canteens, dinner parties, seminars, board meetings, or other such situations where one may be observed and criticised.

It is wrong to avoid the feared objects or situations. Psychological treatment is recommended. This includes:

- Social skill training
- Relaxation
- Exposure to feared situation

Cognitive behaviour therapy is the most appropriate treatment where exposure is combined with management of anxiety.

Agoraphobia

This is fear experienced by anxious individuals while away from home, in crowds or in situations that they cannot leave easily. In addition to the general features in phobia, agoraphobia has frequent symptoms such as depression, depersonalisation, and obsessional thoughts. Situations that provoke fear include buses, trains, shops, and supermarkets. Occasionally, agoraphobia may be precipitated by anticipatory anxiety.

Cognitive hypothesis says that agoraphobia develops in people who are unreasonably afraid of minor physical illness. The biological hypothesis says that the initial anxiety attack results from environmental stimuli acting on those already predisposed.

Meanwhile, the psychoanalytic hypothesis attributes agoraphobia to unacceptable sexual or aggressive impulses. It is commonly found in people who are dependent and who tend to avoid rather than confront the problem.

With regard to treatment, in the early stages, patients are counselled to return to the situation they are avoiding. Later stages require behaviour therapy combined with exposure to the feared situations. Anxiolytics are used on special occasions when the patient is expected to undertake important engagement. However, drugs are discouraged in order to avoid dependence. Antidepressants are used to treat accompanying depressive disorder.

Disorders of Infancy and Childhood

It is important to remember that you should keep in mind that there are special features of working with children. Unlike adults, children are not free and independent. Children are always tied to or dependent upon their parents or some comparable caretakers. They are usually brought for treatment by their parents.

It is impossible, therefore, to make lasting progress without involving either their parents or guardians. The nurse is required to establish good rapport with both the child and the parents/parent substitute. If this is not done, the nurse can easily be left with the child by the frustrated parents.

It is worth noting that children come into treatment with limited coping skills, less developed defence mechanisms and less ability to conceptualise than adults. Nurses should, therefore, avoid direct interpretation of the child's behaviour so as to avoid overwhelming the child with anxiety.

Since children have less impulse control and awareness of control than adults, they need clear and firm limits. In order to assess the child's feelings and problems, it can be useful to use drawings, dolls, puppets, clay and games.

Autistic Disorders

Autism is a state of psychotic disorder which has its onset in early infancy. Initially the disorder was associated with an unsatisfactory mother-infant relationship. This belief is held to be true to this day, however, researchers continue to examine the potential genetic, biochemical, and physical bases for the disorder.

Autistic children are characterised by several symptoms, including:

- Self-involvement
- Withdrawal
- Severe impairment in verbal communication and in interpersonal relationships

- Bizarre stereotyped or ritualistic responses to the environment

Management of Autistic Disorders

Nursing intervention includes observation to ensure safety and to assist in understanding the individual. It also involves establishment of a one-to-one relationship for support and coordination of services.

Phenothiazine medications are frequently used with psychotic children and adolescents. The nurse's role is to teach the family about the therapeutic effects and side effects of such substances.

Be aware that the parents of children diagnosed as autistic tend to blame themselves and may be overcome by guilt. They, therefore, require special support, teaching and reassurance. The nurse should focus on the mother's significance to her child, enhancing her self-esteem and then move to a discussion of specific plans and approaches to the condition.

Developmental Deviations and Specific Behavioural Symptoms

The term developmental deviation implies that a child's maturation is significantly delayed in one or more areas. Developmental deviation may occur in almost any aspect of the child's physical, psychological or social status. However, it is most common in relation to motor, speech and cognitive areas.

Teachers most often detect developmental deviations in pre-school and early school. The most permanent and pathological symptoms in older children are enuresis and sometimes encopresis.

Other forms of antisocial behaviour may result when the child has experienced long periods of frustration or ridicule because of developmental deficits. Such behaviour includes lying (hoping to make them feel important or successful), stealing often focused on taking what the child feels they are not able to earn or achieve and setting fires as a display of mastery or power. Such behaviour and symptoms are problems in themselves, and they contribute to the child's sense of inadequacy and interpersonal isolation.

Nursing Intervention

With regard to developmental deviation, attention must be focused on biopsychosocial assessment. Emphasis is placed on early detection, parental education, and support for the child or adolescent. Family members should

be involved early enough so that they can understand the deviations and adjust their expectations. This can help to prevent social disruptions that can often result from developmental deviations. The nurse can assist parents in establishing clear, consistent and reasonable responses to inappropriate behaviour while underlying causes and solutions are being explored.

Limited behaviour modification plans, negotiated jointly with the parents and child, are often useful in these circumstances. Control of symptoms tends to relieve the overwhelming anxiety of parents and return a sense of security to the child or adolescent. It also limits the adverse consequences of the child's socially obnoxious or self-injurious behaviour, and frees some family energy for the process of examining the causes and long-term solutions.

Attention Deficit Hyperactivity Disorder (ADHD)

This problem is referred to as hyperactivity and is characterised by impulsivity, excessive motor activity, and difficulties in sustaining attention. It is the most common cause of psychological referrals to mental health and paediatric facilities, that is, 16.1% of all types of ADHD (Woolrich, Hannah et al, cited by Carson et al, 2000).

ADHD occurs more in boys than in girls, with a ratio of 9:1. The greatest frequency of occurrence is before the age of eight. Numbers decline thereafter with briefer episodes. Residual difficulties like attention deficit may continue into adolescence or adulthood.

The child may be observed to have any of the following features:

- Excessive or exaggerated muscular activity such as aimless or haphazard running or fidgeting.
- Difficulty in sustaining attention.
- Being highly distractible.
- Failure to follow instructions or respond to demands made on them.
- Having impulsive behaviour as well as low tolerance to frustration.
- They tend to be of low intelligence due to hyperactivity, with an IQ of 7-15 below the average.
- They are socially intrusive and immature.
- They have a high rate of driving offences when they attain adolescence.

- They do not get along with their parents since they do not obey them.
- Their negative behaviours tend to make their peers to view them negatively.
- They usually do poorly in school with specific learning disabilities such as difficulties in reading or learning basic subjects in school.

The causal factors in the Attention Deficit Hyperactivity Disorder are not clear but genetic and social environment are said to contribute significantly. Other factors cited are parental personality problem (Marrison, cited by Carson et al 2000). There is also some speculation relating to dietary factors, especially food colouring, but the latter theory has been partially discredited. Psychological causes have not been conclusive, that is, no psychological cause has been identified.

Treatments and Outcomes

Cerebral stimulants like amphetamines have a quieting effect on children (Pelham, et al cited by Carson 2000). They decrease over activity and distractibility. At the same time, they increase their attention and their ability to concentrate. This enables them to function better at school. Though it does not cure hyperactivity, it is able to reduce behavioural symptoms in about two thirds of the cases.

Certain drugs may be used. These include ritalin (methylphenidate), which is an amphetamine and pamoline, which has been found to be useful in adolescences and young adults. The latter is taken over a long period.

Short-term effects of stimulants are well known but long-term effects are yet to be established. Note that there are similarities between methylphenidate (ritalin) and cocaine, which causes concern since it can be abused.

The other form of treatment is behaviour therapy, featuring positive reinforcement of acceptable responses from the patient, for example, providing immediate praise. It is noted to be good in short-term gains.

When behaviour modification and medication are combined, good results are observed in ADHD. However, the latter appears to be more effective than the former (Pelham and Colleagues, cited by Carson et al 2000).

Drugs should be used cautiously only on those children who do not benefit from other alternative forms of treatment

ADHD Beyond Adolescence

Even without treatment, hyperactive behaviour tends to decrease by the time the children attain their middle teens.

It has been noted that there was less education among young adults who had a history of hyperactivity in childhood. There were also more auto accidents among the hyperactive children. However, only a minority continued to display anti-social behaviour into adulthood or developed psychopathologies. Major depressive disorders were rare among ADHD patients (Alpert, Maddocks et al cited by Carson et al 2000) but a small percentage of the patient population did develop psychological problems like being aggressive, abusing drugs in their late teens and early adulthood.

Mental Retardation

In [DSM IV](#), (Diagnostic and statistical manual iv) mental retardation is defined as 'significantly sub-average general intellectual functioning, that is accompanied by significant limitations in adaptive functioning' in such areas like self-care, work and safety. For one to be diagnosed as having mental retardation, the problem should have started before the age of seventeen years. If it occurs thereafter, it is considered as dementia. Mental retardation occurs among children throughout the world. It tends to increase in severity with age starting at five to six and reaches the peak at aged 15. This increase reflects changes in the demands made on the child by the family and the community as a whole.

Mental retardation is often a burden to parents and a socio-economic burden to the community. Mildly retarded children are the majority and usually appear normal in early stages. With adequate resources for education, they are able to learn acceptable social and survival skills such that they lose the stigma of being identified as mentally retarded.

There are several levels of mental retardation:

- Borderline Mental Retardation: 71-84 IQ
- Mild Mental Retardation: 50-55 to 70 IQ
- Moderate Mental Retardation: 35-40 to 50-55 IQ
- Severe Mental Retardation: 20-25 to 35-40 IQ
- Profound Mental Retardation: below 20-25 IQ

Borderline Mental Retardation: 71-84 IQ

With early diagnosis, parental assistance and educational programs, they can adjust socially, master simple academic and occupational skills, and become self-reliant.



Mild Mental Retardation: 50-55 to 70 IQ

They form the majority of those diagnosed as mentally retarded. They do not show any brain pathology and for this reason are capable of schooling. However, they require supervision since they are unable to foresee the consequences of their actions.

Like borderline mental retardation, they can adjust socially, master simple academic and occupational skills, and become self-reliant.

Moderate Mental Retardation: 35-40 to 50-55 IQ

They are considered trainable, that is, they can master some routine skills like cooking if provided with specialised training in such activities.

They are observed to have the following characteristics:

- Low learning ability and not able to conceptualise.
- Physically they appear clumsy, with poor motor coordination and may suffer from bodily deformities.
- Though they appear unthreatening, they may turn out to be hostile and aggressive.
- They can acquire partial independence with early diagnosis, parental help and

adequate opportunities for training.

- In rare occasions, moderately retarded people may be gifted with specialised skills like outstanding musical ability. This phenomenon is documented but not adequately explained.

Severe Mental Retardation: 20-25 to 35-40 IQ

These individuals are sometimes referred to as 'dependent retarded'. They are observed to have severely retarded speech and motor development. Sensory and motor handicaps are also common among the severely mentally retarded.

They are able to develop limited levels of personal hygiene and self-care skills that make them less dependent on others and although they are dependent on others for care, they can perform simple occupational tasks under supervision after specialised training.

Profound Mental Retardation: below 20-25 IQ

This condition is sometimes referred to as 'life support retarded'. Patients suffering from this condition are usually deficient in adaptive behaviour and unable to master any but the simplest tasks. Physical deformities, central nervous system pathology and retarded growth are not uncommon features. Other problems include convulsive seizures, mutism, deafness, low resistance to disease, poor health: all this combined make life expectancy quite short.

The condition is easily diagnosed in infancy due to obvious physical deformities and grossly delayed development. They remain under custodial care throughout their lives.

The condition has a known organic pathology: it is similar to dementia except in the case of a history of prior normal functioning in case of dementia. It has its origin in genetic factors, often due to chromosomal influence and it runs in families, for example, Down's syndrome.

The condition may originate in infections and toxic agents, especially during foetal development. It is also often seen in cases of prematurity and physical trauma. Premature babies, especially those weighing less than 5.5lbs at birth, develop neurological disorders and often mental retardation.

Another causal factor may be ionising radiation. High-energy x-rays used in medicine for diagnosis and therapy, nuclear weapons testing and leakages at nuclear plants among others

may be sources of ionising radiation. The radiation may act directly on the fertilised ovum or may produce mutations in the sex cells of either or both parents, which in turn may lead to defective offspring.

Malnutrition and other biological factors also contribute to the condition. Traditionally, it has been accepted that dietary deficiencies in protein and other essential nutrients during early development may lead to irreversible physical and mental damage. However, according to current thinking, malnutrition has an indirect effect. It alters a child's responsiveness, curiosity and motivation to learn. These losses may lead to relative retardation in intellectual facility.

Other disorders associated with mental retardation are:

- Chromosome 18-trisomy syndrome
- Tay-Sach's disease
- Turner's syndrome
- Klinefelter's syndrome
- Niemann-Pick's disease
- Bilirubin
- Encephalopathy
- Rubella viral infection

Stress and Adjustment Disorders

Now you are going to look at what many people refer to as 'psychiatric emergencies'. The sub-topics you are going to look at closely are:

- Crisis and crisis intervention
- Suicide and suicidal attempts
- Aggression/violence
- Withdrawal syndromes

Crisis and Crisis Intervention

A crisis refers to a situation when the stress exceeds the adaptive capacities of a person or group.

Stress must be differentiated from trauma. A traumatic situation overwhelms the ability to cope whereas stress does not necessarily overwhelm the person. The condition may occur at an average rate of one to two in ten years. The former is more realistic in modern life.

There are several possible causes of crisis. These include traumatic divorce, a natural disaster such as flood, or the aftermath of an injury or disease that forces difficult readjustments in a person's self-concept and way of life.

The recommended outcome of a crisis situation is when the individual person emerges from the crisis more adjusted than before by developing new methods of coping. However, often the crisis may impair a person's ability to cope with similar stressors in future or affecting the overall adjustment capacity. This calls for psychological help.

People in crisis are in acute turmoil and feel overwhelmed and incapable of dealing with stress by themselves. Crisis intervention provides immediate help for individuals and families confronted with stressful situations like disasters or family situations that have become intolerable.

There are two approaches used in crisis intervention.

Short-term Crisis Intervention Therapy

It is of brief duration and deals with immediate problems of emotional nature. The therapist provides as much help as the individual or family will accept. The therapist helps by clarifying the problem, suggests a plan of action, and provides reassurance and gives the needed information and support. A hot-line worker, usually a hot-line counsellor, provides telephone hotline services.

Immediate Crisis Intervention Services

Timing is critical in crisis intervention since it can reduce the emotional distress. A crisis counsellor provides objective emotional support and tries to provide long-term perspective to allow the victim to see that there is hope of survival. The mental health professional obtains, deciphers, and clearly communicates to victims the most accurate picture of the situation obtainable at the moment.

Post Disaster Debriefing Sessions

The desire to 'unwind' in a psychologically safe environment and to share one's experience of the disaster is a universal need of people who have suffered through a traumatic situation.

Victims are, therefore, encouraged to narrate their experiences with professionals and colleagues. This helps each victim to learn how different people react to a traumatic situation.

Mental hospital care is indicated only for those patients who are considered dangerous to themselves or others. It also applies to a situation where the symptoms are so severe that the victims are unable to care for themselves.

In the hospital, traditional methods of treatment used include pharmacotherapy, occupational therapy, recreational therapy, activity therapy, individual or group therapy. In such a situation, no milieu or social learning program is required. Hospital care is then followed by aftercare that is provided by the community mental health facilities and personnel, the community as a whole and of course, the person's family. This kind of care ensures that the patients readjust and return to full participation at home and community with minimum delay and difficulty.

There are several different types of crises or psychiatric emergencies, which will now be covered individually.

Suicide and Suicidal Attempts

Suicide is defined as termination of one's own life. It occurs more often in depressed patients. Suicide is found to occur when a depressed person appears to be emerging from the deepest state of depression. There are several identified risk groups, which include:

- Adolescents from both deprived and affluent families
- People faced with a state of uncertainty and social disorganisation
- People undergoing downward social mobility
- The elderly

Other contributing factors include substance abuse (especially among adolescents), suggestibility through mass media, depressive episodes and commitment to a cause, for example, kamikaze, the Japanese pilots who destroyed themselves in order to save their nation

Suicide Prevention and Intervention Measures

Measures are aimed at resolving crises through alleviating long-term stressful conditions known to be associated with suicide. High-risk groups are made to understand and cope with problems associated with suicide. Those who come in contact with many people in the community, for example, the clergy, nurses, police, teachers

and other professionals should be trained to be alert and sensitive to suicidal threats.

Management of Suicide and Suicidal Threats in the Ward

All suicidal patients must be admitted for close observation and monitoring. This is enhanced by the use of a suicidal caution card, which requires the nurse to:

- Remove dangerous items like ropes and knives from the patient's reach
- Hand over the patient after every shift
- Monitor the swallowing of drugs to avoid suicide though drug over-dosage

In the interim, the therapist is expected to develop a therapeutic relationship with the patient so as to get to the root cause of suicide from the patient. Once the cause is known, the patient is counselled on how to deal with such problems in future. It is important to involve family members and all the members of the psychiatric team.

Panic States/Panic Disorders

This condition is characterised by the occurrence of 'unexpected' panic attacks that often seem to come 'out of the blue'. For somebody to be diagnosed as having a panic attack, the individual should have been persistently worried of having another attack for at least one month. One must also report at least four out of the thirteen symptoms, which have been identified as characteristic of panic states:

- Shortness of breath.
- Palpitations.
- Sweating.
- Dizziness.
- Depersonalisation, which is a feeling of being detached from one's body.
- Derealisation, which is a feeling that the external world is strange or unreal.
- Fear of dying.
- Fear of 'going crazy'.
- Fear of losing control.

The terror attack subsides in minutes. It is worth noting that, since ten out of thirteen symptoms are somatic in nature, the persons involved usually seek medical attention first rather than look for a psychiatrist. Therefore, physicians who have patients complaining of chest pains and who show no sign of coronary artery

disease should refer such a patient to a psychiatrist.

A distinction should be made between anxiety and panic. In a panic attack the onset is sudden. It reaches a peak after ten minutes and subsides within twenty minutes. Periods of anxiety, in contrast, have a gradual onset, take a long time and the symptoms are not as intense.

The condition affects many people but is most common at the age of between 15-24, especially men. For women, onset may appear between 30-40. Although a panic attack appears to come out of the blue, the initial attack appears to follow a state of feeling of distress.

Although causal factors have not been fully identified, it has been argued that a panic attack can be associated with biological chemical abnormality in the brain or genetic factors, especially in relation to first-degree relatives.

Treatment

Treatment of panic disorders can take several forms.

Benzodiazepines

These include zonax and valium. The patient should be observed for tolerance or dependence. The dosage should be gradually decreased to avoid 'rebound panic' which is usually worse than the initial attack.

Antidepressants

These include tofranil. They are a good alternative since they are not addictive, however, they are not useful in the acute stages, as they take too long to act.

Other forms of treatments include psychotherapy, which has more lasting effects. Behaviour therapy is also another useful alternative.

Aggressive Behaviour (Episodic Dyscontrol Syndrome)

Bach-y-Rita et al (1971) described this condition as characterised by repeated unprovoked episodes of violence. The syndrome has more than one cause and was initially thought to include patients with epilepsy. However, in 1973, Maletzky excluded patients with epilepsy, schizophrenia, pathological intoxication with alcohol and acute intoxication with drugs and used the condition to describe a residual group of patients whose unexplained episodes of

violence were preceded by the sequence of aura, headache and drowsiness.

Half of these patients reported amnesia of episodes and half reported EEG abnormalities, usually in the temporal lobes. Maletzky reported improvement with the use of the anti-epileptic drug phenytoin. These findings have never been confirmed by subsequent studies.

Intermittent Explosive Disorder

This term refers to repeated aggressive behaviour directed to people or property that is out of proportion to the provoking event and is not accounted for by another psychiatric disorder, for example, antisocial personality disorder, substance abuse or schizophrenia. The aggression may be preceded by tension and followed by relief of tension. Later the person feels remorse.

The clinical features overlap with accounts of episodic dyscontrol syndrome but without the associated physical symptoms and signs. The condition is rare if care is taken to exclude other causes. Many psychiatrists doubt whether this behaviour indicates a distinct psychiatric disorder.

Violence

This refers to aggressive behaviour that transgresses social norms. While aggression is not a crime, violence is considered a crime since it results in bodily harm.

Withdrawal or Abstinence Syndrome

Many psychotropic drugs do not achieve therapeutic effects for several days or weeks. After the drug is stopped, there is a delay before the effects are lost. Many drugs, including psychotropic drugs produce neuro-adaptive changes during repeated administration. Tissues, therefore, have to readjust when drug treatment is stopped.

This readjustment appears clinically as 'withdrawal or abstinence syndrome'.

Abstinence syndrome occurs as a result of the use, followed by the withdrawal of, antidepressants, anxiolytic and lithium carbonate and other drugs of addiction. In the case of lithium carbonate, 'rebound mania' is observed.

It is important to distinguish between withdrawal syndrome and relapse of disease.

The following general advice should be followed when prescribing medication:

- Use well-tried drugs
- Give an adequate dose
- Use drug combination continuously but judiciously
- Explain treatment to the patient

SECTION 5: COMMUNITY MENTAL HEALTH

Introduction

In this section you are going to examine the development of community mental health.

Objectives

By the end of this section you will be able to:

- Describe the historical development of community mental health
- List the essential elements of comprehensive mental health services
- Describe the prevention of mental illness using concepts of care associated with the public health model

Historical Overview

Bellak (cited by Kalkman, 1967) says that the first phase of psychiatry as an independent science was witnessed at the end of the eighteenth century. This period is symbolised by the striking off of the chains of the mentally ill by Pinel at Bicetre Hospital in 1793.

Sigmund Freud brought about the second phase in the evolution of psychiatry when he introduced psychoanalysis.

The third phase was the advent of community psychiatry or community mental health. It should be noted that the two terms are not identical in meaning.

In 1946, the Congress in the United States of America enacted the National Mental Health Act. This Act made grants available to the states for developing mental health outside the State hospitals. In 1949, the National Institute of Mental Health was founded under this Act, under the direction of President Kennedy. The Congress enacted Public Law in October 31 1963, which required that mental retardation centres and mental health centres be constructed.

Essential Elements of Comprehensive Mental Health Services

In 1964, the Community Mental Act specified the essential elements of comprehensive mental health services. Each centre was to have:

- In-patient services.
- Out-patient services.
- Partial hospitalisation services, including day care.

- Emergency services, provided 24 hours per day within at least one of the three services mentioned.
- Consultation and education available to community agencies and professional personnel.

There are at least twelve directions and developments, which characterise mental health as contrasted with traditional psychiatry.

Directions and developments, which characterise mental health as contrasted with traditional psychiatry:

- Focus on preventative approach with wide spectrum of community mental health services.
- The focus on group process, the community organisation process, the mental health consultation process, the mental health education process.
- New kinds of treatment facilities, for example, community mental health centres, day and night centres, halfway houses, threshold clubs, etc.
- New treatment methods such as the therapeutic community family therapy and group therapy.
- The use of welfare workers and public health nurses who are in contact with population at risk.
- The shifting of emphasis to individualisation of the patient.
- The growing openness of the hospital to the community.
- The inter-disciplinary efforts in the field of mental health at research and treatment levels.
- Increasing emphasis on research and epidemiological investigations.
- Incorporation of knowledge from fields such as social psychology, sociology and anthropology in order to provide greater understanding of social phenomena.
- The acceptance of planned change within the framework of democratic ideas.
- The focusing on social systems such as the group, the family, the organisation, the hospital and the industry, that is, the basic units in the larger community, which are pertinent to community mental health.

Prevention of Mental Illness using the Public Health Model

Disease evolves over time and the pathological changes become less reversible as the disease process continues. The main aim of health care services is to reduce or to reverse the changes as early as possible, thereby preventing further damage to the body tissues and organs.

A three level model for intervention, based on the stages of disease was developed in 1965 by H.R Leavell and E.G Clark.

The three levels of the model are:

- Primary prevention of disease
- Secondary prevention of disease
- Tertiary prevention of disease

Now move on to look at each of these levels individually.

Primary Prevention

This is the true prevention of disease. The actions of primary prevention are carried out before the disease or dysfunction has occurred in the body. Primary prevention actions are directed at depressing the risks of acquiring disease. The activities include health education, environment sanitation, supply of clean safe water, adequate nutrition, rest, sleep, recreation, personal hygiene, good working conditions, good housing, regular physical checkups, screening for disease, genetic screening and counselling.

Additional activities are immunisation against specific diseases, avoidance of home accidents, preventing road, rail, air, sea and industrial accidents.

Secondary Prevention

This focuses on preventing the development of complications in persons who are already suffering a health problem. Secondary preventive actions are aimed at diagnosing disease early and treating it promptly so that the condition of the diseased individual does not worsen.

The main goal is to cure the disease completely in its early stages or when a cure is possible. If a cure is impossible, secondary prevention slows the progression of disease as well as preventing complications and limiting disability. Some of the secondary prevention activities are:

- Screening tests to detect early pre-symptomatic physiological and anatomical indications of disease, for example, Pap smear, random blood sugar test, etc.
- Case finding and case holding

- Screening surveys and examinations
- Mass treatment campaigns
- Adequate treatment of disease
- Follow-up of treated clients of special clinics and home visits

Tertiary Prevention

When a disease or a dysfunction causes permanent disability, tertiary prevention is used to limit the severity of the disability in the early stages of the disease. In those cases where residual damage is being experienced, disability is permanent and tertiary prevention takes the form of rehabilitation.

Tertiary prevention activities include restoration of functioning and rehabilitation through:

- Retraining and education to maximise use of remaining capacities
- Selective placement
- Work therapy
- Modification of environment
- Home nursing and health visiting

Tertiary prevention care aims at helping the patient achieve as high a level of functioning as possible, despite the limitations caused by illness or impaired functioning.

Psychiatry has traditionally focused on secondary and tertiary prevention. Secondary prevention involves lowering the disability rate by shortening the average duration of nervous disturbances through early diagnosis and effective treatment. Tertiary prevention involves reduction of disability in individuals with long-standing and incurable psychiatric disorder. By contrast, primary prevention is total prevention.

Alternatively one can use the modified public health model.

The Public Health Model

The public health model of 'primary, secondary and tertiary prevention' has been modified in order to provide distinction between prevention and treatment. Prevention efforts are classified into three sub-categories: universal, selective and indented intervention.

Universal Intervention

These are efforts aimed at influencing the general population, mainly concerned with two tasks:

- Altering the conditions that cause or contribute to mental disorders, also known as risk factors.

- Establishing conditions that foster positive mental health, also known as protective factors.

Universal intervention includes biological, psychological and socio-cultural efforts.

Biological Measures - This includes the development of adaptive life style, improvement of diet, having routine exercise, and overall good health habits.

Psychosocial Measures - Here opportunities to learn physical, intellectual, emotional and social competencies are provided. For example an individual is assisted to develop skills needed for effective problem solving, for expressing emotions constructively and for satisfying relationships with others.

The person may also be helped to acquire an accurate frame of reference on which to build their own personality. The patient should be prepared

for problems they are likely to encounter during certain stages of life, for example, problems associated with pregnancy and child rearing must be discussed with women.

Socio-cultural Measures - These measures ensure a reciprocal relationship between an individual and their community. They also encourage social conditions that promote healthy development and functioning individuals, and incorporate services ranging from public education and social security to economic planning and social legislation directed at ensuring adequate health care for all citizens.

Selective Intervention

This model involves the establishment of programs that prevent the development of disorders, before people become so involved with certain behaviour patterns that future adjustments become difficult or impossible.

Examples of successful programs include:

- Education programs, which involve the provision of information to the groups at risk.
- Intervention programs involving the identification of high-risk groups and taking the necessary measures.
- Peer group influence programs, which help youngsters to overcome negative pressures from peers by being assertive.

- Programs to increase self-esteem, which enable the individual to overcome pressure from more dominant peers.

Indicated Intervention

This program emphasises the early detection and prompt treatment of maladaptive behaviours in a person's family and community setting. For example, in a crisis after a disaster, immediate and relatively brief intervention is carried out to prevent any long-term consequences.

UNIT TWO: SOCIOLOGY AND ANTHROPOLOGY

In this unit you will cover familiar information on human societies and their interactions within communities (anthropology). In sociology you will study how societies are structured and the terms used in studying societies.

This unit is composed of nine sections:

Section One: Introduction to Sociology and Anthropology.

Section Two: The Socialisation Process.

Section Three: Social Stratification.

Section Four: Social Mobility

Section Five: Cultural Beliefs, Practices, Social Changes and Effects on Health.

Section Six: Social Change.

Section Seven: Social Institutions.

Section Eight: Conflict Resolution and Negotiation Process.

Section Nine: Application of Sociology and Anthropology in Nursing.

Unit Objectives

By the end of this unit you will be able to:

- Describe the concepts used in sociology and anthropology in the delivery of health services.
- Describe the cultural beliefs, practices and social change that affect health.
- Identify and describe various social institutions.
- Describe conflict and conflict resolution.

SECTION 1: INTRODUCTION TO SOCIOLOGY AND ANTHROPOLOGY

Introduction

According to Perry (1996) sociology is not concerned with teaching us about new things but with teaching us about new ways of looking at common things. Thus, for example, when you study common agents of socialisation like the family, you will find that there are other contemporary agents, like the media, which also strongly impact on the process of socialisation. Each one of us

should, therefore, keep abreast with changes occurring around us that involve human relationships and the ways of doing things.

You will also study culture and its effects on the health of people. This is also referred to as medical anthropology (McElroy Townsend 1996). You should be able to contribute a lot to this section by drawing from your life and field experiences. You will also cover social institutions, such as religious, educational, and political organisations that provide associational services to society (Akinsola 1983). Finally, you will cover human rights, drawing on the knowledge you gained through reference to professionalism and trends in nursing.

In this section you will start by defining some terms in sociology and anthropology before you move on to study the concept of sociology.

Objectives

By the end of this section you will be able to:

- Describe the definition of sociology
- Describe the definition of anthropology
- Define the differences between sociology and anthropology
- Describe the concepts in sociology

Introduction to Sociology and Anthropology

Sociology

The term 'sociology' can be traced to Auguste Comte in 1837. He combined the Latin word for society (socio) with the Greek word for science (logy) thus identifying an area of study that pertained to the science of society. Sociology is the study of social life, social change, and the social causes and consequences of human behaviour. Sociologists investigate the structure of groups, organisations, and societies, and how people interact within these contexts. Since all human behaviour is social, the subject matter of sociology

ranges from the intimate family to the hostile mob; from organised crime to religious cults; from the divisions of race, gender, and social class to the shared beliefs of a common culture; and from the sociology of work to the sociology of sports.

What is Sociology?

Sociology is about people. It is about how people interact and why they behave as they do. Whether you look at a family, a business, or a sporting event, you are looking at something that sociology is involved with. No matter what you do in your personal and professional life or where you go, you can use sociology. Sociological research contributes to our understanding of individuals, groups, organisations, communities and societies. Practising sociologists conduct or assist in problem solving interventions on all of these levels.

Auguste Comte (1837) defined sociology as dealings with all aspects of human activities and relationships, their outcomes, rules and regulations. On such a base, society is organised and controlled. Peil (1977) explained how relationships between individuals or groups function, and how changing circumstances and relationships influence these. For example, a school child is as much a part of a family as a grown up of 18 years who after college, is employed and may marry thus forming a new family unit.

According to Akinsola (1983) sociology is explained as a social science that deals with the organisation of societies, people's patterns of behaviour within the social structure, and how these social structures are arranged in the society.

Anthropology

Anthropology is the classification and analysis of humans and their society, descriptively, culturally, historically, and physically. Its unique contribution to studying the bonds of human social relations has been the distinctive concept of culture. It has also differed from other sciences concerned with human social behaviour (especially sociology) in its emphasis on data from non-literate peoples and archaeological exploration.

Emerging as an independent science in the mid-19th century, anthropology was associated from the beginning with various other emergent

sciences, notably biology, geology, linguistics, psychology and archaeology. Its development is also linked with the philosophical speculations of the Enlightenment about the origins of human society and the sources of myth. A unifying science, anthropology has not lost its connections with any of these branches, but has incorporated all or part of them and often employs their techniques.



What is Anthropology?

Anthropology is divided primarily into physical anthropology and cultural anthropology.

Physical Anthropology

Physical anthropology focuses on the problems of human evolution, including human palaeontology and the study of race and of body build features or constitution (somatology). It uses the methods of anthropometry, as well as those of genetics, physiology and ecology.

Cultural Anthropology includes:

- Archaeology, which studies the material remains of prehistoric and extinct cultures.
- Ethnography, which is the descriptive study of living cultures.
- Ethnology, which utilises the data furnished by ethnography, the recording of living cultures, and archaeology, to analyse and compare the various cultures of humanity.
- Social anthropology, which deals with human culture and society.
- Linguistics, the science of language.

Applied anthropology is the practical application of anthropological techniques to areas such as industrial relations and minority group problems. In Europe the term anthropology usually refers to physical anthropology alone.

Anthropology's diverse subject matter - being human beings in all times and places - reflects the discipline's interest in:

- The human culture dating from the Palaeolithic past to contemporary time.
- The exotic, distant societies and the myriad subcultures of the western world.
- The biological bases of human behaviour and our most elaborate cultural creations.
- The interaction of diverse peoples in colonial and modern contexts.

Anthropological methods, grounded in the practical realities of daily life and direct ethnographic research, are applicable cross-culturally. Perhaps its greatest strength, however, is the perspective anthropology seeks to promote: an understanding and appreciation of cultural diversity, human universals, and the dynamic potential of human culture.

How Can You Differentiate Sociology from Anthropology?

Sociology	Anthropology
Deals with all aspects of human activities and relationships, their outcomes, rules and regulations.	Deals with the classification and analysis of humans and their society, descriptively, culturally, historically and physically.

Here are some terminologies used in sociology that you should familiarise yourself with:

- Group - this is a combination of more than two persons with common values and objectives, for example, a group of boys walking to the market, a family.
- Role - this is defined as an expected behaviour attached to social status.
- Status - this refers to one's position in a society or social group.

Concepts in Sociology

Concepts are ideas, they are expressed through certain words, which are understood to have a particular meaning that defines an underlying reality. Many specific cases are grouped together and a word is used which expresses

what representatives of this group or category have in common.

Culture and Civilisation

The general public often thinks of culture as the aesthetic code of society: art, music, drama and literature. In their definition of culture, social scientists include everything passed down by human society except its biology. This consists of language and technology, laws and customs, beliefs and moral standards. The child is born into a society and learns its culture in the process of growing up. For each individual, there is a specific culture that is the social heritage of a particular society at a given time. The sense of time is an example. Africans are culturally and socially conditioned to divide days and years into regularised patterns. Even with many of us now owning watches there are still marked differences between 'African time' and 'European time'. Punctuality has not yet acquired a cultural value for many Africans.

There is sometimes also considerable cultural diversity within a society and if boundaries can be drawn around certain groups, they may be referred to as subcultures. The subculture would incorporate sets of beliefs, norms and customs among others. For example, in Tanzania most people speak Kiswahili in addition to their local language but there are other differences like some being Christians while others are Muslims. This brings about cultural diversity.

Language is also especially important to culture because it allows human beings to express their symbols and meanings in a way, which can be understood by others. Language must be learned. A child growing up with animals would have no language just as it would have no other culture. It is the main means of passing on the cultural heritage. It allows the development of abstract principles in science and morality, which would be impossible without it.

Civilisation was originally identified with the city because the growth of cities ushered in improvements in man's standard of living, which raised him from the 'primitive' subsistence state. The word comes from civis, the Latin word for citizen, which can be contrasted with the pagani, residents of country districts. A notable component for being identified as 'civilised' in English-speaking African countries is being educated.

Role

A society can be seen as a system of roles, each of which involves relationships between people, patterns of behaviour and rights and duties associated with a particular position. Everyone has more than one role. For example, you may be a son or a daughter, a student, a friend, a citizen, and so on. You also have other kinship, economic, political, religious and recreational roles.

The social structure of a society includes all of its roles and social organisations. An individual's behaviour in society is structured by the roles that they fulfil and the organisations they belong to. Role relationships may be specific or diffuse, broad or narrow or generic or proper. They also differ from one culture to another. All the relationships involved in a particular role can be summarised as the role-set.

Role conflict and role strain may arise if a person cannot meet all the demands of their various roles. An African woman, for example, is expected to hold a full-time job as well as care for a household and several children. In addition to conflict between roles, which are wholly or partly incompatible, there may be psychological strain in carrying out a single role satisfactorily because various members of the role-set make conflicting demands.

A example of system of roles held by an individual Values, Norms and Institution

Kluckhohn defines value as 'a conception, explicit or implicit, distinctive of an individual or characteristic of a group which influences the selection from available modes, means and ends of action.'

Values

Values are usually inferred from observed behaviour. If a person regularly associates with certain people, it can be assumed that they value this relationship. It would be more correct though, to treat values as either dependent variables, that is, the values of a person are the result of their experiences and the society in which they live or intervening variables, that is, given certain causes or pressures, the result will vary according to the person's values rather than as independent variables, which refers to values that directly cause people to act in certain ways.

Norms

Norms are the standards that govern behaviour in roles. They are societal expectations of what is normal. Sometimes, they have been formalised as law, but most norms are less formal. However, many people do not follow norms exactly in their daily lives because they may think it is impossible or just inconvenient. Therefore, a distinction should always be made between behaviour and norms. Often, for example, when you are conducting a study, people do not tell you about societal norms but refer mostly to what it is that they actually do.

Sumner, an early sociologist, divided norms into folkways, mores and laws or stateways:

Folkways

Folkways are customary practices that are considered appropriate behaviour but are not rigidly enforced. For example, if one builds their house in a somewhat different shape from the others, they may be considered eccentric or an individualist but people will not be particularly bothered by their behaviour.

Mores

Mores are subject to strong sanctions because they are considered much more important to the welfare of the society. For instance, wives should be faithful to their husbands and not commit adultery. Mores also include taboos, for example, certain communities are not allowed to eat certain animals.

Laws or Stateways

Laws on the other hand, may be customary or enacted. When the chiefs or elders hold court to deal with disputes over land or wives, they are enforcing customary law based on tradition and public opinion about norms. Large societies often cannot rely solely on customary laws because they comprise a mixed group of people. Consequently, written rules are needed to deal quickly with a changing situation and to make clear to everyone what is expected of them. Thus, the political system gradually develops enacted law, known as stateways. Mores may be embodied in the laws.

Institution

An institution may be defined as an enduring complex of norms, roles, values and sanctions embracing a distinct segment of human life. When certain patterns of behaviour have become a well-established part of the social

structure, it can be said they are institutionalised. The family and kinship institutions are basic to social relations as they give every member of the society a place at birth and are essential for the continuance of the society. The word institution is sometimes used when organisation or association would be better, for a specific group of individuals pursuing a common goal, for example, a university. These provide a focus for research on the political, religious and educational institutions of the society, in which they are found, for instance, studying the effect of participation in the university community on placement in the stratification system after graduation.

Social Group and Community

The study of social groups is fundamental to sociology because patterns of interpersonal behaviour are often structured by membership in one or more groups. The word group may refer to a categorical group, that is, any set of people that the speaker wants to treat as a unit. On the other hand, it is also used for corporate groups, that is, people who interact over a period of time and who have some form of organisation, a sense of solidarity and common values, norms and goals which allow them to undertake joint action. A study of the relations between individuals within the group provides information on factors affecting role performance and the way power, authority and influence are exercised. We may also analyse the relations between groups, the role of social groups in forcing institutional change or change in personal behaviour, or the way various social groups together form the building blocks of the society.

The word community usually implies some idea of locale, frequent social interaction and close ties between members of a group. These ties may be based on kinship, common occupation and so on, as long as they are sufficiently important to provide the members of the community with common interest and goals.

Wolpe notes three characteristics of the communal group: a common identity and culture; male and female representatives of all age groups; and differentiation by power, status and wealth.

Function and Dysfunction

Sociologists are concerned with how a society works as a whole and with how each of the parts fit together. As such, they study the functions of

norms, roles and institutions. It is easy to assume that any patterns one finds are functional, that is, that they help a society to reach its goals. However, frequently one finds patterns which give rise to conflict and seem to work contrary to what the participants intend. Activities that are detrimental to the system are termed dysfunctions. You should note, however, that behaviour that is functional in certain circumstances may be dysfunctional for other goals or individuals.

SECTION 2: THE SOCIALISATION PROCESS

Introduction

In this section you are going to continue to cover the concepts in sociology focussing on the socialisation process.

Objectives

By the end of this section you will be able to:

- Define the socialisation process
- Describe the two parts of the socialisation process
- Identify the agents of socialisation

The Socialisation Process

As you cover the socialisation process you need to note that this process draws attention to the individual and how they fit within the society through the adaptation process, that is, the ability to cope with life changes. Individuals need to develop coping abilities since all situations in life keep changing (Gelder, 2000).

What do you understand by the term socialisation process?

The Socialisation Process

According to Peil (1977) it refers to all the things that a child needs to know in order to function as a confirmed member of society.

Akinsola (1983) defines socialisation as the fundamental social process by which a person is introduced to be part of society into which one was born and learns its culture. Although much of this learning takes place in the first two or three years of life, socialisation continues throughout life. When we attend school, move to a new place, take a new job or whenever we are called to make changes in customs, norms or behaviour, additional socialisation is necessary.

Socialisation integrates a child into the community by teaching them the disciplines, aspirations, social roles and skills necessary for group membership.

By comparing the two definitions it can be observed that socialisation is a process of adjustment and this adjustment starts from birth and continues throughout one's life (Myles 1983). This definition was further expanded by Joseph (1986), who explained that parents, teachers and other social agents define roles for people in society.

Socialisation refers to the development of the individual from infancy upwards; it is intertwined with the educational system, whether through formal education in schools, through non-formal programmes, or through informal education such as family upbringing. It is intrinsically based upon the right to education and hence the maximisation of the potential of the individual in the process of development.

Human infants are born without any culture. They must be transformed by their parents, teachers, and others into cultural and socially adept animals. The general process of acquiring culture is referred to as socialisation. During socialisation, we learn the language of the culture we are born into as well as the roles we are to play in life. For instance, girls learn how to be daughters, sisters, friends, wives and mothers. In addition, they learn about the occupational roles that their society allows them. We also learn and usually adopt our culture's norms through the socialisation process. Norms are the conceptions of appropriate and expected behaviour that are held by most members of the society. While socialisation refers to the general process of acquiring culture, anthropologists use the term enculturation for the process of being socialised to a particular culture. You were educated in your specific culture by your parents and the other people who raised you.

Socialisation is important in the process of personality formation. While much of human personality is the result of our genes, the socialisation process can mould it in particular directions by encouraging specific beliefs and attitudes as well as selectively providing experiences. This very likely accounts for much of the difference between the common personality types in one society in comparison to another.

Successful socialisation can result in uniformity within a society. If all children receive the same socialisation, it is likely that they will share the same beliefs and expectations. This fact has

been a strong motivation for national governments around the world to standardise education and make it compulsory. Deciding what things will be taught and how they are taught is a powerful political tool for controlling people. Those who internalise the norms of society are not likely to break the law or want radical social changes. In all societies, however, there are individuals who do not conform to culturally defined standards of normalcy because they were 'abnormally' socialised, which is to say that they have not internalised the norms of society. These people are usually defined by their society as being deviant or even mentally ill.

Parts of the Socialisation Process

Having defined the socialisation process you will now identify the parts that make up the socialisation process.

The socialisation process is made up of two parts:

- Primary socialisation
- Secondary socialisation

You will study each of these individually.

Primary Socialisation

This is the type of socialisation that starts from infancy with parents and other family members who are in close contact with the young one. The mother plays an active role in bonding with her infant. As the child advances in age, they are taught the expected roles according to age and sex. For example, children are taught to be obedient to parents and other older persons in the neighbourhood. Children also learn by observing and imitating others. Therefore, parents should be role models if they expect their children to attain acceptable behaviour. In due course children will learn how to dress, use the toilet facilities, feed themselves and so on. In the traditional African family, parents and the extended family members were involved in socialising the child. According to Peil (1977), at this stage, the child also develops a personality, that is, identifies the self in relation to society.

In modern times, although parents are still the basic agents of socialisation, there are additional agents. These developments are often associated with the tendency for mothers to be in full time employment. Usually, the infant stays with the mother for six weeks following birth. The baby is then left in the care of hired female domestic help. The mother does this in order to resume her duties in either the government, private or self-employment. It is no longer

possible to have extended family members to help in the care of the young. When the child reaches the age of six years, they are ready to be introduced to socialisation outside the home and they are then able to communicate using a common language. This leads to secondary socialisation.

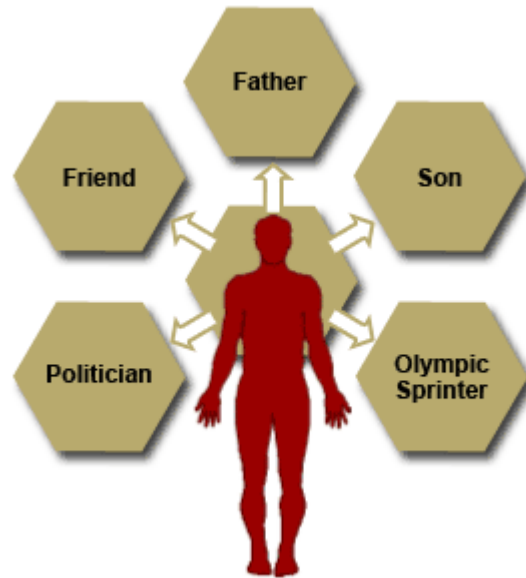
Secondary Socialisation

This takes us outside the home with playmates in the neighbourhood, at school and with other community agents, for example, religious forums. According to Peil (1977), rearing children in an urban area of western Africa is very much the same as in the countryside. For example, parents who are well educated prefer to move from rural to urban areas. They may work as employees of the government and children are encouraged to go to school early and join church groups. All these offer secondary socialisation. In addition, children in various neighbourhoods play with their peers who also influence their behaviour and attitudes. As these children continue their education through primary, secondary and college levels, they come into contact with several social groupings, all of which are in a position to influence their behaviour

During adolescence, the youth often confide in their peers. They no longer feel compelled to express their needs to the parents. When this happens, it is possible for the youth to imitate negative behaviours from their peers, behaviour which is often contrary to their parents' expectations. On the other hand, youths who move to boarding secondary schools may get secondary socialisation from their teachers, who become their new parent figures and role models. The youth of today often develop their own pattern of language for communication, known as sheng in Nairobi, that parents and teachers are unable to communicate in.

As a member of one group, the individual recognises that there are several roles one is expected to fulfil. For example, when one joins the nursing profession as a student, they are expected to continue being a daughter or son, a learner while in class and clinical areas, a member of the student nurses' association, a choir member, a parent and a spouse. All these roles demand the attention of the same individual. This calls for emotional and physical maturity in order to fulfil all these roles without conflicts. For example, as you continue studying,

you will need to share out some of your social roles with family members in order to have adequate time for your assignments



In general, a child is 'socialised' in various ways, for instance, by watching adults. This is often noticeable in the way much of children's play imitates adults. Some socialisation is deliberate, for example, when a teacher or a parent shows a child how to do something. At other times, it is casual or even accidental. A parent or another child indicates that performance has been unsatisfactory and the child must pick up the knowledge they need informally through observation. In addition to verbal instructions and observed behaviour, the child responds to the attitudes expressed through physical posture, tone of voice and other signs, which gradually acquire meaning for them, for example, a raised arm signals trouble. The prime source of socialisation, though, is language. A person who cannot hear or speak has great difficulty communicating with others and is often excluded from groups.

Although all members of the society are socialised, they do not all turn out the same. Each individual comes under various influences and responds to them differently. A child's socialisation may therefore not be exactly the same as that of their parent's. Personality and innate capabilities are important in secondary socialisation. Given the same socialisation, one man may turn out to be much more independent than his brother, or more scholarly or a better drummer.

Listed below are the other classifications of socialisation, click on each link to read a description.

Natural and Planned Socialisation

Socialisation	Natural	Planned Socialisation
	Natural socialisation occurs when infants and youngsters explore, play and discover the social world around them.	Planned socialisation occurs when other people take actions designed to teach or train others - from infancy on.
	Natural socialisation is easily seen when looking at the young of almost any mammalian species (and some birds).	Planned socialisation is mostly a human phenomenon; and all through history, people have been making plans for teaching or training others.

Both natural and planned socialisation can have good and bad features: It is wise to learn the best features of both natural and planned socialisation and weave them into our lives.

Positive Socialisation

Positive socialisation is the type of social learning that is based on pleasurable and exciting experiences. We tend to like the people who fill our social learning processes with positive motivation, loving care, and rewarding opportunities. Negative socialisation occurs when others use punishment, harsh criticisms or anger to try to 'teach us a lesson'; and often we come to dislike both negative socialisation and the people who impose it on us.

Mixed Positive and Negative Socialisation

There are all types of mixes of positive and negative socialisation; and the more positive social learning experiences we have, the happier we tend to be - especially if we learn useful information that helps us cope well with the challenges of life. A high ratio of negative to positive socialisation can make a person unhappy, defeated or pessimistic about life.

Deliberate Socialisation

Deliberate socialisation refers to the socialisation process whereby, there is a deliberate and purposeful intent to convey values, attitudes, knowledge, skill and so on.

Examples of deliberate socialisation include

- School situation
- Parents telling a child to always say 'please'

Unconscious Socialisation

Unconscious socialisation occurs as a result of spontaneous interaction, with no purposeful or deliberate attempt on the part of anyone involved to train or educate and so on. An example of unconscious socialisation is, for example, when a child learns how to use vulgarity by observing a parent caught up in a frustrating traffic situation.

Having covered the various types and classifications of socialisation, you will now cover the agents of socialisation.

Agents of Socialisation

You have already noted that parents and close relatives are the first to socialise children. As the child reaches school age, most socialisation begins to take place outside the home. The primary agents of socialisation make the deepest impression on the personality of the child because they provide the first training. The other agents must, therefore, compete for attention on the already established framework.

Family

The family is made up of parents, children and close relatives. These are the primary agents of socialisation who influence the child's behaviour and attitudes within the society. You will study more on the family in section four on social institutions.

Social Institutions

These are explained as social organisations each with a specific function (Akinsola 1983). Examples of social institutions are the family, schools, religious organisations, government and hospitals. Each of these social institutions is organised to offer a service to community members. When a child enters school they start experiencing secondary socialisation through the teachers, schoolmates and the school environments. All these factors play a part in the child's socialisation.

Peers, School Friends and Neighbours

The peers, schoolmates and neighbours that a child spends most of their waking hours with also become major agents. Children have friends whom they want to be similar to. However, sometimes what their peers tell them may not conform with what the parents are telling them and so they have to make a decision between the two. The decision made depends on the strength of the foundation laid by the parents.

Electronic and Printed Media

These include books, magazines, journals, television, radio, computer (internet) and others. A child may begin to emulate what they are seeing on television and may act negatively if they are not able to filter the good and the bad based on earlier teachings. This can have both positive and negative influences on the child or even an adult.

Generally, it can be seen that various socialising agents encountered by an individual may support each other by promoting the same goals, or they may provide contradictory advice. The child may be taught one thing at home and another at school. The influence of either the parents or the school thus becomes weakened and the child may not fully internalise any norms because they are not sure which ones are most valuable. This becomes more and more frequent as the child grows up. This is because the child encounters other agents of socialisation like the church and other peers and they may not always be carrying the same message. In the end, the child has to choose whom to learn from - either the parents, the friends, the church, etc and so one becomes weakened as another is strengthened.

Aims of Socialisation:

1. To instil discipline (for example, don't walk in front of a moving car).
2. To develop aspirations and ambitions (for example, I want to be a nun, rock star, great sociologist).
3. To develop skills (for example, reading, driving and so on).
4. To enable the acquisition of social roles (for example, male, student and so on).

SECTION 3: SOCIAL STRATIFICATION

Introduction

In this section, you will cover how societies are differentiated. In every society, there are those who take the lead, for example, the elders, chiefs, successful farmers, teachers, lecturers, managers, business tycoons and so on. The difference between those who lead and those who are led may result from factors relating to gender, age and social roles. For example, in some cultures older men are viewed with higher regard than young men, women and children in that order. This is the traditional type of differentiation common in Africa (Peil 1977). In addition, in every society some people are identified as senior and others junior. In the nursing profession, there are similar relationships, for example, the matron and staff nurse. Each is assigned special roles and obligations according to their respective authority.

Objectives

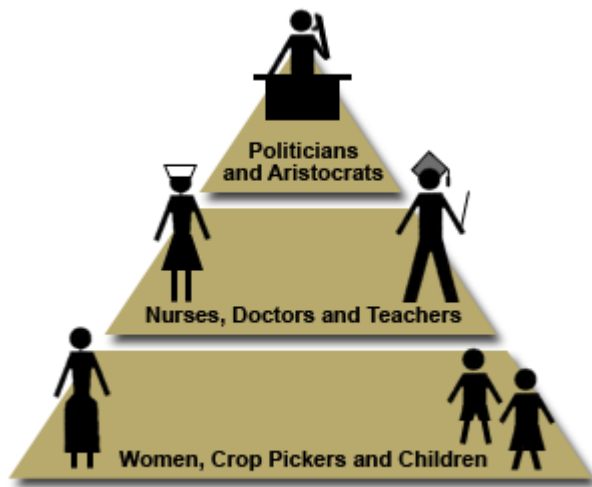
By the end of this section you will be able to:

- Define social stratification
- Identify the theories of social stratification
- Identify the types of social stratification

Social Stratification

The basic idea of social stratification is a series of layers, rather as one bolt of cloth might be piled on top of another. It was developed in European society to explain clashes between the old aristocracy of landed wealth, the new industrial capitalists and the workers, over political and economic power and cultural dominance. Stratification is the organisation of society resulting in some members having more and others having less. Social stratification is thus defined as a process ranking members of society according to wealth, prestige and power. This definition mainly applies in European communities where defined explanation is acceptable. In African societies, members are

ranked according to sex, age, ethnic origin and occupation (Peil 1977).



Social Stratification in African Society

Other definitions of social stratification include the arranging of members of a society into a pattern of superior and inferior ranks, which is perhaps determined by their birth, wealth, power, education, and so on. It can also be said to be the way societies are organised, for example, into clans, castes, chiefdoms, or states within

a society.

Systems of social inequity exist in all human societies. This assertion emphasises two features that are basic for analysis of social inequalities and equalities.

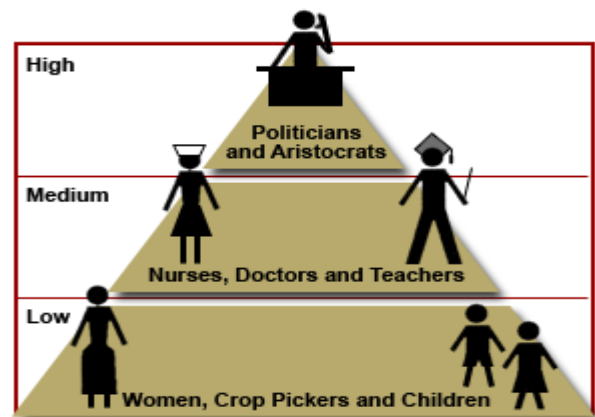
Firstly, the inequalities, no matter what their origin, appear in a social context. Biological differences, real or presumed, may be used as a basis for social stratification, but biology alone does not make a social difference. It is more likely that biology is invoked as a rationale to support established social inequalities. When social definitions with respect to equality change, so do the biological justifications that are used.

Secondly the equalities are systematic. They are organised into patterns that are recognised and accepted by most, but not all, members of the society. Social differences are interlaced in the dominant values of a society; the inequalities are justified by the very beliefs that regulate a society and give it continuity.

A stratification system has both a moral/cultural base and a structural base. Each culture has some view of an admirable person against which individuals may measure their own and others' conduct, an ideal that people try to live up to. This may be generalised or specified as behaviour that is expected of holders of certain roles, for example, a father. Stratification arises from the division of labour, whereby certain roles are admired more than others. Members of the society are valued according to the roles they fill and also according to the way the role is carried out.

Much more attention is usually paid to the structural aspect of stratification (the processes for allocating people to roles and the societal structure which results) than to the cultural aspect (beliefs about how and why people are allocated and the justice or injustice of the process). Some roles are held to be important, but are in fact given to less able people or are poorly rewarded.

How an Individual is Rated in Different Roles



Theories of Stratification

The Functional Theory of Stratification

The functional theory of stratification holds that a society, through its members, makes certain decisions about the allocation of desirable roles. Choice is limited by the number of these roles and the number of people available to perform them. The rewards attached to various roles (wealth, prestige or power) are justified by the service to society involved (especially to societal survival) and the rarity of the abilities needed to fill them.

The Conflict Theory of Stratification

The conflict theory of stratification draws largely on the writings of Karl Marx, though adjustments have been necessary to adapt in the changing nature of twentieth century capitalism. Marx saw society as divided into two major groups (capitalists and proletarians or workers) who are inevitably in conflict. Whereas Marx was particularly concerned only with the economic or market hierarchy, which he termed class, Max Weber suggested that people are also stratified according to status (prestige or lifestyle) and power. These three hierarchies may be closely related, but this is not necessarily so. Marx assumed that those with a high economic position would also have power, but rich businessmen often have less power than higher civil servants on moderate salaries; clergymen and teachers usually have higher status than either wealth or power - though this was more likely some time back.

Status

Another way of ranking society members is according to their status. Status can be defined as any position within the stratification system. This definition says nothing about the basis for status in a stratification system. Thus a particular status or position can be high or low on the basis of the property, prestige or power (or all three) associated with that position. There are two types of status.

Ascribed Status

This is explained as grouping individuals according to their social position, for example, by virtue of one's age, sex or position of birth (indicates that the holder of this position was born within or inherited a given status in society). Ascribed status is a position based on who you are not what you can do.

A good example of ascribed status can be found in India, where the caste system is practised. Members of the upper caste do not in any way interact with those of the lower caste or the untouchables. Members of the upper caste are usually well educated, while those of the lower caste are poor with limited opportunities and are usually manual workers. These two caste level societies do not intermarry (Joseph 1986). This system is also known as a closed system of social stratification.

Therefore, when a society uses ascriptive status rules, people are placed in status positions because of certain traits beyond their control

such as family background, race, sex or place of birth.

Achieved/Acquired Status

Achieved status is a position gained on the basis of merit or achievement. This is defined as the position in society earned through the individual's efforts or choice, for example, being a father, mother, nurse or a teacher.

SECTION 4: SOCIAL MOBILITY

Introduction

What is the outcome of social stratification? Some positive results do occur in the case of open systems that appreciate one's changing status, for example, acquired/achieved status. In Kenya individuals who pursue education to college and university are viewed as being of a higher status than those who are schooled up to primary and secondary levels respectively. Therefore, the daughter of a peasant farmer who pursues her education to the level of a graduate nurse, will have uplifted herself and her parents, thereby acquiring higher status for herself and at times, her parents, this is social mobility. In this section you are going to study social mobility.

Objectives

By the end of this section you will be able to:

- Define social mobility
- Identify the types of social mobility
- Define social mobilisation
- Identify its benefits in the community

Social Mobility

The ability to move up or down the social level is referred to as social mobility. The amount of mobility in a society depends on two factors. First, the rules governing how people gain or keep their position may make mobility difficult or easy. Secondly, whatever the rules, structural changes in society can influence mobility. Social mobility occurs in an open social system while closed systems offer no room for any movement.

Types of Social Mobility

There are two types of social mobility:

- Vertical social mobility
- Horizontal social mobility

You will look at these types in more detail.

Vertical Social Mobility

This refers to the ability of the individual to move up the social ladder, thereby raising their social status and role. It also refers to any upward or downward change in the absolute or relative rank of an individual or group. An example of this would be the nurse, who joins the profession as a community nurse and, by increasing their knowledge through in-service education, acquires the new position of a professor in nursing.



Vertical mobility is often inferred from occupational mobility, and the inference is generally justified because the position of the individual in a pattern of inequality largely depends on their occupation. The change in status between father and son is called intergenerational mobility whereas changes during the individual's work life are known as intragenerational or career mobility. In Africa, intergenerational mobility of females is usually made by comparing the occupations of her father and her husband. For instance, the daughter of a skilled worker who marries a professional man is considered upwardly mobile. Some of the conditions that affect intergenerational mobility include differences between parents and offspring. Thus, if a parent occupies an important position requiring high capacity, their children, if they are less capable are likely to be downwardly mobile. In the same way, children who are more capable than their parents are likely to be upwardly mobile,

especially in open class societies.

Another condition affecting mobility rates is population change where in industrial and industrialising societies, greater population expansion at the lower levels than at the higher levels contributes to upward mobility. Changes in occupational structure can also affect mobility. Changes in the amount of inequality, in the proportion of people at each social level, and in the relative rewards and resources attached to different social positions are not merely a matter of individuals changing their positions within the system of stratification.

Horizontal Social Mobility

This refers to the type of social mobility where the individual maintains the same status. It is also defined as an alteration of position with no significant movement up or down in the system of social stratification, for example a general nurse who trains as a midwife but has no change in salary. This nurse maintains the same status although their role may have changed. Certain characteristics can affect the individual's chances of moving up the social ladder.

Community Size

This is where a large community often results in greater economic differences. This is more apparent in larger cities and thus may be more likely to impart incentives to lower level children.

Number of Siblings

Number of siblings is where an only child or children having one sibling have the best chance of being upwardly mobile.

Mother Dominance

Mother dominance is where the strong mother family seems to be more conducive to upward mobility than the egalitarian or father-dominant family.

Late Marriage

Late marriage, as it has been argued that early marriages encourage downward mobility whereas late marriages encourage upward mobility.

Few Children

Few children, where upwardly mobile couples tend to have fewer children than immobile couples in the social levels into which they move.

Other Types of Social Mobility

There are two other types of social mobility based on different classification systems:

Structural Mobility

Structural mobility is social mobility that results from changes in the distribution of statuses in society. Structural mobility occurs regardless of the rules governing status.

Exchange Mobility

Mobility that is not structural is called exchange mobility. The word exchange indicates a trade-off. In exchange mobility, some people rise to fill positions made available because other people have fallen in the status system. There is little exchange mobility when the ascriptive status rule operates, but if status depends on achievement, there is a fair amount of such movement. Many children of talented and ambitious parents do not inherit the talent or ambition that earned their parents a high rank. Conversely, many children of low status parents are more talented and ambitious than their parents.

Application

As nurses you are the main health care providers to various groups of people. Therefore, in line with the nursing code of ethics, you will have to provide health care services to people of whichever status in society. This enables the nurse to provide the basic health care that people deserve.

The role of the nurse can be related to that of the anthropologist who has to live, stay and work with the particular group. Just like the anthropologist, the nurse may have to live, stay and work with a particular group or a particular community or society and hence learn and understand all their ways of social life.

What is the difference between a community and a society?

Definition of a Society

A society is defined as a group of people who interact together, within a specified territory and have a unique culture, for example, the Nubians living in the Kibera slums of Nairobi, the Maasai who live in parts of Loitokitok/Kajiado District in

Kenya and Pokomo society living along Tana River in Tana River District (Peil 1977).

Definition of a Community

The term 'community' refers to a small group of people who are part of a larger society. For example, the Masai community in Nairobi form part of a larger society that lives in Kajiado District. While in Nairobi, however, this community sticks together and helps one another as necessary.

The Concept of Social Mobilisation

The concept of social mobilisation emerged from the recognition that a genuine participatory approach to development is essential for success and sustainability. Civil society participation in development efforts is therefore increasingly recognised by development agencies and governments. They are seen as essential for promoting good governance - improving responsiveness of national policies and programmes to citizens' needs and ensuring transparency and accountability in policy making and implementation processes.

Genuine participation of citizens however, goes beyond dialogue with or contracting a few non-governmental organisations. It must engage all citizens (women and men, in their various capacities, socio-economic status, affiliations and locations) beyond elections to active participation in making decisions that affect their lives. Engaging people requires efforts and mechanisms that can empower all, but most especially the disadvantaged members of society, to participate effectively in development processes.

Social mobilisation is an approach and tool that enables people to organise for collective action, by pooling resources and building solidarity required to resolve common problems and work towards community advancement. It is a process that empowers women and men to organise their own democratically self-governing groups or community organisations which enable them to initiate and control their own personal and communal development, as opposed to mere participation in an initiative designed by the government or an external organisation.

Effective social mobilisation goes beyond community organisations, harnessing the potential and efforts of government, non-governmental sector and citizens to work towards sustainable social, economic and

political development. The benefits of social mobilisation to community organisations and its impact locally and nationally can be best sustained within an enabling political, policy and regulatory environment and where mechanisms for linking experiences and lessons at the community level to policy are developed.

The Key Elements of Social Mobilisation

From worldwide experience there are four basic elements of social mobilisation.

Organisational Development

Organisational development is a process in which community members and, especially the poor, form their own groups or organisations based on common development interests and needs that are best served by organising themselves as a group. 'Before one becomes a member of a Community Based Organisation (CBO), the individual struggles against a harsh environment. Once they are organised in a broad-based group, the individual has the leverage with which to address and tackle problems which they could not have done alone' (Pandey 2002).

Organisations can be created with a specific focus (for example, a tenants' association, a credit union or cooperative) or as broad-based, multipurpose groups or community organisations with an overall aim to improve the situation of their members and the community in which they live. Organisations with a holistic focus are more inclusive of the poor, (who have a much broader array of needs), and can be effective vehicles for poverty alleviation, community-wide development and establishing strong links with local government. Mobilisation can start with small groups, as the first step for participation in larger community-wide organisations, which are in some cases, associations of small groups. In other cases, community organisations mobilise the poorer members of their organisations into small groups in order for them to work on alleviating their poverty. In both cases, the larger organisations serve as a support network for small groups and an important link to local government (Atwood 2001) and external organisations that provide various forms of services and support (for example micro-finance, marketing, business development support, and so on).

In countries with a longer history of civic engagement, social mobilisation can involve working with existing community organisations

to boost their capacity and power in engaging with government and other actors in addressing their common needs and promoting their interests. So whilst the basic principles of social mobilisation are universal, the approaches used must be appropriate and relevant to the local context.

Lessons learned have indicated the following factors as essential in promoting effective organisational development:

- Homogeneity to the extent possible is an important and essential factor for group or organisational survival.
- Building organisations that are operated on democratic principles, based on a group or organisational constitution. The constitution would often reflect the objectives of the organisation and the norms, values and principles which govern the way the group functions. Promoting norms and values such as tolerance, inclusion, cooperation, equality and good practices early in the building process of an organisation fosters commitment and prevents diversion of the organisation into activities that can destruct the common good.
- Building leadership capacity within the organisation - beyond one individual to several members, to avoid dependency and capture.
- Building incentives into the early stages of development to create interest among community members for organising, especially in communities that are very passive or sceptical about organising.
- Ensuring an inclusive approach (involving all or most community members) in the social mobilisation activities to promote equal opportunities and prevent conflict. A community organisation must leave room for new membership.
- Promoting self-reliance, especially of the poor members of the organisation which would in turn enhance their ability to participate in the organisation's affairs on an equal basis.

Capital Formation for Development through Community Savings

Capital formation (through mobilisation of savings) enhances a community organisation's power to realise its full potential. 'Savings

generated by individual members are the assets of the community organisation and are the first step towards their self-reliance' (Pandey 2002). Accumulated savings can be used for internal credit with interest, to enable individual members to engage in income generation activities whilst at the same time, accumulating the organisation's capital base. They can also be used for enterprise development at the community level. Savings can serve as the basis for access to external services, for example, micro-finance. They can also form the basis for community organisations' contribution to local development initiatives, which is essential in localities, where government capacities to address all social needs of a community are very limited.

Training for Human Resource Development

Community members can maximise their potential not only by organising themselves but also by upgrading their existing skills to better manage new inputs and establish effective links with local government and other actors. The Change Agent (for instance, the organisation or individual facilitating the social mobilisation process) can support direct training, exchange visits and other capacity building activities based on needs identified by the members of the community organisations. These can cover organisational development, leadership, savings and credits programmes, agriculture, natural resource management, and other key areas. Local human resource development can best be promoted when trained individuals take up the responsibility to train other community members.

Socio-economic Development

Socio-economic development initiatives are a great incentive for community members to organise themselves. It is important, therefore, that an initiative which includes social mobilisation provides support in the form of matching grants or access to credit, marketing and other services that will lead to tangible improvements in social economic conditions within the community. The process of identifying community priorities, participatory planning, implementing and monitoring of community projects and managing partnerships with local government, private sector and other actors helps not only to improve local conditions but also to empower people and their organisations. If well facilitated, this process can result in increased institutional capacity, enhanced social status and voice (especially for disadvantaged

people, including women, the poor and youth). These results in turn motivate people to remain organised as they begin to enjoy the benefits of collective action and recognise its potential to create or influence change in their communities.

Facilitating the Process of Social Mobilisation

Whilst there are grassroots or social movements that have emerged from within communities, the isolation, poverty and resulting passivity or powerlessness of citizens, particularly in rural areas in developing countries, calls for external support at the initial stages of the process of social mobilisation.

In practice, social mobilisation is usually an element within a broader strategic framework or development programme/initiative. Since such programmes or initiatives are time bound (in most cases due to donor funding cycles), a clear exit strategy is needed right at the beginning of the initiative, to ensure that the national capacities are created for replication and sustainability. Experience in Central Asia suggests a minimum donor commitment of five years (with gradual withdrawal) and continuous commitment of central and local government to supporting social mobilisation initiatives.

In countries with limited experience of social mobilisation, a combination of international and national community mobilisers brings to bear international experience and local knowledge which are both essential factors for success.

Selection of the right people for this work is critical – emphasising good attitudes, behaviour and the ability for one to work on an equal basis with community members is critical. Knowledge of participatory development concepts and approaches is essential but can be gained through an effective training strategy.

The Benefits of Social Mobilisation

The benefits of social mobilisation are listed below, you will look at each in more detail.

- Poverty Alleviation
- Promoting Democratic Governance
- Environment
- Conflict Prevention

Poverty Alleviation

Social mobilisation is an important tool in the poverty alleviation process, as it enables communities and the poor themselves to engage actively in solving their own problems and effectively tackling poverty in its multi-dimensional form. The principles of social mobilisation ensure equity, hence issues of

gender based, racial and ethnic based discrimination are most likely addressed.

Promoting Democratic Governance

Experience shows that poverty and bad governance mutually reinforce each other, as they foster exclusion of citizens from decision making processes, lack of access to basic services, lack of opportunity, dependency, and limit availability of public goods. Social mobilisation must be institutionalised within government for it to be effective. This would encourage participation in decision making, build capacity for participatory planning, build a common vision on development and ensure transparency. Institutionalisation of such efforts can only be effective if a decentralised system of governance, including fiscal decentralisation, is in place and functional. Social mobilisation can facilitate tripartite leadership at the local level, making civil society more effective as a third and legitimate partner in development.

Creating demand for good governance through social mobilisation must be complemented with increased capacity of the local government to manage and effectively respond to this demand and improve its governance practices. Capacity building efforts must therefore target civil society organisations (including CBOs, elected representatives, etc.) and government.

Environment

By organising people to better manage their natural resources and fight against practices and organisations that degrade the environment through promoting appropriate legal, regulatory and institutional frameworks and policy dialogue.

Conflict Prevention

As people prepare to address common problems, and to collectively improve their socio-economic conditions in an equitable, democratic and transparent manner, possibility of conflict can be significantly reduced.

Conclusion

Social mobilisation is an approach that empowers people to participate actively in development processes – through their own local initiatives and through well informed and

constructive dialogue at the policy level. It is an essential tool for mobilising and engaging isolated, passive and poor members of society, hence its popularity with poverty reduction and decentralised governance programmes worldwide. Its effectiveness depends to a large extent on the appropriateness of the approaches used within a given cultural, socio-economic and political environment. On the whole, it is an effective tool for building a well informed, proactive and strong civil society, making it a valuable partner for government and the private sector in shaping national development that is equitable and sustainable.

SECTION 5: CULTURAL BELIEFS, PRACTICES, SOCIAL CHANGES AND EFFECTS ON HEALTH

Introduction

In this section, you will use your knowledge on culture and experiences of the effects of cultural beliefs and practices on health. Everyone comes from a family with a cultural background. As you learnt in section one, culture derives from all that members of a society teach one another. It is dynamic because it keeps changing and it is passed on from parents to children. Therefore, the way in which each society relates with its surroundings and its culture may affect the community's health. For example, in communities where foodstuffs like honey and wine are gathered or tapped high up in the trees, many may suffer falls leading to fractures of limbs and spinal cords. Therefore, as you carry out community health service, you should always keep in mind the cultural behaviour of your patients.

Objectives

By the end of this section you will be able to:

- Define culture
- Identify the components of culture
- Describe the elements of culture
- List the characteristics of a culture
- Define cultural beliefs and practices
- Explain selected cultural beliefs and practices that affect health of mankind

What is Culture?

Culture is defined as the totality of socially transmitted behaviour patterns, arts, beliefs, institutions, and all other products of human work and thought. According to Coxa and Maed (1975), culture is defined as a group of learned values or acquired beliefs that a person copies from other persons with whom they interact.

It may also be defined as all that members of a societal group teach one another. Kroeber and Kluckhorn (1952) identified 164 definitions of culture. In summary culture can be defined as socially transmitted behaviour patterns, arts, institutions, as well as the values and beliefs that a person copies from other persons with whom they interact.

Culture is also knowledge, some of it conscious and made into coded or traditional forms, such as myths and rules, some of it quite unconscious and automatic, such as the rules and structures that allow language speakers to understand each other. This knowledge is learned both formally and unconsciously within human groups and is heavily dependent upon language as a medium for transmission. Culture is shared between generations and within generations, but this sharing is neither completely uniform, nor without error. There are esoteric (or specialist) compartments of culture in all societies, and various factors affect the accuracy with which culture is reproduced as it passes between individuals.

Humans, as individuals and as members of groups, use cultural assumptions to make sense of the world around them as they live out their lives. They also use culture to create strategies with respect to their group and individual interactions.

Components of Culture

The two components of culture are:

- Non-material culture - these are things that are observed through the behaviour of societal members.
- Material culture - these are the physical things in society.

You will now cover the various forms of each of these two components of culture.

Non-material Culture

There are four various forms of non-material culture, they are listed below.

Language

Language refers to the pattern of spoken or written words used by a particular society in order to communicate. The mother tongue refers to the language of one's parents. You may notice that each one of us learnt a mother tongue that also reflects on our cultural group. For example, the table below illustrates the relationship between the cultural group and the language used.

Cultural group	Language
Maasai	Masai
Agikuyu	Kikuyu
Luo	Dholuo
Giriama	Giriama

Mores

Mores are explained as social norms, which emphasise the expected moral behaviour for societal members. If an individual breaks the mores, the individual receives severe punishments. Some examples of mores are: do not lie, do not steal or destroy other's property and so on. All society members are expected to obey the mores or else they receive punishment. Therefore, it can be said that mores refer to all things that each one of us would like others to do to us. Where mores are written down, they are referred to as laws.

Norms

Norms are defined as socially accepted patterns of behaviour. You should note that norms differ from society to society. They may include children respecting parents and older people in society, as demonstrated by a young person offering an older person a seat in a bus and so on. Another example is that both the young and the old are expected to dress properly according to the occasion. All are expected to observe certain table manners while eating. In some communities, children should be served first, followed by the men and lastly the women. All these norms aim to maintain order. Norms can be further subdivided into two categories, that is,

mores
and laws.

Laws

Laws are written, socially confirmed rules and regulations of conduct, which if violated, are punishable. Laws are enforced by a socially identified agency. For an example of medically related laws, refer to module four, unit one, section two on the mental health act.

Material Culture

According to Akinsola (1983) material culture is defined as the part of culture that includes physical things in any society. Examples of material culture include the type of clothing used, ornaments such as necklaces, bangles, and earrings, kitchenware, type of houses and many more. Akinsola also explains that the importance of identifying material culture relates to how these items are used by individuals in the society. For example, among the Agikuyu people, women and girls learnt to use pots for cooking and gourds for serving food and storing liquids such as milk.

In modern days, nurses are expected to learn how to use computers, new types of blood pressure machines, digital thermometers and others in order to improve the health care they provide. In addition, they are expected to provide nursing care to persons of varying cultural ethnic background. For further details refer to the module one, unit one on professionalism.

Elements of Culture

The elements of culture include:

- Material life
- Language
- Social interactions
- Religion
- Education
- Values

What are the main characteristics of culture?

The main characteristics of culture are that:

- It is learned
- It is shared
- It is an adaptation
- It is a dynamic system changing constantly

Cultural Beliefs

A cultural belief is a personal conviction and disposition to retain and abandon actions taking into account values of one's own culture. Cultural beliefs may pertain to child rearing or housing.

Several studies have noted that, besides inadequate availability of health care services in many areas, especially the less developed countries, certain disease specific and non-disease specific cultural beliefs may influence people's health seeking behaviour. It has even been noted that health services may be under-utilised and health and child care instructions may be ineffective or ignored in traditional and transitional societies where people's ideas and behavioural patterns conflict with the knowledge being passed to them (Feyisetan and Adeokun 1992;

Feyisetan 1992).

Feyisetan and Adeokun (1992) argue that non-adoption of modern preventive and curative measures cannot be attributed to poverty alone since the costs of some of these measures are not exorbitant in several of these societies. Rather, they suggest that the gap between awareness of modern health measures and health seeking behaviour must be sought in the social and cultural determinants of behaviour in such matters as childcare and disease management, since, for most mothers, perceptions of the aetiology of the childhood diseases are rooted in cultural beliefs.

You will now cover a brief review of disease specific cultural beliefs.

Food Taboos

Outbreaks of malnutrition among children in this country may not only be associated with lack of food but also with culture patterns affecting food. For example, in some parts of Kenya, children and women are not given eggs in the belief that the child will learn to be a thief when grown up or that a mother feeding on eggs may harm her unborn baby. Instead, the eggs are reserved for the men to eat or to be sold at the market. In many homes that keep poultry, these eggs could serve as source of protein for young ones, were it not for these cultural beliefs.

Overcrowding

When several family members live in congested homes with a low standard of hygiene, this may contribute to poor health. This mainly occurs in urban centres, where a family may rent one room, which serves as the kitchen, bedroom and

dining room. There may be communal water but often there is none, and in such cases the family has to buy water or fetch it from a stream. Under such living conditions children suffer from diarrhoea, intestinal worms and sometimes malnutrition.

Due to the increased expenses associated with hospital care, parents may decide to take their child to traditional medicine men. Often traditional healers are more easily accessible and services can be paid for later when the parent earns some money and so on. The child will only be brought to hospital much later, if their condition fails to improve.

If you were the nurse on duty, how would you handle this parent and their child?

This is a difficult situation and that is why you covered professionalism module one, unit one and looked at ethical issues in nursing. Adhering to professionalism means you should provide health care to all clients in need, irrespective of their social background and health seeking behaviour.

Having had an overview of the cultural beliefs, you shall now look at some examples of effects of cultural beliefs and how they affect the way of living among people.

An Example of the Effects of Cultural Beliefs on the Diet of the Somalis

'Fat and healthy' is how parents prefer their kids to be, even to be overweight or obese by western standards. Increased interest by Somali parents in the use of high calorie nutrition supplements for their children to boost weight gain has been observed. This practice is leading to feeding mismanagement. Other effects of culture on their diet are:

- Camel milk is believed to be the best of all milks.
- Eating chicken injected with hormones is believed to be bad for the human heart and to contribute toward being fat.
- Breastfeeding women believe that tea increases milk production and therefore they increase their consumption of tea, which is usually very much sweetened with sugar. Women in the educated groups have reported not liking the idea of pumping breast milk, for fear of disfigurement.

An Example of the Effects of Cultural Beliefs on the Diet of the Somalis

Oral Health: Infant Nutrition

Most Somali mothers living in Mogadishu prefer to give birth in a hospital. Somali women who choose to give birth at home use a midwife, who is usually a hospital worker with some western medical training who is paid privately for assisting in the home birth. Whether giving birth in the hospital or at home, a woman relies on the help of midwives and will rarely see a doctor unless birthing complications arise. Somali mothers receive information about how to feed and care for their babies from their mothers and other relatives, and from those who deliver their child.

Infant Nutrition

Breastfeeding

It is culturally important for Somali mothers to breastfeed their babies. Not doing so is seen as a sign of poor mothering. Somali children are breastfed until they are two years old, or until the mother becomes pregnant again. Children raised in Mogadishu are fed breast milk supplemented with goat's milk at six months. Nomadic Somali mothers feed their child cow's milk mixed with water at three months. Few Somali mothers use canned formula milk because it is expensive and is believed to cause stomach problems.

In addition to breast milk, children of urban Somalis are fed soft foods such as bananas and rice at eight months. Children of nomadic Somalis are not fed any solid food until they are one year old. Most Somali children are fed normal solid foods at eighteen months. Normal adult food mainly consists of carbohydrate such as rice, bananas and meat; such foods are cooked until they are soft enough for the child to chew.

Bottle Feeding

In both urban and rural areas, when babies are one year old, most drink from a glass or cup without their parent's help. Bottles are difficult to keep clean and are not usually used. Children who are born outside of the city are given their milk in a traditional hand-made wooden cup. If their children have stomach sickness and the mothers were bottle feeding them, they will stop feeding bottled milk and give them sugar water for three or four days. Children are also fed breast milk during this time. If the symptoms do not abate, the child is taken to a hospital or medication is sought.

Teething

Somalis associate teething with diarrhoea, fever, nausea, and vomiting. Children usually begin teething when they are between nine months and one year old, although it can occur as early as four months. Those who get their teeth earlier are thought to have more difficulties. A soothing oil is sometimes placed on the gums to calm teething children, but pacifiers are not used.

Another example relating to the effects of cultural beliefs and practices on health standards relates to the Muslim community. A report published by the National Bureau of Asian Research, based in the U.S.A., authored by Kelley and Eberstadt, examines the growing HIV/AIDS crisis in the Muslim world. This is a largely unexplored problem and one that is beginning to pose potentially serious dangers at the national, regional and international levels. One of the main factors contributing to lack of action against HIV/AIDS in the region is the belief that premarital sex, adultery, commercial sex work, sex between people of the same gender and injection drug use either do not exist or happen very infrequently in the Muslim world. However, the United Nations Programme on HIV/AIDS (UNAIDS) estimates that nearly one million people in North Africa, the Middle East and predominantly Muslim countries in Asia are HIV-positive. It should be noted that these figures are probably 'severely understated' because UNAIDS figures rely on surveillance data, and a lack of data can be interpreted as a lack of HIV cases, according to the report. The report praises the predominately Muslim nations of Iran and Bangladesh for implementing effective HIV/AIDS prevention efforts. This is another example of the effects of culture on the health of a community.

SECTION 6: SOCIAL CHANGE

Introduction

In this section you will study the effects of social change on health.

Objectives

By the end of this section you will be able to:

- Define the term social change
- Explain the theories of social change
- Describe the three types of social change
- Explain the process of social change

- Explain the steps in social change
- Describe how social changes affect people's health

Social Change

What is Social Change?

Social change is the transformation of culture and social institutions over time. All societies experience change in their social structure and culture over time, explanations of the causes and nature of this change have been part of the sociologist's task from the beginning of this discipline. Societies change because they are in contact with other societies. As a result the ideas, norms and institutions spread from one society to another. Even the most isolated society changes from time to time as its members adjust to varying environmental conditions (such as prolonged drought) or invent new ways of doing things.

In addition, social change takes place when the present cultural patterns are modified, or when new ideas are introduced.

In the past, particularly in most African societies, traditional healers met communities' health needs but on coming into contact with people of European origin, health practices have changed. Hospitals and trained hospital workers are now in place to meet the health needs of societies. However, traditional healers provide health services, though to a lesser extent, to people who still subscribe to traditional healing.

Social change may be studied as a short-term or as a long-term phenomenon. An example of the latter is the Industrial Revolution, which happened during the 18th and 19th century. Social change takes place in various aspects of the society, for example, cultural patterns (religious values, symbols of status), social structure (family adjustment to the absence of migrant fathers), aggregated attributes (the proportion of the population which is illiterate or engaged in farming), and rates of behaviour (increased crime, decreased self-employment).

Change may also be examined from the point of view of the social system, that is, the whole society or from the view of an individual. Mitchell (1999), a sociologist, calls the first view historical or processive change and the second, situational change. The major theories of change have been concerned with historical or processive change, which is concerned with the

evolution of institutions over time and the processes by which societies move from one type to another.

Theories of Change

Before looking at the types of social change, you will briefly take a look at the theories of change. Three major theories have been advanced to explain social change.

Evolution and Differentiation

Early sociologists were concerned chiefly with the origins of society and the transformations necessary to reach the type of society that people are now experiencing. Since Darwin's ideas of biological evolution were gaining acceptance at this time, the theory of societal evolution also became popular. Theories of structural differentiation take humankind somewhat further than the evolutionism from which they are derived. The basic idea is that as societies develop, they become characterised by increased separation and specialisation.

Equilibrium and Conflict

The equilibrium and conflict theory maintains that the basic function of any society is to maintain equilibrium (stability, order) and eliminate conflicts that may arise in the process of change. Conflict may arise mainly during the process of adjustment to forced change, when consensus is imperfect or among people who were inadequately socialised so that they do not fully share the consensus of the majority. The equilibrium theory is better for explaining gradual, long-term change such as the Industrial Revolution and changes applying to the society as a whole, than in accounting for the more sudden political revolution and smaller endogenous changes where conflict often plays an obvious part.

Modernisation

The modernisation theory assumes that change is synonymous with improvement of social conditions, for the benefit of societies. Modernisation is the process by which agricultural societies were transformed into industrial societies. Modernisation theorists tend to see only the front end of the process of social change (what the modern society should look like) and ignore the traditional end of the process. Nevertheless, some attention must be

given to modernisation theories because they are so prevalent and because they alert us to ways of examining long-term change.

Types of Social Change

You have already studied what social change is, that is, an alteration of what makes the society and its relationships. There are three ways in which society changes and you will now cover each of these in detail.

Evolution

The term evolution refers to slow or gradual change, which occurs with very low human effort, with almost unnoticeable changes in social structure. Examples are language, marriage patterns, child rearing practices and so on.

Revolution

This term refers to a rapid and deliberate change, which can radically change a society's way of doing things. Revolutions are planned for a specific purpose and are initiated by direct human action. For example, the Russian revolution and in East Africa, the Ugandan revolution that brought a new political system under President Idi Amin.

Reform

This term refers to a deliberate effort by humans to alter the society's way of doing things. Reforms apply lesser force than revolutions and their effects are much more extensive than revolution. An example is the changes that occurred when Kenya's educational system switched from the 7-4-2 to the 8-4-4 system of education. These changes have influenced the whole education institution in this country so that all institutions of higher learning have had to re-do their curriculum. In addition, other colleges and universities, which accepted Kenyan students based on the old 7-4-2 system, have also re-adjusted their entry requirements to cater for the new system. You must have noticed this widespread type of social change.

How Does Social Change Occur?

Social change takes place when people choose to modify their environment. The changes occur mainly when existing cultural patterns are

altered either due to innovations or when new ideas are introduced into the society.

Here is one example. In many Kenyan communities, like the Kalenjin and Kikuyu many houses were built using mainly grass for thatching. However, social change has since brought about the use of corrugated iron sheets for roofing. One possible explanation for this change follows. In the 1960's, many changes began taking place countrywide, including increased access to education. This resulted in a higher level of education and more young professional women trained for jobs such as nursing, teaching and engineering to name a few. This meant that there was more money to buy iron sheets, which are easily available in the shopping centres.

Another example of change is the function of the family as a source of labour in the farms. In previous years, each family head strived to have a large family who would help in digging, planting and harvesting food crops. However, today farmers increasingly have to hire labour. Why is this so? One reason is that many homes have fewer children due to increased education, improved health care and a rise in the standard of living. Another reason may be that more children are able to access formal education and after completing their schooling they move into the formal sector and are not available for family labour.

Another change, involves technological advances. For example, a few years ago, people were using the landline telephone to pass messages. Today landlines are being gradually replaced by mobile phones. The mobile phone is convenient because one can communicate wherever they are. In health care facilities, it is now possible to quickly reach a health care provider, for example, the consultant to attend to a very sick patient, which decreases the chances of mortality.

These are just a few examples of social changes that have occurred in our country in the last few decades.

Process of Change

There are two processes under which social change occurs. These are diffusion and innovation. You will cover each of these individually.

Diffusion

Diffusion is defined as a process of change involving the selection and adoption of cultural items from another society. The diffusion of culture can be a one-way or a two-way process. For example in Kenya, people have accepted the western way of dress while some of them have adopted our way of dressing such as the Maasai 'shukas' and the Waswahili 'kikois'.

Today, westerners are expressing an interest in indigenous knowledge found in traditional medicine while Kenyans have accepted the western type of medicines in addition to our own. Another example, can be found in the way many Kenyans have embraced different religions, for example, Christianity and Islam.

Innovation

Innovation is the second type of change process and is defined as the process of introducing new items to the society. The innovations come in two forms, known as inventions and discoveries.

Inventions

Inventions refer to existing culture items, which are recombined to form a new item that did not exist before, for example vaccines, intravenous drugs, mobile phones and so on.

When the society accepts these inventions, they affect change. For example, the invention of vaccines against childhood diseases has led to a reduction in infections and better health of the children.

Discovery

A discovery involves finding things that already exist, for example, archaeological findings such as cooking wares and implements, which are then preserved in museums.

You will now cover the basic steps of implementing change in our health set up.

Basic Steps of Implementing Change

Situations may come up when you as a team leader need to implement some form of change at your place of work or even at home. Some of the basic steps that you will need to follow so as to attain your goal are shown below in the following broken cycle diagram.

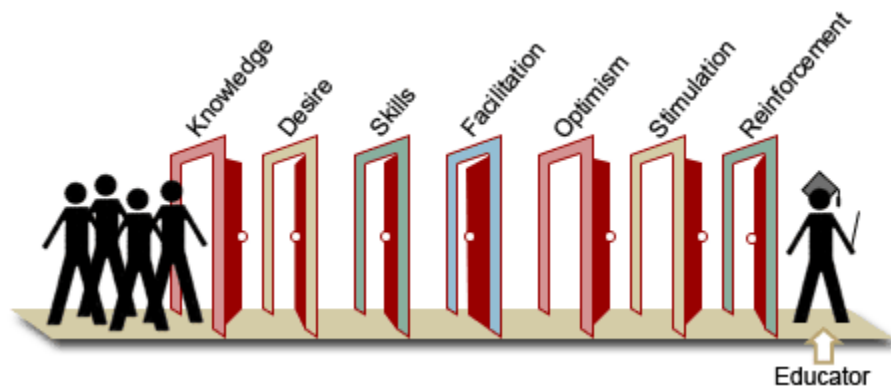


Each one of these conditions is actually an obstacle, so you can think of this model as a set

of seven doors, click next to view this diagram in the way just described.

The Seven Steps of Social Change (The Seven Doors)

This model helps to identify which elements are already being fulfilled so resources can be concentrated on the gaps. The seven elements are listed across the top of each door; knowledge, desire, skills, optimism, facilitation, stimulation and reinforcement.



Knowledge/Awareness

An obvious first step is that people must:

- Know there is a problem.
- Know there is a practical, viable solution or alternative. This is important. People are practical and they will always demand clear, simple, feasible road maps before they start a journey to a strange place.
- Identify the personal costs of inaction and the benefits of action in concrete terms that people can relate to, that is, allow them to 'own' the problem.

An awareness campaign aims to harness people's judgement.

Desire

Change involves imagination. People need to be able to visualise a different, desirable future for themselves. Desire is an emotion, not a kind of knowledge. Advertising agencies understand this well - they stimulate raw emotions like lust, fear, envy and greed in order to create desire. However, desire can also be created by evoking images of a future life, which is more satisfying, healthy, attractive and safe.

Skills

Skills allow you to easily visualise the steps required to reach the goal. People often learn skills best by seeing someone else perform them. The best way to do this is to break the actions down into simple steps and use illustrations to make visualisation easy.

Optimism (or Confidence)

This is the belief that success is probable or inevitable. Strong political or community leadership is probably an important ingredient of optimism.

Facilitation

People are busy with limited resources and few choices. They may need outside support in the form of accessible services, infrastructure and support networks that overcome practical obstacles to carrying out the action.

Stimulation

An inspiration to do something has many times happened in a collective context. This is a kind of inspirational mass conversion, which is based on our human social instincts, like the mass meeting where a personal commitment is made. You need to instil this in your team members. The stimulation could be an imminent threat (like a cost increase), a special offer or competition (based on self-interest), or, better still, some communally shared event, which galvanises action (for example, a public meeting or a festival).

Feedback and Reinforcement

It is always important to get feedback at the end of the day and know whether the change was approved or not and gain perceptions and views on the area of that change.

Social Changes Affecting Health

Social change influences health in a complex way. Health status is changing with the development of societies, but it is not invariably for the better.

Industrialisation

Social change caused by industrialisation leads to mismanagement of natural resources, excessive waste production and associated environmental conditions that affect health. Environmental quality is an important direct and indirect determinant of human health. Poor

environmental quality is directly responsible for around 25% of all preventable ill-health in the world today, with diarrhoeal diseases and acute respiratory infections heading the list. Other diseases such as malaria, schistosomiasis, other vector-borne diseases, chronic respiratory diseases and childhood infections are also strongly influenced by adverse environmental conditions.

Lack of basic sanitation, poor water supply and poor food safety contribute greatly to diarrhoeal disease mortality and morbidity. In addition, the incidence, severity and distribution of vector-borne diseases are affected substantially by human activities such as water and agricultural developments and by urbanisation.

Population

Due to innovations in the provision of health care such as vaccines, availability of drugs, increase in the number of health workers and health care facilities, mortality rate has decreased compared to that of the early 20th century. This has resulted in pressure on available public health care facilities that offer services to increasing populations. Also social change brought about by population increase leads to cumulative effects of:

- Inadequate and hazardous shelter
- Overcrowding
- Lack of water supply and sanitation
- Unsafe food
- Air and water pollution
- High accident rates

All of these factors impact heavily on the health of a society.

Education

Today, many people in Kenya have had basic education. Further, due to easy access to the internet through cyber cafes, more and more Kenyans are becoming better informed about their health and the various treatment alternatives available. As a result, nurses and other health professionals have to strive to keep informed and up to date by achieving higher levels of education in order to meet professional needs and demands for quality care by an informed public.

SECTION 7: SOCIAL INSTITUTIONS

Introduction

Social institutions are organs, which perform some of the functions that benefit society, for example, the government and schools. Each society should have social institutions for survival. In this section you will look at the differences and relationships in social institutions, associations and other institutions.

Objectives

By the end of this section you will be able to:

- Define a social institution
- Describe a family institution
- Describe the educational institution
- Describe the religious institution
- Describe the political institution
- Describe the health care institution

Associations and Institutions

What is an Association?

Associations are official (formal) groups set up for a special purpose, for example, a hospital that provides health care. An association should have a name, prescribed location and a record of rules and regulations to govern its functions. Members of the association have a recognised social structure with specific status and rules. For example, members of a hospital team include the senior nurse, the doctor and administrator in charge. Each of these in charge oversee the activities of the respective qualified specialists.

What is an Institution?

Institutions are organisations, or mechanisms of social structure, governing the behaviour of two or more individuals. Institutions are identified with a social purpose and permanence, transcending individual human lives and intentions, with the making and enforcing of rules governing human behaviour. As structures and mechanisms of social order among humans, institutions are one of the principal objects of study in the social sciences, including sociology, political science and economics. Institutions are a central concern for law, the formal regime for political rule making and enforcement.

Having seen the difference between associations and institutions, you will now look at the various institutions briefly.

The Family

The definition of the family, which is the basic unit of social structure, can vary greatly from time to time and from culture to culture. How a society defines family and the functions it asks families to perform, are by no means constant. However, for the purpose of this study you shall define the family as a universal human institution in a small kinship structured group with the key function of nurturing the socialisation of the newborn.

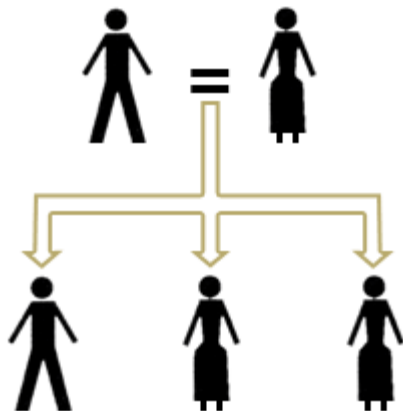
There has been much recent discussion of the nuclear family, which consists only of parents and children, but the nuclear family is by no means universal. In pre-industrial societies, the ties of kinship bind the individual both to the family of orientation, into which one is born, and to the family of procreation, which one finds at marriage and which often includes one's spouse's relatives. The nuclear family also may be extended through the acquisition of more than one spouse (polygamy), or through the common residence of two or more married couples and their children or of several generations connected in the male or female line. This is called the extended family.

The primary functions of the family are reproductive, economic, social and educational. It is through their kin (also variously defined) that children first absorb the culture of their group. Some family institutions include gender, marriage, parenthood and kinship. All these institutions are basic to society because they provide and protect new members, and without them the society would disappear. The bundle of relationships that have come to be identified with the family vary within and between societies.

Kinship Relationship

This consists of parents and children.

Kinship implies ties of blood (biological kinship), descent (jural or legal kinship) and marriage (affiliation). People descended from a common ancestor are referred to as cognatic kin or cognates; those who become kin through marriage are affinal kins or affines. As a basic principle of social organisation, kinship gives a person his place in society; he is the son of X and grandson of Y.



Extended Family

This is the type of family that consists of several generations of relatives all living together or near each other. The relationship is based on birth or marriage, for example, auntie, in-laws, grandparents and so on.

Institutions

Functions of the Family

Can you list at least two functions of the family?

According to George Peter Murdock (1983), the four primary functions of the family are sexual relationships, economic cooperation among members, reproduction and the educational function by which he meant the socialisation of infants and children.

There are other functions of the family some of which you will now cover together with the primary functions.

Functions of the Family

Control of Sexual Behaviour

When a man and a woman marry, they are expected to have a sexual relationship with each other. It is only in marriage that sexual behaviour should be practised. It is within the marital setting that sex is legitimised. This functions to control illegitimate sex and indecencies such as incest, child abuse, rape, and risk of contracting Sexually Transmitted Infections (STIs) like syphilis and gonorrhoea and HIV/AIDS.

Nurturing Children

Couples are expected to have children and nurture them. Primary socialisation also takes place within the family. If mothers have jobs outside the house, house helps and other family members (such as grandparents and older siblings) are engaged to continue with this function of nurturing the child while the mother is away.

Protection

The family should provide basic needs to its members, for example, food, shelter, clothing and health care.

Education

Even today, children are taught at home, for example, social skills such as table manners, washing hands after visiting the toilet and before eating and so on. Parents are expected to continue showing an interest in their child's learning throughout school life.

Legal Function

The parents give a child the birth right as confirmed by the provision of a birth certificate by the government officials. They also have other rights that they should give to the child such as the right to an education, the right to basic needs such as clothing, food and shelter among others.

Spiritual Function

The family instils sense of religious beliefs and thoughts in their children. This could be the traditional African religious belief or the modern belief in one God worshipped in churches, mosques or synagogues.

Educational Institutions

Education is the deliberate instruction through which a society's social and technical skills are acquired (Casper Odegi Awuondo, 1993). It is a lifelong process that begins as soon as a child is conceived. What happens to the mother during pregnancy affects the child's personality development and learning process.

There are two aspects of education: formal and informal.

- Formal education is acquired through formally established institutions of learning. Learning takes place within these while following the laid down curricula of education.
- Informal education takes place in informal places, for example, the work

place, recreational place, among peer groups, in the church or other religious settings. Informal education also takes place during political rallies, voting and wedding ceremonies.

What are the Functions of Education?

Secondary Socialisation

One of the functions of school is to offer secondary socialisation to children. As various teachers tutor them, children not only gain knowledge but also assimilate the values instilled to them by their teachers.

Custodial Functions

Schools take charge of children as learning takes place. This provides parents with freedom to work without distraction. While at school, children are protected from playing dangerous games, for example, playing along the road, throwing stones at each other and so on.

Cultural Transmission

The communication of received beliefs and understandings is a major function of formal education. Education is especially relied on in societies that are culturally self-conscious. Awareness of a cultural heritage is usually associated with concern that traditional values and cultural 'mysteries' will be lost if no one has special knowledge of them. While cultural transmission tends to emphasise respect for tradition, values of criticism and inquiry may be passed on as well as conservative values.

Social Integration

Formal education is a major agency for transforming a heterogeneous and potentially divided community into one bound together by a common language and a sense of common identity

Innovation

To some degree, even the most tradition-bound educational institution is a source of innovation because the teacher is called on to apply their wisdom or expertise to new situations. Early innovations were often accidental and unanticipated, perhaps the result of religious rather than practical intent.

Selection and Allocation

In traditional society, when only a few select members of the community were educated, the school played a smaller role to that of family membership in determining the student's

ultimate role and status. However, under the conditions of mass education, the school system takes over the job of screening and allocating status. How the individual performs in school and the course of study they choose often determines their future occupation, income and prestige

Personal Development

Formal education communicates skills and perspectives that cannot readily be gained through other socialising experiences. The school is also often a place of transition from a highly personal to a more impersonal world and habits such as punctuality may be learned here.

Religious Institutions

Paul Taylor (1996) presents a minimal definition of religion as a belief. Durkheim (1912) defines religion as 'a unified system of beliefs and practices relative to sacred things, that is to say, things set apart and forbidden – beliefs and practices which unite into one single moral community ...all those who adhere to them.' Religion is as old as humankind. Sociologists have noted that in different societies religious beliefs and practices are different. As important as the universality of religion is, it has remarkable diversity.

What are the Foundations of Religion?

Religion has its foundations in the nature of human personality as well as in the requirements of social solidarity. They are:

- Overcoming fear and anxiety to the extent that our world is dangerous and unpredictable, people must endure and try to overcome specific fears and more general anxiety and hence the need for religion.
- Self-justification and the quest for ultimate meaning. We seek an organising principle that will validate our most important strivings and make sense of our sufferings.
- The search for transcendence. Most human experiences are routine and do not evoke strong emotions or strange feelings but there are circumstances that lift us out of ourselves and in which we seem to transcend our everyday self which some religions do through dance.
- Celebration of human powers and achievements. Many religious beliefs and activities reflect pride and exultation rather than humility and despair.

- Making the world comprehensible. In all societies, some effort is made to explain and interpret our environment and religion tries to do this too.
- Supporting social norms and values. By adding divine sanction to human values, religion buttresses the norms of society and unites its adherents into a moral community, whose members feel a deep common bond because they share a belief in what is normally true.

Having covered these, you shall now look at the various functions of religion.

Functions of Religious Institutions

Religious institutions perform several functions.

Unity of Group Members

This happens when members have a common creative belief. For example, in traditional religion, all community members would take part in a religious ceremony. Men would take the lead as the high priest and medicine men made sacrifices when appearing before their gods. By doing so the calamity, be it famine or drought, was resolved. In modern day, religion has the same unifying function.

Humanitarian

Religious organisations usually provide emergency care during disasters, like floods, earthquakes, fires and wars. Organisations such as the Red Cross have their origin from religious organisations for the provision of emergency care.

Reduction of Stress

Religion provides explanation for things inconceivable by the human mind, such as why people die, or what happens after death. This explanatory function serves to alleviate anxiety. Religion also helps members cope with anxiety due to togetherness among most of its members. Religion also helps to meet the psychological and counselling needs of people with chronic or terminal conditions. Some people even consult their religious leaders to pray for healing.

There are many more functions of religion. Next, you shall look at political institutions.

Political Institutions

As you studied earlier, historically in African families the man took the leadership role. However, as a result of population increase amongst other social changes, the family as an institution was unable to continue with its political/leadership functions. More and more people moved away from their kinsmen in search of basic needs and work. The control system of the family was weakened gradually. This led to the formation of political institutions such as governments in order to create and enforce laws so as to maintain functions. The government rules its people through various styles of leadership. The three styles of leadership are:

Autocratic (Authoritarian)

This type of leader controls all the power to make and enforce laws and they assume all responsibility for the actions. This method is used when the leader tells their employees what they want done and how they want it done, without allowing them to participate in the decision making process. They elect themselves into a leadership position. Examples include leaders like Babangida of Nigeria and Adolf Hitler in Germany. This type of leader achieves a lot of power by allowing only political parties that support him and any resistance is stopped using force.

The authoritarian method is sometimes appropriate under particular conditions. When you have all the information to solve the problem, you are short on time, and your employees are well motivated, you may use an authoritarian style. Some people think that this style includes yelling, using demeaning language, and leading by threats and abuse of power. This is not the authoritarian style. It is an abusive, unprofessional style of leadership!

If you have the time and you want to gain more commitment and motivation from your employees, you should use the participative style.

Democratic (Participative)

This style involves the leader, including one or more employees in the decision making process (determining what to do and how to do it). However, the leader is the final decision making authority. Using this style is not a sign of weakness. It is a sign of strength that your employees will respect. A democratic type of government always aims at being responsible to the needs of the common people who elected it.

The participative style is normally used when you have some of the information and your employees have some of the information. This allows them to become part of the team and allows you to make a better decision.

Laissez-faire (Delegative, Free-reign)

In this style, the leader allows the employees to make the decision. However, the leader is still responsible for the decisions that are made. This is used when employees are able to analyse the situation and determine what needs to be done and how to do it. You cannot do everything! You must set priorities and delegate certain tasks.

You will now cover the functions of government.

Functions of Government

For the smooth running of a large society, governments carry out three main functions.

Maintenance of Social Order

The government has the responsibility of keeping social order. In order to fulfil this function, the government enacts laws, which it enforces. It also identifies law enforcement agents who ensure that citizens abide by the laws. Those who do not abide by the laws are arrested and charged in a court of law and may either be fined or jailed. Examples of the law enforcement agents are police officers, magistrates, health officers and prison wardens.

Coordination of Essential Services

Similar to a family unit, the government has to coordinate various activities useful for the effective functioning of the society. To meet this need, the government establishes ministries, each of which has specific activities it is responsible for. In Kenya, nursing services are under the Ministry of Health while education is under the Ministry of Education, Science and Technology. The head of each ministry is a Minister and the technical head is the Permanent Secretary.

Protection of all Citizens

In order to fulfil the function of maintaining security, armed forces are developed to meet these needs.

You have covered some of the leadership styles and functions of the government. On a micro-level, it is important to understand the functions of the local government. These include:

- Providing democratic and accountable government for local communities

- Ensuring the provision of services to communities in a sustainable manner
- Promoting social and economic development
- Promoting a safe and healthy environment
- Encouraging the involvement of communities and community organisations in the matters of local government

You will now learn about one more social institution, the health institution.

Health Care Institutions

In order for the society to meet its health needs, various health care institutions are established. In Kenya there are several types of health care institutions with different functions, as you will now see.

Traditional Medicine

Many African societies had traditional healers, whose indigenous knowledge of folk medicine was respected. They used herbs and some practised magic and divination as they strived to meet the health needs of their clients. Today, fewer people subscribe to services of traditional healers. They mainly provide emotional and social treatment for illness such as mental illness, bereavements and disasters.

Private Health Facilities

These are health facilities owned and/or run by religious and private organisations. They are popular in areas without government health facilities.

Public Health Facilities

These are government-run health facilities and are present in most parts of the country. In Kenya, health facilities are classified according to their structure (mainly size and catchment population) and by extension, their functions. The facilities range from national hospital, provincial general hospital, district hospital, sub-district hospital, health centre to dispensary. The largest hospital in Kenya is the Kenyatta National Hospital. It serves as a teaching, research and national referral hospital. Many nurses, doctors, pharmacists, laboratory technologists and other health professionals have trained here.

In each provincial and district headquarters, there is a general hospital that receives all patients referred from the health centre and district hospitals. All provincial and some district hospitals are also involved in the training of nurses, clinical officers and laboratory

technologists. They also conduct continuing education for their health workers.

In the location and subdivision unit of administration there are health centres and dispensaries respectively. Nurses and clinical officers run these. They offer basic health services to the immediate neighbourhood. Each refers its patients either to district or provincial hospitals.

For further details on the management of health care services refer to unit four of this module.

SECTION 8: CONFLICT RESOLUTION AND NEGOTIATION PROCESS

Introduction

In this section you will study conflict resolution and the negotiation process. As you have already noted, the society assigns different status to individuals according to their roles. Following these differences in status, there is bound to be tension between persons with high status and those with lower status.

For example, there may be a conflict between a matron in charge of a ward and a group of nurses over the allocation of various duties in the ward. Some nurses may feel that some of their colleagues always get lighter duties in the shift such as drug administration and conducting rounds, while they are left to do the rest of the work like bed making, distributing bedpans and such like duties. The group that feels discriminated against may even threaten to take their complaints to the Hospital's Chief Nurse if they are not addressed. The matron then has to come up with a quick solution to this conflict before it reaches the Chief Nurse. One option for the Matron would be to call a meeting of all the nurses in order to come up with an agreement that both sides are happy with. Once an agreement is reached, it should be written down and signed by all present.

A general principle of resolving conflict is acknowledging the needs of each group and reaching a compromise for both. Remember that conflicts will always occur where there are

power relationships, for example, employee/employer, student nurse/nursing officer in charge, parents/children and many more. This may be because of different roles and needs (see section three on social stratification).

Objectives

By the end of this section you will be able to:

- Define conflict
- Identify factors that may contribute to conflicts
- Explain the steps used in conflict resolution
- Describe the negotiation process

Conflict

Conflict is a person's struggle with him/herself, another person, or a thing. It is a problem or disagreement and results in a situation that needs resolution. Conflict is present in every person's life. According to Fowler, conflict is defined as a fight, a struggle with others or groups, also as a collision or clashing of opposed principles. It is inescapable. However, conflict can be dealt with creatively, if a person has the right tools.

What is Conflict Resolution?

Conflict resolution is the process of finding a way to manage or solve a problem. There are several methods of conflict resolution. Some result in win-lose solutions, while others can be win-win. Through programs like peer mediation, children learn to go for the win-win solution!

Situations That May Lead to Conflict

Factors that may contribute to conflict are varied. Here are some examples of the situations where conflict may arise:

- During the process of adjustment to forced change
- When various groups are not in agreement
- When some societal groups feel left out when new agreements are being implemented

Conflict Resolution Styles

There are many different ways of resolving conflict. The three most common ways are fight, flight and flow.

Fight

In a fight, two or more people are aggressive with one another. Fighting can be done with words, weapons or fists. Following a battle of some description there will be a winner and a loser, or both may lose.

Flight

In a flight situation, one party walks away from the conflict. The problem is left unresolved and there may be a winner and a loser. Common 'flight' language includes 'never mind', 'just forget it' and 'whatever'.

Flow

In a flow situation both people walk away from the conflict satisfied with the solution which they have reached together. Conflict resolution encourages everyone to 'go with the flow' and create solutions!

Skills to Resolve Conflict Peacefully

The first thing you need is a willingness to work toward a win-win solution.

Then there are several helpful skills to guide you through the process:

- Be an active listener
- Look and listen for the other person's feelings
- Look for anger cues and triggers
- Maintain good eye contact
- Use a calm voice
- Make sure you have 'cooled down' before trying to work things out

Resolving Conflicts at a Government Level

There are several ways of resolving conflicts at the government level. You will look at each of these in detail.

Appointing a Commission

A commission is a group of people, usually professionals in a certain field who are selected to look into a problem more keenly, so as to come up with a solution. One example is if the prices of basic items continue rising, the government may establish a commission to look into the effect of this increase on workers' wages. The commission/committee is given the mandate to suggest ways to improve the workers' wages, actual remuneration, perhaps to

suggest possible sources of funding and ways of handling future government/workers conflict.

Elections to Change the Leaders

On some occasions due to strained relationships between the current government and populace, an election may be called. In this case the population may elect a new government with new political leaders of their choice. When this happens, the masses feel that they have picked their choice of leaders, thereby averting conflict.

Meeting with Concerned Persons

At times in the work place, conflict may arise between the in-charge persons and other staff members. One of the ways to avert this misunderstanding is to call a meeting where all stakeholders are invited. This provides for an opportunity to speak out, discuss and agree on solutions to be effected by all. Mediators may also be chosen to represent one of the parties. In this way, harmony in the work place is restored.

The Negotiation Process

The process of negotiation consists of three important phases.

The Information Phase

During this phase, you should collect and evaluate information on all factors that will have an effect on the negotiation. Work out a defensive plan to protect sensitive information that the opposition is likely to inquire about. Decide whether the negotiations will be carried out by yourself or an agent.

The Competitive Phase

The bargaining begins during this phase. You should decide who should go first on particular issues. Support your position on an appropriate rationale and actively manage the concession process.

The Cooperative Phase

It is important to understand that, ultimately, cooperation is a worthy and necessary stage in the negotiation process. While acknowledging that negotiations are inherently competitive, it helps to remember the following:

- Be cooperative.
- Do not use threats.
- Assess the value of your position accurately.
- Be willing to share information.

- Approach negotiations in an objective, fair, trustworthy manner.
- Seek agreement in the open exchange of information.
- Get a settlement that is fair to both sides.

SECTION 9: APPLICATION OF SOCIOLOGY AND ANTHROPOLOGY IN NURSING

Introduction

In this section you will see how to apply the information and knowledge you have just learned on sociology and anthropology to your job. It is important to understand why nurses need to study sociology and anthropology. Nursing involves caring for people and the nursing professional is a specialised member of the community that plays a key role in how the society functions as a whole.

Objectives

By the end of this section you will be able to:

- Describe the relevance of sociology and anthropology to nursing
- Describe application of sociology and anthropology in the nursing profession

The Relevance of Sociology and Anthropology to Nursing

Over time, sociologists and anthropologists have deepened our knowledge of the influence and interactions of such variables as social class, race, age, cultural and social contexts in determining health status on individuals and communities. They have provided a body of rich data and have posited different conceptual schemes and hypotheses to explain some of the epidemiological findings on social factors and health.

The importance of social factors in the etiology of health cannot be over emphasised. Studies have directed attention on the importance of social science (including sociology and anthropology) concepts and methods in the study of health and illness. For example, the health status of an individual, including life expectancy and prevalence of chronic disease and disability, is related to marital status, social

supports, as well as simple health habits such as hours of sleep and physical activities.

Although social and behavioural scientists have long stressed the importance of cultural factors in people's health behaviour in perceiving symptoms, seeking health care, adhering to medical regimens and responding to health promotion programs – they are now directing attention to the role of cultural factors in determining health status. This forms rationale for community based public health interventions. Different disciplines are now contributing to the growing body of knowledge of the relationship between society and health.

It is useful for nurses to study sociology and anthropology because it enables them to appreciate that individuals behave in a unique way. It is important to understand that every patient will react in a different manner when under stress. The nurse should recognise this and specifically tailor the nursing process to the individual patient, in order to assess, plan and implement nursing care that will suit the particular needs of the patient. Additionally, the nurse should always remember that individuals are part of a wider community, and try to involve all significant members of the family in the management of the patient.

The Influence of Sociology and Anthropology on Nursing Skills

In the process of interacting with patients, the application of sociological concepts and knowledge facilitates delivery of professional skills of nurses, as they will acknowledge the influences and interactions of such variables as social background and cultural contexts. During this contact period, you should use your observation skills to assess the patient's style of dressing, use of language, age and accompanying relatives. All these observations will provide additional background information for the patient's history.

As you take a detailed history from the patient, you will be in a position to inquire about specific points unique to them. For example, a Somali girl is brought to your ward accompanied by her parents and older brother. Start by greeting the parents, then the patient. If you are familiar with the language use it when greeting them, make them comfortable by offering chairs and explaining that you need to take detailed history then continue. By doing this, the family and the patient feel accepted and welcomed, and this

may make it easier for you to gather all necessary details and record them for sharing information.

How Sociology and Anthropology Influences Nursing Skills

Equipped with sociological and anthropological knowledge nurses should remember that humans are social beings whose physical environment plays an important role. You should be aware of the patient's surroundings, type of housing, ventilation systems, the availability of water and sanitation. You should also be aware of their social background, for example, relationships with the family and spiritual group members and psychological factors, for example if they are grieving, coping with the spouse and/or work. All these factors will influence the health of your patient. These facts should be confirmed with a significant family member or guardian where possible. The information you collect during this process will help the health team in planning immediate and follow-up care. In addition, it will enable you to provide care that centres on the patient and family members, and in so doing you will be in a position to positively influence the patient's health seeking behaviour.

Professional Socialisation

Sociology assists all nurses in the process of professional socialisation and adaptation. As a nurse, you may have joined the profession straight from school. At that time, you were required to undergo a prescribed training process in order to learn the ways of the profession. Then you qualified and now you are a recognised nurse. This whole process is referred to as professional socialisation, that is, you learnt to behave and function as a nurse. On your part you have had to adapt to the world of nursing, patients, shift duties, examination instructors and being involved with other team members. You have also had to maintain the rules and regulations governing nursing practices as recorded by the Nursing Council of Kenya. You joined the 'family' of the nursing profession. Studying sociology and anthropology helps you understand how to fit in with this family in order to meet the health needs of all humans.

UNIT 3: RESEARCH IN NURSING

In this unit you will cover the basic concepts of research, which will include definition, purpose, and contribution of research in the nursing profession. You will also look at the research process, which includes the identification of a researchable topic and developing appropriate research objectives, hypothesis and questions as well as a review of literature that is relevant to your research topic and the research methodology. It also includes data collection, analysis and writing the research report. You will also look at how to develop and implement a research proposal.

This unit is composed of four sections and an assignment:

Section One: Concepts and Contribution of Research.

Section Two: Types of Research.

Section Three: The Research Process.

Section Four: Developing a Proposal.

Assignment: Conducting Research (Field Work).

Introduction

Research is an essential part of the nursing profession. This is because you will not only use it in the planning, implementation and evaluation of your patient's care, but also in the organisation and improvement of the entire health care service countrywide. After covering this unit you will be in a better position to appreciate the significance of research in nursing.

Unit Objectives

By the end of this unit you will be able to:

- Explain the role of research to nursing practice
- Describe the major research types
- Describe the research process
- Develop a research proposal
- Implement the research proposal

SECTION 1: CONCEPTS AND CONTRIBUTION OF RESEARCH

Introduction

In this section you will acquire the basic concepts of research in general, and with specific reference to the nursing profession. The section will cover the definition of research, nursing research, why nurses need to do research and the significance of research in the nursing profession. You will learn how to develop a research topic. It will also cover the ethical and legal issues to consider when carrying out research.

Objectives

By the end of this section you will be able to:

- Define the terms 'research' and 'nursing research'.
- Identify the scope of research in nursing.
- Explain the significance of research to the nursing profession.

Definition of Research

There are several ways to define the word 'research'. For instance, Treece and Treece (1982, cited in Cormack) define research in its broadest sense as an attempt to gain solutions to problems. More precisely, it is the collection of data in a rigorously controlled situation for the purpose of prediction or explanation. Some writers argue that this definition is not adequate since not all researchers will be finding solutions to problems. Neither does all research need to be carried out in a rigorously controlled situation such as in a laboratory. This is just an indication for you to appreciate how difficult it is to get one single definition of the word 'research'.

Scientific Definition of Research

According to Burns and Grove (1999: 3), the word 'research' means 'to search again' or 'to examine carefully'. More specifically, research is diligent, systematic inquiry or study to validate and refine existing knowledge and develop new knowledge. This definition indicates some of the functions of research. It further explains the word 'research' in its literal use and its scientific use at the same time. Take for instance, the terms 'search again' or 'examine carefully'. This means the researcher (the person carrying out the research) has to search for the facts over

and over again. They have to re-examine all facts at hand carefully.

Similarly as Burns and Grove (1999) indicate 'diligence' and 'systematic study' will include certain activities, such as planning, organisation and persistence. Research is meant to validate, that is, prove or disprove existing knowledge or information. For instance, if a certain nursing practice is to be evaluated, then a researcher will need to investigate it and see whether the specific practice is still relevant or needs modification. It is also important to note that in research 'the systematic study' must use the scientific process.

Definition of Nursing Research

Having covered and defined the term 'research', it is now important for you to define 'nursing research'. As with the definition of research, there is no single definition for nursing research, either. However, for the purposes of this unit, you will use the following definition by Cormack (1991:5), which states that nursing research is defined as research into those aspects of professional activity, which are predominantly and appropriately the concern and responsibility of nurses.

As indicated here, research can be nursing research only when it addresses issues that are relevant to the nursing profession. If the topic is not going to have an impact on the nursing practice, it is not nursing research. Thus, it is important to understand that in order to define your research as nursing research; your study must be geared towards improving certain aspects of the nursing practice, education and administration.

However, this does not mean that nurses cannot venture into other non-nursing research. Nurses can undertake any type of research but if they would like to carry out nursing research, then the study should be relevant to the nursing profession.

Nature and Scope of Research in Nursing

Now that you have identified a general definition of research and a specific definition of nursing research, your next step is to find out what nursing research entails and whether nurses really need to do research.

In module one, you covered professionalism in nursing. You learnt that for a profession to be recognised, it must have its own knowledge base. You might have also learnt that a large

portion of knowledge in nursing is either borrowed from other professions or is based on traditions, beliefs and instincts that, for the most part, have not been validated by empirical studies.

In order for the nursing profession to have its own body of knowledge, its professional practice must be based on a sound knowledge developed through scientific research. The knowledge base should come from the various aspects of nursing education, nursing management, nursing practice or from general nursing experience. Nursing research is not an old subject even though nurses have made tremendous achievements in the area in the last few decades.

Initially, nursing research in the early part of the 20th century concentrated on nursing education and the role of nursing and nurses. However, as nurses became aware and acquainted themselves with the importance of research, there has been an increased number of studies targeted at clinical nursing problems (Burns & Grove, 1999).

This started in the 1970s and to-date clinical oriented research problems continue to be the main focus of research for nurses. The importance of nurses' involvement in research is that it enhances the development of the knowledge base of the nursing profession. Research findings aim to develop and refine scientific knowledge for use in practice (Burns & Grove, 1999). Thus, while nursing research is mainly concerned with investigating areas of significance to the nursing profession, it is nonetheless, limited to nursing and nurses although they are at liberty to engage in research on non-nursing areas.

Significance and Contribution of Nursing Research

You have already learnt some of the benefits of nursing research in the previous sections. A brief description of the purposes of nursing research has been outlined by Cormack (1992:7) among others.

The purposes of nursing research include:

- Developing scientific, evidence based reasons for nursing activities.
- Finding ways of increasing the cost-effectiveness of nursing activities.
- Providing a basis for standards setting and quality assurance.

- Providing evidence in support of demands for resources in nursing.
- Barring and defending a professional status for nursing.
- Focusing on priority problems that affect the nursing profession.

The points in the previous page elaborate the purposes of nursing research, but lead you to ask why research is such an important component of the nursing profession. In answering this question, you can look at some suggestions offered by some nursing researchers. A good example is Burns & Grove (1999), who state that nursing research helps in:

- Describing certain nursing observations (phenomenon).
- Explaining certain nursing practices, for instance, the relationship between specific variables (characteristics or attributes).
- Predicting the outcome of nursing activities undertaken by nurses and other health workers.

SECTION 2: TYPES OF RESEARCH INTRODUCTION

When describing types of research, researchers use several methods of classification. According to UNISA (2000: 83), research can be classified as follows:

- Categories, that is, what the study is to be used for.
- Methodological approaches, which includes the research approaches that

the researcher intends to adapt in the course of the study.

- Aims of the study, including what the study aims at achieving.
- The time dimension referring to the time factor of the study, that is, is the study a 'one off' case or one that will take months or even years.

In broad terms, research can be classified into qualitative and quantitative research approaches.

Objectives

By the end of this section you will be able to:

- Describe the qualitative research approach
- Describe the quantitative research approach

Qualitative Methods

According to Burns and Grove (1999:338), qualitative research is 'a systematic, subjective approach used to describe life experiences and give them meaning'. It focuses on the whole issue under investigation, which is in line with the holistic approach the nursing profession advocates for in patient care. As you will see in the table below, there are major distinguishing features between qualitative and quantitative research types. Qualitative research is a type of research where the data collected is in the form of words rather than numbers. The data collected from this type of research is then grouped into categories, themes and patterns (Maalim, 1999).

Quantitative	Qualitative
Focuses on a relatively small number of concepts (concise and narrow).	Attempts to understand the phenomenon in its entirety.
Begins with preconceived ideas about how the concepts are interrelated.	Has few preconceived ideas and stresses the importance of people's interpretations of events and circumstances, rather than the researcher's interpretations.
Uses structured procedures and formal instruments to collect information.	Collects information mainly without formal structured instruments.
Collects information under controlled conditions.	Does not attempt to control the context of the research, but rather attempts to capture that context in its entirety.
Emphasises objectivity in the collection and analysis of information.	Assumes that subjectivity is essential for understanding of human experience.
Analyses numeric information through statistical procedures.	Analyses narrative information in an organised, but intuitive fashion.
Investigator does not participate in the events	Involves sustained interaction with the people being

under investigation and is most likely to collect data from a real distance.	studied in their own language, and on their own turf.
Incorporates logistic, deductive reasoning.	Inductive and dialectic reasoning are predominant.

The data from qualitative research is usually collected through:

- Observation, that is, a participant observer or a non participant observer.
- Focus group discussions.
- Face to face interviews.
- Posted or self administered questionnaires.

Qualitative research can further be sub divided into several categories including historical, case studies, observations, and rapid rural appraisal (which is a more recent innovative approach used in participatory research).

You will now look at each of these categories in more detail.

Historical Research

This is a type of qualitative research that attempts to describe and learn from the past. This type of research is mainly used by social scientists. Historical research is a descriptive type of research where the investigator attempts to record and describe, in a sequential manner, the events under investigation. The findings are then presented in the fullest possible picture. A good example is where a nurse may investigate the historical development of nursing in Kenya and show the events and trends associated with the profession in Kenya.

Historical research has the advantage of teaching us about the past so as to put the problems of today into their proper context. However, when doing historical research, it is important that the researcher plans properly, laying out clear objectives to ensure that they are not overwhelmed by the large amount of materials, losing track of the study. In the recent past, many nurse researchers have ventured into this type of research and produced important results.

Case Study

Another type of a qualitative research method is the case study. A case study is defined as 'an in-depth investigation of an individual, group, institution or phenomena' (Mugenda &

Mugenda, 1999: 173). According to Moore (1988) case studies are used when narrowing the research focus into fewer units or increasing the range of units within the study.

Case studies are commonly used when the investigator is attempting to understand complex phenomena, or the various causes and effects of a certain phenomenon. This is one of the most common research methods used by nurses. Case studies have the advantage of requiring minimal resources when compared with other types of research. Case studies also provide a means of looking in depth at complex situations. At the same time, there are certain limitations associated with case studies, which researchers need to be aware of. These include:

- Results from case studies cannot be statistically validated because no sampling strategy is involved.
- Case studies can be time consuming, particularly when looking into complex long term issues or phenomena.
- Case studies are more susceptible to the 'Hawthorne effect', where the research process influences the study outcome.

Rapid Rural Appraisal (RRA)

A third type of qualitative research is referred to as Rapid Rural Appraisal (RRA). This is an innovative research method used for collecting data in participatory research. This approach emphasises the need for the researcher to acknowledge and appreciate that local research respondents have the knowledge and skills to be partners in the research process (Maalim, 1999). In RRA, both the researcher and the respondents collaborate and learn from each other, getting possible solutions for the research questions (Rifkin, 1996). RRA is important for generating data from the local community such as disease patterns which they (community members) are quite familiar with. There are many RRA tools and techniques for data collection but the following are some of the more common ones.

Mapping

This is drawing of sketch maps by the research

respondents to identify the comparative location and importance of different resources within the research area. This may include health facilities, social amenities and infrastructure like roads, transport and means of communication (Maalim, 1999).

Daily Schedules

This involves outlining the daily activities of community members. Daily schedules are used to identify daily labour patterns and other activities (Jones, 1996:2). This tool enables the researcher to identify and discuss the daily workloads of the community members according to individuals, gender and seasons.

Venn Diagrams

This is the use of circles to indicate the relationships, importance and interactions between individuals and institutions within the research areas. Usually the respondents draw circles of varying sizes. The size of the circle and the distance from the centre indicate the importance of the institution, for example a health centre, to the respondent.

Seasonal Calendars

As the name suggests, this tool is used for gaining information from the research respondents concerning seasonal variations in patterns concerning certain issues of interest. This tool could, for example, enable the researcher to gather data on disease patterns according to the seasons.

Quantitative Methods

Having covered qualitative research as one of the major research types, you will now look at quantitative research. Burns & Grove (1999:23) defined quantitative research as a 'formal, objective, rigorous, systematic process for generating information about the world', with respect to populations' dynamics, characteristics and phenomenon.

It is important to note that, for many years, the quantitative research method has been the preferred method by nurse researchers. This was primarily because, in the early days, quantitative research was seen as the only recognised research or, as it was then called, 'the scientific method'. However, this no longer is the case as researchers have now

understood that qualitative research is as important as, and complementary to, quantitative research methods. Researchers now appreciate that the selection of either quantitative or qualitative research types depends on many factors, including:

- The issue (phenomenon) under investigation.
- The aims and objectives of the research.
- The state of existing knowledge.

At the same time, many researchers now acknowledge that 'although qualitative research and quantitative research do differ, they can also, in specific areas, complement each other' (Grobelaar 2000: 91).

Quantitative research is also subdivided into several types, which you will now cover in detail.

Descriptive Research

Descriptive research is 'the exploration and description of a phenomenon in real-life situations' (Burns & Grove 1999: 24). It involves the systematic collection and presentation of data to give a clear picture of a particular situation. A good example of descriptive study is a survey. Descriptive research also involves the systematic collection of information and aims to explore and describe new facts about a situation, people, activities or events. Descriptive research is important in nursing for the following reasons:

- Assists in the development of new knowledge.
- Forms the basis for future research.
- Generates questions and hypotheses for further experimental study.

In descriptive research, the main focus is the investigation of existing practices, beliefs and attitudes held by people or investigating current trends of nursing

Experimental Research

This is one of the most complex and important research types. It is also commonly used in clinical settings because of its accuracy and reliability. Experimental research has, for several decades, been referred to as the true or scientific research because of its strict adherence to the three major characteristics of control, manipulation and randomisation.

A major difference between experimental and

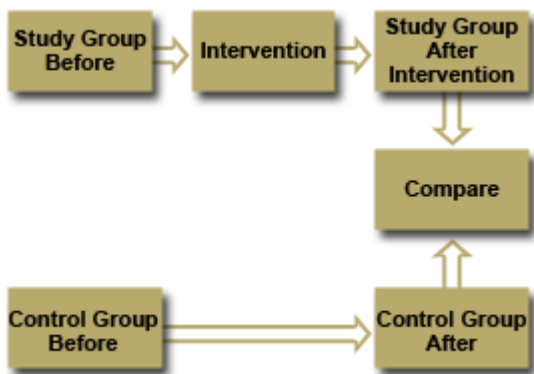
non experimental research types that you as a research student need to note is that, in experimental research, the researcher is the active agent rather than remaining a passive observer (Polit and Hungler, 1999). According to Burnard and Morrison (1990: 30), the major distinction between experimental and descriptive research types include the following:

- Descriptive research merely describes something, whereas experimental research tests a hypothesis.
- Researchers can control variables in experimental research but cannot do this with descriptive research.
- Descriptive research may not have control of the study subjects but experimental research has full control of the subjects under study.
- Experimental research can lead to predictions but descriptive research may not.

Many times, experimental research is subdivided into 'true experimental' and quasi-experimental'. The true experimental definition refers to the method you have just covered. You will now look at quasi-experimental research.

Quasi-experimental Research

This is a type of quantitative research whose purpose is to examine causal relationships or to determine the effects of one variable on another (Burns & Grove, 1999). Quasi-experimental studies involve implementing a specific treatment and then later examining the effects of this treatment using selected methods of measurement. Quasi-experimental study is a type of intervention study.



The purpose of quasi-experimental study is to examine causality. Quasi-experimental designs are developed in order to provide alternative

means of examining causality in situations not conducive to experimental control.

Classification of Research

Research can be classified based on duration of study. There are two main types of research studies, these are longitudinal and cross sectional studies.

Longitudinal Studies

These are the types of studies that are conducted over a long duration of time. A good example is the cohort study where individuals having a characteristic of interest (exposure) are followed over a duration of time. During the time of study the subjects are observed to see if they develop an outcome of interest.

Cross Sectional Studies

These are the studies that are conducted over a short duration of time, for example, a few weeks. Unlike the longitudinal studies they tend to be relatively cheaper. They are initiated where results are required as a matter of urgency.

SECTION 3: THE RESEARCH PROCESS

Introduction

In this section, you will learn about the 'research process'; a very important and significant section of research, and indeed the kingpin of the whole research topic. Included in this section, is a study of 'the steps' involved in the research process.

Objectives

By the end of this section you will be able to:

- Identify a research topic
- Formulate a research problem
- Formulate research objectives
- Describe the justification for your research
- Explain how to conduct literature review
- Describe the research methodology
- Explain the methods of measurement
- Design the data collection instruments
- Explain the implementation of the data collection tools

- Describe the process of analysing the data collected
- Write a scientific research report

The Research Process

It is important to appreciate that the various steps of the research process are not delineated from each other as such, but indeed cyclical in nature, whereby one step leads to the other for its effectiveness. Likewise, it is important to note that researchers have greatly differed in their estimate of the number of steps the research process should consist of. Most researchers have given steps ranging in number from between ten to sixteen.

Despite the large difference in the number of steps that should constitute the research process, the majority of researchers do agree on four general phases of the research process. Brink (1996:56) listed the following four phases as being key to the research process

- The conceptual phase, also called the thinking or planning phase.
- The empirical phase, also called the doing phase.
- The interpretive phase, or the phase where the researcher looks at the meaning of it all.
- The communication phase or the phase of writing and disseminating the research report.

You will now further sub-divide these phases into ten steps for the purpose of your study and look at each step in detail.

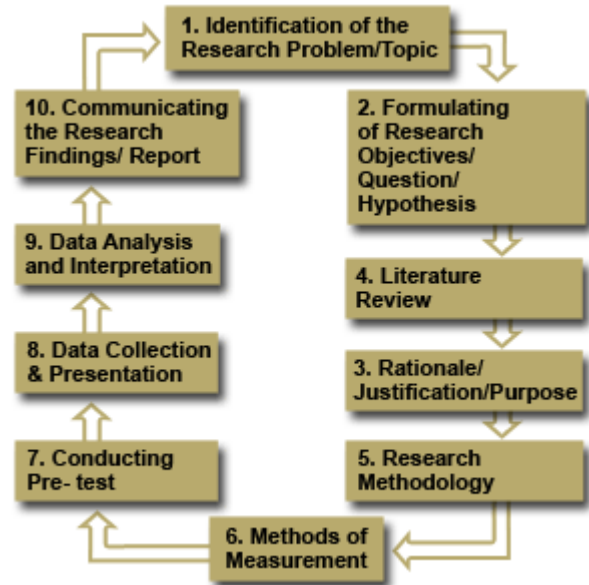
Step One: Identification of a Research Topic

Having identified some of the characteristics of good nursing research, you need also to learn how to identify a researchable topic. For a researcher to identify a good research topic they will require first to list down some of the topics or problems that need to be investigated. It is important to put this in order of priority and then analyse each topic or problem individually.

A research problem is an issue that requires a solution. It could, for instance, involve looking at why certain things are done the way they are

done and not the other way round. In actual fact, a research problem endeavours to answer or address a specific problem or situation. In nursing research the issue that needs to be addressed should be one related to the nursing profession.

The Research Process



You will note that your research starts with the identification of a research problem, which you feel is serious and important enough for you to spend your time researching. This research problem then becomes your research topic and will become the title of your research paper.

What are some of the criteria you should look for when identifying a research topic?

There are certain characteristics or criteria that a good research topic in nursing should possess to ensure that the study is relevant not only to the nursing practice but also to the entire health care delivery system.

- Improve nursing services by contributing to more knowledge and better skills.
- Enhance existing knowledge by filling in gaps that exist.
- Encourage more research on already existing nursing theories.
- Address current concerns or priority areas in nursing.

- Pay more attention to ethical issues (this will be discussed in detail later).

In addition to this, the researcher undertaking the study should have the necessary knowledge and skills. They should also be accorded the necessary resources such as money, manpower, materials and access to the research subjects.

These characteristics are of great significance to the researcher because when adhered to, they ensure that the study is well defined and hence feasible to undertake. It is important to point out that this list is not exhaustive and, as you progress with your research readings, you will learn to identify other important characteristics that a good research topic should have.

How can you identify an appropriate research topic?

Interestingly, among all researchers there is no way to find a researchable topic without having experienced the problem or read about it. It is obvious that, one way or the other, there must be a need/problem that the researcher has experienced and hence feels the need to seek a solution to. It is also possible that research topics are usually derived from problems, but at times, point the way towards making certain changes or modifications from an existing situation.

According to Collins et al (2000), there are three major possible areas that researchers may draw on for their research topics.

A researcher may draw research topics from:

- Existing professional knowledge and experience. It is highly possible that in the course of your work, you have faced several questions that you would like to find answers for. This is indeed the most common source of an appropriate research topic.
- Socially significant issues, that is, the research topic has practical relevance and significance to the society. Here, you as the researcher have to identify the implications of the study to the society. For instance, the study could be in a position to solve an existing and pressing social problem. You as the nurse in-charge of a health centre might have realised that since the introduction of cost-sharing exercises, not many of the low income members of the community are coming for treatment to the health centre. You may decide to

find out why and propose a solution to the problem.

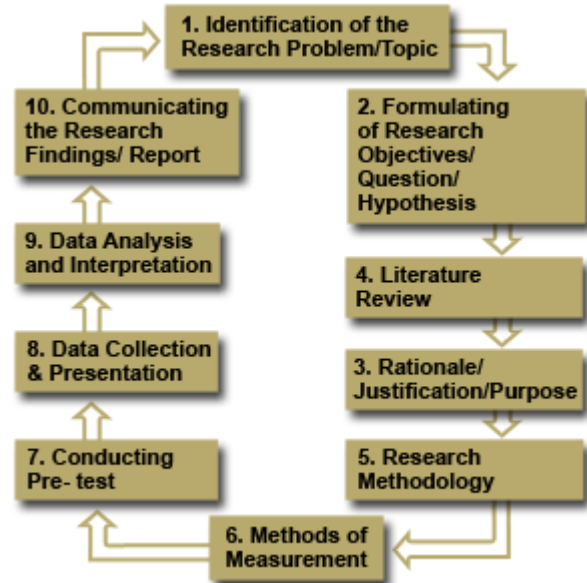
- The study must have scientific relevance and significance as well. It is important to show that the research will, at the end, have academic and/or scientific relevance. This could be used for improving or modifying patients' care.

Therefore, when identifying a possible research topic, look at some of the above factors or others that you think are important for the relevance of your study.

Step Two: Formulation of Research Objectives, Hypothesis and Questions

In this step, you shall learn how to formulate research objectives and research questions. So far you have learnt how to identify a researchable topic. You have also learnt about the different methods of research and their divisions. In this section of the research process you are aiming to 'describe the formulation of research objectives and research questions'.

The Research Process



What is a research objective?

A research objective is a clear, concise, declarative, statement expressed to direct a study.

It focuses on identification and description of variables and/or determination of the relationships among variables. Research

objectives and questions are important for several reasons.

Research objectives help to:

- Bridge the gap between the research purpose and the study design.
- Guide on planning for data collection and analysis.
- Summarise what is to be achieved by the study.
- Build a close link with the statement of the problem.
- Keep the researcher within the scope of study by defining the area of focus.

Research objectives are sub-divided into broad and specific objectives. When formulating good research objectives, the objectives should have the following characteristics, using the acronym 'SMART'.

What do you understand by the acronym 'SMART'?

The acronym SMART stands for:

- S - Specific
- M - Measurable
- A - Achievable
- R - Realistic
- T - Time bound

Example of a SMART Objective

To establish the number of children born at home within the last two years in Ganga village.
Specific – Establishing prevalence of home deliveries in Ganga village
Measurable – Number of children
Achievable – The task is achievable
Realistic – The task is realistic
Time bound – In the last two years

Example of a Non SMART Objective

To find out the level of home deliveries.
The objective is neither specific, measurable, achievable nor realistic. It has also not set out the time frame.

This means the research objective should be specific, in that, it clearly identifies the item at hand for investigation. The objective should also be 'measurable' by being quantifiable. A good objective should be 'achievable' and 'realistic' so that the researcher is able to acquire the set objectives on time (time bound) in form of human, financial and material resources.

Once the researcher has formulated appropriate objectives, the next move is to formulate relevant research question(s). It is important to

understand that without a clearly and well-defined research question, it will be difficult to complete the research process. Sometimes inexperienced researchers find it difficult to formulate questions. Questions can be derived from:

- Your working experience (professional experience).
- Literature search you are undertaking.
- Theoretical frameworks on nursing.

It is important to ensure that the research questions are 'good research questions'. One way of doing this is to use the acronym 'FINER'. The acronym 'FINER' stands for the following:

F - Feasible, allowing one to appreciate the practical limitations.

I - Interesting, sustaining the research process.

N - Novel, able to provide new findings

E - Ethical.

R - Relevant, advancing science or influencing clinical care, health care policy among others.

Example of a FINER Research Question

Do nurses in Kalala hospital practice the hand washing procedure as stipulated by the hospital infection control handbook?

Example of a non FINER Research Question

Are nurses washing hands?

In general, the formulation of a research question assists the researcher to:

- Focus on the study by narrowing it down to the essentials
- Avoid collection of data that are not necessary
- Organise the study in clearly defined parts or phases

Hypothesis of the Study

Having defined and understood the research objectives and research questions, the other concept that you may need to develop during your research is the research hypothesis because not all research is tenable to hypothesis testing, hence some research may include hypotheses while others will not.

Most of the descriptive studies do not have a hypothesis to test but they generate hypothesis. Experimental studies have hypothesis to test.

What is a hypothesis?

Brink (1996:91) defines a hypothesis as 'the formulation of the expected relationship between two or more variables in a specific population'. It is the researcher's prediction or explanation of the relationships between two variables. For example:

Persons with Type II diabetes mellitus who have greater knowledge of their diseases will have a higher rate of adherence to treatment regimen than those with less knowledge.

In the example given, the predicted relationship is between 'knowledge' and 'adherence to treatment regimen'. Hypotheses are applied in quantitative studies in order to guide the study, for example, quasi-experimental and experimental studies. A hypothesis is usually tested and, subsequently either rejected or fail to be rejected by the researcher. The hypothesis helps the study in suggesting prediction, explaining outcome and in guiding the investigation to provide a focus.

What are some of the types of hypotheses?

There are various types of hypotheses.

Directional Hypothesis

A directional hypothesis predicts an outcome in a specific direction. One example is the hypothesis given, which stated that:

Persons with Type II diabetes mellitus and have greater knowledge of their diseases will have a higher rate of adherence to treatment regimen than those with less knowledge.

Non Directional Hypothesis

This indicates there is a difference or correlation but does not specify which. For example:

Persons with Type II diabetes mellitus who follow a structured programme on their condition have a higher rate of adherence to treatment.

This does not indicate a directional relationship.

Null Hypothesis and Alternative Hypothesis

1) Null hypothesis (denoted as H_0)
The null (statistical) hypothesis is used for statistical testing and interpretation. It states no difference exists between groups or no correlations between variables.

2) Alternative hypothesis (denoted as H_1)
This is the alternate hypothesis. It states that there is a difference or correlation.

Variables

What is a variable?

As you may have observed, when looking at the research questions and research hypothesis, reference was made several times to the term 'variables'. You, therefore, need to define what a variable is. Variables are defined as quality, properties or characteristics of persons, things or situation that change or vary. For example: sex (male and female) age (20–25, 26–30 years) academic success, stress and pain. There are four main types of variables that you may come across as a research student.

Independent Variable (Treatment or Experimental Variable)

This is a variable that influences other variables. It is perceived as contributing to or enabling a particular outcome. It is the intervention or treatment that the researcher performs to see the resulting change in the dependant variable. It is also referred to as the input.

Dependent Variable

This is the outcome variable. It reflects the effects (outcome) or response to the independent variable. The dependent variable is the variable that appears, disappears, diminishes or increases. For example, to determine the effects of salt intake on hypertension, the blood pressure is the dependant variable and salt intake is the independent variable.

Extraneous Variables

These are uncontrolled variables that influence the findings of the research study. They influence both the dependent and independent variables. These are called threats to internal and external validity of the study and may bias the selection, the time factor, and the instrument used.

Demographic Variables

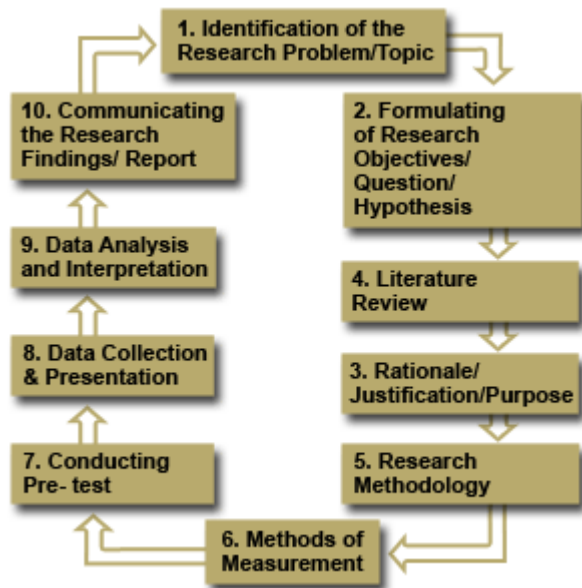
As the name suggests these are demographic attributes. They are variables that cannot be manipulated or influenced by the researcher, for example, age, sex religious beliefs or educational level.

Step Three: Rationale or Justification of the Research Problem

The words 'rationale' and 'justification' are commonly used interchangeably. This is the section of the study that outlines reasons for carrying out the study. Justifications of the study should address some of the following questions:

- What gaps in knowledge will the study address?
- Why is the study important?
- What will the study contribute to the society?

The Research Process



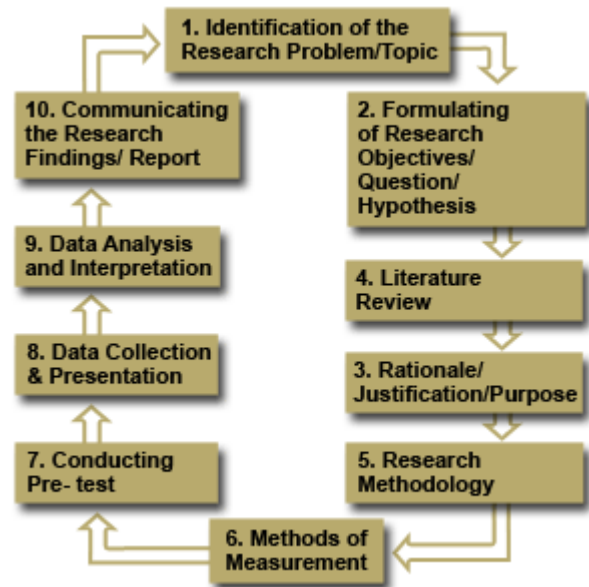
Meanwhile, the significance of the study addresses questions like:

- How will the results be used?
- Who will benefit from the results?
- Is the study worth it?

It is important to state the justification convincingly so as to rationalise the utilisation of resources such as time, money materials and manpower. The rationale of the study should describe the utility and importance of the problem in health care services in general and the nursing profession in particular.

Step Four: Literature Review

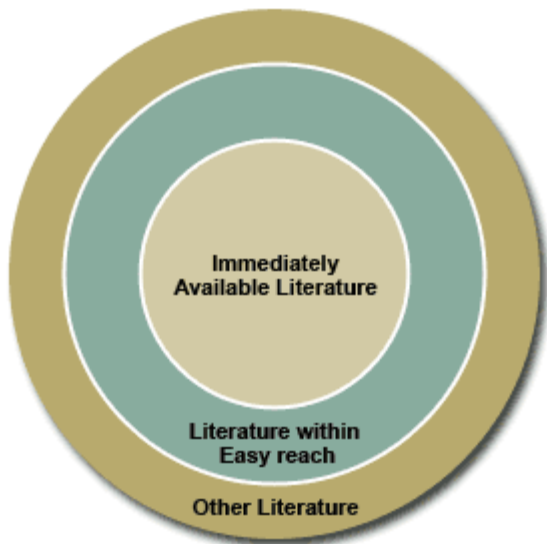
The Research Process



What do you understand by the term 'literature review'?

According to Burns and Grove (1999: 469), 'literature review is a summary of theoretical and empirical sources to generate a picture of what is known and not known about a particular problem'.

Literature review involves more than reading through articles in a journal or research paper. As Mugenda and Mugenda (1999) state, it entails the systematic identification, location and analysis of documents containing information related to the research problem being investigated. In fact, the process of literature review should start with identifying and locating the library, identifying sources and locating the sources.



The main purposes of literature review should be to:

- Determine what has been done already as regards the research problem under investigation.
- Identify strategies, procedures and measuring instruments that have been found useful in the investigation of the research problem.
- Help make the researcher familiar with previous studies and thus facilitate the interpretation of the study.
- Help the researcher to narrow the research topic.
- Help determine new approaches and stimulate new ideas.

When reviewing any literature, the researcher needs to:

- Assess the strengths and weaknesses of past work on the subject
- Report any inconsistent findings
- Identify gaps in the knowledge
- Determine the contribution of proposed study
- Consider the possibility of unintentional duplication

In the search for literature, there are two major sources of information where the investigator can get relevant literature. These are known as primary and secondary sources. You shall cover each of these sources individually.

Primary Source

This is the work written by the person who is actually involved in, or is responsible for, the

generation of the idea published. It can also be information from a person who actually observed or witnessed the occurrence under investigation. The person who conducts empirical research and publishes it in a journal is usually regarded as the primary source of information. When searching for literature, it is important to rely more on primary sources as these give first hand information.

Secondary Source

A secondary source involves summaries or quoted content from a primary source. This type of work is usually a paraphrase of the primary source. Often, it does not give the correct interpretation of the primary sources. It is usually information given by someone who was not a direct observer or participant of the events described.

When conducting a literature search, the researcher has to be aware that there are certain sources where relevant information on a research topic could be found.

Scholarly Journals

These are very crucial documents and are available in all libraries. However, some are more recent than others.

At the same time, there are more scholarly journals on the internet (web), which researchers can access.

Theses and Dissertations

These are research projects written by Masters and PhD students. They are quite important, as they are valuable primary sources of information. They are also the original work of the authors.

Government Documents

These include policy papers, research reports owned by the government, annual reports of hospitals and government ministries and so on.

Papers Presented at Conferences

These are research papers presented at conferences and symposia and are a good source of primary literature.

Books

These are available in most libraries and most researchers or even non-researchers are quite familiar with them. Where the investigator is

unable to locate the required textbook, it is important to seek the assistance of the librarian.

Computers

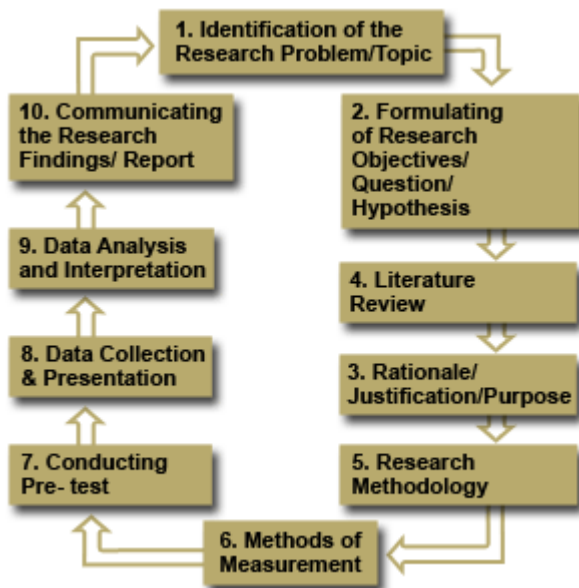
With current technological advances, researchers doing a literature search can access recent information through the internet. Many of the world's refereed journals are online and investigators can always access these, provided they have access to computers and are able to download information. Computers also have databases prepared for literature search. Examples of such databases are MEDLINE or INDEX MEDICUS as well as Pub Med, which nurses can easily access and search for information on the internet.

These are some of the sources of information that nurses doing a literature search need to be aware of. It is important to mention that the above sources of information are not only useful to those undertaking research but also to non-researchers aiming to update their professional knowledge and skills.

Step Five: Highlighting Research Methodology

Research methodology is the fifth step of the research process.

The Research Process



Every researcher has to identify an appropriate research design for use in the study. However,

the selection or identification of a specific study design will depend on several factors. These, according to Harden et al (1995), include the following:

- Available information (state of knowledge) about the problem.
- The nature of the problem and its environment.
- The availability of resources for the study.
- The skills and creativity of the researchers.

It is, therefore, the responsibility of the researcher to make the appropriate research design choice, paying particular attention to its suitability to your research and the available budget for the study.

There are several types of common research designs that you may come across.

- Experimental Design: Experimental and Quasi-experimental.
- Survey Design: Comparative and Correlation.
- Descriptive Design: Descriptive and Explorative.
- Case Study Design.

Experimental Research Design

This is one of the most complex and important research designs. It is also commonly used in clinical settings because of its accuracy and reliability. Experimental research design could be subdivided into true experimental and quasi-experimental.

Experimental research designs are concerned with testing hypotheses and establishing causality. This design tests the hypothesis of relationships, that is, attempts to make predictions of future outcomes based on a causal model implementing strategies to control the predicted outcome. If 'X' occurs 'Y' follows and so on.

Experimental designs try to establish causal links between several factors, for example the effectiveness of a particular drug such as paracetamol in relieving moderate pain.

In an experimental research design, the researcher controls or manipulates the action of the independent or causal variable(s) and observes and measures the action or outcome on the dependant variable. This is the major difference between experimental and non-experimental designs where no control or manipulation is required.

Experimental nursing research is the most logically applicable to clinical nursing practice (Brink, 1996).

What are some of the characteristics of an experimental research design?

An experimental design has certain important characteristics, which you as a research student should be aware of.

Manipulation

This is where the researcher controls the independent variable, which can be an event, intervention or treatment that is expected to have some effect on the dependant variable.

Control

The researcher exercises control over the experimental situation by eliminating the actions of other possible variables beyond the independent variable. This is achieved through manipulating, randomising and careful preparations of experimental protocols and the use of control groups.

Randomising

This is where every subject is given an equal chance to participate in the study. The researcher assigns the subjects to the experimental or control groups on a random basis. To achieve randomisation, you have to first identify the respondents and then place them into groups using random tables, coin tossing or other techniques.

In a quasi-experimental design, some of the above rules are relaxed. For example, there might be no need for having a control group or at times randomisation may not be included. The quasi-experimental design enables the search for knowledge and examination of causality in situations where complete control is not possible.

It is important to appreciate that while experimental research designs are quite useful and commonly used in clinical settings, such as clinical nursing practice, there are certain strengths and weaknesses associated with the design.

Advantages

- Most powerful design for testing the hypothesis of cause-effect relationships between variables.
- It is practical, feasible and can be generalised to some extent. This type of design introduces some control over certain extraneous variables.

Disadvantages

- In most real situations, it is difficult to conduct a true experimental design, since some of the variables cannot be manipulated or controlled.
- At times it becomes quite difficult to get randomised research subjects or even a control group. This is to some extent why nurse researchers are not very interested in experimental research designs.
- As a result of the need for randomisation, control and manipulation with the aim of establishing cause-effect relationships, the design becomes very expensive, both in terms of time and money.

Survey Research Design

The second common research design that you may come across is the survey research design. Survey research design is 'the systematic gathering of information' (Bernard and Morrison, 1992:35). Survey studies are concerned with gathering information from a sample of population.

The purpose of the study is usually to identify general trends or patterns in the collected data, for example, 'nurses attitudes towards smoking'. A survey is designed to obtain information from the population regarding the prevalence, distribution, and interrelations of variables within those populations, for example, using a census, political opinion polls, immunisation sample surveys and so on.

Survey studies primarily yield quantitative data. They are mainly cross sectional in design. They mainly deal with (investigate) what people do, for example, how or what they eat, how they meet their health needs, what kind of family planning behaviour they engage in and so on.

Survey data is collected in number of ways.

- Questionnaires, which are mainly self-administered.
- Telephone interviews, which involves phoning people and seeking their opinions.

□ Personal interviews, also known as face-to-face interviews, where the interviewers meet with the interviewee to seek certain information.

There are several advantages to the survey design. These include:

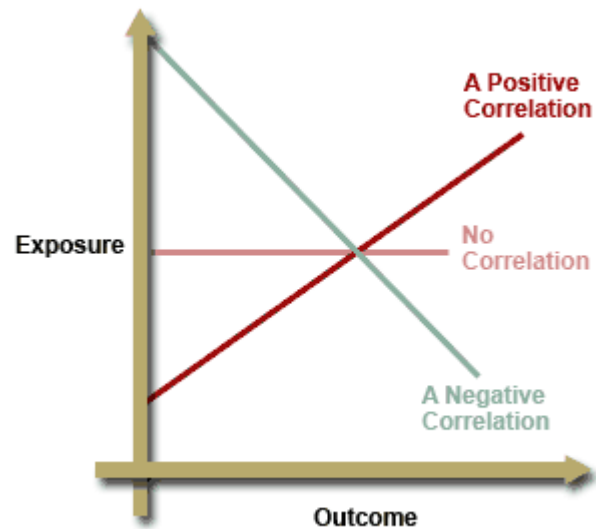
- It is flexible and broad in scope
- It can be applied to many people
- It can focus on wide range of topics

Information generated by the survey method is often superficial as the survey rarely probes deeply. The survey design is better suited for extensive rather than intensive analysis of a situation. It is usually descriptive and specific based on the situation that needs intervention, for planning purposes, monitoring and evaluation of services. An example of a survey is the Kenya Demographic and Health Survey (KDHS) carried out every five years.

In a survey the researcher designs the phenomenon and study but does not manipulate any variables nor do they make any efforts to determine the relationships between variables. However, a comparative descriptive survey is designed to be a comparison between two or more groups to see how they differ on some variables.

In the correlation survey meanwhile, the researcher attempts to determine and describe what relationship exists between variables. For example, the study of the relationship between maternal 'age' and reports of nausea would then be determined statistically through the use of a statistical test known as the correlation coefficient (Brink 1996: 110). One independent variable is correlated with one or more dependent variables. Then statistical methods are applied to describe if the variables relate at all and what kind of relationship they have, that is, positive correlation or, negative correlation.

Variables Correlation Patterns



□ When there is a positive correlation is an indication that the more the exposure the high the outcome of interest, for example smoking exposure and lung disease, which is the outcome.

□ When there is no correlation one would conclude that the exposure is not related to the outcome, for example teething and diarrhoeal episodes.

□ When there is a negative correlation it means that the more the exposure the less the outcome, for example tetanus vaccination and tetanus infection.

Descriptive or Explorative Research Design

According to Harden et al (1999), a descriptive study is the systematic collection and presentation of data to give clear picture of a particular situation. Cormack (1982:178) defines descriptive research as research, which involves the systematic collection of information and aims to discover and describe new facts about a situation, people, activities, or events.

The descriptive research design is grouped as a non-experimental research design. Its main purposes include observing, describing and documenting all aspects of a situation as it naturally occurs. At times, descriptive designs are used as a starting point for hypothesis generation or theory testing. The descriptive study attempts to obtain

complete and accurate information about a phenomenon through observation, description and classification'. Examples of questions in this line of study include:

- How prevalent is the measles disease in this district?
- What are the characteristics of the district's population?
- When are measles outbreaks experienced?

In the exploratory descriptive design, the main purpose is to explore the dimensions of a phenomenon (problem) as well as the major characteristics or facts that influence the phenomenon. Questions to be asked include:

- What is the nature of the problem?
- What factors are related to the problem?

A descriptive study is designed to gain more information about characteristics within a particular field of study. It aims to provide a picture of a situation as it naturally happens. Descriptive study design may be used for developing a theory, identifying problems within the current practice, justifying current practices or making judgments determining what others in similar situations are doing.

In descriptive design, no manipulation of variables is involved as opposed to experimental design. Similarly, no dependent or independent variables are used within a descriptive study design because no attempt is made to establish causality. The overall purpose of descriptive research is to provide a picture of a phenomenon as it naturally occurs, as opposed to studying the impacts of the phenomenon or intervention.

Descriptive research designs vary in their level of complexity. Some contain only two variables while others may include multiple variables. A variety of labels are used to describe descriptive research design. These include:

- Explanatory when the researcher's focus is to generate ideas and work on a field of inquiry that is relatively unknown.
- Epidemiologic, which is a form of descriptive research that is designed to provide information on the independence, prevalence, incidence and correlates of a disease or medical condition in a population, for instance, incidence or prevalence of AIDS in specific high risk populations, for example commercial sex workers in Nairobi's Majengo estate, or truck

drivers along the Nairobi-Mombasa high way).

The emphasis of a descriptive research design is on maximising the study's credibility, usefulness and feasibility. Comparatively, descriptive studies are relatively cheaper than randomised experimental designs. However, certain types of descriptive studies can be very expensive, both in terms of money and time, for example large scale studies. A descriptive research design could be divided into the following categories:

Explorative Descriptive Design

In the explorative descriptive design, the researcher explores a particular problem to discover what is there and if it could be solved. The study focuses on new events, evidence, or practices.

Simple Design

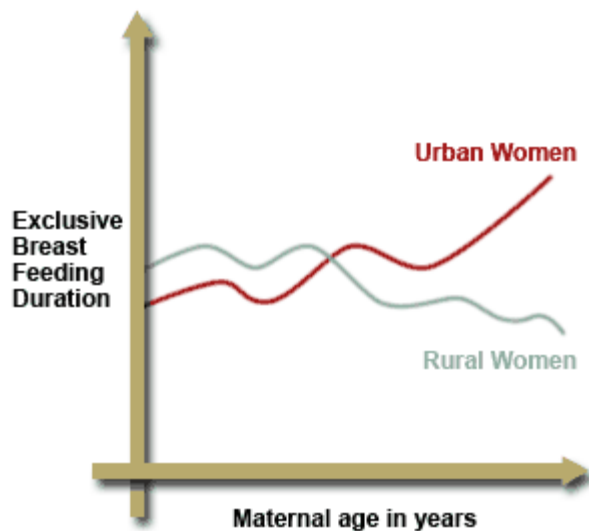
The simple design is mainly a follow up of an exploratory design. The variable of interest has already been identified. This design is used when the researcher intends to examine only a single problem.

Comparative Descriptive Design

The comparative descriptive design is mainly used when the researcher intends to examine and describe particular variables in two or more groups. The concept here is to compare the groups and how they differ or how similar they are in relation to the variable of interest.

Time Dimensional Designs

Time dimensional designs are used in epidemiological studies and are further subdivided into longitudinal that is when it examines changes in a group for a long period and it is cross-sectional where the data is collected at one point in time.



Retrospective Study Design

The retrospective study design is also known as 'export facts'. It is a study design aimed at a looking back in order to link the present with the past or what happened in the past. People having an outcome of interest, for example skin disease, are interviewed to establish whether or not they have had contact with an exposure of interest in the past, for example spraying of agrochemicals.

Prospective Study Design

The prospective study design is similar to the longitudinal study as it starts from the present and ends by looking into the future. It is further divided into two categories: descriptive and explanatory. The subjects for the study are recruited based on presence or absence of an exposure of interest (workers in x-ray department) and followed up over many years to establish if they will develop outcomes of interest, for example cancer of the skin or reproductive health complications.

There are very few features that can be used to differentiate the various types of descriptive research designs. These include:

- Representativeness of the study data sources, for example, whether random, stratified, non probability.
- Time frame of measurement, that is, whether short, cross sectional or longitudinal.
- Whether the study involves any comparisons, for example, with another group.

- Whether the design is focused on a simple descriptive question or more complex, correlative questions.

Descriptive research designs are commonly used when the researcher is attempting to answer 'what is' or 'what was' questions, normative questions and/or correlative questions.

Descriptive or Explorative Research Design

Strengths and Weaknesses of Descriptive Research Design

Strengths	Weaknesses
Lower costs	Does not answer questions of causal-effect relationship nature
Relatively easy to implement	Expensive when complex data collection techniques are used
Ability to yield results in a short period	May not consider variables in depth
Results are relatively straightforward to analyse and communicate to an audience	Generalisability of the findings may not be achieved

Case Study Research Design

The other common type of research design is the case study design. A case study is 'an in depth study of one individual, a group of individuals or an institution' (Brink 1996:116). It is a detailed account of a particular experience event or situation. It is meant to provide a description of people's thoughts, feelings and perceptions.

A case study research design does not aim at providing a causal relationship. Neither does it attempt to test a hypothesis.

Case studies describe the characteristics of one or a limited number of cases extensively. The subject of the case study could be a patient, health centre, a village or a specific disease condition.

An example of a case study that a nurse researcher would like to investigate could be a mother with a bad obstetric history to determine their knowledge, feelings and perceptions of their condition (situation), or a case study on why in a certain health centres mothers are not

coming in for their antenatal services. Such studies could provide significant insight into why things happen as they do.

While the case study design gives significant information, it has certain limitations, which you should be aware of as a researcher.

- They require plenty of time.
- They are costly.
- Have high possibility of subject drop out.
- Data analysis also calls for skills and experience, particularly if the study is carried over a long period of time.

In a case study design, the number of subjects might be very few but the study should be able to address all the interest variables.

When are case study designs used?

Case study designs are used when:

- There is a need to demonstrate the effectiveness of a specific therapeutic technique
- Generating and testing hypotheses
- There is need to generate knowledge on a particular issue or situation that has not been adequately researched on

Sampling Strategies

The process of identifying the appropriate sampling techniques is very important in the research process. However, it is impossible to collect data from the whole population that a researcher may be interested in or intends to investigate. Since the essence of any research is to investigate a particular population, the selection of a representative sample from the specific population is vital. The type of sampling method a researcher uses will depend mainly on the type of research one intends to undertake, the methodology to be applied and the time available for the tasks. Sampling pertains to the identification of the study subjects from the general population a researcher is interested in. A researcher uses a specific sampling strategy because it is the most 'feasible and logical way of making a statement about a larger group' (Rensburg 2000:149).

According to Brink (1996) and Rensburg (2000) state, before discussing the type of sampling strategies available, one needs to define certain important terms that are associated with sampling methods.

Population

Population is defined as 'the entire group of persons or set of objects and events the

researcher wants to study' (Rensburg 2000:147). It is also referred to as all the possible entities or individuals that have the characteristic(s) of interest to the study. The most important aspect is that the population must possess all the characteristics the researcher is interested in.

Sample

A sample is a group of people, or records or a number of observations from a larger population. It is a representative group of individuals selected from a population. A sample aids the researcher to get access to the general population. A sample that is selected appropriately generates data that reflects the true status of the population in relation to the characteristic(s) or variables under study.

Sampling Frame

Sampling frame is a comprehensive list of all the sampling elements in the target population, for example, the list of nurses working in a particular district, the number of under five children in a village or all the households in a village. An important point to note is that it is not always possible to get a sampling frame. In this case it becomes incumbent on the researcher to prepare their own sampling frame.

Representative Sample

A representative sample means that the sample resembles the population from which it is drawn in all aspects. It should possess all the variables a researcher is interested in, for example, educational level, socioeconomic factors, exposure to certain illness and so on.

Sampling Bias

Sampling bias occurs when the researcher has not carefully selected the samples that are expected to represent the general target population. It is usually the fault of the researcher and can have a negative impact on the entire findings of the research (Rensburg, 2000 and Brink, 1996). Causes of sampling bias could arise from the data collection process, for example, what time of the day the data was collected, languages of communication or how the data was collected.

Sampling Error

According to Rensburg (2000:151) sampling error refers to the difference between population

parameters (for example, the average age of the population) and the sample statistics (for example, the average age of the sample group). It is the degree of deviation of the sample from the population from which it was drawn.

Sampling Techniques

There are two basic sampling techniques:

- Probability or random sampling
- Non probability sampling

Probability Sampling

Probability sampling allows for a much more representative sample of the population and enables the estimation of sampling error. It also enables the calculation of differential statistics and allows the study to be generalised to other areas.

Random sampling should take into account knowledge of every element of the population and the availability of a list of all those eligible to make a random selection.

Probability sampling involves a random selection procedure to ensure that each unit of the sample is chosen on the basis of chance. All units of the study population have an equal or at least a known chance of being included in the sample from list provided (Hardon et al., 1995).

The following include some of the commonly used probability sampling techniques.

Simple Random Sampling

Simple Random Sampling is one of the commonest and the simplest methods of sampling. In simple random sampling, each unit (subject) has the chance to be selected. It involves one stage selection. It also allows the researcher access to the study population. Various ways of selecting the subjects exist among which are:

- Identifying the specific target population.
- Formulating an appropriate sampling frame.
- Determining the sample size for the study.
- Adapting a consecutive identification number for each unit in the sampling frame.
- Selecting the desired subjects using a randomised technique.

There are several ways of selecting a random sample using this technique. These include, the lottery method, use of random tables, or tossing a coin to help you decide where and how to start.

For example, if you need to select 30 subjects from a sampling frame of 100, you get 100 pieces of papers and write 'Yes' on 30 of them and 'No' on the rest. You then ask all the 100 subjects to pick a piece of paper each. Those who pick 'Yes' are included in the study.

Systematic or Interval Sampling

Systematic sampling is the selection of every n^{th} element from a sampling frame, where n , the sampling interval, is calculated as:

$n = \text{number in population} \div \text{number in sample}$

Using this procedure each element in the population has a known and equal probability of selection. This makes systematic sampling functionally similar to simple random sampling. It is however, much more efficient and much less expensive to do.

Sampling Techniques Example

For example, suppose you intend to interview 200 KRCHN in-service students out of a total of 2000. To get the sampling interval you would divide the total number of students with the desired sample size, that is, $2000 \div 200 = 10$. Your sampling interval is 10, that is, in a list of 2000 students you will pick every 10th student.

The next step is to decide your starting point. You may use simple random method to do this by writing the numbers 1 to 10 on 10 different pieces of paper. Ask someone to pick any of the pieces and the number that is picked will be your starting point. If 8 becomes the 1st person, then every 10th person, that is, 18th, 28th, 38th and so on is picked for the study.

Stratified Random Sampling

When sub-populations vary considerably, it is advantageous to sample each subpopulation (stratum) independently. Stratification is the process of grouping members of the population into relatively homogeneous subgroups, for example, by education level, socioeconomic structure and so on before sampling. The strata should be mutually exclusive, that is, every element in the population must be assigned to only one stratum. The strata should also be collectively exhaustive, that is, no population element can be excluded. Random sampling is then applied within each stratum. This often improves the representativeness of the sample by reducing sampling error.

For example, you may wish to conduct a study on contraceptive use in a community and you realise you need to stratify the subjects based

on their religious beliefs, being a significant characteristic or variable in decision on usage of contraceptives. This calls for you to divide your desired sample into strata on religious lines, for example, Christians Protestants, Christian Catholics, Christians others, Muslims, Hindu and Buddhists just to mention a few. Each strata is then apportioned a sample size based on the proportion of the number of the people from that religious affiliation in the population. If Protestants are 40%, Catholics 30%, others 5%, Muslims 20% and so on, the samples are apportioned based on those percents.

Cluster Sampling

Cluster sampling is a sampling technique used when 'natural' groupings are evident in the population. The total population is divided into these groups (or clusters), and a sample of the groups is selected. The required information is then collected from the elements within each selected group. This may be done for every element in these groups, or a subsample of elements may be selected within each of these groups.

Elements within a cluster should ideally be as homogeneous as possible. However, there should be heterogeneity between clusters. Each cluster should be a small scale version of the total population. The clusters should be mutually exclusive and collectively exhaustive. A random sampling technique is then used on any relevant clusters to choose which clusters to include in the study.

Non Probability Sampling

There are two principle methods of non probability sampling. These are known as purposive or judgmental sampling and quota sampling.

Purposive or Judgmental Sampling

Purposive or judgmental sampling is where the researcher selects a particular group or groups based on certain criteria (Wilson, 1993:179). In this method the researcher determines who should be included in the study. It is, in fact, the researcher's opinion that the sample is representative of the target population.

Purposive sampling is commonly used in qualitative studies. The main advantage of this method of sampling is that it gives the researcher a free hand to respond according to their judgment. Disadvantages include sampling

biases, the possibility of unrepresentative samples and lack of generalisations of the study findings.

Quota Sampling

In quota sampling, the population is first segmented into mutually exclusive sub-groups, just as in stratified sampling. Then judgement is used to select the subjects or units from each segment based on a specified proportion. For example, an interviewer may be told to sample 200 females and 300 males between the age of 45 and 60.

Convenience or Accidental Sampling

Convenience sampling is also referred to as accidental or availability sampling. In convenience sampling the researcher is unable to control bias at all. This is a method in which, for convenience sake, the study units that happen to be available at the time of data collection are selected and used as a sample (Hardson et al 1995:207).

This type of sampling allows the utilisation of any available target population. For example, if you need to assess the blood pressure of females using depo provera who are above 40 years of age, you will need to check the blood pressure of any female patient above this age irrespective of her parity or other characteristics. In such circumstances there is no sample representation.

Snow Ball Sampling

In social science research, snowball sampling is a technique for developing a research sample where existing study subjects recruit future subjects from among their acquaintances. Thus the sample group appears to grow like a rolling snowball. This sampling technique is often used in hidden populations which are difficult for researchers to access. Example populations include drug users and commercial sex workers. Sample members are not selected from a sampling frame, therefore, snowball samples are subject to numerous biases. For example, people who have many friends are more likely to be recruited into the sample.

Summary of sampling techniques.

Commonly Used Sampling Techniques (Adapted from Wilson, 1993:181)

Sampling procedure	Conditions under which the procedure is typically used
	Probability Sampling Procedures

Simple random sampling	Survey research in which the investigator wants to avoid sample bias and ensure that every element has an equal chance of being in the study.
Systematic sampling	Survey research when a list of the sampling frame is available.
Stratified random sampling	Survey research in which the researcher wants to study particular homogeneous strata or sub-population.
Cluster sampling	Survey research when it is difficult and/or expensive to obtain an exhaustive list of the population and it considers geographical distribution of the sample.
Non Probability Sampling Procedures	
Purposive or judgemental sampling	Surveys or experiments in which the researcher wants to study a group or groups based on particular characteristics or circumstances.
Convenience sampling	Surveys or an experiment that utilises any easily accessible group.
Expert sampling	Survey in which experts on a particular subjects are necessary.
Quota sampling	Surveys or experiments in which the investigator has hypothesis about difficult strata or sub-population.
Snowball sampling	Surveys or experiments in which participants are difficult to identify, hard to locate, or socially devalued. This method relies on the few initial respondents identifying other respondents with similar characteristics.

In conclusion, you have now learnt the definitions of common terminologies associated with samples and sampling. You have also learnt the two major sampling strategies, which are probability sampling and non-probability sampling. In addition, you described in detail examples of each of these two techniques which include: simple random sampling, systematic sampling, cluster sampling (probability sampling)

and quota sampling, convenience or accidental sampling, snowball sampling and purposive sampling (non-probability sampling).

Access to Research Population

In order to gain access to a research population, there is need to specify how you as the researcher achieved this goal. You need to describe how the research areas were identified, the selection process involved, the type of sampling method used and how you managed to gain access to the specific research participants. You will also have to specify some of the ethical considerations involved and how these are professionally managed before the respondents take part in the study.

Prior to commencing the study, you as the researcher should make a formal application to the government of Kenya for permission to conduct the research. This should include two or more copies of the research proposal, accompanied by a recommendation letter from the supervisor(s) as required by the Kenyan authorities. Similarly, if your institution is authorised to conduct research, there may be a 'Research and Ethics Committee'. Such a committee is usually vested with the authority of granting research permits, which you could use. Once the authority to conduct the study in the form of a 'Research Clearance Permit' has been granted, the researcher then reports to the 'District Commissioner (DC) of the area'. The DC will then instruct you to report to the District Officer (DO) of your research area. The DO may further require you to report to the area local chief and assistant chiefs. When the above administrative requirement is completed, the researcher then approaches the village leader to grant further access to the respective villagers. As a requirement, each research respondent should be requested to accept in writing and sign or affix a thumb print. In cases where a respondent can neither read nor write, a consent form should be completed and duly signed after you have clearly explained the purpose of the research.

Always attach a copy of this consent in the appendix section!

You should inform the respondents that their participation is absolutely voluntary and they may pull out of the study whenever they so wish. As part of the contract, you should guarantee the respondents absolute confidentiality during and after the study.

The process described above may vary depending on the type and area of study. For example if you want to conduct a study specific to your hospital or a few hospitals in your catchment area you may need authority from the hospital administrator and heads of departments that are going to be involved.

Step Six: Methods of Measurement

You shall now look at some of the steps involved in the measurement process.

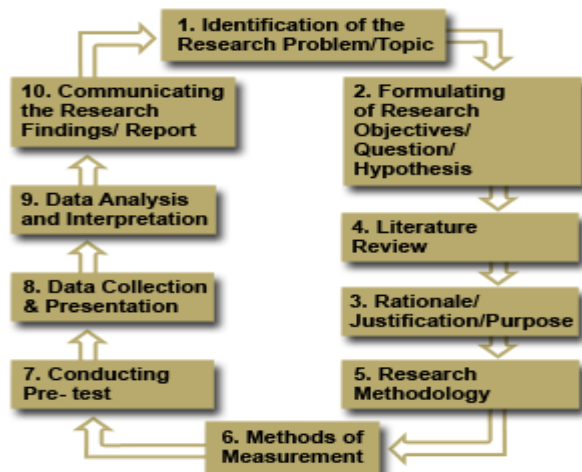
Review of Existing Records

What are some of the advantages of reviewing existing data?

The review of existing records has several advantages. Data collection in any study entails heavy costs in terms of time and money. By reviewing existing data, you should be able to save time and money (Treece and Treece, 1986). For example, if you were to carry out a large scale field survey to determine the national immunisation coverage in Kenya. You would not only require an immense amount of funds but also adequate time to undertake the survey. By reviewing existing data, you the researcher, saves both time and money.

Every researcher endeavours to limit respondent bias. Existing data utilises records, which are unbiased, as the person who collected the data had no knowledge of the future use to which it would be put. Additionally, existing records cover a long period of time, which is particularly useful to the researcher who can only dedicate a short time to their research.

The Research Process



Existing records also save the researcher from the worries and concerns of seeking the

cooperation of the respondents. When you set out to collect data from a respondent for a study, you have to obtain informed consent from the respondent or guardian, where the respondent is a minor or mentally incapable of making decisions. When reviewing existing records, all that you require is the authority to access relevant records, since the data has already been collected.

What are the disadvantages of existing records or data?

Pre-existing data also has its share of shortcomings. Most notably, since the researcher is not responsible for the collection and recording of the data, limiting biases and even ascertaining the authenticity of the data would

be difficult. This can often result in doubts about the validity of the data.

Structured Interview Schedule

A structured interview schedule is a formal and written document where questions are asked orally in either face-to-face or telephone interviews.

The responses are then recorded by the researcher (Bogdan and Biklen, 1992; Oppenheim, 1993). The main advantage of a highly structured questionnaire is that it provides comparability of responses and facilitates analysis (Polit and Hungler, 1993). Highly structured instruments are quite common in quantitative research methods where the application of statistical tests is used to predict the reliability and validity of the data.

The interview schedule is one of the structured instruments used by researchers for collecting data. It is commonly used in telephone interviews but is also applicable to a special category of respondents, such as children, the elderly and the illiterate who may not be able to read and write (Oppenheim, 1993). The instrument is expected to have a high response rate, since the researcher administers it personally. An interview schedule also has the advantage of capturing the respondent's own words.

Despite the aforementioned advantages, the instrument has several limitations that the researcher should be aware of. The instrument demands a much longer time to complete than other instruments, such as questionnaires. In addition, due to the presence of the researcher, respondents may withhold certain vital

information or even change information to please the researcher.

Focus Group Discussions

According to Polit and Hungler, (1993:202) 'Focus group interviews are interviews with groups of 5-15 people whose opinions and experiences are solicited simultaneously. The advantage of a focus group discussion is that it is efficient and can generate dialogue. Focus group discussions have the ability to generate information from the group members. The composition of the group is usually limited to those with similar characteristics, such as socio economic status, so that the members feel free in contributing to the issue at hand. The instrument allows the members to share their views, experiences and opinions. The interpersonal interactions create a free and enjoyable environment.

Krueger (1994:6) notes that 'the discussion is comfortable and often enjoyable for the participants as they share their ideas and perceptions'. Group members influence each other by responding to the ideas and comments in the discussion.

Several advantages accrue from such an instrument. The instrument allows a large number of respondents to be interviewed at one go, which saves time and money. However, one major shortcoming is that the method, because of the number of respondents involved, calls for diligence and skill in ensuring that the process runs smoothly and yields the desired information.

Novice researchers often find this very difficult as the researcher is expected to exercise great care in ensuring that the discussion remains within context while at the same time limiting disruption of the discussion process.

In-depth Interviews

The researcher can also utilise face-to-face in-depth interviews using semi-structured questionnaires for key informants. Key informant interviews are defined as interviews with people who have special positions in the community and whose opinions and experiences are seen as representative of a whole group. They often see the problems of a group rather than of an individual, making them a very useful group of people to interview'.

Semi-structured questionnaires possess a flexibility that allows the researcher to gather in depth information. The instrument enables the participants to give responses in a narrative form

and is quite useful in qualitative research (Polit and Hungler, 1993). The respondent takes the lead and determines the flow of the conversation, which is of great importance when new areas are to be investigated (Polit and Hungler, 1993). Key informant interviews provide valuable and independent information about the research population within a short span of time and save time and money. However, Polit and Hungler (1993) suggest that the main weakness of the instrument is that it requires the researcher to be very articulate.

Non Participatory Structured Observation

Another instrument that can be used for data collection is non participatory, semi-structured observation. Non participatory observation is observing a given situation from the outside. The observer declares their intention to observe and goes ahead to watch the activities being carried out without asking questions or interfering in any way. As the activities to be observed progress, the observer remains in the background, keenly observing and noting down events without comment.

Polit and Hungler (1993: 220), with reference to the relevance of the observational method as a tool for generating data, state that: 'Observational methods have an intrinsic appeal with respect to their ability to capture a record of behaviours and events.'

Furthermore, there is virtually no other data collection method that can provide the depth and variety of information as observation. With this approach, the observers are used as measuring instruments and provide a uniquely sensitive and intelligent tool.

Once you have generated the data, it is important to follow a structured method of data processing and entry. The following steps, adapted from Floyd and Fowler (1993:123), provide a useful guideline:

- Decide on a format, that is, the way the data will be organised in a file.
- Design the code, that is, identify the rules by which respondent's answers will be assigned values that can be processed by a computer.
- Code the data. This refers to the process of turning responses into standard categories.
- Input data into the computer if you are going to use analytic software.

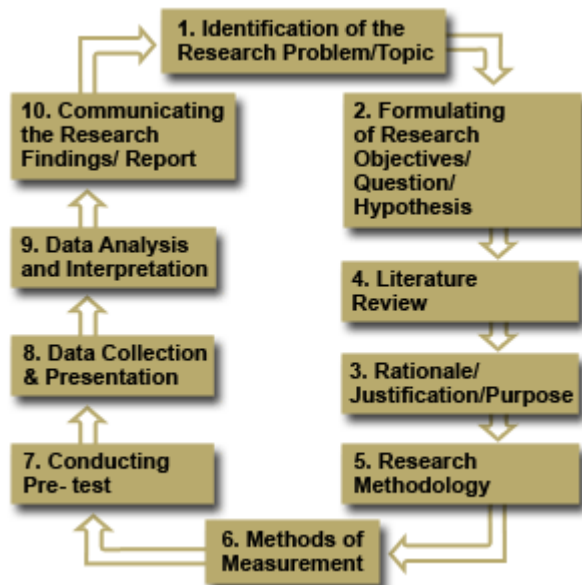
- Completeness and consistency before analysis.

Step Seven: Conducting a Pre-Test or Pilot Study

Before you carry out the full scale data collection process, it is important to conduct a trial to see whether the instruments that you will use for data collection are actually appropriate for the study and whether you are collecting the information you need. To achieve this, you have to carry out a pilot study or pre-test.

Researchers have given various definitions to these two terms. A pilot study may be defined as 'a small version of a proposed study conducted to refine the methodology. It is developed and conducted in a manner similar to the proposed study, using similar research respondents and the same setting. A pilot study may also be defined as 'the process of carrying out a preliminary study going through the entire research procedure with a small sample'. A pre-test usually refers to a small scale trial of a particular research component. The above definitions illustrate why the two terms are used interchangeably.

The Research Process



Why do you need to carry out a pre-test?

The following are some of the purposes of a pre-test or pilot study:

- To determine whether the proposed study is feasible
- Identify any problems with the research design
- To ensure that items in the data collection instrument are stated clearly and have the same meaning to all research respondents
- To assess the time taken to administer the research instrument
- Determine whether the sample is representative of the population
- To determine the effectiveness of the sampling technique used
- Give the researcher the real experience in the field
- Determine the human and financial resources requirement for the study
- Determine the effectiveness of the training given to research assistants where necessary
- Evaluate the procedure for data processing and analysis

When is the appropriate time to conduct a pre-test?

Ideally, a pre-test of data collection and data analysis procedures should be made before the actual full scale study. The advantages of conducting the pre-test before you finalise your proposal is that you can draft the work plan and budget based on realistic estimates, as well as revise the data collection tools before you submit your proposal for approval. The pre-test of the data collection instruments could be done either before training your research assistants or immediately after.

However, if this is not possible, for example, if the proposal is drafted far from the field, and there are no similar research settings available close to the drafting site, the field test may be done after finishing the proposal. However, it should be carried out long enough before the actual field work to allow for a thorough revision of data collection tools and procedures.

Using the Pre-Test Findings

It is important that you, as a researcher, utilise appropriately the lessons learnt from the pre-test or pilot study. For instance:

- Identify any sensitive or irrelevant items in the instruments and rectify them.
- If there was any question that the interviewers had to repeat and explain

several times for the respondents, this needs to be rectified.

- Analyse the results of the pre-test or pilot study as it helps to develop dummy tables.

Ethical Considerations in Research

As you may have noted in the [research process diagram](#), there is no specific step for 'Ethical Issues in Research'. This is because ethical issues cut across the whole research process.

Ethical considerations start right from the beginning when you are identifying your research problem and continue all the way to the dissemination of the research findings. However, for convenience and academic purposes, you will now look at ethical issues in research at this point.

Mugenda and Mugenda (2003:190) describe ethics 'as that branch of philosophy which deals with one's conduct and serves as a guide to one's behaviour'. It is important to note that most professions, including nursing, have a code of conduct to which all members of the profession have to adhere. Similarly, Plooy (2003:118) describes ethics in research as 'that which is morally justifiable'. Research ethics fundamentally consist of collecting, analysing and interpreting data in a way that respects the rights of your participants and respondents.

According to Brink (1996: 39), there are three basic ethical principles that guide researchers including nurse researchers. These are:

Principle of Respect for Persons

This principle involves two main convictions:

- Individuals are autonomous, that is, they have the right to self-determination and this right should be respected. This means the research respondents have the right to:
 - a) Accept or decline to participate in the study without punishment or prejudice
 - b) Withdraw from the study at any stage
 - c) Withhold information
 - d) Seek clarification concerning the purpose of the study
- Individuals with diminished autonomy require protection. This group includes children, the mentally impaired, unconscious patients and institutionalised persons. For this group of persons, you will need to seek the consent of their legal guardian.

Principle of Justice

This includes the subjects' right to fair selection and treatment and their right to privacy:

- Right to Privacy: This is the freedom of an individual to determine the time, extent and the circumstances under which private information will be shared with or withheld from others. The privacy of the subject is considered to be protected if the subject is informed and consents to participate in a study and voluntarily shares private information with a researcher. An invasion of privacy occurs when private information is shared without the respondent's knowledge or against their will.
- Right to Anonymity and Confidentiality: The research respondents have the right to anonymity and the right to assume that the data collected shall be kept confidential. Complete anonymity exists when the respondents' identity is not revealed and the information collected is not linked to the respondent. Confidentiality refers to the researcher's responsibility to protect all data gathered within the scope of the project from being divulged or made available to any other person, which means the research data should never be shared with outsiders. A breach of confidentiality can occur when a researcher allows an unauthorised person(s) to gain access to the raw data of a study or when the researcher accidentally reveals the identity of the research respondents.

Principle of Beneficence

This principle involves an effort to secure the well being of persons. It is the right to protect respondents from discomfort and harm. This principle states that one should do what is good and above all should do no harm. Discomfort and harm can be physical, emotional, spiritual, economic, social or legal.

The Major Content of an Informed Consent

Patients undergoing any operation are required to give informed consent. You may need to obtain informed consent from research respondents who take part in your research project. According Brink (1996:42), informed consent revolves around the following three major elements:

- The type of information you need to obtain from the research subjects.

- The degree of understanding required of the subject in order to give consent.
- The fact that the subject has a free choice in giving consent.

Mugenda and Mugenda (2003:192) state that informed consent should be based on the following factors:

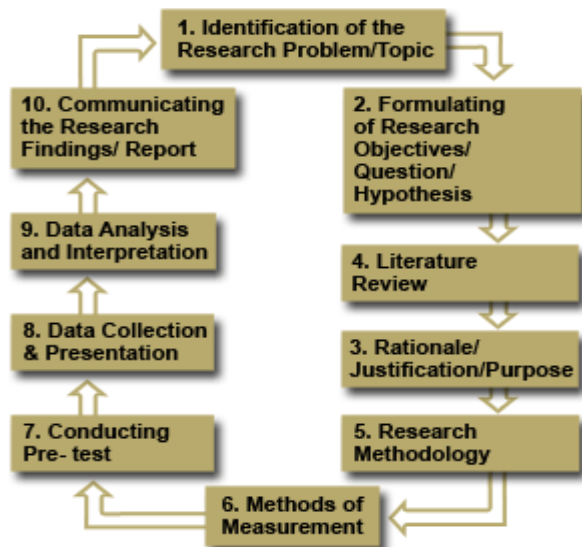
- The purpose of the research study
- Foreseen risks
- A guarantee of anonymity and confidentiality
- Identification of the researcher
- Number of subjects involved
- Benefits and compensation or lack of them

Step Eight: Data Collection and Presentation

Data collection is one of the major steps of the research process. It is the data collection process that will determine the findings of the entire research study. It, therefore, calls for more attention and consideration. There are various data collection methods. However, the approach will depend on the type of study you are undertaking, the study objectives, the design, and above all, the available resources for the study in the form of money, time and the technical skills of the research team.

Burns and Grove (1999: 43) define data collection as 'the precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions or hypotheses of a study'.

The Research Process



Data Collection Plan

Before you begin the data collection process, you need to draw up a data collection plan. A data collection can be developed using the following steps:

- List the tasks that have to be carried out and the people responsible for those tasks.
- Make a rough estimate of the time needed for different parts of the study.
- Identify the most appropriate period in which to carry out the research.
- Schedule the different activities that have to be carried out each week in a work plan.

A plan for data collection should be developed in order to:

- Have a clear overview of what tasks have to be carried out, who should perform them and the duration of these tasks.
- Organise both human and material resources for data collection in the most efficient way and minimise errors and delays that may result from lack of planning.
- Identify problems, for example, limited manpower, that will require modifications to the proposal. Such modification might include adjustment of the sample size or extension of the data collection period.

There are three main stages in the data collection process:

- Stage One - Permission to Proceed
- Stage Two - Data Collection
- Stage Three - Data Handling

Stage One: Permission to Proceed

Consent must be obtained from the relevant authorities, individuals, and the community in which the project is to be carried out. This may involve organising meetings at national, provincial, district or village level. For clinical studies, this may involve obtaining written informed consent.

The principal investigator is likely to be the one responsible for obtaining permission to proceed at the various levels. The health research unit in the Ministry of Health or the institution organising the research may assist in obtaining permission from the national level. In many countries, research proposals have to be screened for scientific and

ethical integrity by national research control centres.

Stage Two: Data Collection

When collecting data, you have to consider the logistics.

This entails identifying who will collect what, when and with what resources and quality control.

Who will collect what data?

When allocating tasks for data collection, it is recommended that you first list the tasks. You can then identify who could best implement each of the tasks. If it is clear beforehand that your research team will not be able to carry out the entire study by itself, you may look for research assistants to assist in relatively simple but time consuming tasks.

Allocating Tasks for Data Collection	
Task	To be carried out by
Record study	Research team
Focus group discussion with health staff before and after individual staff interviews	Research team
Individual health staff interviews	Research team
Participant observation in clinic	Principal investigator
Interview with mothers (community based) before and after delivery	Research assistants, under supervision of research team

How long does it take to collect the data for each component of the study?

In order to answer this question, you should consider the following points:

- The time required to reach the study area(s).
- The time required to ‘walk around’, and build rapport in the community.
- The time required to locate the study units (persons, groups, and records). If you have to search for specific informants, for example, users or defaulters of a specific service, it might take more time to locate informants than to interview them.
- The number of visits required per study unit. For some studies, it may be necessary to visit informants a number

of times, for instance, if the information needed is sensitive and can only be collected after informants are comfortable with the researcher.

- The time it takes to verify the quality of data collected in order to establish its validity.
- The time required for taking field notes on the research process.
- The time required for preliminary analysis of the data.

The data collection plan can be drawn up as follows:

- Calculate the number of interviews that can be carried out each day, for example, four per team member.
- Calculate the number of days needed to carry out the interviews. For example, if you need to do 200 interviews, your research team of five people can do $5 \times 4 = 20$ interviews per day. You will therefore need $10 (200 \div 20)$ days for the interviews.
- Calculate the time needed for the other methods used in the study, for instance, five days for familiarisation and rapport building, five days for focus group discussions, three days for participant observation and so on.
- Determine how much time the research team can devote to the fieldwork.

If the time required according to calculation is more than the time available, it may be necessary to recruit assistants for certain components of the study, for example for conducting interviews.

Recruiting research assistants for data collection may ease the task of the research team, but it must be remembered that the training and supervision of research assistants requires time. Time decisions have to be carefully determined on the basis of an analysis of the pros and cons of the study and its team members. If none of the team has previous research experience, they might prefer a study that they can carry out themselves without, or with only minimum, assistance.

If research assistants are required, consider to what extent local health workers can be used. They often have the advantage of being acquainted with the local situations. However, they should never be involved in conducting

interviews to evaluate the performance of their own health facility or in studies on people's self care practices in their own catchment areas. Local staff from related services, for example, teachers, community development officers or students could also help with data collection. Occasionally, members or community members can collect certain parts of the village health data.

It is advisable to slightly overestimate the period needed for data collection to allow for unforeseen delays. In fact, it is often difficult to implement the fieldwork strictly according to plan, as you may encounter unforeseen problems, for example, adverse weather conditions or transport breakdown. Your philosophy of fieldwork planning should be flexible.

In what sequence should data be collected?

Generally, it is advisable to start with available data. This is essential if the sample of respondents is to be selected from records. Another rule of thumb is that qualitative research techniques, for example, focus group discussions, which are devised to focus the content of questionnaires, should be carried out before the finalisation of the questionnaire. If the focus group discussions are to provide feedback on issues raised in larger surveys, however, they should be conducted after preliminary analysis of the questionnaire.

To use time and transport efficiently, data that is to be collected from different sources in one locality should be collected at the same time, for example, interviews with staff in a health centre, observation of the equipment in the centre, and interviews with mothers living nearby should be scheduled together.

When should the data be collected?

The type of data to be collected and the demands of the project will determine the actual period of data collection. The following should be considered:

- The availability of research team members and research assistants.
- The appropriate season(s) to conduct the fieldwork (if the problem is season related or if data collection will be difficult in certain periods).
- The accessibility and availability of the sample population.
- Public holidays and vacation periods.

Ensuring Quality

It is important that the data collected is of good quality, that is, reliable and valid. Otherwise, you may come out with false or misleading conclusions. Therefore, the possible sources of data distortion (bias) should be addressed. Biases you should try to prevent include deviations from the sampling procedures set out in the proposal, variability and bias in observations or measurements made because:

- The subject being studied changes their behaviour as a consequence of the research. For example, a subject may act more positively while being observed.
- The researcher may use non-standard measuring scales, imprecise or no guidelines for interviewing.
- Researchers themselves vary in what they observe or measure, that is, observer variability. For example, researchers may be selective in their observations, that is, observer bias and measure, question, or note down answers with varying accuracy or follow different interview approaches, with one researcher being more open, friendly and probing than the other.

As a researcher you should avoid variations in both the measurement criteria and the criteria for categorising answers especially in the course of conducting research. Any changes should have been dealt with prior to conducting the research.

There are a number of measures to be taken to prevent or partly correct such distortions, but remember prevention is better than cure. Cure implies surgery. You may have to cut down parts of your data or at best, devise crutches.

There are several ways of ensuring data quality. Prepare a fieldwork manual for the research team as a whole. The manual should include:

- Guidelines on sampling procedures and what to do if respondents are not available or refuse to cooperate.
- A clear explanation of the purpose and procedures of the study. This should be used as an introduction before each interview.
- Instruction sheets on how to ask certain questions and how to record the answers.

Ensure that you select your research assistants, if required, with care. Choose assistants who are of the same educational level, familiar with the topic and the local conditions, but are not the

subject of study themselves and are not biased concerning the topic.

You should train research assistants carefully in all topics covered in the fieldwork manual as well as in interview techniques. Make sure all members of the research team master techniques such as:

- Asking questions in a neutral manner.
- Not showing, by words or expressions, what answers one expects to hear.
- Not showing agreement, disagreement or surprise.
- Recording answers precisely as they are provided, without sifting through them or interpreting them.

You should also pre-test research instruments and research procedures with the whole research team, including research assistants. Take care that research assistants are not placed under too much stress, for example, too many interviews a day.

Arrange for ongoing supervision of research assistants. If you are carrying out a substantially large survey, special supervisors may have to be appointed with supervisory guidelines.

It is also important to devise methods to ensure that the data collected by all members of the research team is of quality. You can do this by:

- Having interviewers check whether the questionnaire is filled in completely before finishing each interview.
- Asking the supervisors to check at the end of each day during the data collection period whether the questionnaires are filled in completely and whether the recorded information makes sense.
- Having the researchers review the data during the data analysis stage to check whether data is complete and consistent.

Stage Three: Data Handling

Once the data has been collected, a clear procedure should be developed for handling and storing it. The following should act as guidelines:

- Check that the data gathered is complete and accurate.
- At some stage questionnaires will have to be numbered. Decide if this should be done at the time of the interview or when the questionnaires are stored.

- Identify the person responsible for storing data and the place where it will be stored.
- Decide how data should be stored. Record forms should be kept in the sequence in which they have been numbered.

Data Entry

There are several factors you need to consider when entering your data. First, you will need to decide on a format, that is, the way you will organise the data in a file. Next, you will need to design a code, that is, the rules by which the respondents' answers will be assigned values that can be processed by the computer.

After this you then do the actual coding, that is, turn the responses into the standard categories you developed in your coding system. Data entry is the next step, which is keying the data into the computer so that you can process it. Finally, data cleaning is the final check you make on the data file for accuracy, completeness, and consistency prior to the onset of analysis.

You should always ensure that your data collection process is ethical in all respects.

In order to ensure that your data collection process is ethical, you should consider the following points:

- How have you planned to obtain informed consent from your informants?
- Are there any categories of informants that need special consideration because of their vulnerable status, for example, children, sick persons, and mentally disabled individuals?
- Are certain parts of the research focussed on sensitive issues?
- How will you handle problems that may arise?
- Do certain parts of your research require extra attention to assure confidentiality?
- How will you handle this issue?

Once you have answered all these questions you are well on your way to ensuring that high ethical standards are maintained throughout the course of your research project.

Training of Interviewers

During the fieldwork, interviews or research assistants may work independently or with one

of the researchers. If research assistants are to go out independently, they may have to carry out the following tasks:

- Do sampling in the field, for example, sampling households.
- Give clear introductions to the interviewee concerning the purpose and procedures of the interview.
- Perform the interview. It is important to give interviewers a standard questionnaire to administer. However, it is not wise to assign difficult tasks, like Focus Group Discussions (FGDs), to research assistants.

It is, therefore, imperative that you properly train interviewers so that they can carry out their tasks accurately and correctly, according to the procedures you have developed. They should never be left to develop their own procedures as this could potentially lead to bias. The training of interviewers may take 2-3 days. The first day should be devoted to theory, followed by one or two days of practical training, depending on the local circumstances and the nature of the study.

Theoretical Training

Research assistants or interviewers must be thoroughly familiar with the research objectives and the methodology. They should, therefore, be provided with a copy of the research protocol. You, as the principle researcher, should discuss important sections of the protocol with them.

- Statement of the problem
- Objectives
- Data collection tools to be used
- Sampling procedure
- Plan for data collection
- Plan for data analysis

Step Eight: Data Collection and Presentation Practical Training

Practical training in interviewing is very important. This may be provided in two stages. First, a role play can be performed during which one of the trainees assumes the role of an interviewer and the other plays the interviewee. Second, a field test should be conducted which will serve two purposes: the training of interviewers and as a test of the data collection tools.

Supervision of Interviewers

If interviewers are used, the responsibility for the research remains with the

principle researcher. To guarantee the quality of the data collected:

- It is important to supervise the performance of the interviewers, especially at the beginning of the data collection period.
- If they are to go out into the field independently, plans should be made to visit them on different occasions.
- As a further quality check, it is important that each questionnaire carries the name or initials of the interviewer, so that it is possible to ask for clarification if certain information is not clear.

Step Nine: Data Analysis and Interpretation

In step eight you learnt methods of data collection. Once you have collected the data according to the planned research design, it is important to put the data in a format that will enable you to make sense of it. In step nine you will learn how to present, analyse and interpret the data collected. You will also need to refer to module three, unit five on Community Diagnosis for further clarification.

Data Presentation

Data presentation is the in which data is displayed for viewing, interpreting and understanding. In section two of this unit, you covered the major types of research, which you broadly classified as qualitative and quantitative. You also identified the specific characteristics of each type. In this part of the research process, you will look at how data from either type are presented and analysed.

The Research Process



Methods of Data Presentation

There are several ways in which data can be presented.

The following are some methods of data presentation, which you may use:

- Tables
- Charts
- Graphs
- Frequency distribution tables
- Histograms
- Narrative method

Qualitative Data Presentation and Analysis

The data presentation and analysis of qualitative research is quite different from that of presenting data collected when using the quantitative research method. This is because qualitative research uses words while quantitative uses numbers (numerical). However, the principles are the same for both types. In both cases the researcher has to do the following:

a) Describe the sample population by providing a description of the:

- Respondents, for instance, key informants or focus group members.
- Age, sex, occupation, educational background and so on.

b) Order, reduce and/or code the data (data processing).

c) Display the summaries of data for interpretation.

d) Draw conclusions.

e) Develop strategies for testing or confirming the findings to prove their validity.

The following steps can be used when presenting and analysing qualitative data:

Organising the Data

The data collected through qualitative techniques is usually quite large, therefore, the researcher will need to put all this information in a simple format that can be understood. This is known as 'cleaning' the data.

Creating Categories, Themes and Patterns

Since the notes from interviews and focus group discussions are not well organised and tend to be fragmented, there is need to put them into categories, themes and patterns. The researcher needs to be very familiar with the

data so as to establish relationships among these categories. One way to achieve this is using the research questions or discussion topics. The researcher may need to put this into matrix form on which the data can be displayed.

Analysing and Interpreting the Data

Once themes, categories and patterns have been identified, the researcher then evaluates the data to determine its usefulness and accuracy. It is important to note that there are nowadays computer programs that can be used to generate themes and categories. You have to follow the set research objectives when analysing and evaluating the data.

Writing the Report

It is important to appreciate that unlike the quantitative research where the report writing is done after analysing the data, in qualitative research techniques, the writing and the analysis go hand in hand.

So far you have seen how qualitative data is analysed and presented in a research report. You will now look at how to analyse and present quantitative data. You will note that here the raw data you collect will usually be in the form of numbers. The process of organising, summarising and visualising quantitative data is referred to as 'descriptive statistics' (Eden, 2003: 211).

The purpose of descriptive statistics is to help the researcher to visualise and identify the patterns that may emerge from the data collected. This will, in turn, assist the researcher in making meaningful conclusions from the results of the study. The main types of descriptive statistics are mode, median, mean and measures of central tendency among others. Refer to module three where these types have already been covered.

In presenting quantitative data, it is very important that you use what is referred to as dummy tables. A dummy table contains all the characteristics of a table but the cells are left empty. Dummy tables are usually constructed during the planning stage of data collection. This helps the researcher visualise how to organise the data and put it in a summarised format. Dummy tables can be used for depicting simple data as well as complex data that could be used for cross tabulation.

In presenting data you can use some of the following methods detailed on the next page in order to make sense of what the results mean.

Tabular Method

As the name suggests, this is where data is presented in tables. Depending on your skills in research and the type of study you have carried out, there are various tabular methods that you could use.

Simple Table

This is usually a single line of characters explaining a few columns of information.

Tabular Method

Mothers Attending Antenatal Clinic			
Age Mothers Years	of in	Numbers of Mothers (n=100)	Percentage
19-24		35	35%
25-28		20	20%
29-33		16	16%
34-38		05	5%
39 and above		-	-
Total		76	76%

Compound Table

This is where a single line of characters has been described by two or more components of information.

Tabular Methods

Face-to-Face Class Attendance of the Distance Learning Programme				
Months	Public Hospital (n=100)	Private Hospital (n=100)	Mission Hospital (n=100)	Total
January	100	90	100	290
February	89	95	85	269
March	95	100	80	275

When constructing tables it is important that:

- You give correct consecutive numbers to the tables and indicate the title of the table at the top.
- Clearly indicate the totals and percentages.
- Show where the data is obtained from, that is the source of the data with the year when the data was collected clearly shown.

Graphic Method

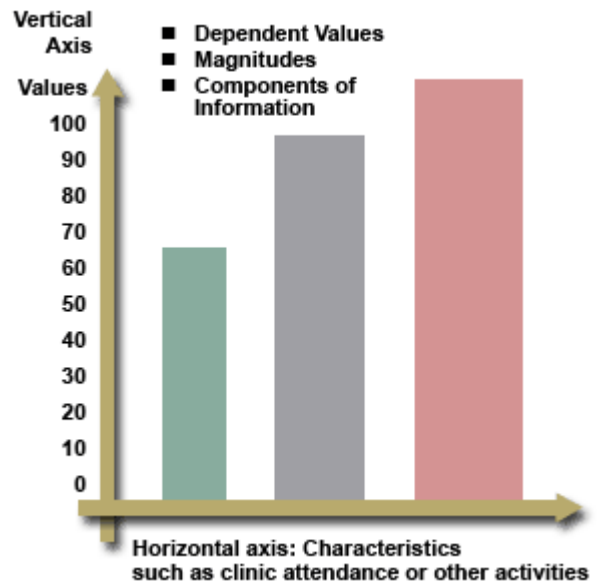
Another format for presenting research data is the graphic method. In this method graphs are used to organise and describe data. This enables the reader to see at a glance the trend of distribution of the data. Graphs have two axes: vertical and horizontal. Scores are usually presented along the horizontal axis, while the frequency is placed along the vertical axis. It is important to note that the intersection point between the vertical and horizontal axes is usually represented by a zero (0). Graphs should be well labelled both along the vertical axis and the horizontal. There are three common graphic methods that you may use for presenting your data.

These are:

- Bar Charts
- Histograms
- Frequency Polygons

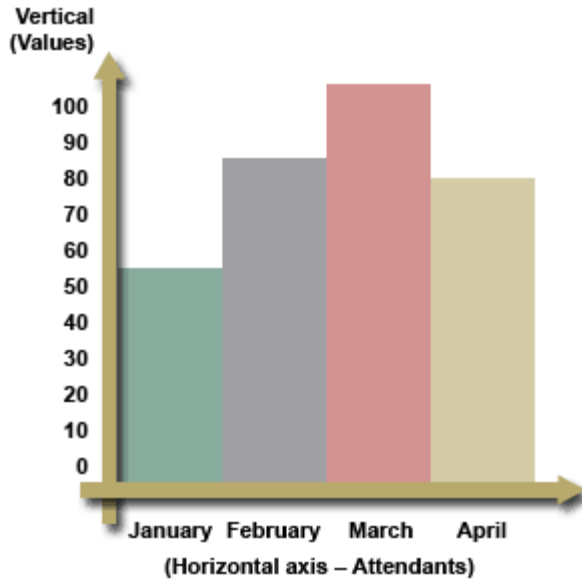
Bar Charts

Bar charts are used when the data being presented is discrete or when the scale is nominal. Bar charts are quite similar to histograms with the exception that there are spaces in bar charts.



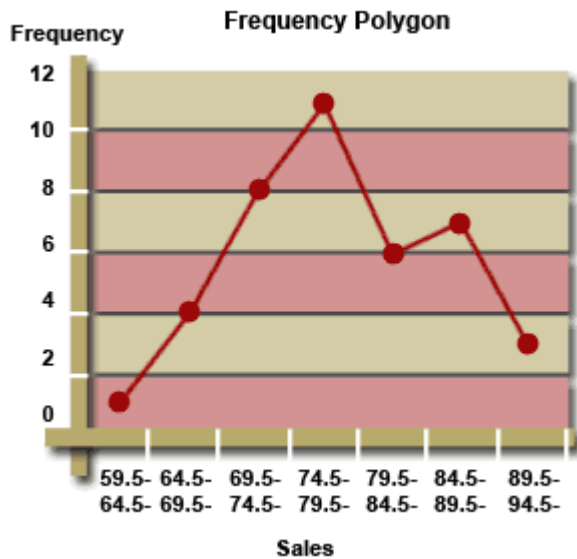
Histograms

Unlike the bar chart, in the histogram there are no spaces between the bars. A histogram in many cases is used to represent continuous variables.



Frequency Polygons

Frequency polygons are drawn based on the frequencies of the observations along the vertical axis against the group or class midpoints. They form a polygon shape hence the name.

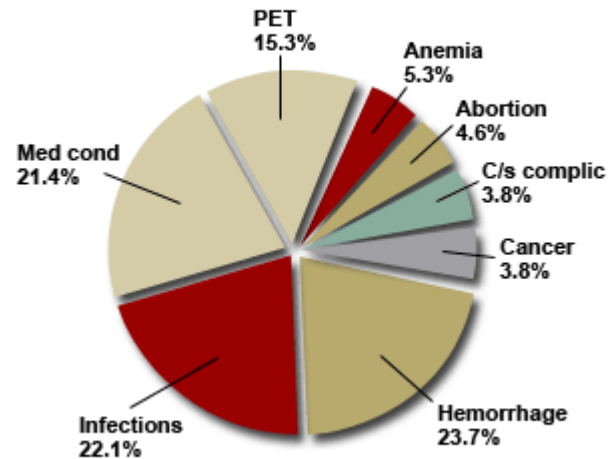


Charts Method

Another way to present your data is to place it on a chart. One of the commonest types of charts used is the pie chart. Pie charts are relatively easy to interpret. Each portion represents a variable. The adjacent figure shows the top four

outpatient cases in a hospital. Note that, in order to present your data on a pie chart, you have to convert it into percentages.

Pie Chart Percentage Causes of Maternal Mortality

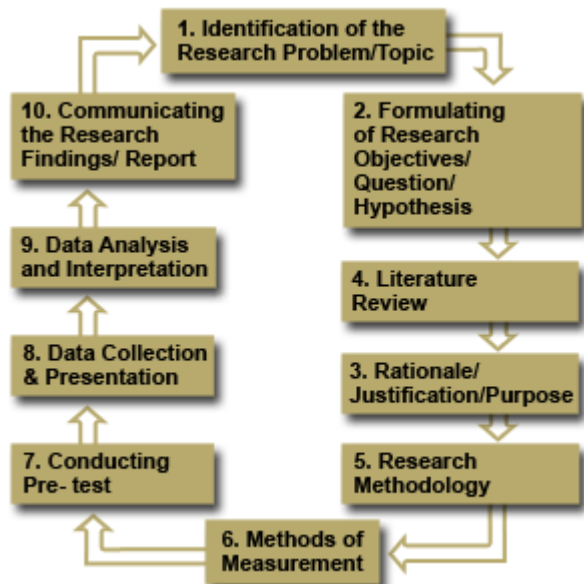


Step Ten: Communicating the Research Findings

The significance of conducting research is to communicate and share the research findings. If you do not disseminate the findings of your study, then nobody will know what the outcome of the study was. There are various ways of communicating the research findings. They include:

- A written report for academic purposes, for example, a dissertation or a thesis, which are a requirement in the obtaining of a certain academic level.
- A written report prepared for managers and policy implementers (some of whom have no knowledge of research methodology). In such reports you need to have a very clear and succinct report without the academic jargons.
- A written report sent as an article for publication in refereed journals.
- Presentations of the research findings in workshops, seminars and conferences.

The Research Process



You will now look at what you need to have in a written research report.

The Title

- The title should be an accurate reflection of the research carried out
- It needs to be both meaningful and brief
- It should not exceed fifteen words (Brink, 1996)

Abstract

The abstract is a very brief summary of the study that includes the purpose of the study, methodology and the major research findings. It should not be longer than one page.

Introduction

In the introduction you need to:

- Introduce the reader to the problem to be dealt with.
- Briefly, but clearly, explain the purpose of the study.
- Emphasise the importance of the study.
- Introduce the key concepts.
- State clearly the hypothesis as well as the objectives or research questions of the study.
- Describe the nature of the research study and the context within which the study has been carried out.

Background Information

Here you have to explain where the study took place and expound on any special circumstances of the study and study area.

Literature Review

The literature review provides an overview of current knowledge of the problem under research. The researcher should be able to show a grasp of the theory applications and apply the knowledge to the research.

The Methodology

Here, you provide information on how the research was carried out. Include enough details to enable another researcher to replicate your research. The methods section incorporates the following aspects:

- (i) Subjects, respondents or participants
- (ii) The task and the material or instruments used. This should include:

- Description of all types of activities that the participants were asked to perform, for example, filling in a questionnaire, participating in a focus group discussion.
- A list of materials and/or instruments used. Give the main characteristics of the questionnaire, for example open-ended, closed questions and so on.
- Description of the considerations, which led to this choice and how validity and reliability were ensured.
- All questionnaires or interview schedules should be included in an appendix.

- (iii) The research design and strategy. Here you have to:

- Specify the chosen design.
- Outline and explain choices which lay behind strategy decisions.
- Analyse the data obtained.
- Give an account of the methods used to analyse data.
- If a statistical design was used, discuss the statistical tests applied to the obtained data to test the various hypotheses.
- Explain procedures for handling missing data.
- Justify the validity and reliability of the scores.
- Outline the reasons why specific statistical tests were used.

Results

The results section presents the findings and involves the following:

- The main results from the data analysis.
- If a quantitative study was done, tables, graphs and diagrams and the outcomes of statistical tests. In a qualitative study, findings are usually presented in terms of the themes, which emerged from the data and, by way of substantiation and illustration, examples of raw data will be given. For example, direct quotes from an interview transcription, or accounts of observation.
- In quantitative studies you must also give the name of any statistical test used as well as the value of the calculated statistics and its significance. Accuracy and conciseness must be adhered to throughout.

Discussion

According to Brink (1996) the discussion of the study incorporates the following elements:

- An interpretation of the findings, with specific reference to validity and reliability. A well developed discussion makes sense of the research results, and must be presented in precise and concise language. In the discussion section, you have to re-state the research questions and hypotheses, and discuss the results with reference to these questions or hypotheses in the order they were posed.
- Conclusions related to questions raised in the introduction of the study.
- Study limitations. Here the limitations of the study should be identified and you should defend the validity of the findings in the light of these limitations. Limitations include factors such as the inherent weakness in the sampling method, faulty designs and controls, weaknesses in the methods used to collect data and so forth. Here you have the opportunity to recommend ways to minimise or eliminate the limitations of the current study and to offer alternative methodology or improvements of the methods of the study presented.
- Generalisations of the research findings. Indicate whether you found what you had expected and how the present results relate to previous research.

Connect the findings with similar studies. If any unexpected, inconclusive or contradictory results were obtained, discuss possible reasons for such outcomes.

- Suggestions and recommendations. Here you have to relate your findings to the questions raised in the introduction. In addition, if you came up with any recommendations as a result of your study, this is the place to state them. You may also give some suggestions concerning further research.

References and Bibliography

Present your references and bibliography in the standard manner.

You can follow the way these are given in your student handbook, or follow any other format specific to your institution. Whatever format you are using, however, you need to remember that all your entries should be made in a consistent manner. Check that the names of authors included in your reference list, are actually mentioned within the text.

Section 4: Developing a Proposal Introduction

In this section you will learn how to write a research proposal, or a research protocol as some researchers prefer to call it, either for funding or for academic purposes.

Objectives

By the end of this section, you will be able to:

- Describe a research proposal
- List three purposes of developing a research proposal
- Identify the major contents of a research proposal

Research Proposal

What is a research proposal?

It is important to be able to define what a research proposal is before you learn how to develop it. A research proposal has several definitions.

However, you will only look at one of them. According to Bernard and Morrison (1990: 15), 'A research proposal is a detailed statement of what you intend to do, why you want to do it and how you will go about it'.

This definition shows that a research proposal is a statement that outlines the what, why and how of your study. It gives an indication of whether you are able to implement the research following the intended research design and methods you selected.

Why develop a research proposal?

A research proposal helps the researcher:

- To sharpen their thoughts and the research methodology.
- To allow others to examine the research project and its methods.
- To get clearance and authority from the government and ethics committee to carry out the research.

Despite the important role played by a research proposal, at times it is a difficult hurdle to overcome, particularly to new researchers. When developing a research proposal, you need to be patient as you might be required to re-write the proposal several times. This is a very common occurrence with all researchers and you, as a student researcher, should not feel discouraged. It should, instead, give you the motivation to clarify and refine your thoughts and ideas. Your peers provide a good resource in such circumstances so you should ask them to read through your proposal and give you their comments.

What should a research proposal contain?

The content of a research proposal varies a lot. This is due to the fact that each institution, for example a college, hospital or an ethics committee, has its own guidelines to be followed by those seeking its approval. Even sponsors of research projects have their own approaches. Therefore, you as a researcher will need to be aware of such variations and abide by them.

- Project title.
- Your name and index number.
- Name, titles and designations of your supervisor, tutor or lecturer.

- Name of the department, and college or university.
- Statement of the research problem.
- Rationale or justification of research.
- Brief relevant literature review.
- Research methodology or design.
- Methods of data analysis.
- Ethical considerations taken into account.
- Preparation of study report.
- Timeline of the study.
- Study budget.
- Appendices.
- Your Curriculum Vitae (CV) where applicable. You as an upgrading nurse have several years of work experience that you should include in your CV.

In conclusion, a research proposal is a very important part of the research process. It is a detailed statement outlining the major components of the research process. It is what you intend to do in your research, why you want to do it and how you will go about it in achieving your set research objectives.

Time Line or Time Schedule

One of the items you will need to include in your proposal is a schedule for your study. The activities you intend to undertake during the process of your study are summarised in a table format. The time lines, activity schedule or Ghent chart are some of the names used to refer to this kind of a table. It has the activities on the first column and on the first row is the duration of time that is required to complete the tasks. The researcher should clearly write the details of the activities which will then be summarised in the time line or Ghent chart.

Time Line of Study

Activity	Jan	Feb	March	April	May	June	July	Sept
Identifying research topic								
Formulating research objectives								
Justification of study								
Literature review								
Research methodology								
Method of data collection								
Conducting a pre-test								
Data collection/ presentation								
Data analysis and Interpretation								
Report preparation/typing								

From this table it is easily seen that you intend to start your research in January and end it in September. On the other hand, the data will be collected in June.

Study Budget

Another item that you are expected to have in your proposal is a proposed budget. You must be careful to include all expenses that you are likely to incur during the research otherwise, you may find yourself unable to complete your research due to lack of funds.

From the following illustration of a proposed budget, note the budget items that you need to include. The amount indicated in the right hand column may vary depending on the quantities you need.

Study Budget			
Budget item	Quantity	Cost per item (in Kshs)	Total amount (in Kshs)
Stationery	-	-	1,000
Photocopying	100pages	3	3,000
Typing	300pages	10	3,000
Binding	10 copies	50	500
Research assistant	5 for 3 days	100 per day	1,500
Travelling allowance	1 person for 25 days	100 per day	2,500
Books, journals and internet services	Estimate	Estimate	5,000

Computer or printer	1 set	70,000	70,000
Total	-	-	86,500

Study Limitation

Limitations of the study should be identified and the researcher should defend the validity of the findings in the light of such limitations. Limitations may include:

- Factors such as the inherent weakness in the sampling method, faulty designs and controls, weaknesses in the methods used to collect data and so on.
- Time factor due to pressure of work.
- Expenses involved if grant is not secured.
- Possibility that some of the respondents may not agree to participate in the study.
- Diverse spread of the target population, which may hinder easy access to respondents.

The researcher has the opportunity to recommend ways to minimise or eliminate the limitations of the current study or to offer alternative methodology or improvements of the methods of the study presented.

Assignment: Conducting Research or Field Work

For this assignment you will put into practice the various aspects of the research process that you have covered in the previous sections of this unit. The skills and knowledge you have gained are now to be put into practice in the field.

Therefore, your next step is to identify a research topic, and following the research process you have learnt, to conduct a research field study. You will do this with the guidance of your research project supervisor.

UNIT 4: MANAGEMENT

This unit gives an introduction to management and is divided into five sections. The first section explains the concept of management and developments in management theory. Sections two and three cover the principles and functions of management respectively. The final two sections cover the utilisation of various management concepts, theories, principles and functions in the management of nursing care services.

On completion of this unit, you should be able to effectively manage the nursing care services in your area of work.

This unit is composed of 5 sections:

Section One: The Concept of Management

Section Two: Leadership and Principles of Management.

Section Three: Functions of Management.

Section Four: Managing Resources, Change and Health Information Systems.

Section Five: Managing Nursing Care Services.

Unit Objectives

By the end of this unit you will be able to:

- Describe the concepts and theories of management
- Describe the principles and functions of management
- Describe the various forms of resource management
- Describe ways of managing change
- Describe the elements of health information systems
- Describe nursing services effectively

SECTION 1: THE CONCEPT OF MANAGEMENT

Introduction

During the course of your practice as a nurse and in your day to day life, you have come across some aspects of management even though you may not have been aware of it. This section will introduce you to the concept of management and briefly describe the developments in some of the management theories which have influenced health and nursing management practice.

Objectives

By the end of this section you will be able to:

- Describe the meaning of management.
- Describe different approaches to the definition of management.
- Describe the importance of studying management.
- Describe the main approaches to the study of organisation's structure and management.
- Describe the historical development of management.
- Describe how management theories apply to nursing practice.

Definitions of Management

Different Approaches to the Definition of Management

Management may be viewed as:

- A social position
- A function
- The people who discharge it
- An authority
- A discipline
- A field of study

Different writers have defined management in various ways. The common definitions are listed below.

Management is:

- The people charged with the responsibility of running an organisation, for example, the management of Kenyatta National Hospital (KNH).
- The process by which resources are mobilised, combined and coordinated effectively to achieve organisational objectives.

- Getting things done.
- Getting work done through the efforts of other people. That is:
 1. People are the most important means or resource for getting things done.
 2. People must work, performing certain activities and tasks to reach certain ends or objectives.
 3. Managers are judged not just on their performance but on the results achieved by their subordinates.
- The efficient use of resources.
- Getting people to work harmoniously together, that is, careful balancing of resources and where everyone knows what they are supposed to do.
- Making a decision, that is, making a choice between two or more courses of action, around an act (what), quantity, quality or authority needed.
- The process of achieving organisational effectiveness within a changing environment by balancing efficiency, effectiveness and equity thereby obtaining the most from limited resources and working with and through other people.

The definition of management is based on two main principles:

- The first principle lays emphasis on people, who are the most important resource in any organisation.
- The second principle emphasises a commitment to the achievement of organisational goals. This is the primary task of management.

Management is active and involves changing behaviour and making things happen, It is also an everyday activity involving interactions between people that are not unrelated or entirely dissimilar to other spheres of life.

It can be regarded as:

- Taking place within a structured organisational setting and with prescribed roles
- Directed towards the attainment of aims and objectives
- Achieved through the efforts of other people
- Using systems and procedures

Why Study Management?

- To learn what leading writers say about management.
- To understand the interrelationship between development of theory and management practice.
- To understand the principles underlying the process of management.

Management Theories

Management theories describe how managers conduct activities, and keep institutions operating in an effective way in order to meet their objectives. The different approaches used by managers have gone through an evolutionary process. In practice, no single approach will be sufficient. Most managers use a combination of approaches to create effectiveness within the organisation. The four main classifications are:

- Classical Theories (Scientific Management)
- Human Relations or Behavioural Approach Theories
- Systems Theories
- Contingency Theories

The theories outlined above are covered in the pages that follow.

Classical Theories

Classical theories, also known as the scientific approach to management started in the later part of the nineteenth and early twentieth centuries. The approach relied on systematic information collection, analysis and identification of causes and effects, followed by effective organisation of management structure. The objective was to develop basic principles that could guide the design, creation and maintenance of organisations. The emphasis was on efficiency and effectiveness. Some of the prominent figures that may be identified with the classical school of thought are:

- Frederic W. Taylor
- Henri Fayol
- Max Weber

Frederic W. Taylor

Frederic W. Taylor, an engineer, was instrumental in conducting research on methods of training workers for increased production. He

believed in the principle 'best management is a true science'.

According to Taylor the objective of management is to secure the maximum prosperity for the employer, as well as each employee. Taylor's system for work improvement consisted of the following steps:

- Observing the workers' performance through time and motion to determine the best way to carry out each task.
- Scientifically selecting the best worker to perform each job, that is, the person with the characteristics and abilities needed to carry out tasks efficiently.
- Training the selected worker to perform tasks in the most efficient manner.
- Appointing a few highly skilled workers in managerial positions.

Most of the views expressed by Taylor can be, and are, applied in nursing, where our aim is to recruit the best qualified workers, train them and appoint them to precise specialised positions.

Henri Fayol

Henri Fayol came up with the functions of a manager, which he identified as planning, organising, coordinating and controlling. He also identified a set of fourteen principles which managers might apply as they perform their duties. Some of these include the division of labour and specialisation, chain of command, centralisation and responsibility. These will be covered in

Max Weber

Max Weber advocated bureaucracy as the ideal form of organisation for a complex institution. He described bureaucracy as having a well defined hierarchy of authority, pyramidal in shape, division of labour based on specialisation and highly specific rules governing employers' duties and rights. He claimed that bureaucracy was superior because it provided stability and reliability in controlling employees.

Although Weber meant well, the term bureaucracy implies slowness and inefficiency in today's society. Bureaucracies are often seen as too rigid to respond to current and rapid changes in the society.

Human Relations or Behavioural Approach Theories

This is the second set of management theories. These differ from scientific theories in that they focus on the use of people as a support service to machines. They also see economic forces as motivators of human performance. The behavioural approach focuses on the manner in which managers interact with subordinates. It is based on an analysis of the relationship between human factors and productivity. Besides meeting the economic goals of the organisation, the managers must try to improve the social and psychological needs of workers, which in turn improve productivity. The following is a brief overview of four of these theories which may be applied in health care institutions.

- Abraham Maslow's Theory
- Douglas McGregor: Theory x and Theory y
- Vroom's Expectancy Theory
- Fredrick Herzberg's Two Factor Theory

Abraham Maslow's Theory

According to Maslow's theory, every human being has basic needs. People are motivated by the desire to satisfy these needs. Once a need is satisfied it ceases to be a motivator. As one need is satisfied, another appears and takes its place, and the individual is then motivated to satisfy the new need. The theory also assumes that a person can satisfy one need at a time. Maslow, a psychologist, developed the hierarchy of needs with the physiological needs at the bottom, which the individuals must satisfy before realising higher level needs. Maslow visualised needs as arranged in hierarchical order starting with basic needs, progressing to higher needs depending on the individual. There are more people at the base of the triangle still trying to satisfy the basic needs and fewer people were on the higher subsequent levels. Only a small percentage of people can reach the top of the hierarchy.

The various needs can be further defined as follows:

- Physiological needs are those needs that are required for survival. These include food, oxygen and sleep, sex and rest.
- Safety needs refer to the need for job security, shelter and a stable environment.

- Love and belonging indicate a need for affectionate relations with others as well as the need to belong to a group.
- Self esteem refers to the need for self respect and recognition. At this stage people strive for power, achievement and status.
- Self actualisation is a need for self fulfilment and is the culmination of all other needs.



People at work experience a variety of needs. Managers should identify ways in which to meet group or individual needs in order to motivate them to work. It is the responsibility of the manager to enable employees to fulfil their needs.

Douglas McGregor: Theory X and Theory Y

McGregor's theory 'X' and 'Y' are a set of management assumptions about the behaviour of subordinates. He noted that most managers make these assumptions about their employees. The first sets of assumption are known as Theory 'X' they include:

- An average human being has an inherent dislike for work and will avoid it if possible.
- As a result of the assumption above, most people must be coerced, controlled, directed and threatened with punishment in order to produce.
- The average human being has to be closely directed, wishes to avoid responsibility and only wants security.

The second set of assumptions known as Theory 'Y' regard people in a more favourable way. They state that:

- Employees like work, which is as natural as rest or play.
- Human beings do not have to be controlled or coerced as long as commitment to the organisation is present.
- Under proper conditions, they will not only accept but also seek responsibility.

Theory 'X' and Theory 'Y' concern the attitudes management has towards the employee. The manager holding Theory X assumptions tends to be tough, authoritarian and supports tight controls with punishments. As a result, they tend to supervise workers very closely.

On the other hand, the manager using Theory Y believes in self control, is democratic, and consults staff. They encourage participation in decision making by subordinates.

Generally a blend between 'Theory X' and 'Theory Y' is more likely to provide effective management although this also depends on the prevailing environmental conditions.

Vroom's Expectancy Theory

This theory of motivation was put forward by Victor Vroom. It examines motivation from the perspective of why people choose to follow a particular course of action.

Vroom introduces three variables. These are:

Valence

This is the importance that the individual places upon the expected outcome of a situation.

Expectancy

This is the belief that output from the individual and the success of the situation are linked, for example, if I work harder then the outcome will be better.

Instrumentality

This is the belief that the success of the situation is linked to the expected outcome of the situation, for example, it's gone really well, so I'd expect praise.

At first glance, this theory would seem most applicable to a traditional attitude work situation where the level of motivation depends on whether the employee wants the reward on offer for doing a good job and whether they believe more effort will lead to that reward.

However, it could equally apply to any situation where someone does something because they expect a certain outcome. For example, I recycle paper because I think it is important to conserve resources and take a stand on environmental issues (valence), I think that the more effort I put into recycling, the more paper I will recycle (expectancy) and I think that the more paper I recycle, the less resources will be used (instrumentality).

Frederick Herzberg's Two Factor Theory

Frederick Herzberg proposed a theory of motivation based on the idea that some factors motivate and some demotivate. He called this theory the 'Two Factor Theory'. According to Frederick Herzberg, these factors fall into two categories. These are:

Two Factor Theory - Herzberg



Hygiene Factors

Hygiene factors are needed to ensure an employee does not become dissatisfied. They do not lead to higher levels of motivation, but without them there is dissatisfaction. Typical hygiene factors are:

- Interpersonal relationships
- Work conditions
- Salary
- Status
- Security

Motivation Factors

Motivation factors are needed in order to motivate an employee into higher performance. These include:

- Achievement
- Growth
- Responsibility for task
- Interest in the job

According to Herzberg, merging the hygiene and motivation factors results in four scenarios:

High Hygiene + High Motivation

This is the ideal scenario where employees are highly motivated and have few complaints.

High Hygiene + Low Motivation

In this scenario, employees have few complaints but are not highly motivated. The job is perceived as a pay check.

Low Hygiene + High Motivation

In this scenario, employees are motivated but have a lot of complaints. This is a situation where the job is exciting and challenging but salaries and work conditions are not up to par.

Low Hygiene + Low Motivation

This is the worst situation where employees are unmotivated and have lots of complaints.

Systems Theory

The third management theory is known as the systems theory.

Unlike the previous theories you have covered, this theory places an emphasis on organisations as cooperative systems. A system is defined as 'a set of arrangements of things so related or connected as to form a unit or organic whole'. The organisation is, therefore, defined as 'a system of consciously coordinated personal activities or forces'(Basawanthappa, 2000). The systems theory explains that organisations come into existence when there are persons able to communicate with each other who will each contribute an action to accomplish a purpose.

For cooperation to be effective the following must be present:

- Place where work is done
- Time when work is done
- Person with whom work is done
- Things upon which work is done
- Method or process by which work is done

This helps in understanding the organisation in a better way.

Contingency Theory

The contingency theory asserts that when managers make a decision, they must take into account all aspects of the current situation and act on those aspects that are key to the situation at hand. The continuing effort to identify the best leadership or management style might now conclude that the best style depends on the situation. If one is leading troops in the Persian

Gulf, an autocratic style is probably best (of course, many might argue here, too). If one is leading a hospital or university, a more participative and facilitative leadership style is probably best.

SECTION 2: LEADERSHIP

Introduction

As a practising nurse, you will spend most of your working life in health care institutions at all levels, from staff nurse to the highest positions of responsibility. Whatever your role, it is important to understand that all nurses lead and manage to some degree. In this section, you will look at leadership and the qualities of leadership in the twenty first century.

Objectives

By the end of this section you will be able to:

- Define leadership
- Differentiate between leadership and management
- Describe the different styles of leadership
- Describe the principles of management

Leadership

The word leadership is an intriguing one and brings up images of all kinds of people. Some names that come to mind include former leaders like President Julius Nyerere, President Jomo Kenyatta and Prime Minister Margaret Thatcher. In nursing, Florence Nightingale may be considered an example of a leader in the profession.

You may also think of a relative or a nurse who has had notable leadership skills.

A leader is anyone who uses interpersonal skills to influence others to accomplish a specific goal. A leader can also be defined as a person who exerts influence by using certain personal behaviours and strategies or a person given authority by the statutes of an organisation to lead a group of people.

Leadership can be defined as 'the use of one's skills to influence others to perform to the best of their ability towards the achievement of goals' (Douglas, 1996). It is the art of getting others to want to do what one deems as important.

Leadership is not a fixed position. It is a process which changes on a situational basis. A manager leads by personally and actively working with subordinates for two main reasons:

- To guide and motivate their behaviour to fit the plans that have been established
- To understand the feelings of employees and the problems they face as they translate plan into action

Managers and leaders are different in the following ways:

- Managers think incrementally while leaders think radically
- Managers do things right while leaders do the right things
- Leaders stand out by being different
- Leaders question assumptions and are suspicious of tradition

'Manager' is derived from the Latin term 'managere', that is, 'someone in control'. A manager uses authority, the legitimate right to govern

Types of Leadership

There are two types of leadership. These are:

Formal

This is when an appointed leader is chosen by the administration and given official or legitimate authority. This form of leadership has the greatest impact when followers accept the leader.

Informal

An informal leader does not have official authority to direct activities of others. They are usually chosen from within a specific group, for example, social group, church organisation or work group. An individual may become an informal leader as a result of a variety of factors including age, seniority, special competencies or personality.

Theories of Leadership

Various writers have attempted to explain the theoretical basis for leaders and leadership. You will look at the two following theories in detail:

- Trait Theory of Leadership
- Situational or Contingency Theory of Leadership

Trait Theory of Leadership

This was the first theory to emerge and was studied from approximately 1900 to 1950. This theory states that leaders possess a set of physical and emotional characteristics that are important for inspiring others towards a common goal.

Some theorists who subscribe to this theory believe that leaders are born with certain qualities that determine leadership ability and

success.

The leader is seen as gifted or develops certain characteristics including:

- Physique, that is, weight, height.
- Intellect, that is, knowledge, judgement.
- Personality, that is, aggressiveness, dominance and authoritarianism.

According to this theory, the leader behaves according to the role expectations of the group.

Situational or Contingency Theory of Leadership

This theory states that the effectiveness of leadership depends on the relationship among the leaders and the task at hand, interpersonal skills and the favourability of the work situation.

However, there are critical factors that must be considered in the above relationships, these include:

- The degree of trust and respect between the leader and follower
- The clarity of goals to be accomplished
- The ability of the leader to reward followers and exert influence

As a result of all the above, leaders were viewed as able to adapt their style according to the situation. For example, if one is faced with a specific situation, they consider the challenges and encourage an adaptive leadership style to understand the issue being faced. The implication here is that you, as a nurse manager, must assess each situation and determine appropriate action, based on the people involved.

Leadership Styles

The styles of leadership used by managers vary from organisation to organisation and are tailored to fit their needs and individual behaviour. There are too many kinds of leaders, personnel, tasks, organisations and environments for any one leadership style to apply.

There are three main styles of leadership, namely:

- Authoritarian or Autocratic
- Democratic or Participative
- Laissez faire or Permissive

You shall now examine each of the leadership styles individually.

Authoritarian or Autocratic

In this leadership style, the leader assumes full responsibility for all decisions and actions. The characteristics of an autocratic leader include:

This style of leadership may be counter productive. It may cause employees to lose interest and initiative and stop thinking for themselves because there is no need for independent thought. It may also lead to loss of motivation, especially where employees find it necessary to adopt an attitude of obedience to an autocratic leader. Due to lack of motivation, the employee may perform dismally. As a result, less than optimal goals are achieved because the resources utilised are the manager's only.

Some forms of authoritarian leadership are applicable to nursing. It is particularly suitable in crisis situations, when clear directions are of highest priority. It may also apply in situations where the people being led are inexperienced.

Democratic or Participative Leadership

Democratic leadership refers to a situation where people are free to express themselves. In contrast to the autocratic style of leadership, the manager here is 'people oriented' and focuses attention on human aspects as well as on building effective work groups.

A collaborative spirit or joint effort exists which allows for group participation in decision making. The leader assumes that employees are eager to perform their jobs and are capable of doing so. The group is seen as having responsibility for goal determination and achievement. Democratic leadership encourages enthusiasm, high morale and increased satisfaction.

Research has shown that this style of leadership leads to high productivity and is the most desirable form in a wide variety of work situations.

Laissez-Faire or Permissive Leadership

Laissez-faire leadership is at the opposite end of the continuum from authoritarian leadership. In this style, the leader lets people do what they want. The leader plays down their role in the group's activity and exercises minimum direction or control. The leader wants everyone to feel good about what they are doing and often avoids responsibility by relinquishing power to followers and permitting them to engage in managerial activities, for example, decision making, planning, setting goals, structuring and controlling the organisation.

This style is often evident when a manager is too weak or feels too threatened to exercise the function of leadership. It is also visible where the manager has a great need for approval and does not want to offend anybody. In this leadership style, the following can be observed:

- Little or no visible leadership
- The manager's tend to be preoccupied with their own work
- There is no communication and direction to the employee
- There is very little teamwork and employees do as they wish

It should be noted, however, that this style could be highly effective in motivated professional groups, for example, in research projects in which independent thinking is rewarded.

Qualities of Effective Leadership

For leaders to be effective in influencing others to perform, they should possess the following qualities:

- Empathy, that is, an ability to look at things from another person's point of view.
- Respect, that is, an effective leader should respect others as unique individuals.
- Objectivity, that is, no bias or prejudice.
- Self awareness, that is, self knowledge, being aware of the impact you have on others and being aware of your ability to make decisions or involve yourself with specific problems.

A nurse manager uses all the leadership styles separately or together depending on their flexibility and the circumstances inherent in each situation. There are many similarities and differences in the behaviour, attitude and conditions present in the various leadership styles. Not all of the behaviours are evident at any one time.

Levels of Leadership

Your success as a leader may also depend on your level of leadership. John C. Maxwell lists the five levels of leadership as:

Position

This is the lowest level of leadership and is based solely on title and position.

Permission

As relationships are developed with others, they give permission to the leader to lead beyond the limits of their job description.

Production

As the group becomes more productive together, leadership is advanced.

People Development

This level of leadership involves developing people and assisting them to reach their potential.

Personhood

This level of leadership involves a lifetime of developing others to their highest potential

Principles of Management

You have previously seen that for a leader to be effective in influencing others to perform, they need to possess certain qualities as well as the ability to use different management styles depending on the situation. You have been exploring the various principles of nursing. You will now look at the management principles that a nurse requires to function effectively and efficiently as a leader.

In section one, you looked at the development of management theories and how they influenced management practice. The principles you are now going to cover were identified by Henri Fayol.

He came up with fourteen principles, which might apply to nurses as they perform their duties.

You will look at the most important ones that apply in your day to day work. These include:

- The Division of Labour.
- Responsibility, Accountability and Authority.
- Unity of Command.
- Teamwork.
- Centralisation and Decentralisation.
- Discipline.
- Line of Authority.

You should bear in mind the theories covered in section one.

Division of Labour

This is one of the basic principles applied in nursing practice to a large extent. It is a way of determining who is responsible for what. In an organisation, no single person can

do everything. In order to achieve organisational goals, people must be assigned tasks according to their skills. The objective of division of work is to produce more and better work with the same effort. The tasks that individuals perform must be related to each other and integrated. This calls for an adequate definition of duties to be duly communicated to all the people concerned.

The idea of division of labour in an organisation makes it possible for work to proceed quickly and smoothly. For example, in a hospital, there is a chief nurse, senior nursing officers and nursing officers. Each of these people have a specific job to perform in order to ensure the success of the organisation. Each person has the responsibility to perform their task in coordination with other people's duties.

Responsibility, Accountability and Authority

Once the employees have been given different tasks to perform, the leader is responsible for the work to be done. Similarly, employees are responsible for the completion of their specific tasks. Both the leader and the employees are accountable for their tasks and responsibilities. Appropriate authority to perform certain functions is also necessary.

You will now examine the three terms and see how the nurse manager applies them in nursing practice.

Responsibility

This is a duty or assignment related to a job. It also refers to each person's obligation to perform at an acceptable level. For example, one responsibility common to a nurse in charge is establishing the patient care assignment for a specific area of work. Nurse managers should always be assigned responsibilities with accompanying authority because, if the latter is not given, role confusion occurs for all individuals involved. For example, a nurse manager may have the responsibility for maintaining high professional standards, but if they are not given the authority to discipline employees as needed, this responsibility may be difficult or impossible to implement.

Accountability

This means that someone must be able to explain actions and results or accept ownership for the results or lack thereof. For example, a

qualified registered nurse is accountable for nursing care given to a patient or client.

Authority

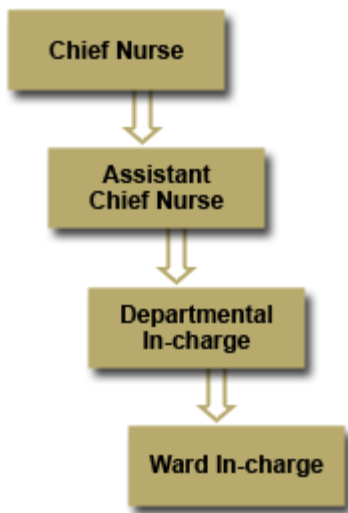
Authority has its base in responsibility. Dictionaries define authority as 'legal or rightful power, a right to command or act, domination, jurisdiction'. Authority defines which position will be superior and which will be subordinate.

The various levels of divisional activities in health organisations are a direct result of the size and complexity of modern institutions. For example, in a hospital, at the top level is the operating authority, that is, the chief nurse who takes the place of employer in the superior versus subordinate relationship. Policy and decisions are made at this level. They delegate responsibility to a group of nurse managers who exercise the delegated authority in supervising the work of others. This is formal authority. On the other hand, responsibility can be delegated for performance of specific functions. This functional authority is based on technical knowledge and personal skills. Both forms of authority are necessary for achieving goals and satisfying individual needs.

Unity of Command

This is another important principle of management. The concept of unity of command is described as 'one person to one boss' or 'one person to one supervisor'. Each individual has one manager to whom they report and to whom they are responsible. This concept is illustrated in the diagram next.

This makes the manager-employee relationship as simple as possible and puts a limit to confusion, mistakes, excuses and delays in the daily performance of duties. For example, in a hospital, the nurses in various wards are responsible to those in charge of the departments or wards, who in turn, are responsible to the chief nurse. All problems are channelled through this unity of command.



Teamwork

In many areas of your work, you are required to work with others in a smooth and efficient manner in order to achieve your objectives. Teamwork has been defined as ‘coordinated action by a group of individuals in regular contact wherein members contribute toward task achievement’ (Sikula and McKenna 1994). A health care team includes nurses, doctors, allied health professionals and support staff who have to work together in order to deliver quality services to the patients.

A team usually has a leader. Leadership is an important part of efficient teams. Group members support one another and their leader because they are all mutually responsible for the objectives and subsequent action. Openness and acceptance are the prime characteristics of an ideal team situation. The nurse manager is tasked with building an effective team in order to accomplish their objectives.

Centralisation and Decentralisation

Centralisation and Decentralisation is frequently applied in health care systems. It refers to the extent to which decision making is concentrated or dispersed within the health care unit. You will now cover each one of them and see how they differ.

Centralisation

This is the systematic retention of power and responsibility at higher levels of the organisation. Organisations vary greatly in their degree of

centralisation. The degree may differ for different tasks and responsibilities. The Chief Nurse is responsible for centralised departments where major decision making and responsibility for key functions is centralised at the top level. Thus, for example, the Chief Nurse would be responsible for budgeting, staffing and quality assurance.

Decentralisation

Decentralisation is where decision making and responsibility for key functions is delegated to the lowest possible managerial level in the department. Thus, a decentralised nursing department places most decision making at the head nurse level with each individual head nurse running their unit independently.

Centralisation and Decentralisation

Centralisation and Decentralisation has its advantages and disadvantages.

Advantages and Disadvantages	
Advantages	
Centralised	Decentralised
No duplication of efforts, that is, special services grouped together.	Increased levels of decision making in organisation.
High cost effectiveness.	Quicker and better decision making.
Managers are experts only in concentrated range of skills.	Increased freedom and flexibility of staff.
Disadvantages	
Centralised	Decentralised
Decisions take too long.	Decisions can be made where action takes place.
Increased levels of organisation are cumbersome.	Risk of employees being treated unequally.
	May shift responsibility and authority to managers unprepared or it.

Discipline

The last principle of management to be covered is discipline. You should be familiar with the term because you may have been involved in disciplining someone, for example, your child or a sibling. On the other hand, you may have been

disciplined or punished after violating rules and regulations either at home or in the work place.

The word 'discipline' originates from the latin term 'disciplina', which means teaching or learning. As it was put forward by Fayol, discipline is 'respect for agreements which are directed at achieving obedience, application, energy and the outward marks of respect'. The primary emphasis in discipline is in assisting employees to behave in a manner that allows them to be self directed in meeting organisational goals. Punishment may be applied for improper behaviour in constructive discipline. This should be carried out in a supportive, corrective manner.

Management usually disciplines an employee for:

- Not meeting laid down standards of performance.
- Violating the rules and policies.
- Insubordination, that is, lack of respect for authority.

The highest level and most effective form of discipline is self discipline because the roles are internalised and become part of the individual's personality (Curtin, 1996). The manager plays a vital role in this. There are several factors that must be present to foster a climate of self discipline. You will cover the factors cited by Health Care Education Associates (1987). They include:

- Employee awareness and understanding of rules and regulations that govern behaviour. These must be clearly written and communicated to subordinates.
- An atmosphere of mutual trust should exist. The manager must believe that employees are capable of actively seeking self discipline. Conversely, the employees must perceive the manager as honest and trustworthy.
- Employees should identify with the goals of the organisation. When this happens, they are more likely to accept the standards of conduct deemed acceptable by the organisation.

Discipline, therefore, is important for the smooth running of the organisation. It should be used as a means of helping the employees grow but not as a punitive measure.

Disciplinary Process

The following is a guideline on the steps in the disciplinary process that can be applied to an employee who has violated rules or regulations.

1. Preliminary investigation and caution to the employee about the problem.
2. A cordial discussion with the offender and a brief warning as to why further violations will not be tolerated.
3. A stronger verbal warning after a further violation of regulation.
4. A formal written warning.
5. A written warning accompanied by suspension from the job for a prescribed number of days.
6. Suspension from the job for a longer period of time.
7. Discharge with opportunity to appeal.

This process provides an opportunity to make amends for violations of the rules and regulations.

Administering discipline is one of the most difficult and resented tasks, but as a manager, this is your final responsibility. Your main concern should be to provide staff that can give safe care to patients and to help employees grow as individual human beings.

Line Authority

Authority is the formal and legitimate right of a manager to make decisions, issue orders, and allocate resources to achieve organisational goals. Line authority is a manager's right to direct the work of their employees and make decisions without consulting others.

SECTION 3: FUNCTIONS OF MANAGEMENT

Introduction

You have so far covered the topics of leadership and principles of management. You will now find out what manager's do in their day to day work and how the principles of management are applied.

Objectives

By the end of the section you should know the five main functions of management. These are:

- Planning
- Staffing
- Organising
- Delegating
- Controlling

Definition of a Function

What is a function?

A function is a broad area or responsibility with many activities aimed at achieving a predetermined objective. Management is viewed as consisting of many functions.

The three main functions of management are:

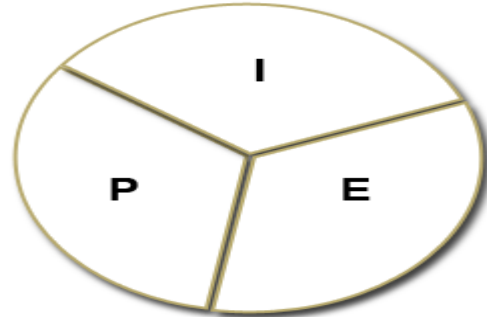
- Planning
- Implementation
- Evaluation

These have however been expanded to include:

- Planning
- Organising
- Staffing
- Delegating or Directing
- Controlling
- Budgeting

All together, they form the acronym POSDCoB.

Functions of Management



P stands for planning

I stands for implementation

E stands for evaluation

Planning

This is the first function of management. In module one, you learnt about the nursing process and the various stages involved. Planning is also a continuous process, it involves going through similar stages. You live in an era of change and therefore, you need to plan your activities.

Planning is a never ending process. It is the beginning of management. Planning is simply defined as deciding in advance what will and will not be done in the next minute, hour, day, month or year. Planning is advance thinking as a basis for action. It involves what needs to be done, how it will be done and mechanisms of evaluating work done. Planning, therefore, is having a specific objective or purpose and mapping out a method before hand. When planning, you should consider the seen and unseen factors, and keep in mind that all factors influence one another.

Purpose of Planning

1. Unleash and capitalise on creativity that resides in people
2. Provide enabling mechanism to question the assumptions on which previous decisions were made.

The Planning Process

The planning process includes a series of activities that the nurse manager sets out to do.

The process is subject to change as new facts become available. If plans are fixed and unchangeable, then they may fail.

The activities involved in planning include:

- Gathering information.
- Setting goals and objectives, that is, what you want to achieve.
- Policy formulation, that is, guiding statements in decision making.
- Developing strategic plans, that is, long term plans designed to achieve goals and objectives.
- Developing tactical plans.
- Developing procedures.
- Budgeting or resource allocation.

The nurse plans and develops specific goals and objectives for their area of responsibility.

The process of planning includes:

- Assessment
- Setting goals
- Implementation
- Evaluation

Assessment

This is the first stage in the process. It involves identifying and clarifying or diagnosing the problem. A good diagnosis pinpoints what is wrong. It may identify a particular situation that needs improvement, for example, the standards of nursing care.

The main questions you should ask are:

- Where is the problem?
- What are the obstacles that are preventing achievement?



Setting Goals

The next stage of the planning process is establishing goals to be achieved. These goals determine the direction of activities and serve as a guide for action. This stage also involves developing a set of actions for achieving the objectives and selecting promising solutions from the alternatives. One should be concerned with what can be done to overcome the problems identified. This requires imagination and originality. Alternatives must be analysed, compared and costed. The alternatives can range from doing nothing or finding a means around the problem, for example, dismissing a member of staff or discharging a patient.

Implementation

This is the third stage, it is very important because if plans are not implemented, they remain theoretical. Some of the principles of management covered in section two, for example, the division of labour, responsibility and accountability are put into practice. Implementation involves decision making, which is the core of planning. These decisions deal with the following issues:

- Activities, that is, noting whether they are carried out as planned and whether services are delivered as intended.
- Manpower should be adequate, at the right place and right time to perform the activities.

- Resources, that is, the physical, financial and information resources needed to perform the activities.

Evaluation

This is the last stage in the planning process. It involves determining the extent to which objectives have been achieved. The main concern for the nurse is to find out the effectiveness of the results, as well as the efficiency in the performance of activities and the economic use of resources. You should ask the following questions:

- Are the results as intended?
- Are the results of value?

If the answer to both questions is 'yes', then the decision would most likely be to carry on as planned. If the answer is in the negative, then a decision will have to be made on whether to re-examine the objectives, activities or both.

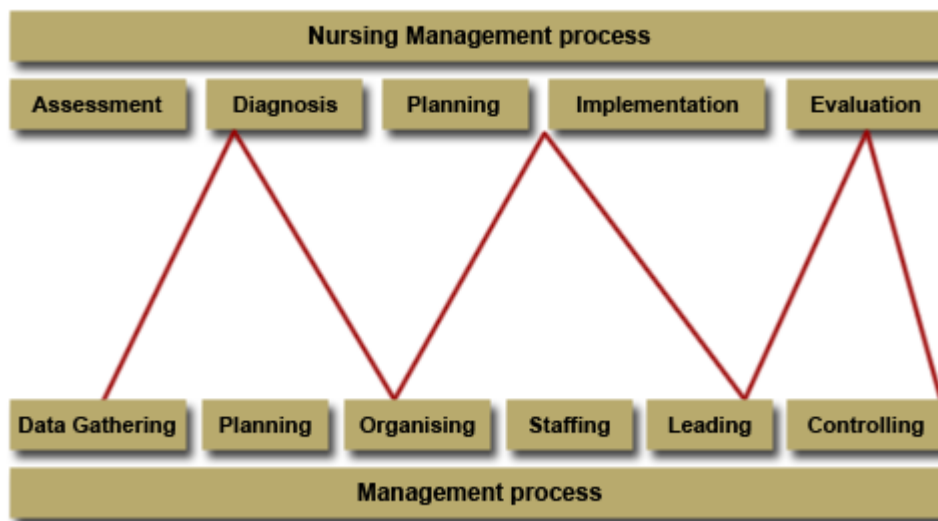
Planning is necessary for several reasons. Planning:

- Contributes to purposeful organisation of work
- Reduces costs because efforts are directed towards desired results
- Provides for integration and coordination of activities
- Minimises haphazard approaches and avoids duplication

The nurse utilises the nursing process in planning for care of specific patients.

*****The management process supports the nursing management process*****

The Nursing Management Process



Staffing

Staffing Process

Staffing involves hiring and retaining staff in an organisation.

The staffing process involves a situation analysis, looking into what you want and whom you can get. It includes:

- Recruitment
- Selection
- Induction
- Scheduling

Recruitment

This is the first part of the process and it involves filling a vacancy. It includes the examination of the vacancy and consideration of sources of suitable candidates. The sources could be internal, that is, from within the organisation, or external.

Selection

This is the next stage, it includes assessing the candidate by various means, for example, interviewing and making a choice between candidates to be followed by an offer of employment. If no suitable candidates are found,

the post is advertised again with a wider scope or catchment area. This may include advertising abroad.

During selection, at least the three best candidates are chosen. In case the best candidate is not in a position to take the job, then the second best is approached until the vacancy is filled.

Scheduling (Duty Roster)

After the orientation is done, the employee is assigned tasks to be performed. Work schedules and time off should meet organisational goals with fairness and equity among personnel. A schedule should adhere to the following:

- Policies, standards and practices of the organisation on the hours worked by professional and support staff.
- Appropriate ratio or balance between professional and support staff.
- Continuity of nursing services and twenty four hour coverage.
- Approved budget.
- Consideration of vacations.
- Allowance of adjustment in case of illness, emergencies or changes in patient care needs.
- Individual needs of staff.

Staff members should be informed of their work schedules at least one to two weeks in advance. The schedules may be either centralised or decentralised.

A centralised schedule is controlled by the chief nurse, matron or a designate who develops a master plan for nursing personnel in the hospital. One of the advantages of this method is that it provides an overall picture of the staffing situation in the organisation. However, it denies the manager the right to make scheduling decisions based on workers' abilities and needs. In the decentralised schedule, the middle and lower levels of management determine scheduling, for example, ward in charges. The manager is, therefore, more accountable at their level and has a greater control of activities.

Factors Affecting Staffing

There are many variables that may affect staff numbers and placement. These include:

- The need to provide nursing services coverage.

- Staff factors, for example, job descriptions, education level of staff, experience and expectations from the organisation.
- Patient factors, including variety of patient conditions, length of stay, the patient population, care needs and fluctuation in numbers.
- Health care organisation factors, including policies and procedures, financial resources available, number of beds per unit, staffing norms, issues of professional coverage and nursing assignment systems.

Since each setting is unique, there is no guide that can stipulate the correct number of personnel needed to provide quality care. However, systems have been developed for guidance, for example, the patient classification system which is a method of grouping patients according to the amount and complexity of their nursing care requirements. In this case, patients are grouped according to the nursing time, effort and ability required to provide care.

Organising

Nurses work in organisations. Nurse managers are expected to organise their work activities based on the staffing patterns. Organising is the process of grouping the necessary responsibilities and activities into workable units, determining the lines of authority, communication, developing patterns of coordination and giving feedback. By organising, you are attempting to answer the question:

How will the work be divided and accomplished?

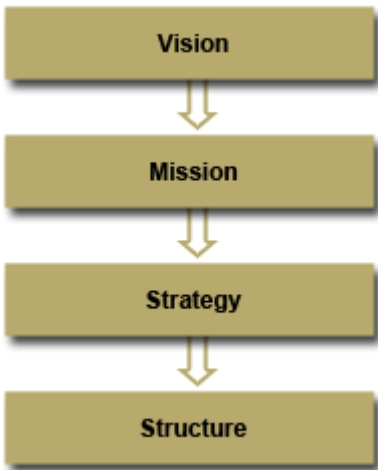
To answer the question, the manager must define groups and assign duties. There are certain basic issues to consider:

- Set up structure, that is, the structured aspects of the organisation that must be set up to indicate activities to be performed and lines of responsibility and authority.
- Develop procedures and policies.
- Determine requirements and decide how duties will be performed.

Organisation

Organisation refers to the structure that is designed to support organisational processes. It is important to design organisational structures

that will respond to changes taking place in the current health care environment. The key factors influencing organisations are the:



Vision

The vision is future oriented, purposeful and designed to identify the desired future of the organisation, for example, the hospital intends to be the best in terms of quality of services delivered.

Mission

The mission communicates the reason for the organisation's existence or being. It identifies the organisation's customers and types of services offered. It enacts the vision.

Philosophy

The philosophy of an organisation is the values and beliefs held about the nature of work required to accomplish the mission and the nature and rights of both the customers and employees.

Organisational Structure

Organisational structure refers to how work is organised and the levels of decision making, authority and responsibility of workers. Structure is a map for communication and decision making paths. The chain of command is depicted in vertical dimensions of organisational charts. The charts are tools to graphically portray the organisational structure. The chart shows:

- Areas of responsibility

- To who and for whom each person is accountable
- Major channels of formal communication
- Interdepartmental relationships

Organisational Chart for the Ministry of Health Division of Nursing.



In organising, the emphasis should be placed on interrelating activities, practices and resources into a systematic and practicable pattern. In this case, the following are necessary:

- There should be a clear goal toward which work effort is directed
- Need for clear authority and responsibility relationships
- Power and authority factors must be present
- Unity of command must be clear
- Authority must be delegated
- Decision making issues must be considered

The supervisor determines and enumerates the various activities, which are required, assigns these activities and gives subordinates the authority needed to carry out the assigned activities.

Communication is an important factor in the organisational process. Effective organising can have several benefits. It can:

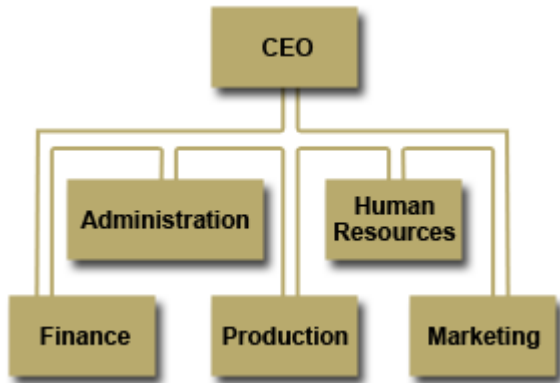
- Enlighten and help eliminate weaknesses, including gaps in responsibility, overlapping of functions, and duplication of effort.
- Provide employee with a well defined hierarchy and set of rules and procedures.

- Enable clear understanding of management expectations.

Types of Organisational Structures

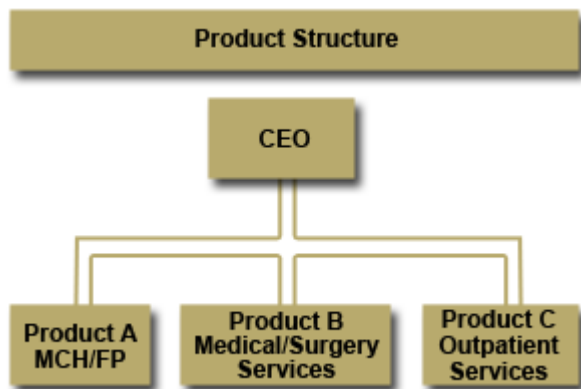
There are various types of organisational structures. Some of them are listed below:

Functional Structure



A functional organisation divides units according to their functions. A hypothetical functional organisation might have a chief executive, general manager in charge of human resources, general manager in charge of marketing, general manager in charge of production and so on.

Product Structure



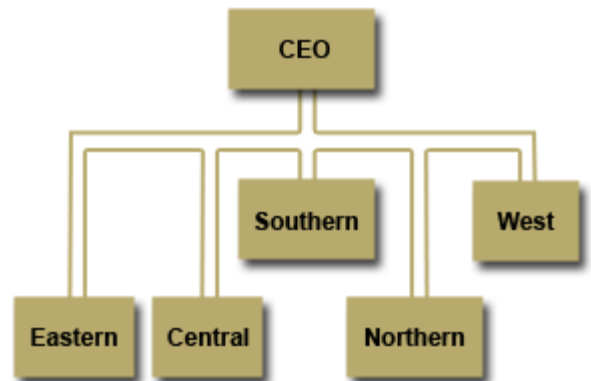
A product organisation divides units according to its products. This kind of organisation might have a chief executive, general manager in charge of consumer products, general manager in charge of industrial products and so on.

Market Structure



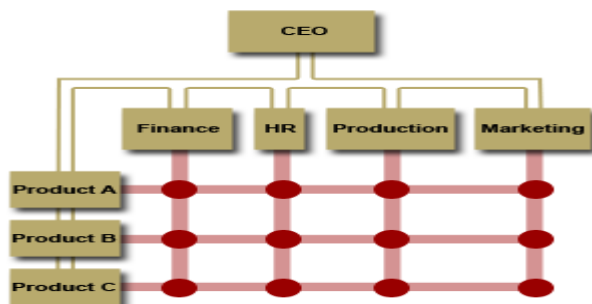
A market organisation divides units according to its target market. For example, this kind of organisation might have a chief executive officer, director of paediatrics, director of gynaecological services and so on.

Geographical Structure



A geographic organisation divides units according to the geographic regions from where it carries out its business. For example, this kind of organisation might have a chief executive officer, director for East Africa, director for North Africa and so on.

Matrix Structure



A matrix organisation structure contains teams of people created from various sections of the organisation. These teams will be created for the purposes of a specific project and will be led by a project manager. Often, the team will only exist for the duration of the project.

Tall Structure



A tall organisation has many levels of management and supervision. There is a 'long chain of command' running from the top of the organisation, for example, chief executive down to the bottom of the organisation, for example, shop floor worker.

Flat Structure



A flat organisation will have relatively few layers or just one layer of management. This means that the 'chain of command' from top to bottom is short and the 'span of control is wide'. Due to the small number of management layers, flat organisations are often small organisations.

Organisational Communication

In units one and two of module one, you covered the various principles of communication. Please refer to your notes on this topic, as they will be useful for the following topic. In this section, you will specifically focus on organisational communication. There is no organisation that can exist without communication.

Communication is referred to as the lifeblood of any organisation. Communication refers to the need to create common understanding. It is, therefore, the process of transmitting ideas and information from one person, the sender, to another or group of people, receivers.

Organisational communication is the exchange of information within the organisation. While employee communication is the responsibility of the manager, the manager's work may be supplemented through some already established means of communication within an organisation. The manager is charged with the responsibility of passing information through various channels.

Formal and Informal Communication

The formal communication system is mainly used. It is based on a chain of command from the top of the organisation to the bottom. This is used for all official messages including directives, procedures, policies, job instructions and so on. An informal communication system can also be used. This is usually oral and not crucial to the functioning of the organisation. It originates from informal groupings, for example, associations or welfare groups. In most cases, messages are transmitted through the 'grapevine' (also known as rumours) and sometimes the communication is distorted or groundless. Such types of communication can cause fear and anxiety among staff and the manager should be aware of its existence and reinforce stability using more formal methods of communication.

You will now look at some of the different types of formal organisational communication.

Vertical Flow

The manager is responsible for passing information through vertical channels of communication, which includes both a downward and an upward flow of communication.

A two way exchange of information is essential in organisations and managers must ensure that there is feedback at all levels.

Downward Communication

Most information within organisations moves from the top downward, that is, from the top levels of management to employees. This may be through face to face communication or written materials, for example, memos or circulars.

The purpose of this form of communication is mainly to inform employees of their responsibilities, commitment to the objectives of the organisation and any other relevant information. Barriers to this form of communication may include:

- The manager may withhold information
- The employee may fail to understand the message
- The employee may get information but this may not be relevant to their needs

Upward Communication

This is the flow of information from the bottom up or from the subordinates to the supervisor. Ideally information should pass freely up the chain of command so that management gets the feedback needed to evaluate results and initiate improvements. Barriers to upward communication may include:

- If employees feel management is not interested in their ideas, they will not offer them.
- At times, bad news gets blocked and is not communicated to the top management.
- Delays in relaying messages.

Delegating

Once you are responsible and accountable for patient care activities, you will find that there are times when a job gets too big and part of it must be entrusted to someone else.

Delegation is the process through which responsibility and authority for performing a task,

function, activity or decision is transferred to another individual who accepts that authority and responsibility (Sullivan and Decker 1992: 216).

Although the delegator remains accountable for the task, the delegate is also accountable to the delegator for responsibilities assumed. Delegation is a dynamic process, which involves three factors:

- Responsibility for work delegated, that is, willingness to do the assigned work or an obligation to accomplish a task.
- Accountability or the obligation to carry out the responsibility or authority or act of accepting ownership for the results or lack thereof.
- Authority, that is, the right to act or empower.

You can delegate only those tasks for which you are responsible.

In delegation, responsibility and authority are transferred, while accountability is shared.

To clearly understand who is responsible for certain tasks, it is important to look at:

- Practice acts, that is, the scope of nursing practice.
- Standards of care.
- Job descriptions for various positions.
- Policy statements regarding the quality of care.

For delegation to be effective, the following must be considered:

- The manager and immediate subordinate must have a good interpersonal relationship.
- The manager must have good administrative skills to be able to delegate.
- The assigned duties should be well understood, well defined and well written to both of them.
- The person to whom work is to be delegated must be assisted to become self sufficient.

Every activity you perform has some benefits to the people involved as well as the organisation. The delegator benefits as they are able to devote more time to those tasks that cannot be delegated and with more time available can develop new skills and abilities.

Meanwhile, the delegate benefits because they gain new skills and abilities that can facilitate upward mobility and build self esteem and

confidence resulting in job motivation and satisfaction. They also have the freedom to exercise initiative and learn how to make decisions independently.

The organisation benefits in that teamwork improves and the organisation achieves its goals more efficiently. Finally, the patient benefits as the quality of care improves leading to increased patient satisfaction.

Delegation Process

The process of delegation involves the following steps:

Defining the Task

This involves determining what can and should be delegated, for example, routine tasks, tasks for which you do not have time and tasks that have moved down in priority. It also includes problem solving and staff development.

Evaluating the Task

You should analyse whether the task involves technical skill or cognitive abilities, for example, the performance of specific procedures and the knowledge level needed to carry out certain tasks.

Determining Who Should Perform the Task

You should be able to match the tasks to the individual. To do this, you should analyse individual skills and capabilities, experiences and individual characteristics, for example, initiative, enthusiasm and knowledge.

Providing Clear Communication About Expectations Regarding the Task

You should plan your meeting with the delegate. Describe the task and give reasons for the task. Inform the delegate by what standards the task will be evaluated and identify any constraints to completing the tasks.

Reaching Agreement

Seek agreement from the delegate that they are accepting responsibility and authority for the task.

Monitoring Performance and Providing Feedback

Analyse performance according to established goals. Monitoring provides a mechanism for

feedback and control and ensures that delegated tasks are carried out as agreed.

Delegation is good because it enables the manager to concentrate on the most important tasks. However, there are some problems which may affect both the delegator and delegate.

On the part of the manager they may:

- Be reluctant to delegate adequately to their subordinates. In some cases, the manager might delegate responsibility and not authority.
- Fail to delegate because they can do a better job.
- Lack the ability to communicate to people what is to be done.

As a general guideline, only routine activities may be delegated. Sensitive issues, for example, disciplinary and staff performance appraisal should not be delegated.

Delegating Process

On the other hand, the subordinate may:

- Decline delegated tasks because it could be easier to ask the manager than to decide for themselves how to deal with a problem.
- Fear criticism for mistakes made, which keeps them from accepting responsibility.
- Lack the necessary information and resources which creates an attitude that might make a person reject further assignments (non supportive environment).
- Lack self confidence.
- Fear liability, keeping in mind that some individuals are not risk takers.

Controlling

Controlling

Controlling is the managerial function concerned with making sure plans succeed. It means measuring and correcting the performance of employees to ensure that the planned objectives of an organisation are achieved. Controlling involves the regulation of activities so that some targeted element of performance remains within acceptable limits. It also guides activities and assures certain minimum standards.

The nurse manager needs to take into account both external and internal environments

because they will influence the way they exercise control.

External Environment

This includes the laws and acts that regulate institutions, for example, the Nursing Practice Act, which regulates nursing practice in terms of registration and licensure, in order to maintain standards of nursing services.

Internal Environment

This includes self regulation within the organisation or nursing department, for example, quality control relating to care of patients, staffing and budget reports.

Importance of Control

Control is important for several reasons including the following:

- To ensure work is done according to the objectives set and activities are carried out as planned, within the allocated time and with the resources provided.
- To enable supervisors to recognise gaps in the knowledge and understanding of the staff, and arrange for appropriate training.
- To enable management to ensure that the resources provided for work are adequate and are being properly used.
- To enable management to identify the cause of work deficiencies.
- To facilitate the recognition and reward for good work done and recognise suitable staff.
- To identify mistakes before they become critical, bearing in mind that prevention is better than cure.

Elements of Control

The nurse manager must ensure that all staff members are conversant with the elements of control. You will now cover each of these elements individually.

Establishing the Standards

The first step involves formulating standards. Standards are yardsticks against which nurse managers devise controls. They are a way to measure and evaluate quality and quantity of performance. They are closely related to organisational goals but are more specific. People must understand the results desired to

avoid confusion. Standards may be classified as:

Tangible and Objective

Tangible standards are physical standards, which pertain to actual operation of the department. They can be quantitative or qualitative, for example, the number of nurses to cover the duty per shift and quality of care expected, for instance, every patient will have a nursing care plan twelve hours after admission.

Intangible and Subjective

Intangible standards may include the reputation of the hospital based on good or bad publicity. They can also refer to the morale of employees, attitudes and relationships between employees and complaints. These are difficult to measure but can be assessed with a degree of confidence.

Actual Performance

After setting standards, they must be measured to identify their achievement. This can be done by direct observation and checking on employees. Observations for control should attempt to identify:

- Inadequate output or improperly performed jobs.
- Deviations from expected standards. Assuming a questioning rather than confrontational attitude.
- Comparisons between actual performances with the laid down standards.

It is important to correctly interpret reasons for deviations from standards.

Some deviations may be due to temporary circumstances, for example, patients may not have had bed baths due to fewer nurses on duty rather than due to poor performance. Corrective Action

If performance falls short of standards, then analysis indicates that corrective action is required. Supervisors must decide what remedial action is necessary to get improved results in the near future. These corrections may require:

- A revision of standards

- A simple discussion with those responsible for taking corrective action
- Verbal reprimand
- At times disciplinary action may be taken where rules and policies are involved
- Better selection and training of staff to enable them to be more effective and efficient
- Reinforcement of strengths by the manager so that the staff are motivated

SECTION 4: MANAGING RESOURCES, CHANGE AND HEALTH INFORMATION SYSTEMS

Introduction

In the preceding sections, you covered the various concepts, principles and functions of management which a nurse manager utilises in the day to day running of a unit. This involves a series of activities that must be performed to achieve certain objectives.

The achievement of these objectives will depend on how well knowledge and skills are applied to a problem, using resources in the most efficient way. To some extent, you have already referred to some of the most important resources, for example, manpower. Nursing management often takes place in situations of scarce resources, and therefore, the main role of the nurse manager is to achieve the greatest results with the resources available. You will also cover change management and health information systems.

Objectives

By the end of this section you will be able to:

- Describe human resource management
- Describe elements of financial management
- Describe materials management
- Describe time management
- Describe the process of managing change
- Describe the health information systems used to provide patient care information

Human Resource Management

The shift in terminology from 'personnel' to 'human resources' is symbolic of a true change in the field. The term human resource reflects the position that people are a resource that needs to be managed strategically in support of the organisation's mission. The effective functioning of an organisation depends upon various resources. Human resources or manpower is one of the most vital resources for the labour intensive health institution.

Human resource management can be said to be an integral part of the role of any person who is responsible for the work of others. In this module, human resource management will refer to a group of specialists concerned with increasing the effectiveness of staff performance in an organisation.

According to Basawanthappa (2002), the main objectives of human resource management are:

- Effective utilisation of human resources to enable the achievement of organisational goals.
- Establishment and maintenance of an adequate organisational structure and desirable working relationship among staff.
- Securing integration of the individual and informal groups with the organisation and thereby ensuring their commitment, involvement and loyalty.
- Recognition and satisfaction of individual needs and group goals.
- Provision of maximum opportunities for individual development and advancement.
- Maintenance of high morals in organisations.

Bearing in mind the objectives covered previously, you will now look at the main aspects of human resource management. These include:

Forecasting Future Manpower Requirements

This involves estimating the institution's demand for labour and matching this with what is available.

Formulating and Proposing Policies

Formulation of human resource policies is done by the human resource management department. The policies have to be agreed upon by top management. The key areas of

personnel policy include recruitment and selection, terms and conditions of employment, training and development as well as labour union issues, for example, laid down procedures on how to handle strikes and disputes. These personnel policies are guidelines for behaviour and state how the organisation will respond in relation to employee affairs.

Recruitment of Staff

This involves preparing job descriptions and specifications, drafting job advertisements, interviewing candidates and assessing appropriate salary levels for new employees. A job description states the principal duties, responsibilities and the scope of authority. A job specification also spells out the vital qualities required in an employee for them to be able to perform a job adequately, for example, specific knowledge, skills, ability and behaviour. These must be prepared before advertising for any job.

Staff Training and Development

Once the employees join the organisation, they require training. This involves induction of new employees as well as training and development. This was covered in more detail in section two. Human resources are the most dynamic of all the organisation's resources. Training and development is important in order to maintain the key skills within the organisation and motivate the staff. This is to enable them to realise their full potential. The human resources department has the responsibility of assessing the training needs, designing training methodology and evaluating training activities to determine their effectiveness.

Staff Retention

It is essential to retain employees within an organisation. Promoting staff is one way of retaining employees. This allows them to advance from one given grade to a higher one. Promotions are based on whether an individual meets the requirements as specified in the job description. The career structure or recognised promotional path should provide an opportunity for all workers to get promoted.

Health and Safety

The employees should be informed about their rights and duties, occupational hazards should be identified and accident prevention measures put in place. First aid facilities should also be at hand.

Welfare

Welfare services are provided for matters concerning employees which are not immediately connected with their jobs although they may be connected generally with their place of work. These include counselling, problems of health or sickness, social and sporting activities, restaurants, child care facilities and special services for retired employees.

Consultation and Negotiation

Opportunities should exist for collective bargaining and liaising with trade unions. Trade unions should be utilised by management as an avenue for consultation and joint planning with employees. Trade unions should not be viewed as antagonists but a partner in planning and decision making. If employees through their trade unions felt appreciated, they would be motivated to perform better and improve the image of the organisation.

Labour Management Relations

Labour management relations has been defined as 'the effort to develop harmonious working relations between employees and management in order for a firm to increase productivity, improve quality of work life and remain competitive'.

Objectives of Labour Management Relations

- To enhance a healthy relationship between employers and employees, that is, a sound, harmonious and mutually beneficial relationship.
- To safeguard the interests of employees and management by securing mutual understanding and goodwill between them.
- To avoid industrial and workplace conflict that could affect production and productivity.
- To preventing or reduce labour turnover and frequent absenteeism.
- To nurture and sustain workplace democracy in order to enhance employee participation in decision making and problem solving.
- To eliminate strikes, lockouts and go slows.
- To allow the government some control over private means of production,

distribution and service provision in the public interest.

The management should never be caught up in a surprise strike if they have been in good relations and communication with the employees. Those in Management positions should not be members of trade unions.

Financial Resource Management

In the previous section, you covered the management of human resources. In this part, you are going to examine financial resource management. Managing finances is one of the most important roles of a nurse manager. Arguments have been put forward that this function should be left to accountants who are specialised in this area. However, if nurses do not have the basic skills to enable them manage finances, they will not succeed in providing nursing services. Most of the resources you will be managing are acquired with money.

Financial planning requires that the manager identifies objectives, policies and procedures. The budget is one of the main tools of financial management.

Budgeting

In simple terms, budgeting involves managing money and how it is used to maintain other resources.

A budget is a means of control, which reflects the plan against which actual performance is measured. It can also be defined as a means of checking the progress made in keeping the expenses and costs in compliance with an organisation's financial plans. Budgeting is the process of planning and controlling future operations by comparing actual results with planned budgetary expectations.

The following are some of the purposes of a budget:

- To avoid spending more than an organisation can afford
- To aid in planning and controlling
- To assist in assessing the financial requirements of the institution
- To indicate the areas in which money raised or received will be spent
- To facilitate comparison of actual performance with budgeted targets

In order to draw up a meaningful budget, the hospital should have a clearly defined organisational structure with responsibilities defined and assigned. Personnel at all levels of management should participate in budget development. The personnel involved should have an understanding of the ideas and financial goals of the hospital.

There must be an adequate system, which provides reliable financial and statistical information to the responsible people. The budget should allow enough freedom to accomplish departmental objectives and must be flexible enough to allow for unpredictable expenditures.

There are two main types of budgets, which the nurse may be involved in preparing:

- Operational or Annual Budget
- Capital Budget

Operational or Annual Budget

This is the organisation's statement of expected revenue or income and expenses for the coming year. It coincides with the fiscal year. The fiscal year is a specified twelve month period during which the operational and financial performance of the organisation is measured. It usually coincides with the calendar year, that is, it runs from January to December or may follow another time frame, for example, the government calendar, which runs from July to June.

The operational budget includes the accumulated estimates of operating revenues and expenses. In nursing management, the revenue is derived from patient fees. Actual payment is generated by a given service or procedure.

The expenses consist of salary and non salary items, for example, personnel emoluments and education, including in service training, on the job training, educational leave and travel scholarships. They may also include personnel uniforms, books, periodical subscriptions, laundry, medical equipment and maintenance, drugs and pharmaceuticals, non pharmaceutical supplies, legal and professional fees and stationery.

The expenses should be comprehensive and thorough. Budgets are prepared by the heads of each ward or department in consultation with staff. Thereafter, the matron, chief nurse or director of nursing services compiles the nursing division budget. In some cases, the director of

nursing services prepares a budget for the whole of the nursing division.

Balanced Budget

A. Income for May 2003		
	Expected Income (Patients Fees)	Kshs 300,000/=
	Other sources of income	100,000/=
	Total Income	400,000/=
B. Expenditure for May 2003		
B₁ Recurrent		
	Food	100,000/=
	Drugs	100,000/=
	Linen	20,000/=
	Surgical Materials	60,000/=
	Miscellaneous	20,000/=
	Total	300,000/=
B₂ Capital Expenditure		
	Purchase of suction machine	100,000/=
	Total Expenditure	400,000/=

As you can see from the figure, the income and expenditure parts of the budget have the same totals, that is, they balance. A budget that has a higher income than expenditure is said to show a surplus while the one with a higher expenditure shows a deficit. If there is a deficit in the budget, it means you have spent more money than you have. This may require you to borrow money or be indebted to your suppliers.

Capital Budget

This is the second type of budget. It outlines the need for major equipment or physical changes in the organisation requiring large sums of money, for example, physical renovations, new construction and new or replacement equipment. Organisations define capital items based on certain criteria, for instance, the item must have an expected performance of a minimum of one year or more and exceed a certain shilling value, for example, fifty thousand. The criteria vary from one hospital to another. Requests for capital items are usually made on a special form or letter, accompanied by a written justification for the item. If there are a large number of items requested, a priority list should be set. Where possible, the period within which items are needed should be specified. Capital costs should consider long

term goals and must complement the organisational objectives.

All nurse managers are involved in the budgeting process. Preparation begins several months before the end of the fiscal year to allow time for careful preparation. In a decentralised system, budget preparation has several steps:

- Review of policies, standards and objectives.
- Top level management projections for the future and preparation of guidelines.
- Middle level nurse managers prepare the annual budget.
- The administrator of nursing services, finance director or manager reviews the budget.
- Budget is accepted or modified.
- Budget is implemented and regularly evaluated.

Capital Budget

A. Income for May 2003		
	Expected Income (Patients Fees)	Kshs 300,000/=
	Other sources of income	100,000/=
	Total Income	400,000/=
B. Expenditure for May 2003		
B₁ Recurrent		
	Food	100,000/=
	Drugs	100,000/=
	Linen	20,000/=
	Surgical Materials	60,000/=
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Managing Materials

So far you have managed human resources and money. The other resource that a manager is concerned with in the organisation is

the materials. Materials refer to drugs, supplies and equipment needed by the nurses and other health personnel to deliver services. For quality and efficient services, the materials must be provided at the right place, at the right time and in the right quantity.

Materials are essential if the health care institution is to achieve its objectives. The nurse manager should know the policies and procedures that relate to materials management. You should be familiar with the following activities:

Demand Estimation

Since a large quantity of materials is used in hospitals, you need to identify your requirements or needs beforehand.

Procurement

Having developed your list of requirements, the next step is procurement or ordering. Some institutions have laid out specific rules and regulations regarding procurement. This is aimed at reducing wastage and maximising the value of money.

Receipt and Inspection

The materials received should be subjected to either physical or chemical inspection. This ensures that you received the right quality and quantity of materials as requested by the organisation.

Inventory Control

Adequate quantities of materials should be available whenever required. Close supervision of movement of materials or consumption rate is a good tool for proper control.

Storage

The materials should be placed in a store within or near the institution. The store should be of adequate size to accommodate all the different materials required, for example, fridges, shelves and cupboards. The materials should also be stored in appropriate conditions, for example, temperature, light as specified by the manufacturer.

It is, therefore, important that the nurse manager adopts the proper procedures for materials management.

Managing Time

Time is an important resource although in many cases, it is not thought of as such. It is sometimes referred to as one of the M's of management and stands for moments. The other M's being money, manpower and materials. For example, you may recall times when you have wished that a day had more than twenty four hours or that a week had more than seven days so that you can accomplish the tasks you had set out to do. This often happens when you are not managing time well.

The demands on time as a manager and a health care provider fall into three categories (Nduba 1999):

- Tasks that have to be performed. These relate to key responsibilities, for example, clinical or administrative duties.
- Tasks that other people pressurise you into doing. Some of these are important and must be done while others you do because you do not want to say no.
- Tasks that you perform because you want to. These are usually out of choice and include tasks that someone else could do just as well, for example, attending a nurses' association meeting.

Time Waster

This is something that prevents a person from accomplishing a job or achieving a goal. Some of the common time wasters include:

- Interruptions such as telephone calls and drop in visitors.
- Lack of clear cut goals, objectives and priorities.
- Meetings both scheduled and unscheduled.
- Lack of daily or weekly plans.
- Lack of self discipline.
- Failure to delegate.
- Ineffective communication.
- Inability to say no.

Principles of Time Management

The following are techniques that you can use to deal with time management constraints.

Goal Setting

The nurse manager sets both organisational and personal goals. The goals are either short or

long term and provide direction and vision for actions as well as time frames in which activities will be accomplished.

Time Analysis

The manager should conduct a survey of how they spend a day. Reviewing the daily schedule and keeping it accurate may demonstrate how time is used.

Priority Setting

The nurse manager identifies time frames for achievement of goals. The 'to do' list should be prioritised by classifying activities as 'one' for urgent, 'two' for not urgent but important and 'three' for less important.

Delegation

The nurse manager can delegate those activities that can be effectively handled by juniors.

Controlling Interruptions

The nurse manager should identify causes of interruption and plan to reduce them. One way of doing this is incorporating some of these interruptions into planned and scheduled activities.

Nurse managers must use time wisely to accomplish everything that is expected of them. This takes a lot of planning.

By now you should be able to manage resources within the organisation. However, in the current health care system, there are a lot of changes including social, technological and educational, which a nurse manager should be able to respond to and manage. According to the theory of evolution, plants and animals have survived countless changes in the earth's environment. For example, the cockroach has been around for three hundred million years and the shark two hundred million years. This is because they have learnt how to adapt to their environment. They have learnt how to survive. The strong survive and the weak die, it is survival for the fittest.

Change has always been, and will always be, a part of us. During your lifetime you must have experienced change in one form or the other, such as moving from one workstation to another, acquisition of new skills or introduction of new methods of nursing care delivery.

Change is the process of making something different from what it was. Change is inevitable and nurse managers should understand and anticipate the reactions to change.

“It is no longer enough to be a ‘change agent.’ You must be a change insurgent - provoking, prodding, warning everyone in sight that complacency is death.” Bob Reich

There are two basic approaches to the management of change (Bennett, 1997). These are:

- To predict all environmental changes relevant to the organisation that might occur and then anticipate how the organisation will be affected by them
- To list all the organisation's major functions and follow this by an analysis of environmental factors that might affect the functions

Once the organisation identifies the need for change, it should assess the possible implications of this change. This may require:

- Definition of alterations in operational methods, staffing levels and the employee's attitudes and perspectives necessary to implement alterations.
- New equipment and systems.
- Redesigning of jobs.
- Restructuring of jobs.
- Restructuring the organisation.

Resistance to Change

Employees may fear change because of its potential for the disruption of the existing status quo in the organisation. The following are some of the reasons why people resist change:

- Insecurity, fear of unforeseen consequences and threats to individual status.
- Skills and experience acquired may have no further value.
- Possible collapse of work groups and interpersonal relationships.

To reduce or avoid resistance to change, we can help the employees go through a change process. Kurt Lewin suggested three steps to overcome resistance:

- Unfreeze, that is, getting rid of existing practices and ideas that stand in the way of change. This requires a high level of communication with employees to convince them that change is necessary.
- Change, that is, teaching employees to think and perform differently.
- Refreeze, that is, establishing new norms and standard practices.

To implement the change process the following approaches will be necessary.

Education and Communication

This is to make employees fully aware of all aspects of the situation and convince them that change is essential.

Participation and Involvement

The employees should actively participate and get involved from the beginning so as to stimulate commitment.

Patience and Tolerance

Management should give support and assistance needed.

A nurse manager has an important role in initiating and managing change. They should recognise the obstacles to change and assist employees to go through the change process.

Health Information Systems

The use of computers in health care is a rapidly growing area. As nursing care becomes more computerised and geared towards telehealth, nurses must be well prepared to be at the cutting edge of information technology (IT). The health care system in Kenya is rapidly changing for the better and the nurse in Kenya needs to be well prepared in meeting the information technology challenges. One of the nurses' new roles will be agents of change in health care revolution (Ball 2005). Studies have shown that nurses spend as little as 15% of their time on direct patient care. As much as half their time goes into documentation. Clinical documentation is an area where IT has had a major influence. As they help coordinate all the multifaceted activities related to patients, nurses must ensure that every aspect of diagnosis and care is carefully documented. Documentation poses a tremendous, often unmanageable, challenge and has become the root cause of many patients' safety and related legal problems (Ball 2005). The key to embracing IT is computer literacy among the nurse care providers.

Information Technology

This is the acquisition, processing and dissemination of information using computers. Whereas in the past and even today in some

institutions, information handling involved dependence on paper, the emphasis is now shifting to creation, storage and transmission of information through tiny electrical impulses. Paper no doubt will continue to be important as a tangible product of the interchange of information. Nevertheless, computers are likely to dominate the scene.

Most healthcare institutions collect comprehensive information about their patients. They also have information on administrative matters related to staff, equipment, supplies and so on. All this information is kept in records, which are either in written documents, tapes or computers.

Records are an important tool in controlling and assessing the workplace. Records should be accurate, accessible and useful.

To achieve goals and maintain efficiency and effectiveness, the organisation uses a variety of tools to collect information, analyse data and make predictions about outcomes. The facts used to produce information, for example, admissions, invoices, receipts, stock issues are termed as 'data' while the process that transforms raw data into information, useful items or summaries of data, is called data processing. The raw data is input into the system whereas information is output, that is, processed data. The process that converts input into output involves sorting, storing, amending, calculating, deleting or retrieving data. Information must be relevant, easily understood, up to date and easily available to the users. This can only be achieved if nurses are computer literate.

Computer Literacy

Computer literacy is 'the minimum knowledge, know how, familiarity, capabilities and abilities in regard to computers' (Burk 1985, 33). According to the western Illinois university senate's committee on computer literacy, the basic competencies considered for academic success are:

- Use of word processing programs effectively
- Use of library databases and catalogues to locate print materials
- Ability to find information on the Internet and evaluate its reliability and usefulness
- Ability to write email effectively and appreciate the ethical issues of computing

Information literacy is a fundamental skill. It is, in fact, the first component on the continuum of critical thinking skills. It includes the ability to identify a lack of information, and decide what information is needed as well as the ability to evaluate and organise the available information (Brevet 1991).

Nursing Informatics

Nursing Informatics is a specialty that integrates nursing science, computer science, and information science to manage and communicate data, information, and knowledge in nursing practice. Nursing informatics facilitates the integration of data, information and knowledge to support patients, nurses and other providers in their decision making in all roles and settings. This support is accomplished through the use of information structures, information processes, and information technology (ANA 2001, vii).

Ball and Hannah (1988), provide a comprehensive description of nursing informatics as the use of any information technology by nurses in relation to the care of patients, the administration of health care facilities, or the educational preparation of individuals to practice the discipline of nursing.

They suggest that nursing informatics includes, but is not limited to:

- The use of artificial intelligence or decision making systems to support the nursing process.
- The use of a computer based scheduling package to allocate staff in a hospital or health care organisation.
- The use of computers for patient education.
- The use of computer assisted learning in nursing education.
- The use of hospital information systems.
- The use of data and information generated from research to form a basis for evidence based practice.

Advantages of Computers to Nurses and Nursing Services

- Time saving is often the most sought after benefit since nurses are keener on doing than on recording (Strachen, 1994).
Speedier recording is possible using

core care plans, and with the use of technology such as bar coders, light pens, or voice recognition. All that is required is a structured language or terminology that can be coded.

- Computers can process information far quicker than the human brain. The vast amount of data nurses collect and record is put to very little use because it takes too long to analyse. All the nurse needs to do is to decide what information they need, what data to collect, how it should be analysed and the computer will do the rest.
- Printed care plans are easier to read than manual records with numerous changes by unknown nurses. The computer can automatically track any changes made to a care plan.
- Computers improve accuracy. A person repeating the same complex calculation one hundred times is likely to get a dozen different answers. A rigorously tested computer repeating the same calculation one hundred times will get the same answer each time.
- Computer software can be designed to undertake validity checks on data, rules can be added, comparisons made and reminders given. These help reduce human error and improve the accuracy of nursing records.
- Improved communication can offer patients considerable benefits. If a network is in place, a computer terminal can be used to access nursing records, day or night, by those who have been granted access to the system through use of passwords. The possibility of better access increases the risk of unauthorised entry into the system. These concerns must be compared with the present reality, for example, how secure are the current records and does the computer offer better security. All that is required is good design, user education and a well managed computer system.
- Computers can offer easier retrieval of information simply through the touch of a button. Nurses can ask questions and

get answers from their own data, for example, how many patients developed pressure sores or how many patients with a sore had a high risk on the Norton scale.

Advantages of Computers to Nurses and Nursing Services

Other benefits include:

- Preventing the duplication of collection and recording of demographic details.
- Linking treatments and procedures with orders to suppliers, pharmacy or catering services.
- Linking nursing cases to research references, producing discharge plans for patients or summaries of care and treatment for other health care professionals and so on.

A Health information system is an integrated system used in health care settings to manage patient information. It is primarily a centralised patient record of demographics, health and financial information (Yoderwise 1999). The information is entered, stored, retrieved, displayed and communicated. A major function is to communicate and integrate patient care data and information, and provide management support.

Health data is entered into the system from computer stations located in the various departments in the organisation and stored in a central computer to be accessed by all patient care services. The systems contain a central database that is written to and accessed by all departments, for example, nursing, laboratory, pharmacy, radiology, physiotherapy and so on. The programs that link the individual departments must be able to 'talk' to one another in order to exchange patient data. For example, the wards need access to laboratory results or the pharmacy may need access to the ward for information like patient height, weight or allergies as entered by the nurse in the patient's clinical chart.

The nurse managers and staff must understand the patient care process from a data information knowledge perspective. They must be aware of the data collected, reasons why it is collected and decisions made based on the data.

The type of information that can be tracked in this system includes:

- Appointments, admissions, discharges and transfers.

- Medication profiles, for instance, prescriptions and allergy reports.
- Care planning.
- Patient acuities.
- Human resources, including staff pay roll, performance, incident reports and staff scheduling.
- Plans, for example, budgeting information.

An information system must provide the following (Yoder-Wise, 1999):

- Information confidentiality and security
- Uniform data definitions
- Standard format for transmitting data
- Sharing of information between departments
- Linking of clinical and financial information
- Patient specific data

An effective health information system is important in order to get the health information required for appropriate planning and decision making. It also assists in monitoring and evaluating the various activities within the organisation.

SECTION 5: MANAGING NURSING CARE SERVICES

Introduction

This section will examine the different health care organisations within which the nurse manager functions and the types of nursing care delivery systems. You will be able to apply various concepts already learned, which will enable you to manage the nursing care services in your organisation more effectively and efficiently.

Objectives

By the end of this section you will be able to:

- Analyse the different types of health care organisations
- Describe the management of nursing care services
- Describe the different types of nursing care delivery systems
- Identify legal and ethical issues in nursing practice

Health Care Organisations

Ownership

Health care organisations have various designations. Private organisations are directed and supported by private citizens. They are usually owned by corporations, associations or religious groups, for example, private or mission hospitals. They can further be divided into two categories. The non profit category ploughs back all profits to its operation or the community while the commercial category distributes profits to investors or shareholders. Meanwhile, government health care organisations are government or state owned. The majority of our organisations in Kenya fall under this category.

Role or Services Offered

These range from specialty institutions, which provide for a specific disease or section of the population, for example, psychiatric or children's needs, to those referred to as general, which provide a full range of services for the whole population. These services may include acute care, ambulatory and rehabilitative services.

Activity and Size

These mainly refer to teaching institutions, which have both a general hospital and a teaching hospital, for example, the Kenyatta National Hospital.

In section four, you covered what an organisation is and how organisations are structured. You will now look at health care organisations. Nurses practice in many different types of health care organisations where they provide direct and indirect care services to patients.

For more information on the different services provided by nurses, refer to module three.

Health care organisations make up the health care system, which provides all the services offered by all health disciplines. Today, many types of health care organisations exist. These differ in terms of:

Types of Health Care Organisations

You have looked at how health care organisations are classified. There are four main types of health care organisations. These are:

Hospitals

These are institutions whose purpose is to serve the whole community, sick or well. Hospitals play a significant role and provide preventive, curative, rehabilitative and health promotion services as well as education and research.

Hospitals are classified into acute care facilities, where the average length of stay is less than thirty days and chronic or long term hospitals, which are designated to care for patients whose average length of stay is longer than thirty days.

The services provided by hospitals include:

- Medical care, that is, the care given by doctors to meet the needs of patients, for example, surgical.
- Nursing services, that is, the care given by the nurses in coordination with other health care team members.
- Emergency care, that is, care given at any time of need for people requiring emergency measures, for instance, acute trauma accident cases, intoxication or poisoning.
- Diagnostic services, which include radiological and pathological services.

- Drug therapy, that is, most hospitals should have a good pharmacy with the drugs required for the care of patients.
- Dietary services, which are important for the nutrition of patients.
- Rehabilitative and recreational services, which contribute to the well being of patients and are therefore, therapeutic.

Ambulatory Based Organisations

This is the second type of health care organisation. Many health services are provided on an ambulatory basis. This refers to the care given by private physicians or in hospitals as outpatient care. The goal is to focus on out patient preventive care and patient follow up care. This serves to reduce the cost of expensive acute hospital care.

Health Managed Organisation (HMO)

The other type of health care organisation is the HMO. This is a new concept in Kenya, which is catching up quickly. This is where an organisation gets people to enrol and pay a fixed periodic fee to the organisation, which determines the kind of services used. The HMO offers hospital and out patient services. Examples of these include insurance companies who cover medical expenses.

Home Health Care Organisation

The last type of health care organisation is home based. The services in this case are offered at home. Professional nurses provide care. They assess the patients' ability to take care of themselves and identify the resources needed to overcome problems and meet patients' needs. These include patients' requiring palliative care, chronically ill patients, the disabled or the elderly.

The nurse manager plays a significant role in all the above health care organisations particularly in managing nursing services.

Managing Nursing Services

The nurse as a leader and manager must ensure that the nursing services are run effectively and efficiently.

This refers to the coordinating responsibility of the nurse, who, in addition to giving care, also works with members of the health care team in providing a comprehensive programme of nursing care (Basavanhappa 2000). The

nurse's main task is to link the team or a nursing department to the larger organisation and to the resources necessary to achieve the objectives. The following are the main responsibilities as regards to managing nursing services:

- The nursing service must be operational twenty four hours a day, seven days a week all year round.
- High quality nursing care must be provided to patients taking into consideration their physical, social, psychological and spiritual needs.
- Resolution of health care delivery problems.
- Policy development.
- Planning, organising, directing and controlling materials and human resources in order to provide effective care. This was covered in sections two and three.
- Utilising the appropriate methods of patient assignment in order to deliver care to patients.
- Research for knowledge generation, better understanding of issues and engineering new methods of management, that is, innovation.

Nursing Care Delivery Systems

The practice of nursing has emerged as an aggregate of complicated duties and responsibilities. There is, therefore, a need to develop certain systems, methods or modalities to ensure delivery of quality care. There are four methods of assignment of patient care in a hospital. These are:

- Case Assignment
- Functional Nursing
- Team Nursing
- Primary Nursing

The changes in these modalities or systems are a response to ever changing needs. These methods may be used separately or to complement one another.

Case Assignment Method

This was the first method to be identified in nursing care delivery. It was popular in the 1920's. Each patient is assigned to a nurse for total patient care while the nurse is on duty. If they go off duty, the work is handed over promptly to another nurse. This means that the patient has a different nurse

each shift. Assignment is made according to the severity of illness and tends to be mostly for acutely ill patients, for example, in the intensive care unit (ICU).

Functional Nursing

The second method is known as the functional nursing method. It was the first major deviation from case method. It began in the early 1950's when there were few registered nurses and more practical nurses available. Nurse aides provided most of the patient care.

This method emphasises the division of labour according to specific tasks. It is 'task or thing oriented' and is determined by the technical aspects of the job to be done. Each nurse has a clearly defined set of tasks determined by complexity, including skills, knowledge and experience in certain nursing techniques, for example, drug administration, wound dressing, bed baths and so on.

In this approach, the nurse in charge must have experience and exceptional knowledge in nursing. The nurse must know the skill level of their workers in order to make accurate assignments. The nurse in charge establishes rigid routines, structures and time schedules.

This method has several advantages:

- It emphasises the efficient delivery of care
- There is little likelihood of confusion over who will do what
- Minimal time is spent coordinating activities
- It is economical in that it allows for the use of less skilled personnel
- Each member can become highly skilled if they do the same tasks repetitively

It proves particularly useful when workers have limited knowledge and experience, facilities and equipment and there is a shortage of staff.

However, there are some disadvantages. These include:

- The nurse tends to lose close contact with patients.
- Fragmentation of care rather than total care. This means that the patient's needs may be overlooked because of failure to fit in compartments or task categories, for example, there may be a nurse skilled in administering medication but none skilled in dealing with anxiety.
- Continuity of care is difficult if not impossible since no single staff member has a complete picture of the client's

needs and responses to nursing or medical interventions.

- There is little avenue for development.

Team Nursing

Team nursing was introduced in the late 1950's to improve nursing services by utilising the knowledge and skills of professional nurses and to supervise the increasing number of auxiliary staff. The philosophy supports achieving goals through group action or team spirit.

Team nursing can be organised in the following manner:

- A group or team of nurses with different levels of skills are assigned to a group of patients. The size and composition of the team is dependent upon the setting.
- The team works together to accomplish a goal.
- They focus on patient centred as opposed to task oriented assignments. These are based on patient needs and the knowledge, skills and experiences of team members.
- A member of the work group is assigned as a leader. In the original concept, the team was led by a registered nurse.
- The leadership role may be permanent or rotated.
- The team works together with each member performing the tasks for which they are best prepared.
- Team members report to the team leader who reports to the head nurse.
- Success is dependent upon effective communication.

This approach has several strengths. These include:

- It allows individual members to make personal and useful suggestions.
- It combines the best thinking of all team members about patients' problems and improves the quality of decision making.
- It cultivates team spirit, which affects the climate and continuity of care.
- There is fragmentation of care and better utilisation of personnel in the performance of quality care.
- There is also the potential for leadership development and it encourages greater staff satisfaction due to increased

guidance and better matching of assignments to skills.

As an individualised care approach, it is often more satisfying to patients. The patients are cared for by a limited number of nurses who know them better. This provides an opportunity for more therapeutic and enhanced nurse-patient relationships.

However, there are also weaknesses associated with this approach. These include:

- It may be difficult to find the time needed for team planning and conferences. This would mean that at times, care plans are not comprehensive enough.
- The time spent in coordinating delegated work and supervision can prove expensive.
- Logistics may hamper team nursing, for example, four or five nurses converging at a medicine cupboard designed to support one nurse

Primary Nursing

This is a newer approach to the delivery of nursing services.

The concept was developed in the early 1970s and is used by many institutions in the developed world. People are becoming more aware of it in this country and some institutions have begun to incorporate it.

The following is the basis for assignment:

- A professional nurse, usually a registered nurse, is assigned to a patient for their total hospital stay or to a small group of patients, not more than four or five.
- This nurse assumes responsibility for twenty-four hours a day for the duration of the patient's stay in hospital.
- The primary nurse assesses plans and executes the plan or may delegate to a secondary or associate nurse to execute the plan during her absence.
- Every nurse serves as the primary nurse for a few patients and as an associate nurse for other patients on other shifts.
- The primary nurse communicates with the physician and coordinates care with other health workers.
- The chief nurse functions as a coordinator of the unit and is a resource person for the primary nurses.

This system has the following advantages:

- It encourages a one-to-one relationship and in so doing promotes total patient care by virtue of the quality of interaction.
- The nurse coordinates all aspects of care, including the physical, social and psychological, which ensures the continuity of care.
- This method promotes increased autonomy and responsibility leading to job satisfaction due to involvement.
- Clients are satisfied as a result of their increased interaction with one nurse who is knowledgeable.

However, there are also several disadvantages associated with this method. These include:

- It limits professional mobility. An associate nurse may find it difficult to follow plans made by another nurse.
- It requires high levels of expertise and commitment from all nurses, that is, patient care may suffer if the nurse is not competent enough to perform all the tasks assigned.
- Primary nursing requires competent practitioners who can function independently when utilising the nursing process. However, not all nurses are comfortable in accepting this responsibility.
- It may be less economical than the other methods since it may require a larger percentage of registered nurses.

Legal and Ethical Issues In Nursing

You have examined the different types of health care organisations and the responsibilities of the nurse manager in the management of nursing services within these organisations. As the manager works and supervises the work of employees, they must be knowledgeable and conversant with the laws and ethics that govern nursing practice.

In module one, you covered legal and ethical issues in nursing. In this section, you will examine the role of the manager in this area. The manager has a responsibility to apply legal and ethical principles in their work and monitor the practice of employees under their supervision.

Legal Issues

The legal responsibility refers to the obligation upon nurses to obey the law in professional activities. The professional nurse should understand their legal responsibility when taking care of patients and be aware of their limitations. Patients have a right to expect professionals to live up to certain safety standards and to demonstrate responsibility and accountability.

The scope of nursing practice is defined and guided by the nursing practice act and the common law. The nursing practice act provides legal regulation for licensure, while common law is derived from legal doctrine and consists of both broad and comprehensive principles based on justice, reason and common sense. The two are responsible for educational and examination requirements, providing licensing for those who meet professional requirements and defining the functions of each category, for example, registered nurse or enrolled nurse.

Nursing practice should not leave room for negligence or malpractice because this can lead to litigation. Litigation is being taken to a court of law by a patient who makes a claim for damages or compensation.

Ethical Issues

Ethics have always been an integral part of nursing. Throughout your nursing practice you have applied the nursing code of ethics. The ethics provide the standards for professional behaviour in terms of what is expected of

nurses. They are based on the principles of what is right or wrong. The nurses' code of ethics serves as a self regulatory mechanism and a source of guidelines for individual behaviour and responsibility.

As mentioned earlier, the nurse manager plays a significant role to ensure that the law and ethics are applied appropriately in nursing practice. The following are some of the roles and functions expected of them:

- Serves as a role model by providing care that meets and exceeds accepted standard of care.
- Ensures that their conduct is as per the nursing code of ethics.
- Makes sure that their staff confine themselves to the scope of nursing practice according to registration, licensure and enrolment.
- Delegates to subordinates wisely.
- Provides educational and training opportunities for staff on legal issues.
- Is aware and makes staff aware about their own values and basic beliefs about the rights of human beings.
- Advocates for clients, subordinates and the profession.

UNIT FIVE: TEACHING AND LEARNING METHODOLOGIES

You have come to the last unit of your course. This unit is designed to help you and other health professionals to become effective teachers who will facilitate learning for their students and patients. In order for you to achieve the goals of this unit, you will need to continue to interact with supervisors, junior staff, students and patients. You will need to read widely and consult when in doubt.

This unit is composed of six sections:

Section One: Historical Background, Trends in and Principles of Education in Kenya.

Section Two: Teaching and Learning Processes in the Health Professions.

Section Three: Teaching and Learning Methodologies.

Section Four: Curriculum Design and Development.

Section Five: Instructional Media and Teaching Aids.

Section Six: Evaluation of Student Performance.

Unit Objectives

By the end of this unit you will be able to:

- Outline the historical background and trends of education in Kenya
- Describe the principles of teaching and learning
- Explain the teaching and learning process including the traditional and innovative process
- Describe and apply various teaching and learning methods
- Explain the process and components of curriculum development
- Select and apply appropriate instructional media and teaching aids
- Evaluate learners using appropriate student performance assessment methods

You will start with the historical background of education and look at a brief overview of prevailing trends in education and their influence on nursing education in Kenya. Next, you will go

through an introduction to the principles of teaching and learning.

Section two focuses on the teaching and learning processes in the health professions while section three highlights various teaching and learning methods and how to apply them. In section four you will focus on curriculum design and development and in section five you will cover instructional media and teaching aids. Finally, in section six you will look at the process of evaluating student performance.

SECTION 1: HISTORICAL BACKGROUND, TRENDS IN AND PRINCIPLES OF EDUCATION IN KENYA

Introduction

Welcome to section one of this unit, which will deal with the historical background, trends in and principles of education in Kenya.

Objectives

By the end of this section you will be able to:

- Outline the historical background of education in Kenya
- Outline the influence of educational trends on nursing education
- Define learning
- Outline the general principles of learning
- List the principles and conditions for adult learning
- Explain the basis for the three groups of theories of learning
- Explain the principles of teaching
- Relate the principles of teaching to learning

The History of Education in Kenya

What do you know about the history of education in Kenya?

Education is as old as mankind and learning takes place in various ways. Individuals are at

different levels of learning at any given time and education influences the way people behave in different circumstances.

It is important for you to know the level of the learners' education so as to be able to select an appropriate teaching strategy.

Education has developed steadily since independence with specific commissions looking at education systems periodically and making recommendations for approval. These are the commissions that recommend changes in the education systems that you see today, like the 8-4-4 system and university education for nurses.

Before the coming of the Europeans to Kenya, most learning took place through the oral narration of events passed down from older generations. Formal learning in schools, including reading and writing, came with the arrival of the Europeans, especially the British, who also introduced the English language. Education was seen as a vehicle for development. Many African learners began to take formal education seriously and many children went to school to be able to learn and communicate effectively.

At independence, the need for educated Kenyans to take over from the colonial authorities became urgent. To provide direction, specific commissions were set up to investigate ways of improving education to fight ignorance, disease and poverty (Ominde Report: 1964). Several other reports were compiled including the Appleton (1995), Angwenyi (1995), and Lloyd and Blane (1996) reports.

There are generally more boys than girls accessing education in Kenya. The government has made concerted efforts to increase enrolment of girls in both primary and secondary schools. The restructuring of secondary schools is highlighted in a number of reports, including those by Mackay (1981), Mungai (1987) and Koech (1999). These reports are available for further reading in your library. Various commissions have also been set up to look into educational matters in relation to the government's vision for the country's socio-economic development.

Influence of Educational Trends on the Development of Nursing Education

Before independence, many people went to traditional healers and herbalists for treatment. The colonialists, through the Imperial British East Africa Company (IBEAC), from 1895-1901 were involved in the creation of a medical

department. This department was meant to oversee the health care of the members of the colonial community, but eventually spread to encompass colonial employees and members of the wider community.

Influence of Educational Trends on the Development of Nursing Education **How have various education trends affected nursing education in Kenya?**

In 1927, a form of 'on the job training' in nursing for Africans was put in place. Trainees were taught reading, writing, arithmetic and hygiene (Ndirangu: 1992). Formal training of dressers started in 1929. Following this, several systems emerged. These included:

- Nursing Council Ordinance (1949)
- Kenya Registered Nursing (1952)
- Kenya Enrolled Nursing (1959)
- Kenya Registered Midwives (1965) in Ngara
- The current Kenya Medical Training College in Nairobi

Following the implementation of these courses, the government realised the need to develop a comprehensive and multipurpose nursing programme in order to address primary health care issues. This occurred long before the Alma Ata Declaration of Primary Healthcare in 1978.

Several qualification courses emerged. These included the Kenya Enrolled Community Health Nurse (1966) and the Diploma in Advanced Nursing at Nairobi University (1968). The latter was the government's response to the need for skilled manpower in nursing to take over senior administrative positions after the colonialists had left (Musandu: 1989). Other courses included:

- Kenya Registered Community Health Nurse (1987).
- Bachelor of Science in Nursing at Baraton University (1987).
- Bachelor of Science in Nursing at the University of Nairobi (1992).
- Bachelor of Science in Nursing at Moi University (1998).
- Masters in Medical Education at the Kenya Medical Training College (KMTC), Nairobi (1999) in conjunction with Dundee University.

Dundee University and KMTC prepare nurses in Bachelors and Masters Degrees in nursing through distance learning.

These changes and developments in nursing education were brought by the improving trends

of basic education, particularly for women in the country. Finally, continuing education enables health workers to keep abreast of the advancing technology and the thinking or expectations of people and communities.

Conversion courses for ECN/EN/EM to registered level have gone on for many years. With the increase in demand, it was deemed necessary to establish distance learning programmes to enable more people to continue their education while still providing services to their patients.

Principles of Learning and Teaching

To begin with, write down your own definition of the term 'learning' then click the link below to compare your answer. Subsequently, think of an example from your work experience, which shows that learning has taken place and click the link below to see an example.

Compare Answer

Learning is a process resulting in some modification in the way of thinking, feeling or doing by the learner.

Learning can also be defined as 'a process of acquiring new habits, knowledge and skills which enable students to do something that they could not do before' (Cox and Ewan, 1998)

Example

At a Maternal and Child Health (MCH) clinic, mothers are taught the importance of immunisation. One mother had previously ignored this advice and lost a number of children due to measles, a preventable disease. She shared her loss with a nurse who encouraged her to attend a child welfare clinic regularly for advice on the care of her baby. A few years later, she was a proud mother of a five-year old enrolled in the preprimary unit. She was now in the frontline, advising others to get their children immunised.

In the example given, lack of knowledge regarding principles of education led to the problems cited in the case.

Learning can take place following positive or negative experiences.

What are principles?

Principles are rules, laws, truth or facts about something. Principles arise as a result of

repeated experience, leading to a deeper understanding of ideas on the processes of teaching and learning. These situations and experiences have tested certain theories in the learning environment.

These theories, in turn, have an influence on the development of principles. These hypotheses or theories explain why and how people learn or don't learn.

What principles of learning do you know?

There are four ingredients of particular importance in a learning situation. These include motivation, information, practice and feedback. These ingredients act as a lubricant for learning. It has also been pointed out that students learn using the following principles of learning:

- Students learn what is relevant and useful.
- Students learn when the material is presented in a logical, sequential order.
- Students learn when they are actively involved.
- Students learn when they receive feedback on their performance.

Model for the Process of Learning and Functions of Teaching



Characteristics of Learning

Several important characteristics of learning can be observed in a teaching and learning situation. These revolve around a situation that:

- Produces a behaviour change in the learner.

- Leads to change that is gradual, adaptable and selective.
- Results from repetitive practice and experience.
- Is not directly observable, it is abstract.

This means that there are activities the learner must do in order to learn. For example, learners listen to somebody or to a sound. They talk to each other, observe activities, watch a practical example, perform under instructions and are able to repeat an action following a demonstration.

Other important characteristics, also referred to as conditions for learning include the following three as outlined below.

Feedback and Evaluation

Learning is a consequence of experience from repetitive acts. People need to be able to check what they are learning, try it out for themselves and correct mistakes. This is related to motivation and it produces a sense of satisfaction from the lesson when the learner realises that they can also perform.

Practice and Repetition

Learning evolves from competence through repetition. This applies both to skills and knowledge. Learning is something that people do or participate in doing. As the saying goes, 'practice makes perfect'.

Systematic Approach

Learning is easier if it is organised systematically. It should start from the known to the unknown. As you teach, you should relate the new information to the old information that the learner already knows.

The more the learner participates and feels involved, the more they learn. When learners cooperate and collaborate, they learn better and can help others to learn.

Principles and Conditions for Adult Learning (Andragogy)

Adults learn differently from children. The art of helping adults to learn is called andragogy while the art of helping children to learn is referred to as pedagogy.

Which principles of adult learning can you list?

Principles and conditions for effective adult learning include:

- Individual pace.
- Active learning.
- Integrated learning.
- Cumulative learning.
- Learning for understanding and application of knowledge.
- Relevant and useful learning.
- Interest for learning.
- Progression in learning.
- Open minded, reflective and critical learning.
- Respect for teachers and students.

The Basis and Foundation of the Theories of Learning

There are three main schools of thought in the theory of learning.

Cognitive Theories

These theories originated from a group of scholars who studied the ways in which knowledge is acquired, stored, correlated and retrieved. Cognitive theorists believe that knowing is a mental process that results in one being aware of a situation or project. You will now look at several of these theorists in turn.

B. S. Bloom

He proposed three domains of learning. These were:

- Affective domain, that is, concerned with attitudes.
- Cognitive domain, that is, concerned with knowledge.
- Psychomotor domain, that is, concerned with muscular and mental activities.

According to Bloom, there are levels of learning that a learner must go through, starting from the basic existing knowledge to the highest level possible, that is, from simple to complex. The teacher should cater for the relevant levels of the learner. Learning skills involve a certain amount of knowledge and appropriate attitudes for their proper performance.

D.P. Ausubel

Ausubel emphasised that learning should start from the known to the unknown and from simple to complex. He noted that new information fits into existing knowledge like a key fits into a lock. For example, a child is taught how to cook ugali after learning how to make uji. The initial steps of this process include lighting a fire, measuring an amount of water in a cooking pot and bringing it to boil. This is followed by mixing an amount of flour into a thin paste, adding it to the boiling water and then stirring for a specified time until the uji is ready. In the case of ugali, the process starts in the same way, except that the flour is put directly into the boiling water and stirred constantly into a thick paste. Thus, once the child knows how to prepare uji, they will not need to learn the initial stages of how to bring the water to a boil, but will only need to learn what is different in the preparation of ugali, that is, that the flour is stirred in directly in the boiling water.

J. Bruner

Bruner recommended discovery learning. The teacher provides problems for the learners to solve on their own and the resources with which they must do so. The learner must have adequate information about the resources, that is, their functions and use.

This is an innovative approach that reminds the learner they can learn if they want to, and that in problem solving, there are many ways to approach a situation.

What observations would you make from the scenario below?

'Catering students are given vegetables to chop up and a sharp knife. They are in a hurry and cut themselves with the knives. The next time they are given the same task and the same knives, they use them carefully and complete the task without cutting themselves'.

Some observations include:

- The learner is challenged to discover things for themselves
- The learner uses known knowledge to create new knowledge
- Getting the right solution motivates the learner

- The learner will be able to tackle issues for themselves

Behaviourist Theories

Some of the main behaviourists of the 1920s included Thorndike, who looked at learning objectives to direct goal, Pavlov who studied the conditioning reflex, punishment and reinforcement and Watson who was interested in active participation, that is, learning by practice. You will now look at several other theorists in more detail.

B.F. Skinner

According to Skinner's theory, it is possible to increase the probability that learning will occur and behaviour will be shaped in the direction the teacher wants, if the behaviour is rewarded. In order to maintain the strength of that behaviour, reinforcement by continued rewards is necessary. To be effective, the reinforcement must be immediate, and should be positive rather than aversive. Successive steps in the learning process should be as small as possible, each successful act being followed by a reward.

Skinner's research was based on a study of the behaviour of rats and pigeons. It has been mainly applied to young children and has not been very successful with adult learners. The process of programmed learning is based on this theory.

R. M. Gagne

Gagne categorised learning into different domains so that the different conditions for learning and assessment could be planned accordingly. The domains identified by Gagne are motor skills, verbal information, intellectual skills, cognitive strategies and attitudes.

Gagne's approach is a useful one as it helps in planning effective learning experiences. For example, skills cannot be imparted unless students are given the opportunity to practice under supervision and are given feedback on their performance. By identifying these areas, the teacher can plan content for knowledge, skills and attitudes and assess the learners appropriately.

Gagne insisted that skills could not be learnt unless students were given opportunities to practice under supervision. He also added that students must be given feedback on their

performance. His contributions are related to what is referred to as cognitive theory.

Example 1

Think of a patient that has not been able to utilise their limbs to perform a specific function. As the patient's condition improves, you encourage them to move that limb. Each time they make progress, you reward them with praise. The patient feels encouraged to do more next time. They gain more courage.

Example 2

When your supervisor says something nice about your action; you feel good and want to continue to perform well.

Humanistic and Social Psychologists

Carl Rogers

Rogers provided a learner-centred view of learning. His main propositions were that:

- All humans have a natural potential and desire to learn.
- Learning occurs when the student perceives relevance related to their own purposes.
- Significant learning is acquired through doing.
- Learning is more effective when the learner is responsible for choosing their direction, discovering resources and formulating problems.
- Most learning is self initiated and involves the whole person, including their feelings as well as intellect.
- Self evaluation is a basic skill that is necessary for effective mature learning.
- Learners should retain a continuing openness to change.

Rogers' approach significantly contributed to adult learning principles. The use of small groups' discussion, where the teacher is a guide and a friend, rather than leader, has become increasingly popular. It is based on Rogers' philosophy.

Abraham Maslow

Traditional teaching and learning has concentrated on force-feeding prescribed knowledge and has neglected to encourage the

development of the student as a person with a role in society. According to Maslow, education should help students to look within themselves, and from this self knowledge, develop a set of values which will guide them in their working life. Maslow emphasises the importance of learning for self enhancement rather than simply for utility. This view is relevant to adult learners who decide to continue with their education out of interest, rather than in order to gain extra degrees or qualifications. Implicit in this approach is the importance of the individual in deciding what to learn and how to learn it.

Consider the following statements and think about whether you agree or disagree with them.

- Rogers' approach has contributed immensely to adult learning. Your interest in this programme has met most of the conditions listed in the previous page.
- Maslow emphasises the importance of learning for self-enhancement rather than for a specific use. He believes one learns to fulfil specific needs.
- Adult learners decide to continue with their education out of interest rather than in order to gain qualifications. The adult therefore decides what to learn and how to learn it.
- What about yourself? Your participation in this programme affirms what Maslow is referring to.

Conditions That Make the Environment Conducive to Learning

Learning is encouraged in an atmosphere that:

- Encourages people to be active
- Emphasises the personal nature of learning
- Accepts that difference is desirable
- Recognises people's right to make mistakes
- Tolerates imperfection
- Encourages openness of mind and trust in self
- Makes the individual feel respected and accepted
- Facilitates discovery
- Puts emphasis on self evaluation and cooperation
- Permits confrontation

Did you know that a health professional learns through self learning and self discovery? You will have already learnt a lot after training, and not necessarily in class, but from your practical experiences.

Write down five conditions under which you learn best and then click the link below to compare your answer.

You learn best when:

- You know what your goal is.
- You are motivated by the relevance of these goals to your personal/professional needs.
- You work in small tutorial groups.
- You can alternate between personal study and work in a small tutorial group.
- You are in an active situation, with responsibility and a specific objective.
- You are in an enhancing environment (calm, good staff/student relations, competent teaching staff, lively atmosphere).
- You are able to work at your own pace.
- You are able to put what you have just learnt into practice (repetition).
- The learning will help you solve a problem.
- You have opportunities for formative self evaluation and critical review by others (peer criticism).
- You are exposed to different types of stimuli (visual, extended listening summary, review).
- You face the challenge of being evaluated or tested.
- You know how to inform/instruct others.
- You are able to have outside contacts (travel, conferences).

List a few descriptions or definitions of what you consider teaching to be.

Teaching is an interaction between the teacher and the learner under the teacher's supervision in order to bring about expected changes in the learner's behaviour. It is important for you to know the educational level of the learner in order to be able to select the most appropriate method and language for teaching.

Why Would You Want To Teach?

There are many reasons for wanting to teach. You may want to assist learners to:

- Acquire, retain, comprehend and be able to use knowledge.

- Understand, analyse, synthesise and evaluate.
- Achieve skills at a certain level.
- Establish habits which are helpful for their development.
- Develop certain attitudes.

Methods or Approaches used when Teaching.

There are several approaches that can be used when teaching. Generally, a teacher talks to learners. However, the teacher should also:

- Talk with learners
- Let the learners talk to each other
- Show learners how to perform certain tasks
- Allow learners to practise and supervise themselves

As you can see, the learner is kept busy or occupied under the supervision of the teacher.

Principles of Teaching

There are several principles of teaching.

Active Learning

As a teacher, you should encourage learners to actively participate during teaching and learning sessions. You can do this in many ways:

- Give students activities to perform.
- Ask questions.
- Set problems or projects.
- Give feedback. Tell learners how well they are doing. Show or tell them how they could have done better.

Clarity

Make your teaching as clear as possible. You can do this by speaking audibly, writing neatly and selecting your visual aids carefully and appropriately to convey a meaning to the learner.

Mastery

Ensure mastery by continuously assessing the learners as well as assessing them at the end of courses.

Individualise

Vary teaching methods. This allows you to take into account the individual differences of the learners.

Motivate

Motivate your learners by making sure that your teaching is interesting, relevant and rewarding to the learners.

Planning for Teaching

Planning is very important. It involves six key elements. These are:

Decision Making

In decision making, the teacher must make key choices regarding:

- What the learner should learn. This can be done by preparing learning objectives.
- The content, which should be arranged in sequence or progression. Appropriate learning activities and teaching methods should be selected.
- The amount of time to be allocated to different learning activities, assessment procedures and methods to be used.
- Identification of resources needed for teaching. Learners should be informed about the teaching plan.
- Evaluation, which should be carried out both for teaching and learning.

Communication

Communication is a major principle in both teaching and learning. If a teacher cannot communicate, learning becomes a problem. The teacher can use various methods to ensure effective communication. The teacher can:

- Explaining to and advise the learner
- Help the learners exchange ideas
- Provoke the learners to think
- Use varied teaching techniques
- Detect whether the learners understand and take appropriate measures

Resources

Adequate resources must be provided to ensure effective teaching and learning. The resources must be prepared and obtained before teaching starts. To ensure that resources are available, a teacher can:

- Request all required resources in advance.
- Prepare, select or adapt educational materials (hand outs, exercise books) for the session.
- Arrange learning experiences, especially those that provide opportunities to practice skills, for example, field visits.
- Arrange for learners' attachments and projects.
- Involve other health service personnel in teaching the learner.
- Arrange access to materials, such as libraries, audiovisual programmes and microscopes.

Counselling

Teaching and learning can be difficult for both the teacher and the learner. The teacher should provide support to the learner.

The teacher should:

- Show the learner that they care
- Listen and attempt to understand their student
- Help the learner to identify their options so as to make decisions
- Provide advice and information that helps the learner

Assessment

Teaching and learner assessments must be planned and incorporated into all teaching and learning activities. Assessments guide teachers on what should be taught next and the depth of what should be taught. The teacher can plan for assessments in many ways.

The teacher can:

- Design assessments that measure how much the learner will have learnt.
- Use the assessment to guide the learner's learning.
- Use the assessment to give feedback to the learner.
- Use the assessment to decide whether the learner is competent to provide health care.
- Encourage the learners to self assess and assess others.

Continuing Self Education

Continuing education is vital for all health professionals because of the rapid increase in knowledge as well as the rapid changes in technology that characterise the world today. Learners perceive the teacher as a resource for information, skills and advice. Therefore, you as a teacher must stay informed through self education. This means that you should know the subject matter that is to be taught and where to find relevant information. You should also know the health care delivery systems and any other relevant resources that are locally available.

The learners should be able to see you as a model for continuing learning.

Training Inventory Interpretation Sheet

The adjacent illustration shows 24 statements which you can either agree or disagree with.

You can interpret these statements on teaching and learning and classify them into three learning styles. These are:

- Dependent learning
- Collaborated learning
- Independent learning

Select a teaching style to suit the content that you are going to teach. It should be possible for a teacher to match a learner's style to a trainer's role.

In response to the aforementioned learning styles, a trainer's role may be didactic, collaborative or facilitatory. The trainer should be able to match these different styles to help the student learn.

Statements

1. A teacher helps students to learn.
2. Teaching is organising and passing on information.
3. A teacher is a person who passes on information.
4. Teaching is organising situations to enable learning.
5. Learning is acquiring information.
6. Learning is turning information into knowledge.
7. Information is the same as knowledge.
8. People learn in nearly the same way as animals.
9. People learn what interests and makes sense to them.
10. We teach to make learning easier and quicker.
11. We can only teach what we already know.
12. We teach to ensure people learn the right things.
13. We can only teach people to learn things we know.
14. People learn better if things are clearly explained.
15. People learn better if they find things out for themselves.
16. It is important to influence what people learn.
17. People learn if they see how something relates to them.
18. You can teach people even if they don't want to learn.
19. What the teacher wants to teach is as important as what the learner wants to know.
20. Theory is as important as practice.
21. We teach so that people can know things.
22. We teach so that people can do things.
23. Knowing about a thing is not always the same as being able to do it.
24. Teaching can take place without learning.

Balance Between Theory and Practice

As a teacher, you must seek to maintain a balance between theory and practice. This will help you to consider the total time available and how it is to be spent in the course. You need to give more time to learning rather than teaching. Skills are best learnt through practice. Practical sessions need more time to reinforce skill learning and application of theory to practice.

Ask yourself the following questions from time to time to chart your progress. How important is this skill to the learner? Is it too complex to be understood? Is it too complex to be mastered?

SECTION 2: TEACHING AND LEARNING PROCESSES IN THE HEALTH PROFESSIONS

Introduction

Welcome to section two of unit five. This section will deal with the teaching and learning processes in the health professions.

Objectives

At the end of this section you will be able to:

- Explain what the teaching and learning process entails.
- Distinguish between traditional and innovative teaching and learning processes.
- Describe and prepare a lesson plan.
- Explain and apply micro teaching skills.
- Explain and apply innovative teaching skills (super skills) appropriate for adult learners.

Traditional Teaching Process

What do you understand by the term 'teaching processes'?

Based on what you have learnt about the learners, the learning environment and the factors that motivate people to learn, you should be able to prepare the content of what you want your learner to know, plus the accompanying skills and attitudes. Before you begin to teach,

you will have to identify the topic and content. This topic may be identified in relation to a problem or a need you may have noted in the community following a community diagnosis. All this information is contained in the curriculum. A curriculum is developed from the broad objectives of a syllabus.

In this section, you will be introduced to the process that will enable you to select a learning experience, and to properly prepare and deliver it to your learners.

In order for you to be able to go to a classroom, a laboratory, a clinical setting or a field practical site to teach, it is necessary for you to first of all identify the exact area to be taught in a curriculum.

You should define the subject matter or the topic you will teach and the specific objectives and contents to be covered. Depending on the allotted time, you have to make a lesson plan and implement it. This is the process that an effective teacher follows.

Lesson Plan

After you identify your content and accompanying skills and attitudes, you will develop a teaching plan. This plan is also referred to as a lesson plan.

A lesson plan is a written description used in a teaching and learning situation to guide the teacher to systematically present the subject matter in a logical, interrelated and integrated way such that learning is reinforced and enhanced. Before you plan a lesson ask yourself the following questions:

- Who are your learners?
- What is the learner's entry behaviour? In other words, what is their educational level?
What is their background? How is it related to what you plan to teach?
- What shall you teach?
- What are your objectives for teaching this topic?
- Which teaching methods shall you choose?
- How best shall you motivate the learners in their own learning?
- In what activities will you engage the learners in order for them to understand the objectives and perform?
- What resources do you need?

- How shall you monitor the progress of your teaching?
- How shall you check that the lesson was a success?

Example of a Lesson Plan	
The following is an outline of a simple lesson plan	
• Topic:	HIV/AIDS
• Time:	9.00-11.00am
• Date:	10/01/06
• Venue:	Lecture Theatre II
• Teaching and Learning Method:	Lecture and Discussion
• Summary:	By students

Another example of a lesson plan can be seen in the 'Training of Trainers' (TOT) training schedule below and also by clicking [here](#) and [here](#).

Lesson Plan: Week 1-3

Date	Day	Time	Division of topic	Learning Objectives	Classroom Methods	Practical Methods	Aids
Week 1	Mon	8 - 9	Introduction to Immunisation	Name diseases which immunisation can prevent. Recognise the vaccine ampoules. Observe and describe clinic routine.	Lesson and Handout. Demonstration in class. Class handles vaccines.	Observation in the clinic followed by questions and discussion.	
	Wed	9 - 10					
	Thurs	10 -11					
		11 - 12					
Week 2	Mon	8 - 9	Storage and Maintenance of vaccines	How to complete an order form. Calculation of amount necessary.	Exercises with examples. Different exercises using different populations.	Examination of working refrigerator. Assist in clinic work.	Record book to record observations .
	Wed	9 - 10					
	Thurs	10 -11					
		11 - 12					
Week 3	Mon	8 - 9		How to maintain a kerosene fridge. Checking procedure when not in good working order. How to store vaccines in the fridge.	Diagram of model in class. Lessons on faults and repairs.	Observe methods of storage. Assist with giving vaccines.	Record book to record vaccines given.
	Wed	9 - 10					
	Thurs	10 -11					
		11 - 12					

Date	Day	Time	Division of topic	Learning Objectives	Classroom Methods	Practical Methods	Aids
Week 4	Mon	8 - 9	Giving immunisation	TEST. National immunisation schedule.	Handout to learn lesson (brief). Lesson on contradictions.	Continue practising giving immunisations in clinic.	Class test on learning of first 2 weeks.
	Wed	9 - 10					
	Thurs	10 -11					
		11 - 12					
Week 5	Mon	8 - 9	Educating mothers and community	How to communicate with mothers.	Discussion of mother's attitude found by previous clinic experience.	Practise talking with mothers in very small groups.	
	Wed	9 - 10					
	Thurs	10 -11					
		11 - 12					
Week 6	Mon	8 - 9	Assessment period	Explaining side effects to mothers. How to conduct a home visit.		Discussion on side effects seen so far in the clinic. Discussion on best approach. Role play.	Written test (brief). Practical exercises. Checklist assessment on technique
	Wed	9 - 10					
	Thurs	10 -11					
		11 - 12					

Lesson Plan: Week 4-6

Date	Day	Time	Division of topic	Learning Objectives	Classroom Methods	Practical Methods	Aids
Week 4	Mon	8 - 9	Giving immunisation	TEST. National immunisation schedule.	Handout to learn lesson (brief). Lesson on contradictions.	Continue practising giving immunisations in clinic.	Class test on learning of first 2 weeks.
	Wed	9 - 10					
	Thurs	10 -11 11 - 12					
Week 5	Mon	8 - 9	Educating mothers and community	How to communicate with mothers.	Discussion of mother's attitude found by previous clinic experience.	Practise talking with mothers in very small groups.	
	Wed	9 - 10					
	Thurs	10 -11 11 - 12					
Week 6	Mon	8 - 9	Assessment period	Explaining side effects to mothers. How to conduct a home visit.		Discussion on side effects seen so far in the clinic. Discussion on best approach. Role play.	Written test (brief). Practical exercises. Checklist assessment on technique
	Wed	9 - 10					
	Thurs	10 -11 11 - 12					

Step	Content	Activity	Time
1.	TOT characteristics of the adult learner, components of effective teaching	Overview/discussion	30 mins
2.	Effective and likeable teaching	Lecture/discussion	30 mins
3.	Traditional teaching skills. Innovative teaching and learning skills	Poster question, group work. Plenary Discussion	} 1 ½ hrs
	Traditional teaching methods. Innovative teaching methods.	Lecture, Discussion, Demonstrations	
4.	Illustrations important in all medical training - Illustrate	Poster question, group Work, illustrate, discuss. Do same, Try Attitude	} 1 hr

You should always assess your teaching during and at the end of the lesson!

Micro Teaching Skills

Effective implementation of a good lesson plan in traditional teaching processes requires the teacher to apply special skills known as micro teaching skills.

This is done by developing specific teaching skills within a small group of students as the audience in a simulated situation, instead of suddenly being faced with a large number of students, which can be threatening.

Micro teaching involves self assessment and recognition of one's weaknesses and strengths. When used with peers, they act as both learners and evaluators of the teacher's performance.

In all institutions of higher learning, there are six teaching skills commonly taught. They are referred to as micro teaching skills.

Write down what you think are the six skills on a piece of paper and click the link below to compare your answer.

Micro teaching skills consist of:

1. **Set induction**, which is the skill of appropriately introducing a topic or starting a lesson and capturing the learner's attention.
2. **Stimulus variation**, that is, the skill of varying focus movements, speech and content delivery to retain the learner's attention.
3. **Reinforcement**, which is the technique of rewarding students to promote good behaviour and attention.
4. **Questioning**, that is, the technique of using questions to promote interaction with learners to hold their attention.
5. **Use of examples and explanations** that promote learning.
6. **Closure**, that is, helping learners achieve 'mental' closure of a learning session in ways that help them to remember what they learn, for example, by encouraging students to summarise what they have learnt.

Innovative Teaching Processes

In traditional teaching and learning processes, the emphasis is on the teacher and how they facilitate learning for the students. In the innovative educational processes, the burden of learning shifts to the learner. The teacher is transformed into a facilitator.

What is innovative education and how do innovative processes differ from traditional teaching and learning approaches?

In the innovative teaching and learning process, the teacher, like in the traditional process, must identify the area to be taught, define the subject and topic as well as the objectives and content to be learnt from a curriculum. These aspects of the teaching and learning process are inescapable for all teachers.

Problem Based Learning

Problem-based learning (PBL) is a curriculum development and delivery system that recognises the need to develop problem solving skills as well as the necessity of helping students to acquire necessary knowledge and skills (Stephen et al 1993).

For innovative teaching learning methods such as Problem Based Learning (PBL), the teacher must, therefore, develop tutorial problems which will be used to guide the achievement of the objectives as stated in the curriculum. The teacher will also produce a booklet, which contains those problems, as they will be used in teaching the course. In addition, the teacher will also develop a tutor guide to be used by the facilitator of the course, which must contain the solutions and useful tips for guiding the learner. Innovative learning processes are best described after the tutorial booklet and tutor guides have been developed. After these have been developed, a tutor can then provide a copy of the booklet to each student and have a copy of the booklet and tutor guide for themselves.

Innovative processes are, therefore, more difficult during preparation but easier during tutorials and actual course delivery. Once in the tutorial room, the tutor can follow any one of the following processes to conduct the tutorial with the students.

The Three Step PBL Tutorial (ABC) Process

In the three step PBL tutorial process, students have to go through the following three steps with the guidance of a tutor.

Tutorial 1

Read through the problem, define terms, clarify concept, analyse problem and set learning objectives. Solve any problem (if possible at this point), for example, on a Monday. Students identify their own learning objectives (SOLO).

Self Directed Learning (SDL)

Self Directed Learning (SDL) means that the students study and look for information on their own. They may do this on Tuesday, Wednesday and Thursday in preparation for the tutorial session on Friday.

Tutorial 2

This is the second tutorial during which students do the presentation of gathered information, solution of problems and synthesis. This might, for example, take place on a Friday.

The Seven Step PBL Tutorial Process

In the seven steps PBL tutorial process, students follow these steps.

Step One

Clarify terms and concepts not readily comprehensible

Step Two

Define the problem

Step Three

Analyse the problem

Step Four

Draw a systematic inventory of the explanations inferred in step three

Step Five

Formulate learning objectives

Step Six

Collect additional information outside the group (SDL)

Step Seven

Synthesise and test the newly acquired information

The Ten Step PBL Tutorial Process

There is also a ten step PBL process. Sometimes, it is not possible to conclude a tutorial in the three or the seven steps. In such cases, students may have to follow the ten step PBL tutorial process, which consists of the following steps:

- Step One Clarify terms and concepts not readily comprehensible
- Step Two Define the problem
- Step Three Analyse the problem
- Step Four Draw a systematic inventory of the explanations inferred in step three
- Step Five Formulate learning objectives
- Step Six Collect additional information outside the group (SDL)
- Step Seven Synthesise and test the newly acquired information
- Step Eight Draw inventory of unresolved issues in groups
- Step Nine Second self directed learning (SDL)
- Step Ten Meet again and synthesise the newly acquired information

The Fifteen Step PBL Process

The fifteen step PBL process was developed and used at the Moi University, faculty of health sciences. It is organised in the following manner:

First Tutorial

- Step 1 Group organisation : Introductions.
 : Selection of chairman.
- : Selection of scribe.
- Step 2 Reading through the problem (aloud).
- Step 3 Identifying the problem.
- Step 4 Defining the problem.
- Step 5 Raising learning issues.
- Step 6 Resolving issues based on prior knowledge.
- Step 7 Organisation of the unresolved issues.
- Step 8 Developing learning objectives from the organised, unresolved issues.

First Self Directed Learning (SDL)

- Step 9 Information gathering from all available resources.
- Step 10 Students meeting alone, under their chairman, to collate information and identify the objectives based on information that is so far not available.

Second Tutorial

- Step 11 Discussion of available information to check for

correctness and completeness.

- Step 12 Identification of objectives so far not addressed, with a view to identifying the resources from which to obtain information.

Second SDL Period

- Step 13 Information gathering on difficult objectives.
- Step 14 Final collation of information and solving of the problem (students meeting alone under their chairman).
- Step 15 Identifying areas that are difficult to understand and seeking help, for example, overview (if necessary) or seminar.

Of all these various processes, the major steps are encompassed in the three step process. This simply presents a problem to the learner, gives them time to do self directed study and enables them to discover and present their solutions. All of this is done with the help of the tutor.

Super Skills of Innovative Education

Do you remember the six micro teaching skills covered earlier in relation to traditional teaching? You will now cover modern innovative teaching and learning skills. They are commonly referred to as super skills and are most appropriate for adult learners. Super skills, which bear the acronym FAGIPW, emphasise that a tutor ought to:

Super Skills of Innovative Education



Thus, the tutor should not simply stand up and lecture their students for hours. They should enable the students to study and, during tutorials, should freely participate in the students' learning under their tutorship.

The traditional and innovative teaching and learning processes thus call for the use of different skills. An effective teacher should be aware of them.

SECTION 3: TEACHING AND LEARNING METHODOLOGIES

Introduction

Welcome to section three of unit five. This section deals with teaching and learning methods you can use to ensure effective learning for your students and patients.

Objectives

By the end of this section you will be able to:

- Describe the various teaching and learning methods.
- State the advantages and disadvantages of the teaching and learning methods.
- Explain how knowledge, skills and attitudes can be taught
- Outline clinical teaching.
- Distinguish traditional from innovative teaching and learning methods.

- Outline the changing roles of tutors and students in innovative teaching and learning methods.

Teaching and Learning Methods

What teaching learning methods do you know and when would you use them?

You looked at a few teaching and learning methods when you covered the lesson plan. This section presents some of the teaching methods commonly used, indicating some of their advantages and disadvantages to guide you in the choices you make.

Learning can be great fun, but only if the right method is applied at the right time to the right type of learner.

Varying methods of teaching can make learning fun because:

- Individuals are different and one method may be effective for one learner but not for another.
- Every task involves a number of subtasks, which are carried out differently. One teaching method may not be appropriate for all subtasks.
- A variation of teaching methods results in a variety of stimuli. This helps to sustain the attention and interest of the learner.

In this section, you will review the most commonly used teaching methods, both traditional and innovative. The amount of information given is limited to a brief overview, advantages and disadvantages.

Amri et al (1993) in 'A Guide for Training Teachers of Health Workers' provides more information.

Traditional Teaching Methods

Traditional methods include among others lectures, demonstrations, practicals, role-plays, fieldwork, clinicals, projects and small group discussions. You will look at the innovative methods later in greater detail. For now, you will start with the traditional methods.

Practicals

A practical lesson is where students perform tasks. These practicals could also be performed in their future working areas. Practical have many advantages and a few disadvantages.

Advantages

- It provides a better understanding of the lecture content
- It leads to creativity on the part of the student
- It is effective for stimulating independent thought and changing attitudes
- It is a good way of achieving a desired level of competence for the student
- It provides immediate feedback on the performance of the teacher
- It provides for the individual student to be helped by the teacher
- It provides an opportunity for development
- Interpersonal relationships between teachers and students

Disadvantages

- It is not an economical way of using manpower and resources.
- It takes time to carry out practical work.
- It needs administrative staff for preparation and maintenance of materials.
- It requires special accommodation arrangements for students, that is, closer to the area where the practical will take place.

Lecture Method

A lecture is a lesson given orally by a teacher.

Write down what you think are the advantages and disadvantages of the lecture method, then click the following links to compare your answer.

Advantages

- It is economical in the use of time
- Appropriate for large groups
- Use of a single lecture theatre
- Allows for the use of experts in delivery of content by expert

Disadvantages

- Some students may be left behind
- Poor student involvement
- Impersonal
- No respect for individual pace
- Does not help students learn how to solve problems

Field Visit

Learners are taken to the actual area where activities are taking place, for example, a factory, school, water treatment plant so that they are able to see and relate to what they have learnt on the specific topic. The field visit may include some practicals.

Advantages

- It provides the actual experience. Some things cannot be learnt in school.
- Students can observe and participate in the use of theory.
- Provides for creative and independent thought on the part of the student.
- Provides an opportunity for developing interpersonal relationships between students, teachers and field staff.
- It can help promote competence.
- Provides time for questions and discussion.
- Information comes from multiple sources.

Disadvantages

- It is not an economical way of using manpower and resources.
- It creates administrative problems in arranging programmes.
- It may confuse students because there is usually a wide gap between theory and practice.
- If it is not well supervised, learning potential may be lost and it may turn into a social event.

Demonstration

A specific learning task is performed by the teacher while students observe and learn. This method is mainly used to show learners how to perform. The demonstration should be repeated by the learners to ensure that they have understood. This method has several advantages and disadvantages.

Advantages

- It provides an economical way of using manpower and materials.
- It provides audio-visual observation of the subject.
- Students understand the subject matter better after seeing a demonstration.
- It may be a good means of teaching where resources are readily available.
- It provides a way of pacing a student's way of learning.

- It can provide a wide range of knowledge in a limited time.

Disadvantages

- It is a one-way learning process from instructor to students.
- Students are just passive observers as it may not provide for activity on the part of the students.
- It may not provide the necessary repetition depending on the individual's pace of learning.
- It has little regard for students' individual differences.
- There is no immediate feedback to the instructor on what has been learnt.
- It is relatively ineffective for achieving competence unless students are given opportunities to practise.

Individual Learning

There are several advantages and disadvantages to the process of individual learning.

Advantages

- Students can work at their own individual pace.
- Students can learn at the time and place of their choice.
- Students can request teaching whenever necessary.
- Students can omit parts they already know.
- Teachers can prepare a standardised body of information.
- The method can provide for creativity and independent thought on the part of the student.
- It can help achieve the desired competence.
- It can provide immediate feedback to the teacher.
- Students' performance does not decline with time.
- Students learn how to express themselves clearly.

Disadvantages

- It is an uneconomical way of using resources.
- The programmed materials have to be maintained.
- It needs administrative staff.

- Information usually comes from a single source and may lead to a one way learning process.
- No teamwork and interpersonal relationships between students.
- It takes time to prepare materials for individual learning.
- It has no regard for the students' individual differences.

Seminar or Workshop

A seminar is a session headed by a teacher, a trained senior student or an enthusiastic student from the class, where an assigned subject is discussed. The subject has to be prepared beforehand and presented by the student. The other students will then discuss, criticise and comment on the material presented. The teacher should be available to be consulted by the group. This is important as the students may need to confirm factual information with the teacher.

Advantages

- It promotes interpersonal relationships between students.
- Students can learn a lot from each other.
- It allows for teamwork and personal flexibility.
- Teachers can encourage full participation by all students.
- It provides creativity and independent thought on the part of students.
- It provides immediate feedback of knowledge gained.
- It facilitates exchange of ideas.
- It trains students to work independently in preparing papers for presentation.
- It provides greater control of communication between students and teachers.

Disadvantages

- It is not an economical way of using manpower unless senior students act as supervisors and teachers are only called in as consultants.
- It is too slow to cover more than a limited amount of subject matter.
- It may suffer from interruptions.
- It cannot provide the repetition necessary for individual needs.

Tutorial

A tutorial is a discussion session between a teacher and a small number of students. The smaller the number of students, the more effective the tutorial is. The number of students in a tutorial should not be more than eight. However, the best teacher to student ratio is 1:1. A tutorial must not be a mini-lecture given by the teacher. The teacher should talk as little as possible and encourage the students to think and learn independently.

Advantages

- Communication of knowledge is two-way between teacher and students.
- It provides personal contact between students and teachers and provides activity for the student.
- Teachers can give full attention to individual differences between students.
- It provides an opportunity for detailed discussion of students' work.
- It provides immediate feedback for both teacher and student.
- It encourages the creativity of the learner, including the application of the knowledge and problem solving.
- The learner tends to regard knowledge as an open system. It is relatively effective in changing attitudes.
- It provides a better understanding of the lectures.

Disadvantages

- It is not an economical way of using manpower
- It moves too slowly and covers only limited subject matter
- Students need to do some work on the subject beforehand
- It cannot provide the repetition necessary depending on the individual
- The instructor or an active student may dominate it
- It is liable to interruptions

Project

A project is an assignment given to an individual learner, a pair of learners or a group of learners in which they carry out a piece of independent work on a particular topic. The learners have to organise the assignment and prepare a written report to submit to the teacher. A project may be relatively simple, for example, to be carried out within a week, or it may be

more complex, for example, to be carried out over a period of several months or even a year.

Advantages

- It provides activities and calls for creativity on the part of the student.
- It encourages initiative in the student.
- It encourages learners to be independent.
- Learners can work at their own pace.
- It may provide opportunities for interpersonal relationships between learners and people from other departments.
- The results of a project provide feedback of students' progress to the teacher.

Disadvantages

- It takes time to carry out a project.
- Learners may find that the project adds too much to their workload.
- It creates administrative problems in arranging programmes.
- Unless sufficient time is allowed, the learners may produce a superficial report.

Small Group Discussion

Small group discussion is an appropriate technique for encouraging learners to analyse, synthesise and evaluate the knowledge that they acquire (higher order cognitive skills). For example, they may choose to look into the causes of a disease or a custom practised within a community. A group discussion can be instructor-centred or learner-centred (Refer to the unit on Community Diagnosis for Focus Group Discussion).

Advantages

- Allows sharing of resources within the group, that is, there is shared commitment to learning. Learners help each other with difficult points.
- Provides learners with opportunities to interact with the instructor and fellow learners.
- Learners learn to evaluate the logic of and the evidence for their own and other's positions, that is, learning is through self expression and intercommunication.
- Allows learners to become active participants in the learning process rather than passive recipients of information from one source. The work motivates students to learn more.

- Provides an opportunity for the synthesis of varied experiences and data derived from lectures, laboratories, clinics and readings. The student grasps the idea of self learning without fear of failure.

Disadvantages

- Dominance of vocal and aggressive members over others in a group may hinder equal growth of all members in the learning process.
- A group discussion does not guarantee that an objective will be accomplished within a fixed time.
- The members of the group must bring to the discussion a body of information that is sufficiently broad and deep.
- Lack of planning by the group leader or the group itself concerning the agenda and specific learning objectives.
- As the size of the group increases, the efficiency and effectiveness of the method will decrease.

Simulation

This instruction method is used to enable learners to develop skills in dealing with 'real life' situations and 'problems' in a classroom setting. The use of a skills lab such as the one at the Kenya Medical Training College and the practical rooms in other centres are examples. You will have gone through objective-structured practical examination during your training and will agree that it is better to make mistakes in these practical simulations than in the real setting with real patients.

There are two methods of simulation - the simulation game and simulators.

Simulation Game

- a) Take a written case history. Set multiple choice questions for the learner to answer after reading or listening to the case history.
- b) Present a recording of chest sounds for the learner to listen to. Ask the learner to report on what they heard. Compare this with the official report.

Simulators

Simulators are operational models such as the obstetrical phantom or model for first aid teaching. They present real life situations and allow the learner to interact by practising skills relevant to the situation.

Advantages

- Simulation can create the link between the training situation and the real life situation. The more similar the stimuli in the situations, the more positive transfer there is from one to the other.
- Simulations provide a responsive environment. There is always some immediate feedback.
- Simulation is a relatively cheap method and often provides experience in a low cost model for a high cost environment.
- Simulation can minimise time. Problems of real life can be programmed in advance and dealt with over a variable length of time. The opportunity to confront real problems in hypothetical settings means subsequent problems cause less alarm, greater confidence, and less harm to all involved.
- Simulation allows learners to make their first serious mistakes in a simulated situation rather than in a real one.

Disadvantages

- Simulation techniques cannot simulate all dimensions of a real life situation.
- The planning and development time required for a simulation technique may prove to be costly.

The usefulness of simulation depends on its accuracy or true reflection of reality.

Rationale for Choosing Teaching and Learning Methods

Guideposts to Choosing an Appropriate Method

There are few guideposts to choosing an appropriate method. Usually, the choice is primarily based on the lesson objectives. The objective is what you want your learner to be able to do at the end of the session.

For example, you may want the learner to be able to:

1. List the steps in taking a patient's blood pressure.
2. Take a blood pressure reading
3. Share a health message with a patient, for example, explain to a pregnant woman her dietary requirements.

The skills involved in the three examples are all different.

The next step in choosing a teaching and learning method is to consider its practicality.

How much time does it require?

Where will the teaching take place?

How many learners are involved?

At what level are the learners?

Finally, you should gather the resources required to deliver the lesson. Whatever method you choose, keep in mind that effective learning should always be fun. By gathering resources in advance, you will be sure that your simulators are functioning well and can be manipulated to suit the learning environment.

Teaching Skills

There are different types of teaching skills. Cognitive skills refer to knowledge application, while thinking skills, refer to the ability to make decisions, choose appropriate alternatives and exercise caution. Finally, psychomotor skills relate to the use of the hands, the ability to do things or perform procedures.

There are several methods used for teaching skills. These include:

- Describing the skill.
- Explaining the reason and stages in performing it.
- Demonstrating the skill.
- Performing the skill correctly with an explanation of what you, as the expert, are doing.

When teaching skills, practice is essential!

Encourage the learner to practise the skill through projects, simulations, job experience, fieldwork, workshops, laboratory case studies, ward rotation and apprenticeship.

Innovative Teaching and Learning Methods

What innovative teaching and learning methods do you know?

All of the methods discussed in the previous section fall in the category of what are referred to as traditional teaching methods. Some of these methods, however, have been improved in implementation to be referred to as modern or innovative methods. These include:

- Problem Based Learning (PBL).
- Self Directed Learning (SDL).
- Small Group Tutorial (SGT).
- Community Based Education and Service (COBES).
- Computer Aided Education (CAE).
- Student-centred, Problem-Based, Integrated, Community-Oriented, Electives and Systematic (SPICES).

Of all the innovative methods mentioned, the best known is probably PBL. In this method, instead of hours of lectures and demonstrations by the teacher, a problem is used to guide student learning using the innovative teaching and learning process (steps 3, 7, 10, 15) previously outlined. All that is needed to guide learning is a tutorial problem. Students then follow the steps as guided by their tutor and achieve the intended learning outcomes.

Tutorial Problem

What does a 'problem' in PBL mean?

A problem may mean any of the following:

- A problem that is clinical, theoretical, research based or related to real life.
- An idea.
- A situation.
- An event.
- An outbreak of disease or disaster.
- A newspaper cutting.
- A list of objectives.

Innovative methods are often used in combination with other methods to facilitate student learning. The SPICES method, which is also a curriculum development strategy, has several characteristics that distinguish it from traditional teaching and learning methods as illustrated in the following table.

Characteristics of the SPICES Method	
'SPICES' Approach Vs	Traditional Approach
Student centred	Teacher centred
Problem based	Information gathering
Integrated	Discipline based
Community oriented	Hospital based
Electives	Standard programme
Systematic	Apprenticeship based or opportunistic

The main advantage of the innovative methods is that the responsibility for learning is placed on

the learner's shoulders. In the process of learning, the learner develops many skills, which gradually transform them into an independent learner. The learning skills they develop include:

- Problem solving skills
- Communication skills
- Clinical reasoning skills
- Self directed learning skills
- Emotional/social support skills
- Thinking skills
- Team work
- Continuing education skills

The only disadvantages of innovative educational methods are their resource-intensive nature and the need to have many tutorial rooms to accommodate the small groups of students instead of the traditional huge lecture hall.

Teaching Attitudes

Can attitudes be taught?

Attitudes are rather vague things and are hard to define or explain. They are influenced by one's values and feelings. Despite these problems, you have to try to teach your learners how to acquire the right attitudes to enable them to assist and care for patients.

An attitude is a tendency to behave or think in a certain way, for example, having respect for ideas that other people have. Certain attitudes are formed or changed during training. Attitudes can be taught by providing information to shape ideas through lectures, films, stories, providing live examples and so on. In the latter, the teacher acts as a model by letting the learner take part in a role-play.

List five words that describe feelings/values then click the following link to compare your answer.

- Kindness
- Willingness
- Accuracy
- Empathy
- Dedication
- Honesty
- Patience
- Respectfulness
- Gentleness

There are several ways in which you can provide experiences for learners to develop the right attitudes. For example, seeing a patient suffering from a particular disease touches the feelings of the learner, who may feel sorry for the patient, and may later internalise the

situation by imagining themselves in a similar situation. The learner makes a resolution to avoid such a situation and learns how to advise and react towards such patients with empathy.

You can also organise small group discussions with seven to twelve participants with specific objectives. You can also provide role-play exercises where learners act the part of different people or patients to reveal some of the feelings involved.

In summary, you can best teach attitudes by providing:

- Information to shape attitudes, for example, facts about AIDS.
- Examples or models to shape attitudes (advertising goal).
- Experience to shape attitudes, for example, opportunities to work in a hospital.
- Discussion to shape attitude, for instance, by sharing your own opinions.
- Role plays, for example, playing the role of doctor, nurse or patient.

The Role of the Tutor in the PBL Process

List down the roles of the tutor in PBL then click the following links to compare your answers.

In the innovative teaching and learning processes, the tutor plays even more roles than the teachers in the traditional teaching methods.

These roles include having to:

- Establish rapport.
- Explain goals, objectives and functions.
- Explain procedures and roles of students and tutor in PBL.
- Focus attention.
- Keep the ball rolling.
- Encourage active participation. Referring back questions, comments, suggestions to group.
- Intervene in conflict situations.
- Reinforce group discussions.
- Control the group.
- Distribute and redirect questions.
- Probe further, if necessary.
- Encourage analysis, synthesis and evaluation of problem (data).
- Encourage students to develop qualities of individuals in group.

More roles

- Intervene to keep the group and the discussion on track and stimulate thinking by encouraging hypothesising.
- Maintain continuity and focus.
- Encourage students to review and redefine explanations.
- Encourage students to make connections, that is, link concepts and principals with processes and so on.
- Encourage evaluation of achievements.
- Encourage students to summarise discussions.
- Encourage students to act as a change agent in the group.
- Give solutions.
- Process helper.
- Resource linker.
- Catalyst.
- Encourage group interaction, reinforcements and agreement.
- Act as gate keeper.
- Assist students to go through the process of PBL.
- Assist students to understand their abilities and limitations.

The Role of the Student in the PBL Process

The student in the PBL process plays more roles than the student in the traditional teaching and learning methods. Such roles include:

- Active participation, which includes listening, contribution to the discussion and asking questions.
- Carrying out analysis, synthesis and evaluation of the whole learning process.
- Making connections, linking concepts and applying principles.
- Reviewing and redefining explanations.
- Evaluating achievements.
- Summarising at various stages.
- Acting as a change agent, that is, as a solution giver, process helper, resource linker and catalyst.

Clinical Teaching

How would you describe clinical teaching?

Clinical teaching is teaching in the clinical or practical setting, similar to the environment within which the learner will practice in future.

What is nursing?

The answer to this question has been provided elsewhere in this module. Earlier on, you identified that your learner is going to be a nurse. Since you have already covered the methods of teaching, you will now highlight the issues that affect the quality of work (nursing) in this section.

Virginia Henderson (1958) states that 'the unique function of the nurse is to assist the individual (sick or well), in the performance of those activities contributing to health, to recovery (or to a peaceful death) that they would perform unaided if they had the necessary strength, will or knowledge.'

Essentially, nursing is nurturing people back to optimal health. It involves specific tasks or skills each of which can be split up into specific activities to complete a task. The task or skill has content, information or knowledge that explains its purpose, that is, what it is for? and how it should be done?

In clinical teaching, you want your learner to put that knowledge into action. You want your student to get involved with the patient. Involvement brings in emotions and feelings. Nursing is 'caring'. It is here that you must teach the learner to empathise. They can nurture and care without getting carried away by the effects of the illness or situation through empathising. Empathising helps the learner to get involved and yet stand apart enough to carry out the necessary professional activities.

No learning can take place until certain basic needs have been met. You need to ensure that the physical needs of the learner have been met for them to concentrate. For example, if the learner is wearing uncomfortable shoes on duty, you need to advise them of the importance of wearing comfortable shoes.

You may offer alternative solutions or refer the student to somebody who can help them directly. You may not be in a position to do much but the fact that you showed concern will move your learner. The learner also needs to feel that they belong, which is a good way to boost self-esteem. The learner needs to feel welcome. It is important that you establish a good working relationship. A warm smile and a few encouraging words will go a long way to make your student feel settled.

When the basic needs mentioned previously get fulfilled, your learner will want to learn at a higher level and exercise mastery of the skills. At this point, you should find out the relevant learning situations available in the clinical setting. Give the students the necessary support to remain successful and encourage them to look for other learning situations on their own.

While nursing, the nurse shares the triumphs, sense of achievement, and sadness of the bereaved who have lost a loved one, or the amputee, or the young with a terminal disease. Nursing is giving hope and support toward recovery or relief from discomfort, or toward a peaceful, dignified death.

Hope and support will help the patient regain confidence and self reliance.

Throughout this process, confidentiality must be maintained to enhance the trust of the patient.

As the learner carries out procedures, they need to learn how to contain personal negative feelings, for example, contempt, revulsion of unpleasant sights or aversion. Above all, the learner must learn how to maintain their integrity and the professional code of ethics and etiquette (see module one of this programme for more information). This is necessary because the student will be learning how to protect their patient from malpractice and negligence.

How do you ensure that you are providing quality nursing care?

Mastery of the theory is important because it gives you the foundation. Scientific knowledge adds appropriate technical skills and encourages you to develop the right attitudes. The result is the development of sound clinical judgment, which is the sign of an experienced nurse.

Role of a Clinical Teacher

As you plan to teach in a clinical setting, ask yourself the following questions:

- Is the learner performing safely, kindly and with confidence?
- Is the learner aware of the reason for each procedure?
- Is the patient the focus of the procedure?
- Is the demonstration enabling the learner to link with the theory covered earlier?

As a clinical teacher, you therefore should be:

- A skilled, experienced nurse concerned with the maintenance and improvement of standards of patient care.

- Concerned to help your learner to develop their potential as a nurse.
- Able to gain satisfaction from caring for patients.
- Able to gain satisfaction from teaching, especially individuals and small groups.
- Keen to create a favourable environment for learning.
- Alert to the opportunities available for facilitating learning in the clinical situation
- A model for your learner.

The theories of learning can help yet again. Revise these!

SECTION 4: CURRICULUM DESIGN AND DEVELOPMENT

Introduction

Curriculum Design and Development

Welcome to section four of this unit. This section focuses on curriculum design and development.

Objectives

By the end of this section you will be able to:

- Define a curriculum
- Describe the components of a curriculum
- Explain factors that influence curriculum development
- Describe three approaches to curriculum development
- Outline the process of curriculum development

Curriculum

What is a curriculum?

Write down what you think is the definition of a curriculum and then click the link below to compare your answer.

A curriculum is a description of all that takes place in an educational institution from the first to the last day of training. A curriculum has been likened to a racecourse and it entails all the activities and the events, which take place from the first event to the very last. A curriculum is

also the document in which all the activities, transactions and the events of a training programme are described.

A curriculum can also be defined as a programme of study.

Components of the Curriculum

The following are important components of a curriculum.

A Statement of Justification

Gives the justification/rationale and philosophy of the training programme and why the programme is required.

Resources

An outline of the physical, administrative and financial requirements for the course. It is also a description of the minimal facilities in terms of buildings, equipment and personnel.

Entry Requirements

Description of the entry requirements for the students and methods of selection.

Educational Goals and Objectives

Describes the goals and educational objectives of the course

Content

This is what will be covered in a course according to the stated objectives.

Learning Experiences

Are intended to be descriptions of the teaching and learning methods to be employed during the educational programme.

Programme

Outlines a logical sequence of events.

Duration

Specification of how long each unit or learning block should last.

Assessment

Outlines methods of continuous evaluation, final certification, remedial activities and referral of failed candidates.

Course Descriptions

Highlights the title, unit, course objectives, course content and code for each course taught in the programme.

Factors Influencing the Development of a Curriculum

There are several factors that influence curriculum development.

Academic Factors

The teachers who teach the main subjects of a discipline often borrow from their past experiences and merge them with the current trends of the discipline. For example, you now have more nurse graduates who are prepared in advanced nursing practices and you can introduce content that was not included before. Thus, theories of nursing, trends, research and so on that were only taught in higher nursing programmes at university level previously are now incorporated into your curriculum. The new content is designed to make you a more effective practitioner in the provision of quality health care.

Social Factors

What is taught has to reflect what is current within the contemporary society. This means it has to be relevant to the needs of the local people socially and culturally. For example, with the advent of AIDS, this new topic has had to be included in the content. The topic bears a lot of importance to human existence and is emphasised in all branches of health care and development.

Economic Factors

The cost of implementation of a curriculum can determine the type of health worker trained by a given country. In developing countries, staff are often trained at a lower level of education in skills that are usually taught to university graduates in highly industrialised countries. This is because in developing countries, university education adds a cost burden to the limited resources. Thus, for example, midwives in developing countries carry out life saving measures that are left for experts in industrialised countries.

Political Factors

Politicians or political investors can influence the numbers to be trained and even the level of training. For instance, the introduction of the quota system in the Kenyan basic education system was politically motivated with the aim that all ethnic groups might receive equal attention.

This, therefore, implies that an individual does not develop a curriculum.

It is a cooperative process in which many interested parties contribute.

Consultations must be made where possible from all people who might be involved in the development of your health curriculum. These are the people who, in one way or another, exert influence directly or indirectly or decide what activities should be involved, including the style of implementation of the curriculum. These people fall into two categories: internal and external participants. You will now look at the first category.

Internal Participants in Curriculum Development

Internal participants in curriculum development include individuals from professional associations, ministries of health and education, boards of examinations, administrators of the training institutions, teachers and students. This group of participants is, therefore, called internal because they are directly involved in the curriculum and so have a greater impact on its development. They develop the curriculum, teach it and evaluate the curriculum and the students.

External Participants in Curriculum Development

The external participants constitute the second category. Although are not directly involved in curriculum development, they are either beneficiaries of the product, service or provide resources to facilitate its implementation or may liase within the institution in various ways. As such, they can easily influence decisions made by the internal group. This group comprises the community, business, industry and non governmental organisations. When consulted properly, these two groups ought to produce a curriculum that enables the desired change in health care services.

Major Approaches to Curriculum

Development

There are several approaches to curriculum development.

Subject-centred Approach

This is carried out by subject specialists, who determine the subdivision of content and the methods and timing of instruction.

Integrated Approach

This approach attempts to integrate or combine in a meaningful way, disciplined knowledge to impact wholesome learning for student application.

Competency-based Approach

It aims at identifying professional competencies required and the teaching required to achieve these competencies.

These approaches, as outlined by Ngatia (Afya Journal 1986) have advantages and disadvantages. The subject-centred approach, for instance, emphasises the acquisition of disciplined knowledge rather than its application. In the integrated approach, knowledge can be wholesome and meaningful but integration can fall short of adequate vertical and horizontal integration. The competency-based approach is preferred for professional training by most curriculum developers.

Developing a Curriculum

Throughout modules one and three and particularly in units one and two of module three, you looked at the community health profile needed to identify community health needs. The steps included conducting a survey or community diagnosis to specify the community's priority needs. After data collection, the next step was to organise the information into a report to give feedback to relevant groups for a follow up health action in response to the identified needs.

Your next task is to describe what activities the graduates of the programme will perform with respect to meeting the required health needs. This should be summarised in a job description.

The next step is to determine what knowledge, attitude and skills graduates will need to acquire

to enable them perform those tasks. This is known as task analysis.

Very briefly, a curriculum, therefore, must contain the following components:

- Objectives
- Content
- Teaching methods
- Assessments
- Entry requirements
- Programme schedule

What other components would you add to the above list?

Mutema, Kangethe and Naweya (1999) outlined a simple ten-step method of developing a competency-based curriculum that has been found useful in the development of any curriculum.

The Process of Developing Competency-Based Curricula

Ten Steps to Competency-Based Curriculum Development	
Step 1	Identification of health problems or needs.
Step 2	Identification of professional roles and functions.
Step 3	Performing task analysis on professional roles and functions.
Step 4	Development of educational goals and objectives on the basis of professional functions and task analysis.
Step 5	Identification and selection of subject matter or content to be learnt.
Step 6	Identification of teaching and learning methods.
Step 7	Identification or selection of learning resources.
Step 8	Identification of assessment tools to determine learner performance.
Step 9	Curriculum implementation.
Step 10	Curriculum review and change.

SECTION 5: INSTRUCTIONAL MEDIA/ TEACHING AIDS

Introduction

Welcome to section five of this unit. This section focuses on instructional media or teaching aids, which are used to enhance learning.

Objectives

By the end of this section, you will be able to:

- Describe projected and non projected teaching aids
- Outline the major advantages and disadvantages of teaching aids
- Select appropriate teaching and learning sessions
- Take appropriate care of teaching aids

Learning from the Environment

What senses do we use to learn from our environment?

You learn more effectively if you use more than one of your senses. The more senses you use, the more effective your learning becomes. The senses are:

- Sight – visual.
- Hearing – audio.

- Smell – nasal.
- Taste – taste.
- Touch – tactile.

Modern technology enables learners to combine the use of several senses. This is achieved through the use of various types of teaching aids. There are two kinds of aids:

- Projected aids
- Non projected aids

You will now examine each one in more detail.

Projected Aids

Projected aids include:

- Overhead transparency (projector).
- Kaleidoscopes.
- Films.
- Video cassettes.
- Slides.

These are powerful tools because they bring real situations close to the student. It is important that you obtain appropriate aids. However, it should be noted that they are expensive and can be difficult to maintain. Because the overhead projector is relatively cheap and easy to maintain, it is described here in detail to encourage its use in training institutions.

The Overhead Projector

This is one of the most commonly used teaching aids.

The overhead projector (OHP) projects transparencies from a horizontal table via a prism or mirror and a lens. A bright image appears on a screen behind the teacher. The set up of the screen depends on the type of room and the size of the audience. There are two possibilities of projection. These are:

- Projection from behind.
- Projection to the side (better viewing).

When lecturing, stand to the right or left of the projector so that you can easily point out the important areas that you want the learner to grasp. You can also view what the learner is seeing simultaneously. You are advised to expose only what you are discussing and not the whole transparency so that the learners can concentrate and take down important points. In this way, the rest of the presentation will not distract learners.

There are several points you should remember when preparing transparencies:

- Do not write too near the edge or you might lose half of the image. Leave at least an inch of margin all round.
- For more complex drawings, prepare a pencil sketch then lay the transparency over the sketch and copy onto the transparency. You can also copy a diagram from a book.
- Lettering should not be too small, about 4mm (an eighth of an inch).
- A transparency should convey one theme. Put as much information as necessary but as little as possible on a transparency. Ensure clarity and impact.
- Leave room for future alterations.
- Jot down your lecture notes on the frame of the (OHP).
- Keep the content down to ten lines with ten words per line.
- When masking, use thin paper. This ensures that the lecturer sees the whole transparency but the audience only the information that has been revealed.
- Overlays - do not use more than six build-ups or brightness will be impaired.
- Store your transparencies with care. Avoid moisture and dirt.

There are several advantages of using overhead projectors.

These include:

- You are able to face the classroom and point out features appearing on the screen easily using a pointer.
- It may not be necessary to darken the room.
- You are able to project a wide variety of materials.
- Transparencies can be used as an illuminated blackboard during the lesson. Alternatively, they can be put on top of each other showing stages of development of an idea or structure.
- You can easily trace diagrams and drawings if you require them.
- You increase your learner's curiosity by using multiple colours on the transparencies both permanent and temporary depending on the pens and ink used.
- An overhead projector, therefore, has endless possibilities in the hands of a resourceful teacher and can be used at all levels of education.

- However, there are several disadvantages of using an OHP. The teacher must not stand in front of the image. The acetate sheets are expensive to obtain, but spoilt and cleaned x-ray film is a useful alternative. You should get a transparent, slightly bluish sheet that can be used in the same way as transparent acetate sheets.

Special felt pens are used for writing on the transparent sheets. If they are difficult to obtain, the glass pencils used in laboratories are a substitute. Erase with water or with spirit for semi-permanent ink.

For care and maintenance of the overhead projector and transparencies, take the following steps:

- After finishing a demonstration, do not remove the wire plug from the socket but switch off the lamp and keep the fan running until the bulb has cooled down (there is a thermostat fitted in most types of OHP).
- Keep lenses and mirrors free of dirt.
- Keep a spare bulb in stock at all times.
- Store semi permanent transparencies together with master copies of handouts in a file with the unit block or subject concerned. They can then be found easily and used again the following year.

The Liquefied Crystal Display (LCD) Projector

Another projecting aid is the LCD projector and computer. In this system, material is typed into the computer and projected onto a screen.

Non Projected Aids

Non projected aids are aids that you can find within your environment. You can select these well in advance of the lesson and pre test them before classroom use. These include the chalkboard, pictures or cartoons, flipcharts, posters, handouts and flannel boards.

The Chalkboard

The chalkboard is the most easily available, convenient and most popular teaching aid. As with all teaching aids, it requires planning in order to achieve effective learning. In planning how to use the board, ask yourself the following questions:

- Which parts of the lecture are important enough to be placed on the board?
- Which aspects of the lecture are likely to be unclear?

- Which diagrams and/or drawings can be used to explain difficult points?
- Which are the main points or steps in the lecture?
- Will the use of the chalkboard save lecture time? Do you need to use the chalkboard before the learners assemble or is it possible to use a less time consuming aid, for example, slides on the OHP?

To enhance learning while using the chalkboard, you are advised to:

- Write only the essential points and examples, like in your lesson plan outline. This helps the learner copy and fill in all other relevant information as you build up from introduction to conclusion.
- Ensure your writing is large enough to be seen by all learners. Plan the board so that information develops from one stage to the next. Remember, the board is not a scrap paper.
- Deliver the lecture to your audience and not to the board. If you have to write, lecture first, then write on the board. Stand next to the board at such an angle that you can see your learners frequently. Maintain eye contact with the class. You can make your chalkboard work more interesting for your learner by using several different techniques.

Templates

You can cut out shapes of card or plywood to outline figures, which are often needed, for example, a triangle in mathematics, oval for eggs, round for oranges and many more. These can be cut out in advance and fixed on the boards as you explain them.

Bounce Pattern

This is a thick tough paper in which a certain outline, for example, the map of a country with its regions has been punched out along the outline. Hold the paper against the blackboard and flicker a chalky duster along the perforated line. When the paper is taken away, lines of dots appear which you can join to produce the desired drawing.

Semi Permanent Line

Use soft chalk soaked in a sugar solution to draw on the board. The drawing can be wiped off with a damp cloth.

These can be in the form of slides, photographs, picture drawings, line drawings or cartoons. Good and appropriate pictures are sometimes difficult to obtain or prepare.

Hints on preparing good pictures, even for non artists, are described in Chapters 11 and 12 of 'Helping Health Workers Learn' by D. Werner and B. Bower (Hesperian Foundation).

Flipchart or Cards

You will have used these before, for example, when preparing a demonstration for a nutrition lecture in a maternal child health (normally referred to as MCH) clinic. Flipcharts or cards are cheap and easy aids to prepare. They can be made from butcher paper, old calendars, paper boxes, manila paper and so on. The pictures can be drawn by somebody else or traced from a book. The pictures should be labelled in legible handwriting. When labelling remember:

- To use thick felt pens.
- To use different colours for emphasis.
- To write in lower (small) case letters, not capitals.
- Not to write too much.

When making a presentation using flipcharts, do not read the chart as you talk. As you prepare the lesson or the materials for teaching, make notes at the back of the flipchart to guide your discussion. This way you can secretly read your notes as you teach and still face the audience.

Posters

Posters take longer to prepare than flipcharts. They may consist of words, pictures, or a mixture of both. Unlike flipcharts, posters are usually single leafed. Posters need a lot of planning and testing before use. They can be prepared for two types of viewers:

- For a mixed (heterogeneous) audience, for example, on a street for the general public.
- For a captive audience, for example, in a class.

When a poster is being prepared for a heterogeneous audience, it should deliver the message at a glance. When preparing a poster, remember to make it simple, use simple language and avoid difficult words or slang and put as little as possible on the poster.

The Real Thing or Object

The best teaching aid is 'the real thing'. For instance, it is much better to teach mothers how to wash a baby by using a real baby rather than a doll. A live baby cries and kicks whereas a doll does not. The mothers need to see and learn how to handle an active, lively, small baby kicking and splashing in water. Each mother can then do a return demonstration with their own baby as you observe and reassuringly respond to their concerns. You will agree that this is a very good example of teaching the mother/learner how to wash a baby.

Try as much as possible to use 'the real thing' in your lessons. Your first thought should be, is it possible for you to demonstrate 'the real thing' to your class in this lesson? If this is not possible, you should then think of other teaching aids that are simulations of the real thing. The closer the simulation to the real thing, the better the teaching aid is. This is an important consideration in helping the learner to internalise and later transfer the impression they get to the real thing. It also helps the learner to acquire the right attitudes and find the right expressions to use from the start.

Handouts

Can you remember asking for notes from your teacher? They are an example of a handout. Handouts are written papers given out by teachers to students. They act as guides for work to be done, or references to be looked up. They help remind students of the main points to remember from a learning experience. You should not use them as substitutes for manuals, texts and references. A handout is both a visual aid to learning and an addition to private study.

The purpose of the handout is to help you to:

- Indicate objectives of the lesson exercise. Ask yourself what is it for? Who is it for? Is it needed?
- Indicate the relevance and define the area to be covered.
- Provide additional theoretical information.
- Provide a stimulus to further thinking.
- Give instructions for practical work. The instructions should be specific and complete.

Your handout, therefore, should:

- Set out the structure of a lesson to promote attainment of the objectives

- Benefit learning
- Provide an infrastructure for the topic
- Emphasise a framework for interaction between the facilitator and learner
- Help the learner to receive detailed information
- Guarantee the accuracy of the transferred information

You should take care while designing or preparing handouts so as not to reproduce a textbook. The following guidelines are useful when preparing a handout:

- Your introduction should relate the new material to the learner's past experience.
- You need to summarise the major ideas.
- You should use major and minor headings.
- You should leave space between paragraphs and sections for learners to make notes.
- You need to simplify your expressions.
- You should label your illustrations, tables and graphs appropriately. A series of diagrams building up to a complete concept may be more helpful than one detailed diagram.
- You are advised to put questions and exercises within the text to stimulate thinking.
- Your content, language and spelling should be accurate.
- The statements should be consistent with other text or manuals which the learners use.
- Your handouts must be clear and arranged in a logical order with good arrangement of headings, words and diagrams on the page.

The Flannel Board

This is the device of choice for teaching villagers.

All rural educators should know how to use it. It is based on the fact that materials with rough surfaces tend to adhere to each other. If flannel cloth is not available, alternatives can be found. The board is put in front of the class, sloping slightly backwards. Cards with a rough surface, for example, sand paper can be placed on the board in the desired position.

The cards can be moved or taken down at will. Make cards in large print or written words, for

instance, newspaper cuttings, photographs or dissected posters.

Advantages of the Flannel Board

- It tells a story in which you can see things happen
- It has strong colours that please
- The pictures are large enough and can be seen from a distance
- The pictures are mostly things that people are familiar with
- It arouses interest and questions

Disadvantages of the Flannel Board

However, there are also several disadvantages associated with the method. These include:

- Barazas are usually too big for flannel pictures to be seen from the back.
- When flannels are used in open air, the wind may blow the flannel graphs away.
- The apparently miraculous way in which the picture sticks to the board is a distracting novelty.
- ***Even the best designed teaching aid cannot replace practical work with patients and the community.***

How do you store your teaching aids?

Good, durable teaching aids can be reused. Keep your teaching aids neatly in a resource learning kit (cupboard/store). Each item should be labelled clearly for easy access. Maintain an inventory of the various aids in stock. When you lend out items the borrower should sign for them. On their return, you should check the condition of the items first before storing them. This is to ensure that you keep readily usable items in your resource centre or cupboard

Storage of Specific Aids

Maps and charts are stored while rolled up. To avoid long searches, their titles should be written on the back and then stored in a way that they can easily be seen.

Slides are best kept in hanging files with a list of contents on the filing cabinet.

Overhead transparencies and master copies of handouts are put in a master file together with other material on that particular unit.

The master copies are numbered corresponding to the number of the stencils and stored in or near the stencil room. These are filed in either alphabetical or numerical order.

When a handout is needed, the master copy is retrieved and the handout reproduced. Handouts need to be regularly updated with current information. Models, samples and specimens can be stored in the library permanently.

How to Use Teaching Aids

The following steps will ensure that you use teaching aids appropriately:

- Select the teaching aids to suit the lesson.
- Preview the teaching aids to ensure they convey the message you want.
- Plan how and in what order you intend to use your teaching aids, you could number them in pencil.
- Present your teaching aids appropriately and give adequate explanation.
- Evaluate your teaching aids with the same class.

Selecting the Teaching Aid

As the teacher, ask yourself the following questions:

- Do you need an aid of any kind?
- Will an aid help you achieve your objective or make the lesson more effective?
- If the answer is yes, what kind of teaching aid is best suited to your purpose?
- Is the chosen aid available or does it have to be borrowed or constructed? What are the alternatives?

Previewing and Evaluating the Teaching Aids

Preview your teaching aids before use to avoid unpleasant surprises. During your preview, plan for explanations or comments you may wish to make during the presentation of the lesson. Ask yourself the following questions:

- Will the aid help achieve the objectives?
- Does the aid focus on one main idea?
- Is the aid depicting a real situation?
- Does it stimulate the imagination of the learner?

Planning

In your plan, you should:

- Introduce the subject in a stimulating and interesting way to arouse curiosity.
- Describe the main body of the lesson. This is the chief vehicle for transferring information.
- Recapitulate, that is, restate or repeat the lesson in summary to assist in consolidation of knowledge.

Having determined the role of the teaching aid, the learner's mind must be prepared to obtain the maximum benefit from the aid. Tell your learner what to look for as you explain and comment where necessary.

Presenting a Teaching Aid

Your students see you as an expert. You should check the mechanical equipment to ensure that it is in working condition. If you are working with a community on a field trip, make sure you have obtained consent from the involved persons (see Community Diagnosis module).

Evaluating the Teaching Aid

Evaluation refers to the process of looking back at what has been done to see whether the set out objectives have been met and to what extent. After presenting your teaching aid, answer the following questions:

- Was the presentation successful?
- Did the aid achieve its purpose?
- Was the objective reached?

You can find out the answers to these questions through:

- Discussion with the learner
- Asking and answering questions from the learner
- Questionnaires and assignments to be completed by the learner
- Weekly test

Having considered all these factors, you are now in a position to use the aid.

It is the aim of the lesson that should dictate the type of aid to be used.

SECTION 6: EVALUATION OF STUDENT PERFORMANCE

Introduction

Welcome to section six which is the final section of this unit.

This section deals with the sensitive issue of evaluating student performance.

You will now look at the objectives of this section.

Objectives

By the end of the section, you will be able to:

- Explain the concepts of assessment and evaluation and why these are important in learning.
- Explain the interrelationship between the four major aspects of evaluation.
- Outline how to assess knowledge, skills and attitudes using different assessment tools and methods.

The Concept of Assessment and Evaluation

What is evaluation of student performance?

Performance assessment is a measure of assessment based on authentic tasks such as activities, exercises or problems that require students to show what they can do. The results of the assessment can then be used for comparison with those of other students. This is called evaluation and it can be measured.

Evaluation involves placing a value on the learner's performance in order to make a decision about the learner and the subject that was taught. It includes examining and assessing of the learner.

Assessment refers to the process of finding to what extent the learner has achieved the set objectives. This is done through examinations which are the tool or process used to determine the learners degree of learning.

Why should you evaluate the learner?

You should evaluate the learner in order to:

- Help the learner to understand themselves.
- Help in the retention and transfer of learning.
- Motivate the learner.
- Predict the level of the learner's future performance.
- Judge the learner's achievements.

- Monitor the learner's progress for the purpose of providing feedback.
- Determine teaching effectiveness.
- License the practice of a profession.
- Identify the weak and strong areas of a course.
- Grade and rank students.
- Gauge the reputation of school performance.
- Protect society, that is, inform the community of the extent to which graduates constitute a potential danger.

There are two types of evaluations. You shall now look at each of these in detail.

Formative Evaluation

When you were a student and had to learn how to perform a certain task, you were allowed to do it in small sessions. The ward in-charge would check to see whether you were on the right track and probably comment and show you the next step to take. This is similar to formative evaluation.

Formative evaluation is progressive, that is, the learner and learning are evaluated on a continuous basis. It provides feedback on the strengths and weaknesses of the learner. It is performed frequently, that is, after small units of learning.

Why do you think formative evaluation is useful?

It gives an early diagnosis of the learner's problems during the learning process, which enables corrective measures to be taken.

There are several examples of formative evaluation. These include placement testing or pre-testing, which are conducted for the purpose of gauging to what extent the learner possesses the skills and abilities needed to begin instruction. This also helps to determine whether the student has already mastered some of the material that is set to be taught. This way, you can alter the content of the lesson.

You should place the learner at the appropriate level of the programme. At the end of a module, identify the learner's successes or failures and make the appropriate adjustments in instruction and learning. Use the placement test as a diagnostic test to identify severe learning problems.

Summative or Terminal Evaluation

Summative or terminal evaluation is usually carried out at the end of a term, course or programme for several reasons. It enables you to award grades, certificates or licenses to the student for practice and/or select learners for a further educational programme.

A good evaluation system should include both formative and summative evaluation. Formative evaluation gives diagnostic feedback to both the teacher and the learner, while summative evaluation reveals the student's ability to integrate and apply learning.

The content evaluated is selected from the entire course work covered in the term or year with samples of all learning tasks. It should include:

- Knowledge
- Skills
- Attitudes

Assessing Knowledge

Knowledge can be assessed through use of essays, short answer tests, multiple choice questions (MCQs), true or false questions, matching tasks, fill in the blanks and oral questions.

Essays are easy to set. It is important to remember to make them valid, reliable and objective. They should ask the learner to describe and analyse issues. Be very specific and describe exactly what the student should do. You should also prepare a marking scheme.

One of the main objectives of scoring is to award the correct marks for a given test, exam or evaluation. Two types of scoring are important for you to consider.

Analytical Scoring

Analyse the correct response by making out a list of crucial points, which must appear in the answer in advance. You should then compare the student's answer to these points and award marks for them. You should also consider integration, coordination and organisation when awarding marks.

Impression Scoring

In impression scoring, you should first analyse the correct responses as is the case in analytical scoring, then read the script to get an impression for adequacy. You should then transfer the impression into a grade. The papers (scripts) may be sorted out by quality, that is, 25% low, 50% middle, 25% high to form the normal educational curve.

Rules to be Observed When Marking Essays

Since you may have many scripts to mark, you need to organise yourself in order to be able to mark them fairly. The following points can help you achieve this:

- Arrange for independent marking of papers or at least a sample of them if the class is too large.
- Conceal the name of the student, that is, use numbers or letters.
- Grade answers question by question and not student by student.
- Discuss the answers with students to ensure learning, that is, provide feedback.

Multiple Choice Questions (MCQ)

These are questions where four or five answers are given and the student has to choose the correct or best answer. A typical MCQ question has three parts, namely:

- The question itself or the stem
- The correct answer
- Distracters or incorrect answers

How do you choose good questions?

There are several factors to take into consideration when choosing questions. These include:

- Questions should be simple, straightforward and should relate to what was taught.
- The question should emphasise the aspects you want to teach.
- Choose good distracters.
- Do not make incorrect answers ridiculous.
- Choose distracters from among the type of mistakes the students commonly make.
- Do not make the correct answers obvious.
- See the question below for an example of a wrong and a right answer.

To improve the health of the children in your area which of the following would be the most useful in your dispensary?

Answers:

- a. Ten more staff
- b. An ambulance
- c. Upgrading to a hospital
- d. Fridge and vaccines

Your answer would be (d) because neither (a), (b) nor (c) are possible for a dispensary. Sometimes the correct answer is obvious for other reasons. See the next example.

The best food for a young child is:

Answers:

- a. Tinned milk.
- b. Goat's milk.
- c. Cow's milk.
- d. Breast milk with extra solid food after four months.

Your answer would be (d). Here, the correct answer is much longer than the distracters and the student may choose it for that reason only. It has been made too obvious.

Using common mistakes for distracters can be very effective. Here is a good example.

A child with fever has been admitted to your health centre. He does not seem to have any infection. You have given him some chloroquine. What else should you do?

Answers:

- a. Check for dehydration
- b. Give antibiotics
- c. Refer him to hospital
- d. Give aspirin

You will agree that the answers (b), (c) and (d) are all common mistakes made at health centres? The correct response is (a).

You can use MCQs to test different things. Although all MCQs only really test knowledge, you can test different types of knowledge with them. Read the next question, what does it test? Does it simply test what students know about vaccines?

Your kerosene got finished last week and your refrigerator has not been working. If you get a new supply of kerosene next month and the refrigerator starts working again, your vaccines:

Answers:

- a. Will all cause bad reactions
- b. Will all be effective
- c. Will all be useless
- d. Will work again after they have been cold for 24 hours

What does the next question, in contrast, test?

Josephine's road-to-health card shows that she was born in December. She has had only one immunisation, the first DPT, given in February.

It is now May. What immunisations does she need?

Answer:

- a. BCG only.
- b. BCG and DPT.
- c. BCG, DPT and polio.
- d. BCG, DPT, polio & measles.

Your answer should be (c).

You can therefore see that MCQs can be used to test different sorts of knowledge. They can also be used for pre and post test purposes. They would help you gauge how effective your teaching is and determine whether or not the students are learning.

Assessing Skills

Skills can be assessed through the use of:

- Objective structured clinical examination (OSCE)
- Objective structured practical examination (OSPE)

For both methods, candidates pass through a number of examination stations to answer or solve various problems. Questions vary from practical skills, knowledge, application and testing of attitudes. All candidates get the same experience.

Objective Structured Practical Examination (OSPE)

Practical skills are very important components of training in all professions.

Failure in practical tests is equivalent to failure in the whole examination.

You should not allow excellence in theory to compensate for a failure in practicals.

OSPE examinations must be objective, valid and reliable. They should define the competencies a worker needs to develop in order for them to successfully perform the job. This ensures that all examiners have similar expectations.

Look for a correct diagram in a clinical case. Assess the student's skills using rating scales or a checklist. You should set short answers to practical problem solving skills questions to ensure objective assessment. In order to improve the validity of the test, you should increase the sample thus increasing the range of competencies to be tested. Draw up in advance a table of specifications to be tested on.

Objective Structured Clinical Examination (OSCE)

This is a comprehensive examination of a patient. The student spends 15 to 60 minutes with a patient and then discusses that patient with a panel of examiners (long case). The exam should be set up in the following manner:

- Brief examination of a patient followed by oral questions (known as viva voce).
- Assessment of the learner's actual work during practice using rating scales.
- Assessment of log and procedure books.
- Case record and case reports.
- Models or phantoms.

The following are stages of setting an OSPE:

- Identify topics/competencies to be tested on.
- Decide the number of stations and timing.
- Allocate topics and competencies to be tested.
- Set up instructions for examiners rating scales/check list for each station.
- List resources required for each station. These include examiners, markers and observers, patients, normal persons and simulation and room furniture, that is, beds, clocks, bells and so on.
- Allocate marks for each station.
- Allocate marks within the station, that is, for each item of the question.

- Prepare standard/model answers for the questions.

The main advantages of OSPE include:

- OSPE separates the assessment of process and product by ensuring that the student performs the procedure as they are being observed.
- Allows adequate sampling of skills.
- Allows analytic and objective observation of skills because the observed skill is quite specific.
- Can be used as quick feedback for students and teachers, especially before certification, as a revision tool.

However, OSPE also has several disadvantages.

- The process can appear impersonal
- It takes time to organise
- It can interfere with the provision of other services

Assessing Attitudes

- The student's attitude is an important ingredient in delivering a good service. By assessing this skill, a student will learn the importance of having a good attitude and will understand what is expected of them.
- Attitudes can be assessed indirectly, that is, as the candidate performs a skill. This will have to be over a long period so that your assessment is based on repetition of the same attitude over time. Assessing of attitudes should be a continuous process to give a student the chance to internalise the specific attitude.

What do you use to assess attitudes?

- Pencil and paper test questions can be set for knowledge based tests. However, simulations, allowing the observation of gestures and actions, are a better way to see the actual display of attitude.

Types of Tools

You can use a rating scale based on a table analysis (TA). There are two types of scales:

- Scale of 5-1. This should remind you of the XY forms you had to have filled in by your

ward in charge. A simple satisfactory to unsatisfactory scale is another example.

- Semantic differential, that is, a scale on opposite characteristics. This can be used on attitudes alone. One example is given below.

Example:

Please tick where the student exhibits this behavioural characteristic.

- Keen and willing – does minimum work.
- Accepts instructions – ignores instructions.
- Polite to patients – Rude.

Set up instructions for examiners' rating scales/check list for each station. List resources required for each station including examiners, markers and observers. Allocate marks for each station and within each station, that is, for each item of the question. Prepare standard or model answers for the questions.

Developing Assessment Tools

You can develop an assessment tool by following these basic steps:

- List the objectives you wish to evaluate.
- Identify the expected learner outcomes (knowledge, attitude and skills).
- Specify the tools of assessment such as essays, MCQs, OSPE, and so on.
- Allocate marks for each objective and develop a marking scheme.
- Construct questions for the whole test.
- Arrange questions from the first to the last.

Grading

This refers to the awarding of marks, score or a value to the assignment performed. Some examples of grading include:

- Percentage of 0-100%.
- Pass or fail, good, average, excellent.
- Percentiles.
- Letter grades, that is, A, B, C, D, E or F.

Valuation of student performance is important. This is mainly because it gauges the extent to which educational objectives have been achieved and guides the teacher in deciding what steps need to be planned next to facilitate learning for the students.

THE END