

**MODELS OF PSYCHIATRIC NURSING EDUCATION IN  
DEVELOPING COUNTRIES: COMPARATIVE STUDY OF  
BOTSWANA AND NIGERIA**

by

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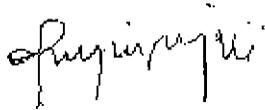
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*Declaration*

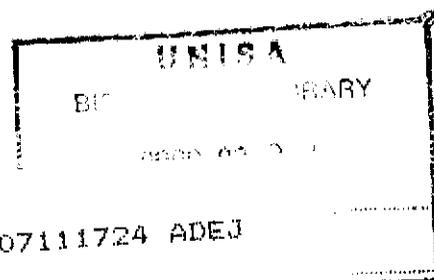
I declare that:

The Models of Psychiatric Nursing Education in Developing Countries: A Comparative Study of Botswana and Nigeria is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



Oluyinka Adejumo

02 April 1999



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## *Abstract*

Against the perspectives of the mental health needs of the people of Africa, this study explored and compared the models of psychiatric-mental health nursing education in two sub-Saharan African countries – Botswana and Nigeria. The primary purpose of the study was to assess the design, the implementation, the factors that influence and the perceived usefulness of psychiatric-mental health nursing education programmes in developing African countries, using Nigeria and Botswana as examples.

A self-reporting questionnaire, administered to psychiatric nurse educators from the two countries of concern, provided the primary source of data. A curriculum evaluation checklist based on Horan, Knight, McAtee and Westrick (1984) was used to assess the components of the existing psychiatric nursing education curricula from the two countries. Discussions were also held with practising psychiatric nurses and officials of the nursing regulatory bodies from the two countries.

Data from both countries revealed that participants used various terms to describe the same model for psychiatric-mental health nursing education adopted in their countries. Botswana, however, adopted a more functional generalist basic diploma nursing education approach which encouraged a more advanced post-basic diploma specialisation and practice in community psychiatric-mental health nursing. Nigeria's model leaned towards a hospital centred basic specialisation with no defined role for the generalist nurse within

the psychiatric-mental health nursing care system. Community theme occurred in both countries' curricula with varying degrees of emphasis, as all the programmes claimed the intent to make psychiatric-mental health nursing service available to individuals, families and the communities at all levels of care. Psychiatric-mental health nursing education programmes of the two countries had been influenced at different times by war, colonial history, changing standards of health care delivery, government health policies, economic status of the country, professional status of nursing and the changing standard of education.

A model that streamlined psychiatric-mental health nursing education within the general system of education in both countries was proposed. It was stressed that one key concept that must underlie the development of psychiatric-mental health nursing education was the need to create a mental health nursing role that would be appropriate for people's health needs rather than the needs of the health care system.

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**Key terms:** Nursing Education, psychiatric-mental health nursing education, Nursing, education models, mental health, Africa, developing countries, pathways for psychiatric nursing education.

## LIST OF ABBREVIATIONS USED

Abbreviation	Meaning
AIDS	Auto immune deficiency syndrome
ANA	American Nurses' Association
ANOVA	Analysis of Variance
BNC	Botswana Nursing Council
BSN	Bachelor of Science in Nursing
CBL	Competency Based Learning
CBNE	Comprehensive Basic Nursing Education Programme
CBNP	Comprehensive basic nursing programme
CE	Continuing Education
CHE	Centre for Health Economics
CIA	Central Intelligence Agency of America
CPN	Community Psychiatric Nurse
CQI	Continuous Quality Improvement
CSCE	Cambridge School Certificate Examination
df	Degree of freedom
DHT	District Health Team
DSM	Diagnoses and Statistics Manual

Abbreviation	Meaning
ECSACON	East, Central and Southern Africa College of Nursing
EN	Enrolled Nurse
Fed	Federal
FHD	Family Health Division
FMH	Federal Ministry of Health
FWACN	Fellow of the West African College of Nursing
FEW	Family Welfare Educator
GBD	Global burden of disease
GDP	Gross Domestic Product
GN	General Nursing
HIV	Human immuno-suppressive virus
ICN	International Council of Nurses
IHS	Institute of Health Sciences
IHS/UB	Institute of Health Sciences in affiliation with the University of Botswana
ILO	International Labour Organisation
INFJ	International Nursing Foundation of Japan
JAMB	Joint Admissions and Matriculation Board

Abbreviation	Meaning
KSA	Kingdom of Saudi Arabia
MCH/FP	Maternal – Child Health/ Family Planning
MFDP	Ministry of Finance and Development Planning
Min	Ministry
MOH	Ministry of Health
MSUCN	Michigan State University College of Nursing
NDP	National development plan
NIMH	National Institute of Mental Health
NLN	National League of Nursing
NMCN	Nursing and Midwifery Council of Nigeria
NUD*IST	Non Numerical Unstructured Data Indexing searching and Theory- building
PBL	Problem Based Learning
PHC	Primary Health Care
PREP	Post Registration Education Programme
PSC	Professional Service Committee
RCHN	Registered Community Health Nurse
RHT	Regional Health Team

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Abbreviation	Meaning
RHV	Registered Health Visitor
RM	Registered Midwife
RMHN	Registered Mental Health Nurse
RMN	Registered Mental Nurse
RMPA	Royal-Medico-Psychological Association
RN	Registered Nurse
RPN	Registered Psychiatric Nurse
RSA	Republic of South Africa
SANA	South African Nursing Association
SANC	South African Nursing Council
SD	Standard Deviation
SERPNI	Society for Education and Research in Psychiatric-Mental Health Nursing
STD	Sexually transmitted diseases
UB/IHS	University of Botswana and the Institute of Health Sciences
UK	United Kingdom
UKCC	United Kingdom's Central Council for the Registration of Nurses and Midwives for England and Wales
UNICEF	United Nations Children's Fund

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Abbreviation	Meaning
USA	United States of America
VDC	Village Development Committee
WACN	West African College of Nursing
WB	World Bank
WHO	World Health Organisation
YWCA	Young Women's Christian Association

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## Chapter 1

### **Introduction**

#### *1.1 The Problem statement*

Variability and diversity in pre-nursing education and in nursing education programmes have been fairly well documented for countries in Europe, the Americas and a few Asian countries (ICN 1985; Affara & Styles 1993). Not much has been documented in this regard, however for developing African countries. While sub-regional, but sometimes isolated, efforts are being made to redefine and reorient nursing and midwifery education in African countries, one branch of the nursing field, psychiatric-mental health nursing, does not seem to feature prominently in these considerations. Intensive searches for literature on psychiatric-mental health nursing education in Africa that yielded only intangible results, serve to demonstrate this point.

Against the backdrop of the prevalence of communicable diseases, high maternal and infant deaths in the developing world, community health nursing and midwifery would appear to be justifiable priority areas of emphasis in nursing education. Recent reports, however, published on behalf of the World Health Organisation (WHO) and the World Bank (WB) appear to cast serious doubts on the practice of judging a population's health from its mortality statistics alone. Describing the global burden of disease (GBD), the reports, based on a comprehensive assessment of mortality and disability from diseases, demonstrate that disabilities caused by mental health problems play a

major role in determining the overall health status of the developing and the developed world (Murray, Lopez & Jamison 1994:97-107). Of the leading causes of disability world-wide in 1990, unipolar depression, alcohol use, bipolar affective disorder (manic depression), schizophrenia and obsessive compulsive disorder were among the top ten (10) diseases that were responsible for the number of years lived with a disability (World Health Organisation 1997:online). In a WHO collaborative project on psychological problems in general health care (WHO 1998:online), described as the largest ever WHO project that deals with the form, frequency and outcome of psychological disorders seen in general health settings, findings revealed that as many as 64% of the patients in general care settings have either a well defined mental disorder (24%) or are suffering from clinically significant symptoms suggestive of a psychological problem (40%). Nigeria is one of the countries included in the WHO project in reference, among fourteen other countries of the world.

The global picture of mental health is not different for Africa. Mental disorders have been reported to be a common feature of health problems encountered in general hospitals, primary health care and community settings in Africa, as in other third world countries (Abiodun 1990; German 1987a, 1987b; Kiganwa 1991; Reeler, William & Todd 1993; Sebit 1996). Several studies reported morbidity rates in mental health problems that are similar to those observed in developed countries (Abiodun 1989; Harding et al 1980; Orley & Wing 1979). Referring to a previous WHO (1975) report, Odejide (1990) indicated that about 10% of the general population and one fifth (20%)

of the patients attending curative services (health centres, out-patient clinics) in the developing countries have mental health problems, presenting predominantly with somatic symptoms. Similar statistics of high incidence of mental health problems in Africa have been reported by Giel and Van Lujik (1969), Ndetei and Muhangi (1979). The same picture of high incidence of psychiatric morbidity was reported in populations of children and pregnant women in Nigeria (Abiodun 1992; Abiodun, Adetoro & Ogunbode 1993). This picture may have been compounded further in Africa today, faced as it is with war, political instability, violence, displacement, hunger, poverty, unemployment, substance abuse, immuno-suppressive diseases, over-population, population shift, emigration and immigration, which are all known to be associated factors in mental health problems on the African continent (Levin 1988; Madela & Poggenpoel 1993; Mkhize 1994; Stockman 1994).

One of the three major challenges identified for nursing education in a WHO document is the development of nursing education that would be “responsive to changing epidemiology, language, and cultural needs” of the people (WHO 1992:5). The question “How is the nurse prepared to meet the challenges of the unfolding mental health epidemiology among the people?”, will seem to echo, in a different way, the age long question by the International Council for Nurses (ICN) repeated in ICN (1997:2): “Who is ‘the nurse’ and how is he/she prepared?”. This is a question that is acknowledgedly far from being resolved from the global perspective (ICN 1997), let alone in Africa. Questions like this raise the issue of relevance in nursing education, coupled with professional and individual identity at local, national and international levels.

More specific questions arise here as to whether nursing education in Africa can be said to be sufficiently geared towards meeting the identified contemporary challenges for mental health care.

Murray and Lopez (1996), following observations in other parts of the world on the burden of diseases, predicted that mental health problems will be the leading cause of disability adjusted life years for both males and females throughout the developing regions of the world by the year 2020. It is of interest to examine how nurses are being prepared to fulfil the role of psychiatric-mental health nursing care giver, given the global picture of mental health problems, and the increasing threat of mental health problems in the developing African countries. The Professional Services Committee (PSC) of the ICN probably had this type of situation in mind when it recommended that nursing education be further examined “in the light of current and projected changes in health care system, availability of health resources and employment opportunity for nurses” (ICN 1997:1).

Noticeable efforts are being justifiably directed towards nursing in its general form with emphasis on making nursing education relevant to the health needs of the people. Given the present situation it would seem that preparing nurses for the role of meeting the mental health needs of the people should be one of the major priority areas of concern in nursing education. It is with this situation in mind that the following questions are being asked:

1. How are nurses being prepared to render psychiatric mental health care in developing African countries?

2. How can the models of psychiatric nursing education be described in the developing African countries?
3. How do these models differ from one country to the other?
4. Why are there differences?
5. How suitable are these models for the countries?
6. What constraints exist within the models?
7. What improvements can be envisaged?
8. What models of psychiatric nursing education can be proposed that will be appropriate for psychiatric-mental health needs of developing African countries?

To answer these questions for the whole of Africa, made up of 54 countries with diverse socio-cultural and geo-political identities, presents feasibility problems given the limitations of resources available for this project. Equally, while there may be a global preaching of universality in approach to nursing education for the profession's global identity, and for the mobility and career opportunity of its practitioners, a variable amount of regional and country differences may still need to be tolerated for obvious political and historical reasons. For practical purposes, two developing sub-Saharan countries are therefore selected for study. These are Botswana, a country in Southern Africa, and Nigeria, a country in West Africa (Figure 1.1).

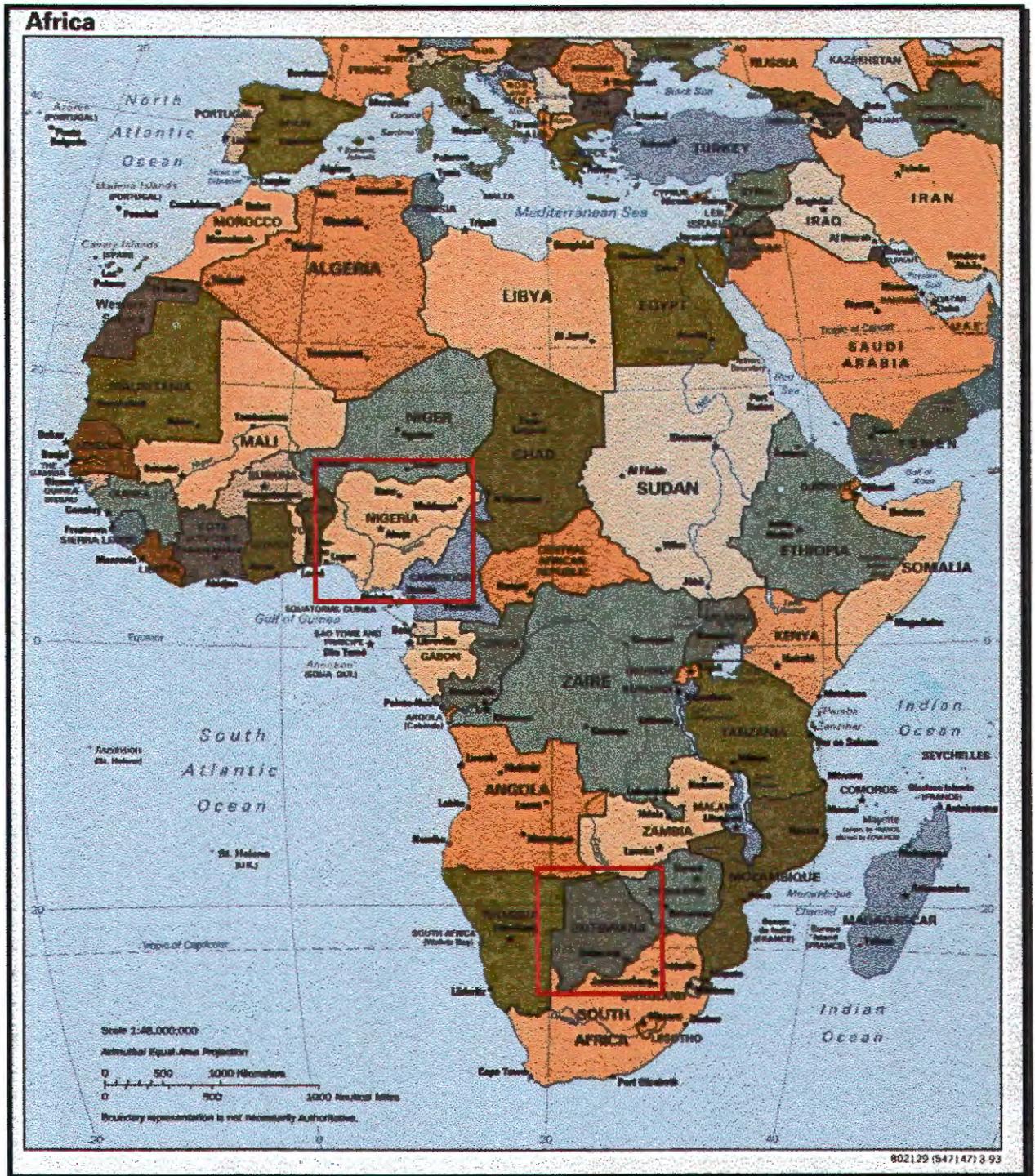


Figure 1.1: Map of Africa showing positions of Nigeria and Botswana in the inserts, adapted from University of Pennsylvania, Institute of African Studies Online Maps (available: [http://www.sas.upenn.edu/Africa\\_Studies/CIA\\_Maps/Africa\\_19850.gif](http://www.sas.upenn.edu/Africa_Studies/CIA_Maps/Africa_19850.gif))

## 1.2 *Background to the Problem*

Interest in this study came about as a result of the researcher's exposure to nursing education, and in particular, psychiatric nursing education, in the two selected countries: Botswana and Nigeria. The period of exposure spanned twenty five years, which included a period of training as a psychiatric nurse in Nigeria in the early seventies, as a general nurse towards the end of the same decade, as a university graduate with a degree in nursing science in the early eighties, and later a master of science degree in clinical psychology undertaken because of an interest in human behaviour and mental health. The researcher worked as a psychiatric nurse at different times in Nigeria and in the Kingdom of Saudi Arabia (KSA). In addition to this practical experience, teaching at a diploma awarding school of nursing, at a degree awarding department of nursing at a university in Nigeria, and further exposure to teaching health professionals in Botswana, as a faculty member of the Health Sciences Institute of Botswana, provided further impetus for this study.

Experience as a psychiatric nurse in the Kingdom of Saudi Arabia exposed this researcher to psychiatric nurses from different countries viz.: Britain, America, India, Egypt, Tunisia, Philippines, Australia and the New Zealand. Observing varying, sometimes conflicting, standards of knowledge and practice espoused by psychiatric nurses from different countries raised the initial curiosity of "How are psychiatric nurses prepared in these various countries?". Affara and Styles (1993) have noted with concern the variability in the educational background of nurses around the world:

*At one extreme are those educated in nursing at the high school or secondary school level. At the other extreme are those educated within universities, sometimes at the graduate level. Curriculum content may be narrow, technical and practical; it may be broad, liberal and highly theoretical. Programmes may be isolated or they may be integrated with other disciplines and professions. Experiences may be confined to hospitals or extended into communities. No further education beyond the basic programme may be required or continuing further education beyond the basic programme may be required or continuing education may be mandated for nurses to maintain their qualification for practice.*

(Affara & Styles 1993:26)

Information specific to sub-Saharan Africa is scanty within the available documents on psychiatric nursing education models. This lack led to the decision to conduct a kind of comparative analysis through more systematic observation and documentation of the types and outcomes of psychiatric nursing education in the two countries most familiar to the researcher: Nigeria, country of birth, education and long years of varied nursing experience; and Botswana, place of work between March 1993 and December 1996.

These two countries share some commonalities in the aspect of continuing debate as to what would be the best for the nursing education system and structure currently and in the next millennium. From the early eighties to date, Nigeria has been grappling with the resolution to the following key areas identified by Kujore (1990: 21):

1. *Goals of Nursing Profession in Nigeria*
2. *What nursing is*
3. *Who the professional nurse is*
4. *Mode Concept of nursing practice*
5. *The types of nursing education that will ensure (sic) practice*
6. *Where the education will be based*

7. *The types of nursing administration and organisation that will support the goals of nursing*
8. *System of accountability and Quality assurance*

The Botswana experience revealed within the information provided by Mmatli and Mosieman (1995) that it required a presidential directive based on reports by external consultants to restructure nursing education in Botswana. This directive specifically instructed that the enrolled nursing cadre be phased out through retraining in upgrading programmes, and that all nursing educational institutions be affiliated to the University of Botswana. Despite this development for nursing education in Botswana, the changing dynamics in the health needs and problems of the people still demand that areas of nursing specialities like psychiatric-mental health nursing education be continually examined.

### *1.3 Purpose of Study*

The primary purpose of this study is to provide information and documentation regarding psychiatric nursing education models in developing African countries on the basis of a comparative analysis of Nigeria and Botswana. The study is designed to:

1. examine the present model(s) of psychiatric nursing education in two selected African countries, Botswana and Nigeria,
2. determine the historical antecedents to the present model(s) in the two countries,

3. appraise the adequacy and appropriateness of the model(s) in the two countries, and
4. make a comparison between the approaches adopted by the two countries.

This is with a view to proposing alternative approach(es) for psychiatric nursing education in the selected countries and other similar countries of sub-Saharan Africa, if necessary. The main aim is that a model would be proposed on the basis of the findings in the study. The model so proposed is expected to be consistent with the development of skills and knowledge that would be required by nurses to enable them to provide appropriate psychiatric-mental health nursing care to the people both now and beyond the year 2000.

#### *1.4 The Research Questions*

This study will attempt to answer the following questions:

1. What are the models of psychiatric nursing education in the selected countries of Botswana and Nigeria?
2. How do these models differ?
3. What are the reasons for these differences?
4. What benefits are derivable from these models?
5. What drawbacks do these models have?
6. What improvements can be envisaged?

7. How do the psychiatric nurse educators in both countries rate the appropriateness of the psychiatric nursing education programmes to the actual post qualification experience in psychiatric nursing practice?
8. Are there differences in the perceptions of the psychiatric nurse educators in each country about the appropriateness of the training programme in that selected country?
9. What differences exist in the conceptual framework, philosophy, programme goals, the administration, curriculum content, faculty, outcomes (students and graduates), and the ancillary resources of psychiatric nursing education in the two countries?
10. Are there omissions or duplications of essential contents in the studied curricula?
11. Who are the teachers and what are their educational and professional qualifications?
12. Who are being trained as psychiatric nurses in Botswana, and in Nigeria?
13. How long does the training take?
14. What are the skill emphases?
15. What improvements will be necessary for the growth of psychiatric nursing in the two countries concerned?

16. What model(s) will be deemed to be appropriate for future education and training of psychiatric nurses in Botswana and Nigeria?
17. What are the implications of the suggested models for psychiatric nursing education in the selected countries?

### *1.5 Assumptions underlying the study*

The following assumptions are basic to the entire process and the expectations in this study:

1. Nigeria and Botswana are developing countries with mental health problems similar to those of other developing countries of the world.
2. Health care, and in particular, mental health is affected by multifarious factors of history, economics, culture, politics, government, technology and the entire psychosocial system of the peoples involved.
3. The entire world is in a dynamic state, and several changes have effects on the mental health of the people.
4. With changes in knowledge, technology, social, cultural, economic and political structures in the world, there is a regular need to assess the patterns and mode of education that contribute to the mental well-being of the people.
5. An assessment of patterns or models of education in a field, such as mental health nursing, is capable of providing attention to areas of strengths and/

or weaknesses in programmes in order to reinforce the strengths or to correct the weaknesses respectively.

6. Educators functioning within an educational programme are capable of giving information that is relevant to the nature and expectations of the programme.
7. Educational curricula provide documentary evidence of the total learning experience of learners in a programme.
8. Explainable similarities as well as differences would be present in the mental health nursing programmes of Botswana and Nigeria.

### *1.6 Significance of the study*

Literature about models of nursing education and in particular psychiatric nursing education is apparently scanty in developing Africa. An exception to this rule might be found in the Republic of South Africa (RSA) where textbooks and journal articles abound on the nursing profession and nursing education systems. Reports that detail the development of nursing education and the nursing education system in RSA have been documented by Mellish (1984), Searle (1975, 1976), South African Nursing Association (1975), and Williamson (1977). In other parts of Africa, systematic documentation of nursing education programmes based on scientific evidence is scanty if not totally non-existent. Kupe's similar documentation on Botswana for her doctoral thesis chronicles the development and progression of nursing

education in Botswana up to the late eighties (Kupe 1991; Selelo-Kupe 1993). After reviewing the available literature, it is noted in particular that a study of this type, contrasting findings for Botswana and Nigeria, has not yet been reported. This study will, therefore, serve to provide such documentation for future reference and for possible further action or for generating further research.

In this era of movements across the frontiers in African countries and other countries in the world it has become imperative to examine the nature and the systems of certain aspects of nursing education in these countries. Probable differences in nursing education need to be explored and documented to enable the health care authorities to make informed choices as to which qualifications to acknowledge in which countries. Exploration of differences in nursing education has become ever more important as large number of African nurses relocate to the UK, USA and Arab speaking countries. The movement of nurses out of Africa also stimulates the movement of nurses among African countries. However, as there are bound to be differences in the nursing education and nursing philosophies of the different African countries, movement of nurses among these countries is not a simple task. This study will start to address the issue of nursing education in different African countries.

In order to analyse and gain a clearer understanding of the phenomenon of psychiatric nursing education in the selected developing African countries, systematic information is required on the prevailing situation and models.

Such information would be vital for the future development of nursing education and the substance of such education in these countries in particular and also in the subregion. An articulated observation to provide information and evaluative reports about a specialised and an integral field of nursing education in two developing countries, Nigeria and Botswana would seem to be a welcome development in view of the scarcity of such information in current literature. This kind of study has the potential to illustrate the level of congruence in the process and content of psychiatric nursing education vis-à-vis the expectations in actual practice and for the people's mental health needs. This present study would appear to be firmly in line with the call by the Professional Services Committee of the ICN (in ICN 1997: 1) for further examination of nursing education in the light of current and projected changes in health care systems. Such related areas would include those of changing epidemiology, the provision of health care resources and employment opportunities for the practitioners of nursing in general with specific reference to psychiatric-mental health nursing.

The intended appraisal will provide information about the effectiveness of existing models, describe the models if otherwise undescribed, and provide justification for the continued use of such models. Justification would be based on the effectiveness and the efficiency with which the models facilitate the achievement of the objectives identified for human service needs in a post qualification practice of psychiatric nursing. Development and description of models of psychiatric nursing education that are relevant to a country's national health problems have implications for continuous quality

improvement (CQI) for nursing education and practice. Based on the findings of this research, such relevant implications will be specified. The generated information can be used to foster international accreditation and innovations, if not a form of revolution, in psychiatric-mental health nursing education of the studied countries, as we move into the 21<sup>st</sup> century.

This study has the potential of stimulating similar comparisons of nursing education models between other African countries. Similar studies can be stimulated to compare Anglophone and Francophone African countries, or even a survey of the entire psychiatric-mental health nursing education for the whole of the African continent that take into consideration, not only the English or the French speaking countries, but the Portuguese and the Arab speaking countries as well.

## *1.7 Definition of key concepts*

The following key concepts used throughout the study are defined or explained in this section to ensure that the researcher and the readers attribute similar meanings to these concepts.

### **1.7.1 Models:**

Borrowing ideas from Scott (1984:9), 'model' in this study is defined as a conceptual framework, the structure, the form of practice, or the system on which particular teaching/learning strategies for psychiatric nursing certification are based in the studied countries.

**1.7.2 Psychiatric Nursing:**

Also used interchangeably with 'psychiatric-mental health nursing' in this study, psychiatric nursing describes that specialised area of nursing practice which uses theories of human behaviour as its science and purposeful use of self as its art, toward both preventing and correcting the impacts of mental disorders and their sequelae, as well as the promotion of optimal mental health for the society, the community, and those individuals who live within it (ANA 1976:5; Stuart & Sundeen 1983:981).

**1.7.3 Nursing:**

As used in this study, 'nursing' generally implies the professional care given by nurses to individuals, families or communities to help maintain health or to recover from disease or injury.

**1.7.4 Psychiatric Nursing Education:**

This is defined as a kind of nursing education that prepares a nurse to acquire competencies in psychiatric-mental health nursing, so as to be able to care for patients with psychiatric or mental health problems. It includes the knowledgeable use of psychiatric - mental health and behavioural concepts in patient care.

**1.7.5 Psychiatric nursing competencies:**

These include the abilities, skills, judgement, attitudes and values required for successful functioning by a nurse in a psychiatric-mental health setting. (Gale & Pol 1977:24).

### *1.8 Scope and Limitations of the study*

The study focuses on the entire field of psychiatric-mental health nursing education in Botswana and Nigeria. The study was directed at gathering and comparing information about the educational system, influencing factors, the input, the process and the output within the entire field of psychiatric-mental health nursing education in Botswana and Nigeria. The extent of the study covers information obtainable from the educators or other nursing personnel actively involved in the training and the education of nursing students towards giving or providing psychiatric or mental health nursing care in Botswana and Nigeria. It also compares material obtainable from the examination of the content of the different nursing curricula in use for the education of nurses in the two countries.

This study also takes into consideration the opinion of the officers in charge of the licensing authority for nursing practice in both countries. The full range of the study therefore covers the analysis of the phenomenon of psychiatric-mental health nursing education in Botswana and Nigeria on the basis of information available from educators, practising nurses, licensing body officials and the nursing curricula.

This study would be seen, however, to be limited in its scope because it does not proceed beyond the description and comparison of the existing situation in the two countries. While it attempts to make suitable and constructive suggestions on the basis of findings and the expectations of health delivery into the next millennium, these are only suggestions and could be subjected to

more critical consideration. Another limitation of this study is the extent to which the picture painted by the respondents can be reasonably said to be a true and accurate reflection of the situation in the two countries. This may be a rather difficult conclusion to draw for a country like Nigeria with such diverse social, geographical and educational representation among the respondents. Nigeria is still treated as an entity in this study because of the centralised control of nursing education in the country despite the apparent possible variations in the education and cultural background in the west, the east and the north of the country. The findings in this study, therefore, should be read with these limitations in mind.

### *1.9 Organisation of report*

This report is presented in 6 chapters. Chapter 1 introduces the whole study, the background of the study, the questions being asked by the researcher, the significance of this study, its scope and limitations. The meanings that the terms used would carry in the study were also provided in this chapter.

Chapter 2 is devoted to the explanation of the theoretical and the conceptual frameworks for this study. It discusses the applications of Lewin's field theory (Lewin 1951; Murphy 1966) and the Horan, Knight, McAtee and Westrick's (1984) model for curriculum evaluation to the study.

Chapter 3 is devoted to the review of literature that was deemed to be relevant to the understanding of the study. Literature reviewed included material that provided information about the educational, geopolitical, health and cultural

factors of the countries, the historical background of psychiatric-mental health nursing education, and some possible models of psychiatric-mental health nursing education. The review also included what information could be obtained about the situations of nursing education in Botswana and Nigeria.

Chapter 4 is devoted to the methodology of the study. This chapter describes the design, the determination of the respondents, the instrument for data collection, the procedure for the collection of the data, and how the data was analysed. This chapter explains the rationale for the choice of design and the process adopted in the collection of the data.

Chapter 5 is used to present the outcome of the data analysis. The findings include those obtained from the primary source of data through the use of the questionnaire, analysis of the content of the available nursing curricula, analysis of the recordings during the focus group discussions, and the discussions with the officials from the licensing bodies for nursing in the two countries. These findings are presented mainly as figures, tables and direct quotations in comparable formats for each country.

Chapter 6 is devoted to the discussion of findings with the intention of answering all the research questions that were raised in the first chapter. This chapter also contains the conclusions and recommendations that are derived from the analysis of the research findings.

The remaining portion of the report consists of the references, and appendices that could help to throw more light on the information provided in the main report.

## Chapter 2

# Theoretical and Conceptual Frameworks

## *2.1 Introduction*

The conceptual frameworks in this study provide a basis for description and analysis of the current situation, the process and content of psychiatric-mental health nursing education in the two countries being studied. Two frameworks were adopted. These were Lewin's field theory (Lewin 1951; Murphy 1966) and Horan et al's (1984) model for curriculum evaluation. The adoption of two conceptual models was to provide the means of (1) describing and analysing various factors in the selected countries associated with the present models of psychiatric-mental health nursing programmes, through a force field analysis of these factors, and (2) analysing the content of the psychiatric nursing education programmes using a conceptual framework that would provide a guided focus on the elements of a nursing curriculum.

## *2.2 Lewin's Field Theory*

The thrust of Lewin's theory is the conceptualisation of 'field' as a totality of coexisting facts, conceived of as mutually interdependent, that drives, maintains, or impedes change in a given situation (Lewin 1951:240; Mey 1972:xii). In essence, an existing condition and a later change are the results of differing constellations of forces in that 'field'. Factors or variables in a given

situation, in their number and magnitude, serve to maintain the situation, drive it towards a new situation or impede the movement of the present situation towards a more desirable one. According to Mey (1972:xvi), algebraic conceptualisation of the field seems useful to explain effects, on the basis of the reciprocal influence of the magnitudes and number of the variables on one another.

The use of Lewin's field theory analysis in nursing research for the purposes of understanding factors associated with a phenomenon is not new. Davis and Farrell (1995), used Lewin's field theory of change to analyse the factors affecting the delegation of tasks by the registered nurse to patient-care assistants in acute care settings. A qualitative analysis of factors in the work environment that influence nurses' use of knowledge gained from continuing education (CE) programmes by Scheller (1993) adopted Lewin's field theory analysis for this study. Ouellet and Rush (1989), and Wright (1988) both used the field analysis theory to describe the forces influencing nursing curriculum.

For the present study, the framework of Lewin's theory serves as a mechanism to analyse and understand the present situation of psychiatric-mental health nursing education in Botswana and Nigeria. Assumptions here are that the present situation in Botswana and Nigeria is maintained by certain conditions or forces. Some of these forces support each other. While some forces could be driving this situation towards a more desirable situation, others might be restraining the move. The interlocking of these forces produces a "status quo" or a situation of "quasi-stationary equilibrium" as described by Lewin

(1951:158). Figure 2.1 below provides a diagrammatic representation of the framework.

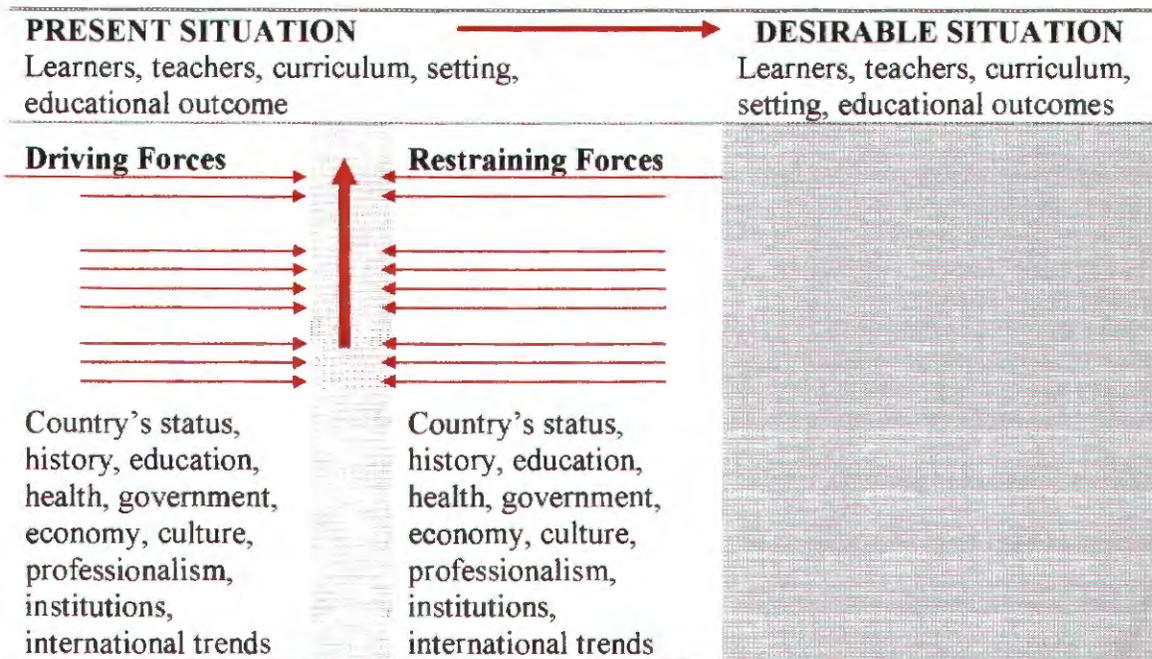


Figure 2.1: Lewin's force-field model (modified from Wright (1988:6)

The driving forces, if greater than the restraining forces, would be capable of propelling the present situation toward a more desirable situation. The restraining forces are the obstacles to movements in the desirable direction. These existing conditions need to be studied as they currently exist, because as referred to by Lewin in Mey (1972:xiii) "life space or 'contemporaneity' endures through time, is modified by events and is a product of history". The forces in the field of psychiatric nursing education in the selected countries are assumed to be numerous, but conceptualised to include such factors as social,

physical, psychological, economic, cultural and even political factors which could be explained in terms of their linkage to the field at this time. It is possible that within these categories of factors, there are those driving as well as those resisting desirable changes or developments.

### *2.3 A model for curriculum evaluation by Horan, Knight, McAtee and Westrick.*

Nursing educational models are expected to be guided by stimuli from societal realities in the area of health care delivery, professional nursing trends, and community expectations. This assertion informed the decision of the faculty of Michigan State University College of Nursing (MSUCN) to develop a conceptual model for programme evaluation that was deemed generally adaptable to other forms of nursing education programmes that could be found elsewhere (Horan et al 1984:319).

This model is identified as suitable for the purpose of guiding the assessment of the psychiatric-mental health nursing model to be described in this study. It is one conceptual model that views a programme evaluation as:

*... a process of describing and judging an educational programme through the systematic identification, collection, and interpretation of specific information for the purpose of assisting decision-makers to choose among available alternatives (Horan et al 1984:319).*

The conceptual model for nursing programme evaluation was, by its development, designed to direct the examination of elements and the relationships among the elements of a nursing educational programme (Horan et al 1984:319). The choice of this conceptual model, therefore, is in line with

the concern of the present study, which is primarily to describe and compare the present models of psychiatric-mental health nursing education of two selected African countries. Figure 2.2 (see page 26) presents an adapted diagrammatic representation of the model for a nursing programme evaluation.

The model divides the concern of nursing programme evaluation into 3 parts:

1. Intracurricular components
2. Implementation components
3. Outcome components.

Each of these components is to be examined for completeness and relevance to societal realities.

The model takes into consideration the need to evaluate the internal and external consistencies in an educational programme. The intracurricular and the implementation components are used as the measures of internal consistency, while the relevance of the outcome components to the societal realities and expectations provides the measure for external consistency. The point about the societal realities in particular is of interest in this study because of the peculiarities of the social, cultural, economic, health and development status of sub-Saharan countries represented by Nigeria and Botswana.

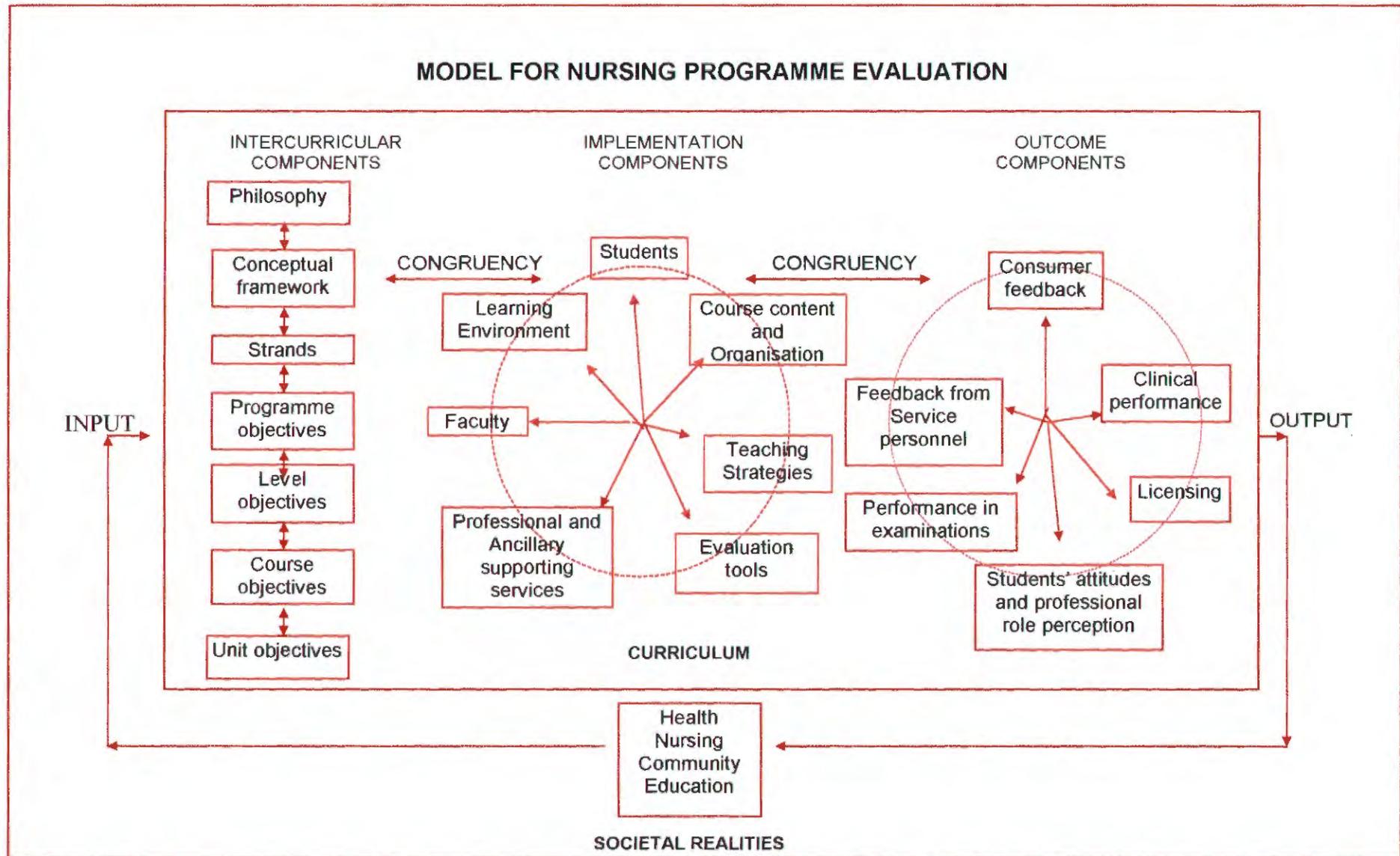


Figure 2.2: A model for Nursing Programme Evaluation adapted from Horan et al (1984): A model for curriculum evaluation.

Psychiatric nursing education, as in the case of the education of other health professionals in any country, must be relevant to the people's health needs as well as their stages of development. This is corroborated by the emphases of health care delivery systems in recent times with inclinations towards Primary Health Care (PHC). The PHC approach is often defined as:

*...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation, and at a cost that the community can afford to maintain at every stage of their development ... (WHO 1978:3).*

A nursing education curriculum within the contemporary society, therefore, would be expected to show congruency to the realities of the total society. It is expected that psychiatric-mental health nursing education for the selected countries would equally articulate the philosophical basis of nursing, and in particular psychiatric nursing, with the current trends in the health care delivery system. These expected components were deemed to have been taken into consideration while describing the elements of concern in the curriculum evaluation model of Horan et al (1984), which is adopted for the present study. The essential concepts in the model are further explained in terms of the elements and the interrelatedness of the elements, horizontal congruency of the components, and relevance to the societal realities.

### **2.3.1 Intracurricular components**

The elements of the intracurricular components include such aspects of the curriculum as the philosophy, conceptual frameworks, strands, the programme objectives, level objectives, course objectives, and unit objectives.

### **2.3.2 Implementation components**

The elements of the implementation components include those aspects of the curriculum that describe the students, the faculty, the course content, course organisation or structure, the learning environment, the professional and ancillary supporting services, and the evaluation tools and evaluation process.

### **2.3.3 Outcome components**

The elements of the outcome components relate to such things as the clinical performance of the students and the graduates, the consumer feedback, feedback from the service personnel, students' attitudes and professional role perception.

### **2.3.4 Societal Realities**

The societal realities are those aspects of the total society which influence the entire field of nursing education. These include such aspects as the profession and the professional status of nursing, current trends in education and health care, as well as the characteristics of the community. Such realities would have to be viewed within the context of the African culture, the PHC initiatives, the economic realities of the moment, and the professional status of nursing in these countries.

The elements in each category are related to those within the same category and to those in the other categories within the curriculum. The congruency bi-directional arrows in the diagram explain the horizontal relationships and the interrelatedness of all the components and the elements of the curriculum.

The feedback loop of the model moves from the output, through the societal

realities to the input, as may be necessary towards the improvement of the programmes.

## *2. 4 Conclusion*

Attempts have been made in this chapter to describe two frameworks that would be used as the context in which to examine and organise the data for this study. The use of the MSUCN model complements the field analysis theory of Lewin earlier described for use in this study. While the Lewin field analysis provides the guidance for the inclusion of all possible factors in the field that impact on the psychiatric nursing education programmes in Nigeria and Botswana, the adapted MSUCN model provides the means of evaluating the components of the curriculum of concern in this study. Since the framework for a study “helps to organise the study and provides a context in which to examine a problem and gather and analyse data” (Brink 1996:29), complementary frameworks are used for this study. The analysis of the field of psychiatric-mental health nursing education in the two countries is fitted within the framework of Lewin’s field theory, while the information needed for the analysis of the curriculum components is pitched within the framework of Horan et al’s (1984) curriculum evaluation model.

### Chapter 3

## **Literature Review**

### *3.1 Introduction*

The literature review in this study will look at the settings in Nigeria and Botswana, the two countries under study, to put the geographical entities, the socio-cultural climate, their governments, their education and health care systems into perspective. The literature will further examine the historical perspectives in psychiatric-mental health nursing education in general, and specifically in Botswana and Nigeria. The review will also explore current views on nursing education models with specific reference to psychiatric-mental health nursing education in the two countries. Efforts will be made, within the review, to clarify metaparadigmatic concepts and other concepts such as psychiatric illness, mental health and mental health disorders. Finally, research studies related to psychiatric nursing education in these two countries will be compared.

### *3.2 Background Information on Botswana and Nigeria*

#### **3.2.1 Republic of Botswana**

The Republic of Botswana is a landlocked area of about 600,730 square kilometres, straddling the tropic of Capricorn, between longitude 20 degrees and 30 degrees east of the Greenwich Meridian (see figure 3.1). Botswana is bordered by Zambia and Zimbabwe in the North, Namibia in the West, and the

RSA in the south and the East. Its longest South-North distance is 1,110 kilometres, while West-East distance is about 960 kilometres.

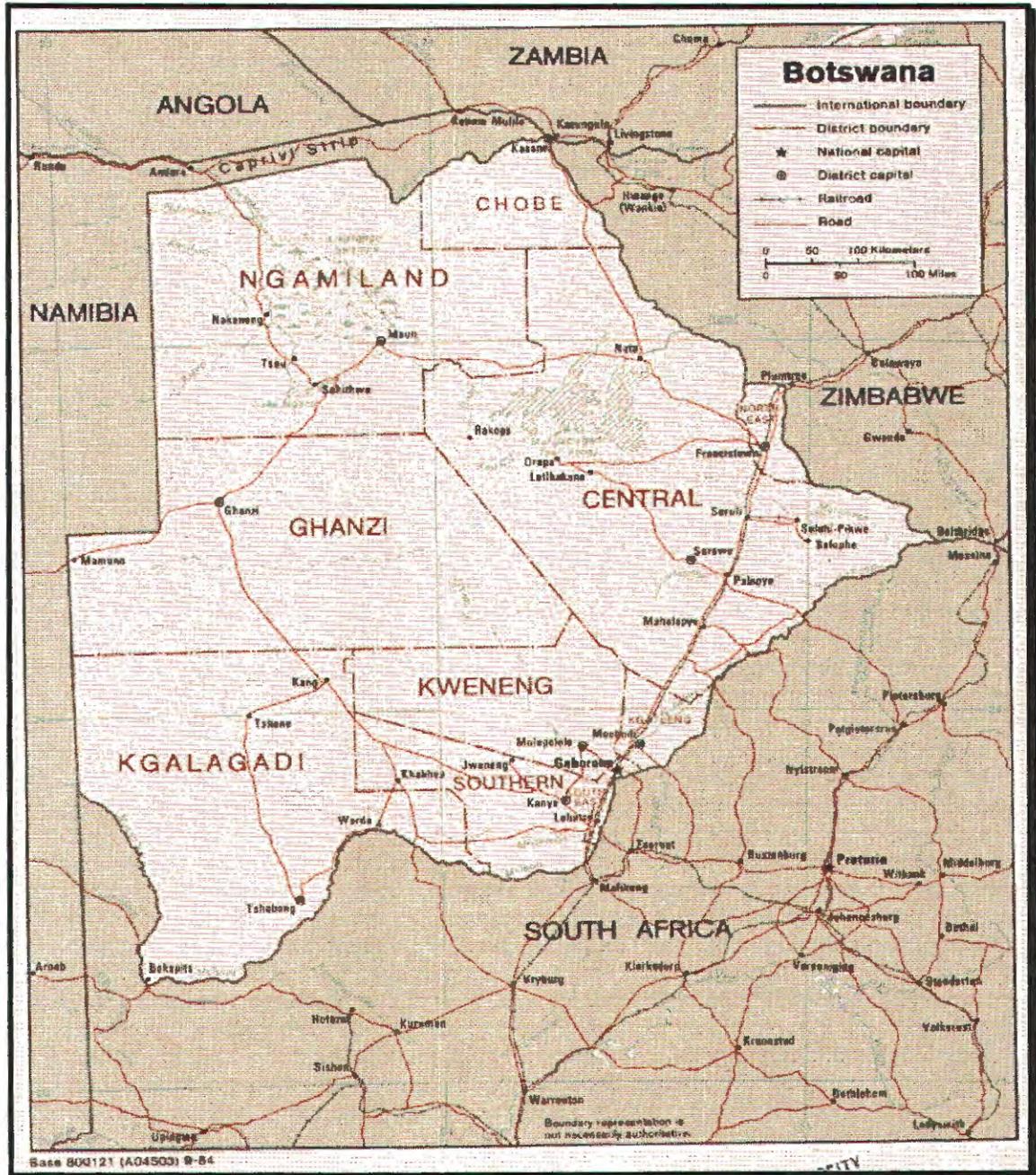


Figure 3.1: Map of Botswana

Source: African Studies, University of Pennsylvania (available online: [http://www.sas.upenn.edu/African\\_Studies/CIA\\_maps/Botswana\\_19842.gif](http://www.sas.upenn.edu/African_Studies/CIA_maps/Botswana_19842.gif))

Its surface area compares favourably with the size of France and Kenya, which is about 2/3 the size of Nigeria. The Botswana Central Statistics Office (1996:v) puts the enumerated de facto population of Botswana in August 1991 at 1,326,796. It has a present estimated population of about 1.5 million people based on an annual growth rate of about 3%, and is expected to reach about 1,700,654 in 2001 (Central Statistics Office 1996:v). About 2/3 of the population occupy the narrow eastern strip from the south to the north of the country. This distribution is probably due to the presence of rivers that provide water, and a major tarred road along this axis, which links South Africa and Botswana with Zimbabwe, as well as providing a link with Zambia through the Caprivi strip of Namibia. Parson (1984:4) reported that it is “in this area that arable farming is possible, grazing for goats and cattle is most available, and about 80% of the people live”. The remaining vast western portion of the country is largely semi-arid, flat and sandy, except for the small portion of the north western inland along the Okavango river and its delta which may be wet with some green vegetation, particularly when the summer rainfall is good. A trans-Kalahari freeway, which opened in 1998, traversed the breadth of Botswana from her eastern border with the RSA to her western border with Namibia to connect the RSA with Namibia through Botswana. It is unknown what implications this opportunity for freer movements across the Kalahari Desert would have for developments in the western part of Botswana. At the time of conduction this study, however, the western part of Botswana was largely undeveloped.

The Batswana, as the people of Botswana are generally referred to, are predominantly of Tswana stock and are divided into eight principal groups, with Setswana as their main language. The Bamangwato are the largest group and occupy an extensive area in the north east; the Bakwena and the Bangwaketse are found in the south; the Batawana live in the south west area; the Bakgatla, Bamalet, and the Batlokwa live in the south east; and the Barolong live in the extreme south east. The nomadic Bushmen live in the Kalahari Desert which covers a large part of the south western portion of the country bordering on Namibia. Other smaller ethnic groups include the Bakalanga in the north east, the Basarwa and the Baherero in the west (Bahr & Johnston 1992:420-422; Melamu & Manyeneng 1988:10). The religious inclination of the peoples of Botswana is 50% Christianity, and 50% indigenous beliefs (World Fact Book 1997:online). Ben-Tovim (1987:45), however, states that the Batswana, on the whole, believe in the living spirits of the ancestors, witches, and other magical beings who are believed to maintain a continuing and direct interest in the everyday happenings in the life of the Batswana. Psychiatric nurses, especially those trained in western traditions, would need to take note of the importance of these religious concepts in influencing people's daily "normal lives".

Botswana's climate is generally subtropical, though northern Botswana lies within the tropics. The climate varies according to altitude and latitude. It experiences a period of summer between the months of September and April with variable rainfall from about 250 mm in the Kalahari to about 700 mm in the extreme north east area. The day temperature may approach 40 degrees

Celsius in the hottest month of January. The winter period is usually between May and August, with the possibility of night temperature falling to 0 degrees Celsius during the coldest month of July.

Since independence was granted on September 30, 1966, Botswana runs a republican constitution that recognises the separate roles of the legislature, the executive and the judiciary. The legislature is the supreme authority in the country, the executive initiates and directs national policies while the judiciary interprets and administers the law of the land.

More than 80% of Botswana's population depends on agriculture for their livelihood, but only about 10% of the potentially arable land is cultivated because of lack of water. Crop production is limited by the unpredictable rainfall and the lack of irrigation facilities. The most important agricultural activity is livestock farming, mainly cattle, sheep and goats. The country boasts a strong economy within the African region, with a GDP purchasing power parity put at 4.3 billion US dollars, and per capita income of about \$3,130 (MFDP, 1991:13). The main source of government income is from the exports of diamonds, meat and meat products, and copper-nickel matte.

Though the government has policies of planned economic developments the economic changes in the country carry along with them the usual tensions of technological changes, rapid urbanisation, changes in life styles and increasing interactions with foreigners who occupy many academic and government posts in the country. Unemployment is put at about 17% (MFDP 1991:18), but at 25% by the World Fact Book of 1997 (Available Online: 10/05/1997).

The general educational system provides for a primary school education of two types: the English or Setswana medium for seven years. Secondary or high school education of five years leads to the writing of the British Cambridge School Certificate Examination (CSCE), set and marked in Cambridge. This CSCE at either 'O' or 'A' level<sup>1</sup> still serves as the entry requirement into post secondary certificate, diploma or degree programmes of a variable number of between 2 - 4 years in Botswana today. Education is relatively free for the Batswana from the primary school to the university, being subsidised by the government. Approximately 90% of children of primary school age, and 30% of secondary school age children, are enrolled in educational institutions throughout the country (MFDP 1991:11). The reported adult literacy rate between 1980 and 1995 varied from 41.0 to 80.5 as reported by WHO country office and the UNESCO (WHO 1996:online).

The health service delivery system in Botswana is anchored on the government's recognition of the PHC approach to health as an effective and efficient way of providing health care to its people (MOH 1995:3).

Nevertheless, like most African communities, the people have their own idea of what causes and constitutes illness and death, be it physical or mental illness, and their initial approach to seek health invariably reflects these beliefs. Some 80% of rural villagers have access to potable water and about 85% are within 15 kilometres of a health care facility (MFDP 1991:12). Life expectancy at birth for the total population is 63.56 years, 60.54 years for

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<sup>1</sup> "O" or "A" level indicates Ordinary or Advanced level passes respectively. "O" levels are equivalents of Senior School Certificate passes, also known as "Senior Grade", while "A" level passes are equivalents of Higher School Certificate passes, also known as "Higher Grade".

males and 66.67 years for females, as reported by the WHO country and regional offices (WHO 1996:online; World Fact Book 1997:online).

### ***3.2.1.1 Health Care System in Botswana***

The health policy adopted by the Botswana government affirms that Botswana is committed to the goal of health for all by the year 2000. It accepts PHC as the most appropriate strategy for the attainment of Health for All (MFDP 1991:359; MOH 1995:3). The PHC strategy, in essence, shapes the health care delivery system of the country. Health activities and services are organised and provided at different levels of sophistication and coverage by the central government, the local authorities (also referred to as the district or town councils), missionaries, private individuals, and some large companies.

At the lowest level of the health care services are the mobile stops (once or twice weekly) in very remote areas as the first point of contact, followed by health posts, and clinics respectively. Any rural village of a population between 500 - 1000 people is expected to have a health post and at least a family welfare educator (FWE). The FWEs must have completed at least a primary school level of education, and are selected for this role in the first instance by the village development committee (VDC), for approval by the regional health nurse who is a member of the regional health team (RHT).

The FWEs have to undergo a period of training for 3 months at a Rural Training Centre in order to be able to perform the following roles:

1. a health motivator and educator in family and community health;

2. community's first point of contact and referral to higher level health personnel.

Larger villages may have health posts staffed by enrolled nurses in addition to FWEs (MOH, Botswana 1984:15-16).

The next level in the health care system is provided at the clinics. In addition to the services offered at the health posts, such as the adoption of basic health practices relating to nutrition, pre- and post-natal care, tuberculosis, and sexually transmitted diseases (STDs), nurses at the clinics cover a wider range of educative health programmes. They collect statistics, carry out immunisations, and have up to ten beds for curative and maternity cases.

Criteria for the establishment of a clinic in the rural area is that there should be a population of about 4,000 - 8,000 people within a radius of 15 kilometres, while in larger villages or towns a clinic is expected to serve a population of about 10,000 - 12,000 people. Each clinic is staffed by at least one registered nurse. Professional supervision for the health posts and clinics is provided by the regional or district health teams (RHTs or DHTs), which were initially part of the ministry of health but were later transferred to the Ministry of Local Government and Lands. Each DHT is supposed to consist of a regional medical officer who is also the team leader, a regional health inspector, a regional public health nurse, a regional health education/nutrition officer, a regional social welfare officer, a tuberculosis co-ordinator, and health assistants for sanitation. Some regions also have *psychiatric nurses*. Ben-Tovim (1987:87) reported the first initiative that began around 1980 to ensure

that psychiatric nurses based in district hospitals were encouraged to embark on a programme of regular visits to the PHC facilities including both clinics and health posts in their respective areas.

The next level of health care facilities in Botswana is made up of primary hospitals, district hospitals and national referral hospitals. Though all health facilities provide a combination of curative and preventive services, these hospitals are the main curative referral facilities. The hospitals are expected to cater for populations of between 35,000 - 100,000 people and are found in towns and large villages. Responsibilities for the hospitals are held directly by the Ministry of Health, providing professional and technical support services. At the top of the facilities are the 2 main referral hospitals at Gaborone and Francistown, respectively, and one specialist psychiatric hospital located in Lobatse. These referral and specialist hospitals are meant to cater for the referral needs of the entire country. According to available records (Central Statistics Office 1996:99), Botswana in 1994 had in place 701 mobile stops, 310 health posts, 200 clinics, 13 primary hospitals, 7 government district hospitals, 3 mission hospitals, 3 mine hospitals, a government psychiatric hospital, and 2 national referral hospitals.

The Botswana Ministry of Health, advocates an integrated and comprehensive system of health care (MFDP 1991:359), and has a number of special units to deal with particular health programmes or disease problems. Such units include:

1. the maternal and child health/family planning (MCH/FP) unit for the planning, organisation and evaluation of MCH/FP services;
2. the health education unit for the conduct of general health education campaigns; and
3. the nutrition unit, charged with the responsibility of developing strategies and programmes to reduce undernutrition, establish social and geographical profiles of risk groups, and act as a functional liaison unit between the ministry of Health and other organisations involved in nutrition work.

These three units comprise the Family Health Division (FHD) of the Ministry of Health. The community health division of the ministry of health is made up of the communicable diseases unit, charged with the responsibilities for programmes to control diseases like auto-immune deficiency syndrome (AIDS), tuberculosis, malaria, bilharzia and diarrhoeal diseases; environmental health and sanitation unit with responsibilities for public health concerns; and the occupational health unit, for workers' health promotion and protection.

Supporting or complementing the ministry of health's efforts in providing health care to the peoples of Botswana are other ministries, missions, large scale commercial private sector employers, private (modern and traditional) practitioners, and a host of other non-governmental organisations. For example, within the ministry of Local Government and Lands is a department

of Social and Community Development whose officers have the major role of helping the local communities to analyse their needs, plan for them, and implement those plans. The department also deals with the problems of juvenile delinquents and destitutes, as well as the *follow up and counselling of psychiatric patients* (MOH 1984:21). The medical and Christian missions operate the mining and the mission hospitals with clinics found across the length and breadth of Botswana. Other corporations also operate either hospitals or clinics for their employees and their dependants. Private hospitals and private doctors' clinics are being established in the big towns in particular. A number of voluntary community service organisations, such as the Red Cross, Botswana Christian Council, the Botswana Council of Women, the Young Women's Christian Association (YWCA), the Lions' Club and the Round Table provide direct and indirect assistance for the provision of health services to individuals, groups and communities within the scope of their philanthropic activities.

### ***3.2.1.2 Health problems***

Botswana is subject to the usual causes of ill-health linked to poor socio-economic conditions which appear to be permanent features of the developing countries and in particular, of sub-Saharan Africa. Health problems are those usually associated with inadequate food, illiteracy or low levels of education, poor environmental conditions, and inadequate or lack of clean and safe water supplies. These are mainly communicable diseases and deficiency diseases. Diseases associated with affluent and urban life styles such as cardio-vascular diseases and road traffic accidents are, however, also becoming common

features of the Botswana health scene. Authorities have also established that STDs/AIDS, malignancies and alcohol abuse are now major health concerns of the Botswana people (MOH 1984:24-25; MFDP 1991:359). There are several indications for the need to make deliberate and conscious efforts to develop, improve or expand the psychiatric-mental health nursing services for the peoples of Botswana. Melamu and Manyeneng (1988: 94) pointed out that evidence from the psychiatric hospital and the psychiatric units of the district hospitals indicated a steady rise in the incidence of mental health problems, in particular those related to alcohol and drug abuse. Today, health problems of the people of Botswana appear to have taken another turn with the revelation that Botswana has one of the highest recorded incidences of HIV infection in Africa (AIDS Analysis Africa 1997:1; MacDonald 1996:1325). A seroprevalence rate as high as 30% has been reported within specified regions in Botswana (AIDS Analysis Africa 1997). AIDS related deaths are on the increase in Botswana. With this scenario, HIV/AIDS-related psycho-neuropsychiatric problems identified by McDaniel, Purcell and Farber (1997) and Hunter (1993) become high possibilities among the people of Botswana. Complex mental health issues surround the problems of AIDS itself, and these have been investigated and discussed by other researchers. High incidence of depression has been reported among HIV-infected persons (Katz, Douglas, Bolan, Marx, Sweat, Park & Buchbinder 1996). In a related study, Catalan (1995) indicated that infection with HIV has severe psychosocial implications for the persons infected and those who are experiencing AIDS-related bereavement. This assertion were also supported by Sikkema, Kalchman,

Kelly and Koob (1995). High rates of suicide and suicide attempts have been noted elsewhere among HIV-infected patients (Millard 1995; Sherr 1995). The immense mental health needs of children living with loved ones who have AIDS or HIV infection were highlighted by Roth, Siegel and Black (1994). Similar mental health consequences of parental loss due to HIV-infection were described by Taylor-Brown, Teeter, Balckburn, Oinen and Wedderburn (1998). Scenarios like this can impact on the mental health wellness of the people in Botswana.

### *3.2.1.3 Nursing Education in Botswana*

Nursing education in Botswana is at the core of the education of health professionals in the country. Nurses constitute 63.87% of the total number of trained health personnel available in Botswana according to the report of the Health Manpower plan for Botswana 1988-2002 (MOH, Botswana & CHE University of York 1988:14). The projected health manpower development up to the year 2002 still expects that 6 out of every 10 trained health personnel will be nurses (MOH, Botswana & CHE University of York 1988:20-21).

Botswana runs five autonomous Institutes of Health Sciences that produce the majority of the trained nurses for the country. The five Institutes of Health Sciences evolved from being satellites of the multi-disciplinary National Health Institute with the main campus at Gaborone, when in April, 1993, the National Health Institute changed to the Institute of Health Sciences. This was in line with the objectives of the Botswana Government's National Development Plan 7 (NDP 7) "to increase training capacity and improve the

quality of training of health personnel” (MFDP 1991). The Institute of Health Sciences in Gaborone runs nine (9) programmes which include:

1. General Nursing,
2. Midwifery,
3. Family Nurse Practice,
4. Nurse Anaesthetist,
5. Health Education,
6. Environmental Health,
7. Medical Laboratory technology,
8. Pharmacy Technology,
9. Dental therapy.

Molepolole Institute of Health Sciences offers programmes in General Nursing, and Community Health Nursing; the Institute in Lobatse includes General Nursing and Community Mental Health Nursing in its programmes; Francistown offers General Nursing and Midwifery programmes, while Serowe is a centre for the training of midwives and for the upgrading programme from Enrolled Nurses to General Nurses (EN-GN). Qualified nurses are produced mainly by these Institutes in addition to 3 other mission oriented Colleges of Nursing at Kanye Adventist Mission Hospital, Mochudi’s Deborah Retief Mission Hospital, and Ramotswa’s Lutheran Mission Hospital.

Nursing Education in Botswana generally falls into three categories: Basic and post-basic diploma programmes are offered at the Institutes of Health Sciences and the affiliated Nursing Colleges and Schools, while the post-basic

degree programmes are offered at the University of Botswana. Table 3.1 presents the Nursing Education Programmes in Botswana, while table 3.2 presents the corresponding institutions offering these programmes (MOH 1992; University of Botswana 1997).

The basic or the pre-registration nursing programmes lead to the initial registration as Registered Nurse by the Nursing and Midwifery Council of Botswana. These include the 3-year basic general nursing (GN) programme, and the Enrolled Nursing to Registered Nursing (EN-RN) upgrading programme. The EN-GN upgrading enables the enrolled nurses to register as qualified general nurses after undergoing a specially designed 12 months full time upgrading programme for this purpose. The basic EN course, though already being phased out, before upgrading, was for a period of 2 years.

The Post-basic or post-registration nursing programmes are for Registered Nurses who are willing to pursue further courses of specialisation at the diploma levels. Such programmes include: post-basic midwifery, family nurse practice, nurse anaesthesia, community health nursing, and community mental health nursing programmes.

The University of Botswana offers a Bachelor of Education (B. Ed) Degree in Nursing as a 3-year post-basic nursing degree. It has also commenced offering Masters degree programmes in Nursing during the 1996/1997 session (University of Botswana 1997; ICN 1997:12).

**Table 3.1 Nursing Programmes in Botswana**

Level	Nursing Programmes	Requirement	Duration
Basic Diploma	1. General Nursing	School Certificate Cambridge 5 papers	3 years
	2. EN-RN Upgrading	EN Certificate	12 months
Post-Basic Nursing Diploma	3. Community Mental Health	Basic Nursing Diploma	12 months
	4. Midwifery	Basic Nursing Diploma	12 months
	5. Family Nurse Practitioner	Basic Nursing Diploma	12 months
	6. Nurse Anaesthetist	Basic Nursing Diploma	12 months
	7. Community Health Nursing	Basic Nursing Diploma	12 months
Post-basic Degrees	8. B.Ed Nursing	Basic Nursing Diploma	3 years
Graduate studies	9. Masters in Nursing	Bachelors degree in Nursing	2 years



The Basic General Nursing course in Botswana prepares the nurse as a generalist. It is designed as a broad based foundation type of training that will enable the nurse to function within the mainstream of the health care delivery system. The post-basic diplomas, on the other hand are expected to build on the broadly based generalist approach adopted in the pre-registration programmes, so as to satisfy the nursing specialisation demands in health care delivery to Botswana's citizens.

All Nursing training institutions are affiliated to the University of Botswana. The University of Botswana has responsibility for maintaining the standard of education to meet the requirements for the award of the Basic and Post-Basic nursing Diploma Certificates which are needed for registration with the Botswana Nursing Council (BNC).

### **3.2.2 The Federal Republic of Nigeria**

The Federal republic of Nigeria, situated along the West Coast of Africa, lies between latitudes 4 and 14 north of the equator, and longitudes 3 and 14 east of the Greenwich Meridian (Federal Office of Statistics 1985:1). It shares borders with Benin and Niger Republics in the West, Cameroon in the East, Niger and Chad Republics in the north, and the Atlantic Ocean's Gulf of Guinea and the Bight of Biafra in the south (see figure 3.2). Nigeria has an estimated area of about 923,770 square kilometres. The longest distance from north to south is 1,046 kilometres, and from west to east is 1,126 kilometres (Graf 1988:1; Federal Ministry of Information 1991:1).

The population figure in Nigeria is a statistic that has generated much controversy. Nigeria has a multi-ethnic population of over 100 million people (Graf 1988:1). From an official figure of 55.7 million in 1963, the present estimated figure can be “anything between 98 and 165 million” (Kuteyi<sup>2</sup> 1992:1). The estimated 1995 population according to the World Fact Book (1997:online) is 101,232,251 with 3.16% annual growth. This population makes it the most populous country in Africa. Its peoples are of great ethnic, linguistic, cultural, and social diversity. There are estimates that Nigeria has about 250 recorded languages (Hawes, Coombe, Coombe & Lillis 1986:6), and a figure of between 250 - 500 ethnic groupings (Graf 1988:5; Allan 1978:402). Nine of these ethnic groups are numerically dominant. These groups are the Hausa-Fulani group in the north west and north central parts of Nigeria, the Kanuris in the north eastern part, the Tiv in the Benue and the Plateau area of the middle belt region, and the Yoruba occupying almost the entire south western region of the country. The others are the Edo in the region between the south west and the south east regions, the Igbo occupying almost the entire eastern portion of the south of Nigeria, the Ibibio-Efik occupy the extreme south eastern part, while the Ijaw are found in the Niger delta area in the extreme south as the river opens into the Atlantic. Hausa, Igbo and Yoruba are the most widely spoken languages in the country, with English as the official language.

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<sup>2</sup> Dr OEK Kuteyi in 1992 was writing as the then Director of Population activities in the Federal Ministry of Health and Human Services, Nigeria.

The use of English as the official language in Nigeria reflects the bond that Nigeria has with the United Kingdom (UK). Partitioning of Africa at the Berlin Conference by the European powers turned the area known today as Nigeria, into a British colony in 1883 (Tenquist 1996:13).

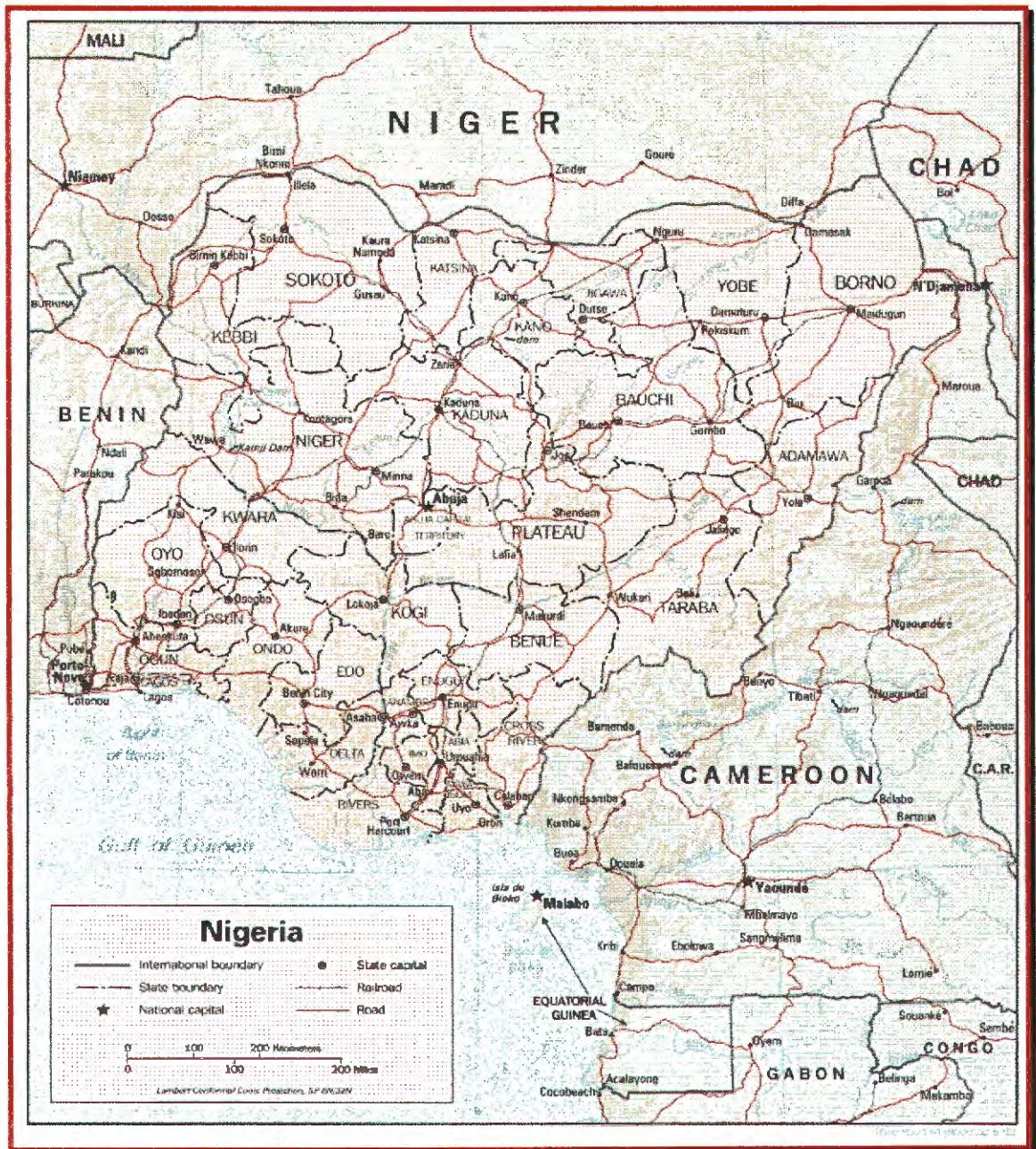


Figure 3.2: Map of Nigeria

Source: African Studies, University of Pennsylvania (available online: [http://www.sas.upenn.edu/African\\_Studies/CIA\\_maps/Nigeria\\_19877.gif](http://www.sas.upenn.edu/African_Studies/CIA_maps/Nigeria_19877.gif)).

The north and the south of Nigeria were former separate British Niger protectorates until amalgamation in 1914 when the country got the name Nigeria. It remained a British colony until independence on the 1st of October 1960. Though Nigeria is English speaking, it is exclusively surrounded by French speaking countries.

The principal religions of the people are Islam and Christianity. Estimating the size of the population for each religion accurately has the potential to become a volatile issue in Nigeria (Graf 1988:175). About 50% of the population are estimated to be Muslims, who are mostly found among the Hausa-Fulani and the Kanuris of the northern part, while about 40% are Christians of various denominations and sects, mostly found among the peoples of the southern parts and the Tiv in the middle belt (Federal Ministry of Information 1991). The remaining 10% are said to be practising traditional African religion. These are mostly those in the predominantly Christian area who continue to practise their traditional African religions despite a pervading Christian influence.

The Muslim-Arab influence is especially noticeable in the culture of the peoples of northern Nigeria, while the European and Christian influences are more noticeable in the behaviour of the peoples of the southern part. While the religious influence is indistinguishable from the indigenous cultural elements in the north, the European and the Christian influence has led to drastic conflicts with traditional values and attitudes of the people of the southern parts.

Abuja is the nation's new capital since December 1991. Lagos, the old capital, is the nation's major business centre. Close to 50 towns and cities are known to have populations varying between 100,000 and more than 1,000,000 people (Federal Ministry of Information 1991:4). The implications of urbanisation for Nigeria are captured by Young (1976:89):

*The rapid growth of cities creates social arenas where competition for survival is intense, and where the consciousness of other groups locked in combat for the same resources deepens.*

This type of scenario described by Young would be seen to have serious implications for mental health. Some of the major cities include Kano, a major centre for trans-Saharan trade for many centuries, Maiduguri, the capital of the old Borno Empire which used to be one of the largest states in the world during its heyday. Ibadan in Oyo State had a population of more than 1,000,000 in 1963. Oyo city used to be the capital of the old Oyo Empire whose boundaries extended into parts of the present day Benin Republic. Port Harcourt is the centre of operations in the oil industry, Calabar in the south east was the site of Nigeria's pioneering export zone. Urban population represents about 30% of the entire population. Population density is generally higher in the southern part than in the north. Over 40% of the population are below 15 years of age.

The climate in Nigeria is generally tropical, but differs sharply from the north, bordering the Sahara desert, to the south, bordering the Atlantic Ocean. The coastal climate is mainly equatorial, that of the far north is arid, the bulk of the middle portion between the north and the south is very tropical. There are two seasons, the dry season between November and April, when the dry dust-laden

north easterly winds blow across the country, and the rainy season, between the months of May and October, when the moisture laden south-westerly winds blow from the coast bringing in the rains. Rainfall in the south is about 1,500 mm per annum, decreasing to about 500 mm in the north. Temperature ranges between 22 degrees Celsius and 34 degrees Celsius. Several big rivers like the River Niger, from which Nigeria derives its name, Benue, Ogun, Oshun, Cross and Benue drain into either the Atlantic ocean or the Lake Chad at the north eastern corner of the country. The geographical features of the country firmly put it in the malaria parasite carrying mosquito belt.

Nigeria is a federal republic, presently having a thirty-six state structure. Military rule has prevailed for 28 years out of the post independence 38 years of Nigeria. The country survived a civil war that was fought to prevent secession between 1967 and 1970, with its attendant post war problems. Accounts of the war in Nigeria have been documented by the likes of Kirk-Green (1971) and de St Jorre (1972). Figures of lives lost during the war were put between 500,000 and 1,000,000 (Graf 1988:43). Thousands of others were maimed, and large amounts of properties lost. After the war, keeping a military force that developed to 250,000 from the pre-war number of less than 20,000 became unnecessary. Discharge from the army had a number of other implications such as joblessness and access to military weapons. Post-war studies conducted on the health of the people in other parts of the world had shown propensities for psychotic symptoms in association with chronic post traumatic stress disorders amongst soldiers and war victims (Hammer 1997). Incidence of major depressive episodes, bipolar disorders, alcohol or

polysubstance abuse, panic disorders and phobias were known to have increased among individuals exposed to war and violence (Achte, Jarho, Kyykka & Vesterinen 1991). The post war situation in Nigeria would therefore, appear to be capable of having some complex effects on the social and mental health of Nigerians. This is a situation that continues to underscore the need to have efficient and relevant psychiatric-mental health nursing care services that would be able to cater for the needs of the people of Nigeria.

Nigeria runs a three-tier system of government, the federal, the state and the local governments. The government operates a mixed economy in which private individuals, corporate bodies, and government participate in business activities. Major sources of government revenue are derived from petroleum exports, manufacturing and agricultural products. The 1994 estimated GDP purchasing power parity is put at 122.6 billion US dollars; with a per capita income of US\$1,250 (World Bank 1996:online). With a galloping inflation of 53% in 1994, unemployment at 28%, and an external debt of \$29.5 billion, the country continues its structural adjustment programme embarked on since the mid-80s. Political instability that has plagued the country since its independence in 1960 is evidenced by the series of successful or failed military coups which may have further aggravated the economic position of this country. Further investments are not coming because of the political instability. The impact on the mental health of the people may have to be estimated on the basis of the severity of emotions, which may normally accompany diminished access to funds for individuals in an atmosphere of

political and civil disorders. This kind of situation would call for programmes in preventive and promotive mental health care services, an indication for the need to have an effective system of producing capable psychiatric mental health nurses for the country.

### ***3.2.2.1 Education in Nigeria***

The current officially recognised educational system of the country is based on 6-3-3-4 model. The first 6 years are spent in the primary school, the subsequent 3 years in the junior secondary school, the next 3 years that follow in the senior secondary school leading to the award of the Senior Secondary School leaving Certificate, and the last 4 years in the University or other higher institutions of learning (Onokerhoraye 1984:18-26). Since higher education in Nigeria can be defined as “any form of education which takes place after secondary education” (Onokerhoraye 1984:24), nursing education that admits candidates only after completing secondary education qualifies as higher education. Schools in Nigeria are either government funded or privately owned up to the secondary school levels with variable standards. Universities are funded solely by federal or state governments. Undergraduate university education at the federal government owned universities is tuition free, but the students are expected to buy their own books, and stationery as well as pay for their own accommodation and feeding. Some of the state government owned universities might charge tuition fees where the states are not able to carry the burden of education for the state.

### *3.2.2.2 Health Care System in Nigeria*

Health care delivery is pursued in a multifaceted approach with greater emphasis on the PHC towards providing health for all by the year 2000. The national policy on health in Nigeria describes a 3-tier system of health care delivery. Formal health care is, therefore organised at three levels: primary, secondary and tertiary (Ransome-Kuti<sup>3</sup> 1992:7).

- i. Primary Health Care provides general health services of preventive, curative, promotive and rehabilitative nature to the population, and it serves as the entry point of health care.
- ii. Secondary health care provides specialised services to patients referred from the primary health care level through out-patient services and in-patient services of hospitals, for general medical, surgical, maternal and child health services. These facilities are provided at the district, divisional or zonal levels of the state.
- iii. Tertiary health care consists of highly specialised services which are provided by teaching hospitals attached to the medical schools of the universities; and other specialist hospitals designated to cater for either orthopaedic, ophthalmologic, or psychiatric problems. These are located in different areas of the country.

The above description represents the formal or the western style health sector. From available records, thirteen medical schools/teaching hospitals were

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<sup>3</sup> Prof Olikoye Ransome-Kuti in 1992, was the Federal Minister of Health in Nigeria.

listed. There were approximately 9,818 government-owned and 2,713 privately-owned health facilities with a total capacity of 96,776 beds (FMH, 1988)

Primary and secondary health care services, as a matter of national policy, are expected to be taken care of by the government at the local or state level, but a large number of these health facilities and provisions are funded and administered by religious missions, communities, non-governmental organisations or some individuals in private practice. The responsibility for tertiary care - referral hospitals - invariably lies with the federal government. (FMH 1988; Oladimeji 1990)

While the above western-style health care system may have been well described in the country's health care policy, Erinoshio (1989) and Ohiorhenuan (1988) noted the fact that health care delivery in Nigeria (and possibly in other developing countries of Africa) can be categorised under two distinct systems, namely, the local and the western style. Other writers referred to this as traditional and modern (Good, Hunter, Katz & Katz 1979; Onokerhoraye 1984). The local health care system consists of the traditional and/or the spiritual 'healers' whose services are extensively utilised by the educated as well as the non-literates in the country. Pearce (1988) reported that in Nigeria, though the western-style health system may be highly favoured in terms of utilisation, large numbers of people do patronise the faith healers, herbalists and the diviners. During prolonged illnesses, including *mental*

*health disorders*, people tend to use more than one type of health care delivery system.

### 3.2.2.3 *Health problems in Nigeria*

Health problems in Nigeria cannot be divorced from the socio-economic and cultural characteristics of the peoples of Nigeria. Like any typical developing African country, major health problems identified are those commonly attributed to ignorance, poverty and squalor (Akinkugbe, Olatubosun & Esan, 1981:25). Statistics (Kuteyi 1992:3; CIA 1997:online) point to age structures in Nigeria as:

0-14 years: 47%

15-64 years: 52%, and

65 years and over about 3%

Birth rate is 43.16 births /1,000 population, and 12.01 deaths/1,000 population.

Shehu (1981:25) identified the socio-economic and cultural characteristics of the peoples of Nigeria as:

*High proportion of young people - over 40% below the age of 15 years*

*Predominantly rural population where over 80% are in rural environs and are mainly illiterate*

*A predominantly agricultural economy with a generally low standard of living, and*

*Limited resources resulting in inadequate health infrastructure*

This assertion may sound strange to those who know Nigeria as a rich oil-producing nation. The same writer while talking about the health characteristics identified that communicable diseases are rampant, with a high incidence of malnutrition complicated by poor sanitary conditions. The mere

size and diversity of the social, economic and cultural status of the peoples of Nigeria have brought about complexity in the nature of health problems in the country. With the abundance of large urban and cosmopolitan cities all over the country, diseases associated with affluent and urban life styles have become common features of the health problems. Trauma from road accidents, industrial and domestic accidents, injuries sustained as victims of robbery and other forms of violence from civil or political actions, cardiovascular diseases, STDs/AIDS, malignancies, alcohol and drug abuse, are part of the major total health concerns of the peoples of Nigeria. Epidemiological studies in Nigeria have shown that mental disorders are as prevalent and incapacitating as in developed nations of the world (Abiodun 1991a; Jegede & Baiyewu 1989; Leighton, Lambo, Hughes, Leighton, Murphy & Macklin 1963).

#### ***3.2.2.4 Nursing Education in Nigeria***

From a figure of about 35 formal nursing or midwifery schools reported at the time of Nigerian independence in 1960 (Oyedepo 1985:31), institutions involved in the training and education of nurses and midwives in Nigeria today have increased to 152 (see appendix 1). These are:

Schools for basic nursing education	62
Universities for basic and post-basic nursing education	4
Schools for basic or post-basic midwifery education	62
Other institutions of higher learning for a number of post-basic nursing studies	24
Total	152

The NMCN is responsible for the setting, the supervision and the marking of examinations leading to approved qualifications in general nursing, midwifery and psychiatric nursing in Nigeria.

Approved nursing programmes recognised by the NMCN are generally in 4 categories (Appendix 2). The duration of each programme and the prescribed entry requirements in the various curricula are presented in table 3.1.

Nursing at the University level in Nigeria started in 1965 as a co-operative arrangement between the WHO, UNICEF and the University of Ibadan (Adelowo 1989:66). The purpose of university education for nurses at that time was to prepare registered nurses for leadership roles as nurse tutors and nurse administrators, to enable nursing to meet the changing needs in health services in Nigeria and Africa. Out of a total of thirty-seven universities in Nigeria today, only two more universities have since joined in the education of nurses at the degree and post-graduate levels. These are the universities at Ile-Ife and Enugu in 1973 and 1983 respectively, the former offering the BNSc comprehensive basic degree, and the latter offering a post-basic degree in nursing (JAMB 1997; Igbinosun 1990; and Olade 1996).

A fellowship programme in nursing was located at the University of Ibadan by the West African College of Nursing (WACN) to cater for the needs of the member West African states. An objective of this programme is to prepare clinical nurse specialists for the curative and preventive health care settings in

the West African communities<sup>5</sup> (Osei-Boateng 1992:178). The programme is usually of 2 years duration leading to an earned fellowship of the West African College of Nursing (FWACN) in any of the following faculties:

1. Medical-Surgical Nursing
2. Community Health Nursing
3. Maternal and Child Health Nursing
4. Psychiatric-Mental Health Nursing
5. Administration Management and Education (Adedoyin 1988:4)<sup>6</sup>

### *3.3 Historical Perspectives on Psychiatric-Mental Health*

Descriptions of individuals considered to be ‘mad, possessed, or lunatic’ abound in human histories, ancient and modern. Though beliefs about the causation of these ‘afflictions’ in the ancient times may be quite different from what is currently believed to be the causes, it is from these beliefs about the causation of the illness that care and cure approaches, as deemed appropriate, are developed and sustained (Gemma 1993; Nolan 1993). For example, a widespread belief in ancient times was that all illness and other health related problems were caused by supernatural forces, gods and demons of nature whose wrath have been incurred through violation of their rule(s) or by not

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<sup>5</sup> West African College of Nursing’s member states are The Gambia, Ghana, Liberia, Nigeria and Sierra Leone - mainly the Anglophone countries along the West African Coast.

<sup>6</sup> Dr Cecilia Adedoyin was the Co-ordinator for Nursing Affairs of the West African College of Nursing in 1988.

fulfilling their wish(es). From these beliefs about the nature of illness arose treatment and care modalities as provided by the attending ‘healers and caregivers’ of those days, which would seem to be based on a combination of magical and religious rituals (Gemma 1993). Similar beliefs still persist in several communities all over the world and especially the countries being studied, Botswana and Nigeria (Ben-Tovim 1987:54-58; Erinosh, Usman & Mkpume 1981:21-28). It is worth mentioning, however, that views of mental illness, which are surprisingly contemporary, differing from the previously held belief of supernatural causes, have been reported as early as the period of Hippocrates. Hippocrates seemed to have pioneered the knowledge that illness should be ascribed to natural rather than supernatural causes (Singer 1928). The Romans were reported to have built institutions for the poor and the mentally ill, while Cicero was known to have developed an interview guide similar in content to the contemporary ones for the assessment of mental health status of disturbed and distressed individuals which was extensively used by physicians throughout the Roman Empire (Clarke 1975). During this period, another Roman physician and a teacher, Seranus, was reported to have surprisingly taught that healing was contingent upon *caring relationships* (Nolan 1993). This, apparently, became a view to be echoed centuries later by the likes of Peplau (1952, 1988), Rogers (1942, 1961, 1970) and Sullivan (1953, 1972).

There was no major development reported in the scientific care of the mentally ill until the later part of the nineteenth century. Treatments were largely primitive and neglectful through the middle ages, but, at best spiritual as the

church provided care to the poor and the insane, with monasteries allowing penitents or those who were severely disturbed to live with the monks and participate in their spiritual exercises and daily work (Clarke 1975). In Europe and England, though special institutions were reported to be existing for the custody of mental patients in the 14th century, the goal of such institutions at that time was exploitation rather than curing, as reported by Critchley (1985). The keepers in these institutions were there to collect fees for putting the patients on public view. It was not until about the middle of the 18th century that William Battie (1707-1776), a pioneering physician in the treatment of mentally ill patients, recommended that attendants of the mentally disordered in the madhouses, asylums and the hospitals be carefully selected and trained, after he had concluded that a caring environment promoted healing (Nolan 1993). This model of custodial care marked the advent of the care for the mentally ill throughout history in Europe and America (Nolan 1993; Burgess 1981). The emphasis of custodial care initially was actually the protection of the society from the 'deranged' patients, keeping the patients safe, and managing their lives for them since they were deemed incapable of managing their own lives (Burgess 1981). This implied that patients were to be chronically institutionalised with only a remote possibility of returning to their family or community.

The development of psychiatric nursing and psychiatric nursing education can only be appreciated against this background of the treatment and care of the mentally ill. Although nursing functions have existed since ancient times, the emergence of professional nursing, and specifically of psychiatric nursing, is a

product of the late nineteenth and twentieth centuries in the western world and elsewhere in Africa and other developing countries (Wilson & Kneisl 1992:16). Reports indicated that Theodor and Friedericke Fliedner at Kaiserworth in Germany founded the first systematic school of nursing in 1836. This was the school allegedly visited by Florence Nightingale in 1851 before she organised a nursing school in England after the Crimean War (Wilson & Kneisl 1992:16). Credit, however, must be given to Nightingale for being one of the first to note that nursing care has a psychosocial as well as a biological component, and that the influence of nurses on their clients goes beyond just physical care, but that it equally has psychological and social effects (Nightingale 1946, 1992). In the spirit of this assertion by Florence Nightingale, Linda Richards, a graduate of Boston Training School, in the USA, who believed that the mentally ill required skilled nursing care, developed the first well reported psychiatric training programme for nurses at McClean Hospital in Boston, USA in 1882 (Burgess 1993; Carter 1986; Martin 1985).

Historically, psychiatric nursing education appears to have had a parallel, rather than an integrated, development with general nursing education. The need for psychiatric nurses in most instances developed from the custodial needs of asylum inmates. Such is the origin and the advent of formal psychiatric nursing training reported in the USA as far back as 1882 and at the instance of the Royal-Medico-Psychological Association (RMPA), now the Royal College of Psychiatrists, in Great Britain at about 1890 (Brooking 1985).

The first formal training centre for psychiatric nursing in Nigeria was established in the year 1950 after the asylum at Lantoro in Abeokuta changed its name to the Lantoro Hospital towards the end of the 2nd World War. (Adelowo 1989:52). Ben-Tovim (1987:78-80) described a similar situation for Botswana. The years 1946-1978 were referred to as the asylum years for Botswana (Ben-Tovim 1987:78). With a total number of 496 psychiatric patients on admission in Lobatse Mental Hospital at a point in 1978 (Ben-Tovim 1987:80), and only nine (9) psychiatric nurses in practice in the whole of the country by 1979 (p. 83) it was clear that more nurses with mental health care skill would be required in a country like Botswana. It was with this background that the community mental health nursing programme started in the late 1980s at Lobatse, as one of the post-basic nursing programmes of the National Institute of Health, now the Institute of Health Sciences, to address the mental health care needs of the country (Botswana MOH 1989:5).

### *3.4 Health, Mental Health and Mental Disorder*

Viewed in consonance with the World Health Organisation's (WHO) definition of health, health is a composite of the social, psychological, physical and spiritual well-being of individuals, families, groups, and communities which must be promoted, maintained and restored (Stewart 1990). Health or wellness is viewed by Neuman (1982) as the "condition in which all parts and subparts (variables) are in harmony with the whole of man". Health is normally viewed as a dynamic state on a continuum, with most individuals falling somewhere between absolute health and absolute disease. Harmony

here presumes that man is in reciprocal action with the environment, which is made up of surrounding internal and external forces. These forces continue to produce constant changes. When in harmony, individuals experience wellness, and disharmony reduces the wellness state. In this light, the consideration of the environment becomes critical because it accounts for, and contributes to the needs, drives, perceptions and goals of all living beings. According to Antonovsky (1985) a few of the many components that comprise health are physiological, psychological, social, cultural, and spiritual factors. Neuman (1982) further maintains that a person is in an optimal state of health when the person's total needs are met.

Meanings assigned to concepts like mental illness, psychiatric illness, mental disorder and mental health are influenced by who is using the term, the purpose of use and the audience. Whereas the definition of mental disorder as proposed by the DSM IV is that of a "clinically significant behavioural or psychologic syndrome or pattern that occurs in an individual that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability)", researchers have found out that concepts like "mental health" and "mental illness" do not arise exclusively from the individual (Longo & Williams 1986:265). Neither can mental health or illness be ascribed exclusively to changes in the psychological functional status of the body's (brain's) biochemistry of the individual. Wilson and Kneisl (1992:3) pointed out that these concepts are interactional and derive their meanings from the definitions given to certain acts by certain audiences and at specific times. They are outgrowths of intra

and interpersonal processes. The point being stressed here is that in understanding mental health and the phenomenon of mental illness, it will not be enough to study the bio-psychological determinants of mental health status alone, but it will be necessary to look at the social conditions under which someone is labelled “mentally ill”, who applies the label and what are the consequences of the labelling.

In describing the phenomenon of mental illness, Irving (1983) asserts that mental illness is different from all other kinds of illness. Her impression is graphically captured by the following statements:

*In the first place, it is neither mental nor illness in the usual sense. It is not a disease of the brain or intellect, although it affects both. It is not a disease of the body with physical symptoms, although it may include these. It is not a disease of the culture or society in which it occurs, although it may affect both. In an attempt to lessen the strangeness of mental illness and promote greater acceptance and understanding of it, we have bent over backwards, perhaps too far, in insisting that it is like any other illness, “like breaking a leg,” for instance. But it isn't a disease like any other. It is instead a disease of adjustment, a faulty way of living, and its symptoms are expressed in the way one behaves. It is an inability or failure on the part of an individual to behave in accord with the expectations of his society. Mental illness affects the whole person, and all of his functions. He does not think, feel, act as he should, that is, in accord with reality. There may be disruptions in the physical, emotional, or social aspects of his being. The paradoxical, inappropriate, unacceptable, unrealistic, ways in which he behaves are the symptoms of his illness. (Irving 1983 :7)*

Patients' behaviour cannot be classified as funny or sad, good or bad. Despite the fact that mental illness affects the entire person, not only certain parts, patients do have areas of healthy as well as sick functioning. Some patients are known to function well except for specific kinds of distortions in their thinking. A mentally ill patient is similar to, yet different from every other person. The degree of his health or illness depends upon how well his interactions with people around him satisfy his basic human needs. The form

his illness takes is related to the kind of person he is, the way he has learned to behave, and the amount of success he has had in his experiences with others.

### *3.5 Nursing and Psychiatric-mental health Nursing*

Nursing is primarily concerned with meeting the health care needs of individuals and the society (ANA 1976). Flowing from King's (1971) theory of goal attainment, the basic assumption is that nursing involves caring for human beings with the goal of health. Neuman (1982) states that the function of nursing is to assist individuals, families and groups to attain and maintain a maximum level of total wellness by purposeful intervention. Psychiatric-mental health nursing clearly shares the common mission of nursing; it is concerned with preventing and correcting the impacts of mental disorders and their sequelae, as well as the promotion of optimal mental health for society, the community, and those individuals who live within it (ANA 1976). In the words of Fox (1988), psychiatric nursing's focus is on meeting and promoting the physical, psychological, functional, social and spiritual health care needs of mentally ill individuals on a 24-hour basis. Fox's description of psychiatric nursing here focuses on the role of psychiatric nurses as providers of health care to meet the total needs of a mentally ill individual.

Similarities abound in the history of psychiatric nursing all over the world. It has often developed with the care of the mentally ill from custody to the community (Barker 1990; Grob 1991; Hunter 1974; Klein 1981; Nolan 1991; Osted, Katz, Neufeld & Jennings 1986; Smoyak 1993). Psychiatric nursing

from these reports would appear to be closely linked with each country's history of psychiatric care. These histories, almost without exception, have trends that link psychiatric nursing evolution from the asylum to the community. Jones (1972) documented, in three parts, the development of mental health services from the time of the asylum system in Britain, the disappearance of the asylum system, the emergence of hospital care and the gradual deinstitutionalisation of mentally ill people.

Modifications in attitudes and approaches to care appear to have progressed as the mentally ill moved from asylum into psychiatric or mental hospitals specially designed for the mentally ill, and later into the general hospital settings. The advent of care of the mentally ill in an integrated care setting which allows the mentally ill to be taken care of within a traditional general care setting probably created the need to further look at the training agenda in nursing education. This trend has matured in the context of PHC in several countries of the world to a more contemporary approach that puts the care of the mentally ill within the context of their own community (Church 1986; Grob 1991)

Psychiatric Nursing and mental health nursing are terms that have been used interchangeably in the past. Since the first introduction of the phrase "psychiatric and mental health" at the 1951 conference of the National League for Nursing Education in New York<sup>7</sup>, the trend is to refer to 'psychiatric - mental health nursing' (Martin 1985:50). This would appear to be a more

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<sup>7</sup> The National League for Nursing Education in the USA held a conference on Advanced Programmes in Psychiatric and Mental Health Nursing in New York, 1951.

comprehensive term embracing a focus on mental health and mental illness. While there may be several ways of describing psychiatric- mental health nursing, a great deal of agreement exists in the focus of the definition of several authorities. The American Nurses' Association (ANA) as far back as 1976 defined Psychiatric-Mental Health Nursing as:

*...a specialised area of nursing practice employing theories of human behaviour as its science and purposeful use of self as its art. It is directed toward both preventive and corrective impacts upon mental disorders and their sequelae and is concerned with the promotion of optimal mental health for society, the community, and those individuals who live within it. (ANA 1976:5)*

In a glossary of terms, Wilson and Kneisl (1992:999) echo this position of ANA by defining psychiatric nursing as “a speciality within the nursing profession in which the nurse directs efforts toward the promotion of mental health, the prevention of mental disturbance, early identification of and intervention in emotional problems, and follow-up care to minimise the effect of mental disturbance”. The preventive and the rehabilitative components of this definition puts it on course with the PHC approach to health care delivery. These are the undeniable emphases of contemporary strategies for health care delivery in all the corners of the globe.

Four core mental health professions are usually described. These are: psychiatric nursing, psychiatry, psychology and social work (Stuart & Sundeen 1983:12). The common ground for the four core mental health professions will appear to be their concern with mental health problems. Psychiatric nursing has, however, been identified to have a wider scope of concern. Writers generally agree that within the context of the contemporary

approach to health care, the phenomena of psychiatric and mental health nursing extend to care in wide-ranging human responses to mental distress, mental disability and mental disorder (Loomis, O'Toole, Brown, Pothier, West & Wilson 1987; Wilson & Kneisl 1992:4)

This aspect of nursing, therefore, is faced with dealing mainly with behavioural rather than physical symptoms of illness, an additional skill that must be compulsorily acquired and developed by nurses who want to care for the mentally ill or who find themselves in a situation where they must care for clients with mental or emotional disorders. The first task in psychiatric/mental health, in the words of Irving (1983:7), therefore, will be for the nurse to learn to understand human behaviour and learn to accept her client's behaviour as part of the symptoms of his illness, requiring attention in such a way that he is helped to find more effective ways of responding to life experiences.

Smoyak (1993), summarising the uniqueness of psychiatric nursing viewed against the other three core mental health disciplines writes:

*While all four of the core mental health professions share roughly the same body of knowledge, the psychiatric nurse is unique in the following respects; 1) uses biological as well as psychosocial theories in providing holistic health care, 2) provides continuity of patient care, 3) plans, monitors, and executes transitions for patients among modalities, services, and settings. and 4) defines the jurisdiction of his or her practice to be the diagnosis and treatment of human responses to actual or potential health problems.*  
(Smoyak 1993:321).

Some authors refer to psychiatric nursing as being the basis, the heart, the core and the very art of nursing itself (Peplau 1952), while others think of psychiatric nursing as being strictly limited to the care of patients diagnosed as mentally ill. Irving (1983), however, reiterates that the primary purpose of

psychiatric nursing is to help the patient find greater satisfaction of his basic needs and more effective ways of behaving in order to obtain that satisfaction—in other words, to help the patient find greater success in living.

She further writes:

*Psychiatric nursing is definitely not a neat set of procedures or rituals that ends with a cure. It is rather an arduous, personal, human struggle toward health.... a process of human communication which involves two people, one a nurse and the other, a patient, and their relationship, the sum of their interactions with one another (Irving 1983:7).*

### 3.6 The Psychiatric Nurse

In strict professional usage, there may be discrepancies in who is recognised as a psychiatric nurse depending on the country and the professional orientation of the user. According to the ANA, a psychiatric nurse is a registered nurse in a psychiatric setting who possesses a minimum of a bachelor's degree (Wilson & Kneisl 1992:999). There is, however, evidence that two categories of psychiatric nurses are recognised in the USA. These are the psychiatric nursing generalists and the psychiatric nursing clinical specialists. The former may have received basic nursing preparation in a diploma, associate degree or baccalaureate programme while the latter are graduates of a master's programme providing specialisation in the clinical area (Stuart & Sundeen 1983:11; Wilson & Kneisl 1992:37). In Britain, as reported by Bowers (1996) psychiatric nurses usually have three years basic psychiatric nursing education in one of the hospital-based schools of nursing, a one year post-basic education in psychiatric nursing (RMN) or a one year post-basic community psychiatric nursing (CPN). In Botswana, a psychiatric

nurse must be a registered nurse with at least a diploma in psychiatric or community mental health nursing. In Nigeria, a psychiatric nurse must possess at least the equivalent of a 3-year post-secondary school training in psychiatric nursing acceptable for registration with the NMCN, without necessarily being a registered general nurse, or a 12-18 months post-basic general nursing training in psychiatric nursing, also registerable with the NMCN. Peplau (1962) described the psychiatric nurse as a clinical specialist in interpersonal techniques. A clinical specialist, from the USA point of view, must be prepared at the masters' level in order to be qualified for that role (SERPN 1996:33).

### *3.7 The psychiatric nursing student*

Characteristics of psychiatric nursing students vary according to how psychiatric nurses are prepared. Psychiatric nursing students will differ in situations where training schools prepare direct entrance students who have not received any other form of basic education in general nursing, when compared with those schools preparing psychiatric nurses at a post-basic nursing level. Students prepared at the university levels would also seem to differ in some characteristics when compared with those prepared at the pre-university entrance levels, even if only by educational requirements.

Studies have shown that requirements for admission into a psychiatric/mental health nursing training or educational programme vary, depending on the country and the type of nursing programme. While success in high school

examination is enough in some countries, others require at least a basic qualification in general nursing, in other instances a non-nursing degree from a University is all that is required to enter into the clinical speciality of psychiatric nursing (Adelowo 1989; Wright 1988). Pre-entry requirements will be found generally to fall into the following categories: basic educational qualification, age, experience and motivation.

Irving (1983) opined that the nursing student who is aspiring to be a psychiatric nurse is a unique individual, but like other individuals, a product of her own life experiences. She is not a particular kind of personality, or set of attributes, or accumulation of special qualities as we are made to believe in some old classic texts about nurses, but someone trying to acquire, and adjust to, specific knowledge and skills required in caring for others, in this case, the sick and the mentally disturbed. In essence, the nurse who is beginning her study and practice in psychiatric nursing is often most likely to be influenced by some of the commonly held misconceptions about the mentally ill, the causes and courses of psychiatric illness, their treatments, and how other human beings should handle the problems of mental illness. She may also have her own idea(s) of what nurses would be expected to contribute to the care of the mentally ill. She will, therefore, have her own attitudes, feelings, and actions towards the care of the mentally ill. Sometime these attitudes, feelings and actions, if unmodified, may be inappropriate and harmful rather than helpful to patients. One can infer from this premise that an aspiring psychiatric nurse must be able to recognise, understand, and correct her own inappropriate attitudes and approaches to care if she is to deal therapeutically

with people. Psychiatric nursing students are invariably required to possess a degree of maturity, motivation, determination and a pre-entry level standard of educational preparation that would be suitable for the type of learning expected in psychiatric nursing education programmes.

### *3.8 Evolution of Psychiatric Nursing Education*

Most of the histories of formal psychiatric nursing education derive from what is known about the evolution of psychiatric nursing education in Great Britain and in the USA. These are the two countries that have most significantly influenced the educational and professional developments of all aspects of nursing in Botswana and in Nigeria (Adelowo 1989; Selelo-Kupe 1993). Reasons advanced for these influences would be that Nigeria and Botswana were former British colonies, while human and material resources for the education, training and practice in nursing had largely been American or British oriented. Very little information about psychiatric nursing education in Africa exists in relation to the period preceding the Second World War. Historical reports from the two countries of influence, Britain and the USA provide similarities in the way the need for attendants trained to relate humanely with the asylum inmates was identified. Nolan (1991) and Peplau (1989) described similar situations for Britain and the USA, respectively, chronicling how the informal training of the asylum attendants developed into the establishment of first training programmes for people who had to care for the mentally ill in these countries. Several reports point to the fact that formal psychiatric nursing training began at the McClean Psychiatric Asylum in

Waverly, Massachusetts, USA, in the later part of the 19th century (Carter 1986; Gemma 1993; Martin 1985; Nolan 1991; Peplau 1989; Smoyak 1993). Available records show that these first psychiatric nurses graduated from the school at Massachusetts in 1882. In Great Britain, the preparation of 'mental nurses' as a form of inservice training was reported to have begun a little later. Nolan (1991) reported that training started at the Royal Albert Asylum in Lancaster about 1886, while Anton (1981) reported that the inauguration of a national training scheme for mental nurses was in 1890. Both authors confirmed that the registration and recognition of this form of psychiatric nursing training belonged to the medico-psychological Association, and not the nursing council. Graduates of these psychiatric nursing programmes, unlike the graduates of general hospital schools of nursing, could find employment only in asylums. The belief then was that nurses caring for clients with physical disorders should be trained in a general hospital and that those caring for clients with mental disorders should be trained in a psychiatric hospital. This notion dominated nursing education well into the 20th century. America was faster in recognising the negative implications of this split in the preparation of nurses, in that within a short time, psychiatric nursing components became an essential part of the basic nursing curriculum. As early as 1897, nurse educators in the USA had been calling for broad and liberal education for "all those who call themselves trained nurses", and for "sufficient variety in nursing experiences to produce all-round trained nurses" (Peplau 1982). One of the earliest responses to this call was the inclusion of psychiatric nursing components in the curriculum of general nurses by the

school of nursing at Johns Hopkins Hospital in 1913 in the USA. This heralded the beginning of a slow but very important change in the structure of nursing education programmes for nurses. By around 1935, fifty percent of the psychiatric nursing schools in the USA had been affiliated to general hospitals so that psychiatric nurses at that time could have 2 years training experience in a mental hospital and one year in a general hospital. By 1955, a psychiatric nursing component had become mandatory in the curriculum of trained general nurses in the USA. This was so because the National League of Nursing (NLN) of America made the provision of a clinical experience in psychiatric nursing in addition to teaching psychiatric nursing contents, a requirement for the accreditation of nursing schools in that country (Martin 1985). The obvious intention of the American model of nursing education was to bring all the components of the nursing field into the generic nursing curricula. Baccalaureate education of generalist nurses with integrated psychiatric mental health and behavioural concepts in the general nursing curriculum paved the way for academic graduate education in psychiatric nursing at the graduate and the post graduate levels. The quest for what to teach in a psychiatric nursing graduate curriculum, according to Peplau (1989) invariably resulted in educating the would-be psychiatric nurse specialists to develop one-to-one nurse-patient relationship skills. The need for these skills led to the development of the psychotherapeutic dimensions (psychotherapeutic model) in psychiatric nursing education and practice. Today, psychiatric nursing education in the USA is integrated in all clinical nursing courses, specialisation is at the graduate level, with a focus on the

psychotherapeutic dimensions of practice, and the care of the mentally ill or the mentally disabled in the community (Peplau 1989).

The training of the asylum attendants in Britain on the other hand was left in the hands of the medico-psychological association, and it was only in 1923 that the General Nursing Council of Britain inaugurated its own training scheme for mental nurses (Nolan 1991). This was reported to have run parallel with the Royal Medico-Psychological Association's mental nursing programme until 1951, when the latter ceased. The General Nursing Council in Britain awarded the "Registered Mental Nurse" certificate to the graduates of psychiatric nursing programme after three years of training. The syllabus, at that time, concentrated on anatomy, physiology and first aid in the first year; physical diseases in the second, and psychiatry and nursing in the third year.

The early psychiatric nursing curriculum and texts were influenced by the nature of the setting where care was given, and the psychoanalytic explanations of mental health problems which started to gain grounds at the turn of the century. Nurses who would function in psychiatric settings were taught mainly by physicians, with materials largely based on the writings of Freud and his followers. At that time, the focus of psychiatric nursing activities was the provision of 'kind' but custodial nursing care to the inmates of asylums or mental hospitals. Smoyak (1993) reported on the training given and the expected role of the early psychiatric nurses who received such training. The work that would be ascribed to the nurses then, was managing

the environment and assuring that the patients' basic needs for nutrition, hygiene, safety, and fresh air were met (Smoyak 1993). The pattern of education required greater period of time to be spent in the wards and less in the classroom. Specific medical-surgical procedures were added to the custodial care syllabus of psychiatric nurses with the advent of the somatic therapies. These added skills became necessary when psychiatry introduced treatments like deep sleep therapy, insulin shock treatment, psychosurgery and electro-convulsive therapy, into the management of psychiatric patients in the 1930s. The expected roles of the psychiatric nurse received new emphasis during the 1950s with the advent of interpersonal theories. This must have marked the beginning of the development of the psychotherapeutic role for nurses, and in particular, psychiatric nurses.

While in the beginning, Britain and the USA had similar training courses for general and psychiatric nurses in schools of nursing, largely based in general and mental hospitals respectively, by 1946 in the USA, efforts were already in process to move most basic nursing education programmes to the baccalaureate level. In fact, the first university based, three-year hospital nursing programme was started in 1909 at the University of Minnesota, in the USA, and by 1919, it had developed into a five-year baccalaureate nursing programme (Ellis & Hartley 1992:59).

Martin (1985) further chronicled some major events that modified psychiatric nursing education between the years 1949 and the 1950s. In 1949, a conference organised by the National Institute of Mental Health in the US

recommended a guideline for putting mental hygiene content primarily into the baccalaureate nursing programmes and including psychiatric content at the graduate level. By 1951, the conference of the National League for Nursing Education in New York looked at advanced programmes in psychiatric-mental health nursing where an agreement was reached to designate the basic nursing graduate as a 'staff nurse' and a graduate of an advanced nursing programme as a 'psychiatric nursing specialist'. The consensus among the nurse educators at this time was that nursing education should be upgraded to provide knowledgeable use of psychiatric-mental health and behavioural concepts in patient care. With this mainstreaming of psychiatric nursing into the nursing education programme, psychiatric nursing education as a speciality got gradually moved from its largely diploma and baccalaureate base to the realm of master's preparation, in the USA.

In contrast to the American approach, Britain had historically offered nursing courses at certificate levels. Psychiatric nursing, like General Nursing, was offered as basic pre-registration programmes, and it was only recently, in the 1990s, that Britain started having post-basic psychiatric nursing programmes. The Community Psychiatric Nursing (CPN) course, in particular, was offered as a diploma or combined with a degree rather than certificates (Bowers 1996). The innovations of Project 2000, in Britain, have just brought the UK pre-registration education of nurses to diploma level, and it is being recommended that the post-basic education, like psychiatric nursing, should move to the degree level, as enshrined in the post registration education and practice policy (PREP) proposals of 1994 (UKCC 1986, 1994). Demands for

academic status in the training of nurses in general, not only psychiatric nurses, need to be seen as part of the general move drift towards higher educational standards for the improvement of nursing care as well as enhancing the status of nursing as a profession.

The models of training for general nurses and psychiatric nurses particularly in Britain, probably owing to colonial bond, and less so in the USA, would seem to have influenced the pattern of training used in the production of trained nurses in Nigeria and Botswana to date (Adelowo 1989, and Selelo-Kupe 1993).

### *3.9 History of Psychiatric Nursing Education in Nigeria and Botswana*

From available records, psychiatric nursing training would be deemed to have started in Nigeria about 1944. This was during the time that the institutions generally referred to that time as lunatic asylums or prisons were established, and some untrained attendants were appointed to give custodial care to the inmates. Adelowo (1989) reported this phenomenon, and explained that the main objective of these institutions and the type of training given to the attendants that time was to be able to keep and maintain the mentally ill patients in custody. Custodial care was to ensure that the inmates would not constitute any danger to themselves or to the public. The need to have such custody must have been accentuated by the large number of patients resulting from World War II. Studies have reported an upsurge of World War II related mental disorders consequent upon brain injury (Achte et al 1991), accusations

of unpatriotic conduct (Retterstol & Opjordsmoen 1991), post traumatic stress disorders and neurotic reactions (Jaffe 1968; Niederland 1968). Similar higher psychiatric hospital admission rates were reported by Beebe (1975) and Dohan (1966) when describing the sequelae in the Pacific conflicts of World War II. By 1947, the colonial government in Nigeria would appear to have adopted a more contemporary view of the mentally ill, by hiring a qualified psychiatric nurse from Britain, and awarding study scholarships to some Nigerians to study mental health nursing in the UK. By the year 1950, the first formal training centre for psychiatric nursing was established at the Lantoro Mental Hospital in Abeokuta, to offer a 'selection course' for inspectors and clerical officers who were interested in, and sufficiently motivated to study, psychiatric nursing at that time (Adelowo 1989:52). The attendants in other lunatic asylums located in Yaba and Calabar also took advantage of this selection course. The selection course continued until the arrival of the then Dr Adeoye Lambo<sup>8</sup> from England to Abeokuta in 1954. He improved on the selection course and established the premier school of psychiatric nursing in Nigeria at Aro Mental Hospital in Abeokuta. Official recognition as a Nursing training institution was accorded the school in 1958 by the Nursing Council of Nigeria. The school remained the only psychiatric school of nursing in Nigeria until 1972 when another psychiatric school of nursing opened in Enugu, in the eastern part of Nigeria, for a post-basic training of registered nurses who wanted psychiatric nursing as a second nursing qualification. Subsequently, more psychiatric schools of nursing were established in

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<sup>8</sup> Later as Professor Adeoye Lambo, the first Nigerian psychiatrist, and former WHO Deputy Director General, now retired.

Kaduna, Calabar, Benin, Aba and Eket. At the time of writing this report, Nigeria has seven formal schools of psychiatric nursing spread over the country (NMCN 1997). By the end of October, 1997, a total of 3,859 names were listed on the register of psychiatric nurses by the Nursing and Midwifery Council of Nigeria (NMCN 1997).

The NMCN is solely responsible for prescribing the minimum standard for the nursing curricula in Nigeria. These various nursing curricula were expected to have psychiatric-mental health nursing components in them. In essence, curricula for the training of General Nurses, the Midwives, Psychiatric Nurses and other post-basic nursing programmes are developed by the NMCN. This, in the words of Smeaton (1982:80), when referring to similar experience in Britain, "... is, nevertheless, merely a syllabus to be administered and not much of a mandate to nurse educationists to develop a curriculum...". A situation like this, where emphasis are only on training without due consideration for broad based education, becomes an important issue to be considered when nursing programmes demand the status of education and not just training (Aina 1976). The existing situation described here must be another inherited tradition from Britain, that appear to be the source of most of the educational models in Nigeria.

In Botswana, psychiatric nursing education is a much more recent phenomenon. The hospital for the mentally ill was built in Lobatse as an asylum in 1946 and was changed to the State Mental Hospital after Botswana's independence in 1966 (Ben-Tovim 1987:79). From fewer than 70

patients in 1966, the number of in-patients at the Lobatse Mental Hospital rose to 120 in 1970, 200 in 1972, and 415 in 1974. Although by 1978 the Hospital contained 496 patients, mental health nursing schools were not yet available in Botswana at that time. The earliest trained psychiatric nurses in Botswana received their professional education from other countries in Africa and Britain. Only in 1982 with support from the WHO, was a post-basic community mental health nursing programme started at Lobatse mental hospital to supply Botswana with specialist nurses in community mental health nursing. The programme of mental health nursing education in Botswana would therefore be largely influenced by the WHO's strategy for the delivery of mental health services in developing countries. The central concern of this strategy was the "decentralisation of mental health services, integration of mental health services with the general health services, and the development of collaboration with non-medical community agencies" (WHO 1975:5). As at the middle of 1998 in Botswana, the total number of nurses registered as psychiatric nurses in Botswana was a hundred and ninety three (193). There were just nine of them in 1979 (Ben-Tovim 1987:83). Basic psychiatric nursing skills required for the care of the mentally ill and to work in mental health care setting are an integral part now of the basic diploma nursing curriculum.

### 3.10 Models of Psychiatric Nursing Education

Literature is replete with different descriptions of educational models that have been adopted at various times by educators concerned with the design of educational programmes for nurses. Searle (1988:168) asserts that “nursing education determines the nature of nursing”. Brooking (1985) graphically brought home this assertion while describing the association between the level of care and the educational provision for psychiatric nursing in Great Britain (see figure 3.3).

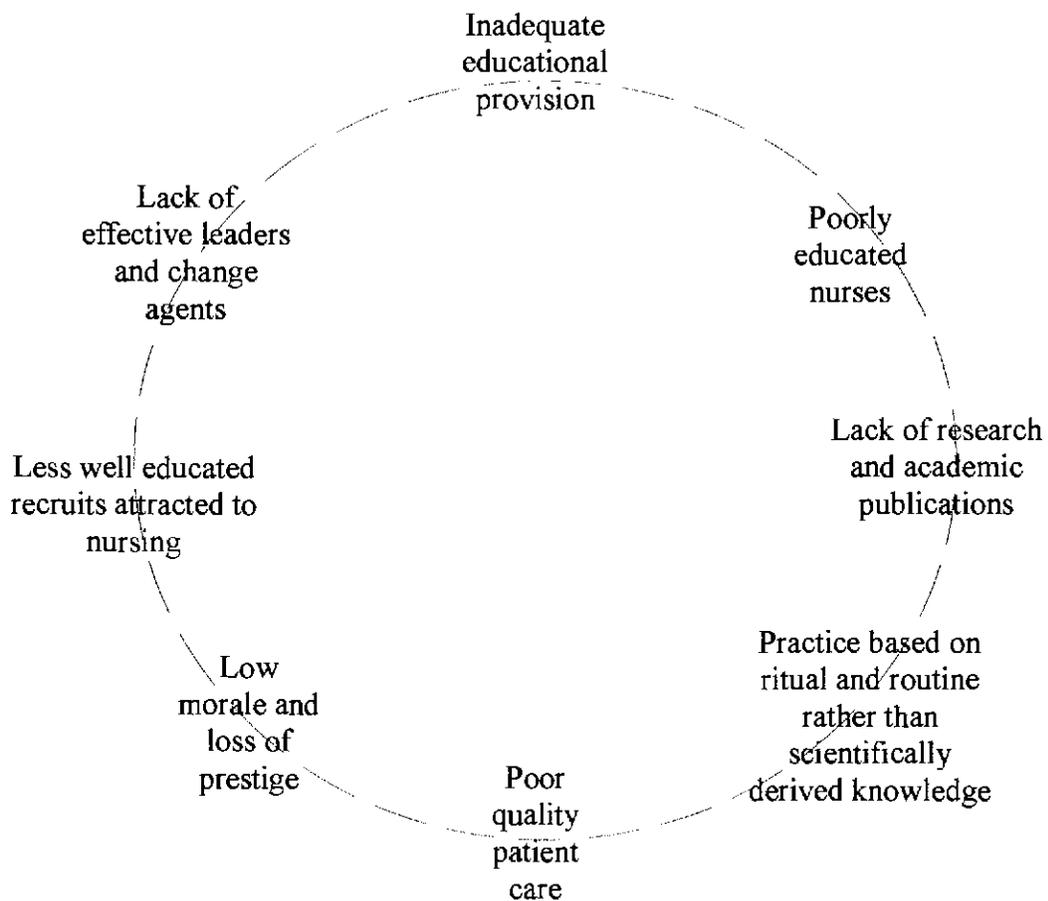


Figure 3.3: The vicious circle of continuing low levels of care in psychiatric nursing (Brooking, 1995)

Brooking's link of nursing education with the type of care available in Britain at that time can be applied to similar situations that occur elsewhere in developing as well as developed countries. Dobbs (1988), Martins (1988) and McCain (1985) have demonstrated the role of the type of nursing education received in the professional socialisation of nursing students. Professional socialisation of nursing students is seen as a developmental process occurring primarily during the period of formal education. The socialisation of nursing students would be expected to lead to motivated, independent, responsible performance of acquired competencies, and a commitment to professional practice.

Models of nursing education, and in particular of psychiatric nursing education, have been individually and collectively influenced by the history of nursing education. In developed countries, the general educational system, level of technological advancement, shifting emphases of health care, the need for professional development, socio-political and economic phenomena would be a few of the factors that influenced their choice of educational models. The following models of nursing, or psychiatric-mental health nursing, education have been described at different times in the literature. While the descriptions may have separated the concepts, it will be unusual to find an educational programme utilising only one of these models. What is usual is to have a programme combining two or more of these various models in the implementation of programme goals. The following are samples of models that have been described at various times, and are in no way exhaustive.

- **Apprenticeship:** Students are trained in hospitals' schools of nursing, and are paid for their education by apprenticeship. Students learn on the job as paid students. Services are expected in return for the money received. Students are part of the work force in the hospitals or the clinics. Historically, education or training of nurses in many parts of the world evolved through this model. Nursing education up till the early half of this century in the USA followed this pattern (Ellis & Hartley 1992). The scenario has only recently changed in the UK when Project 2000 moved the education of the nurses from certificate to diploma and degree levels obtainable from colleges, polytechnics and universities (Bentley 1996; Crotty 1993; Gibbs & Rush 1987). In Nigeria, Ogundeyin (1987) described a similar existing situation of nursing education but she recommended that a College approach should be adopted for the education of basic and post-basic nurses in the country.
- **Medical/Disease model:** This educational model derives from the framework of care that drives the curriculum content. It is used to describe the kind of nursing education that utilises contents that are based on specific identified medical or psychiatric disease like schizophrenia, depression and mania as a framework for care. In this approach, nursing is only relevant for as long as there is a medical or psychiatric diagnosis. This is the phenomenon described by Bendall (1977), and summed up by French (1981:24) that in this position, nursing and nursing education... "virtually have no power, status, or role outside medicine". Within the politics of the education of health professionals, medical doctors seem to favour this kind

of educational model for nurses. Tenacity to this model is observed where the medical profession wields major influence in the design and implementation of the nursing curriculum (Simpson 1995). Brown and Seddon (1996) noted that medical dominance is one of the more obvious features of the health care system, and that this is particularly apparent in the case of relationship between nursing and medicine. When used as a model of nursing education, there is a tendency to find heavy reliance on the use of physicians to teach content in the psychiatric nursing programmes (Clifford 1989).

- **Nursing model:** A nursing model of psychiatric nursing education operates on a well grounded theory or model of nursing as the basis for specifying the expected role of the nurse after education. The emphasis of education here derives from the meaning ascribed to nursing and the metaparadigms of nursing. The roles and responsibilities of nurses are as prescribed by nursing rather than medicine. A conceptual framework of nursing invariably drives this kind of education with goals often directed towards making it possible for the students after qualification to be able to:
  - *make a holistic assessment of their clients' needs - that is, consider their total physical, psychological and social needs;*
  - *identify, from the data collected, the strengths and weaknesses in their clients on which to build a program to regain health, or to retain health;*
  - *identify what needs to be done with the client to regain, or to retain the optimum level of health possible;*
  - *assess their own skills and know what they are capable of doing, seeking appropriate help whenever necessary (Reynolds 1984:25).*

- **Community model:** This model develops as a result of perceived needs for psychiatric nurses to extend their care of, and relationships with, patients to the world outside the hospitals. This model must have borrowed from the idea summarised by David Mechanic (1969:69) that the:

*...mental hospital as it existed did much to isolate the patient from his community, to retard his skills and in general to induce a level of disability above and beyond that resulting from the patient's condition... great emphasis has been given to the idea that patients should be kept in their home surroundings and that the necessary services should be provided to them and their families so that they can cope with the problems that arise.*

Community-based learning programmes have been described by many authors in the production of nurses with basic psychiatric-mental health nursing skills (Uys, Subedar & Lewis 1995). In Britain, early community psychiatric nursing services developed from the extension of ward-based nursing staff's jobs into outreach schemes to follow up patients discharged into the community (Peat & Watt 1984 in Bowers 1996). This is the type of training that leads to the conferment of the title of community psychiatric nurse (CPN) in the UK.

- **Competency based learning (CBL) model:** This model is rooted in the notion that competence can be achieved by any student who has access to appropriate learning resources, and the time to use them effectively. The student as the central focus of the model is seen to be goal-directed and self-critical. The goal setting and self-evaluative aspect of the model were chosen as the keys to evaluation of competence. Competence in professional education means the possession of sufficient skills and information to be able to function effectively in the society (White in Scott,

1984). This suggests that students in an educational program, who are competent, have mastered or are mastering the various socially ascribed and self prescribed roles they will play upon graduation. Gale and Pol (1977:24) described the scope of competence as including the abilities, skills, judgement, attitudes and values required for successful functioning in a particular position, in this case, a professional nursing role. Scott (1982) outlined the major components of CBL strategies. These, according to her, are based on: a) explicitly stated criterion referenced learning outcomes; b) flexible time parameters; and c) selected instructional approaches. Ashworth and Morrison (1991), however argued, while looking at the wide similarities that this model shared with the implementation of UK's Project 2000, that the competence-based strategy could be faulty and ill conceived because of some highlighted inherent problems with this model.

- **Problem based Learning model:** This model of education is anchored on the development of self directed learning skills that enable learners to encounter and identify personal learning needs, set their own realistic learning objectives, locate and choose appropriate resources, design learning strategies and generate their own evaluation procedures (Brookfield 1985:14).

The problem base of the learning is usually achieved by exposing the learner to real life health care problems or situations, from where the knowledge and skill deficits are identified, through a facilitated critical

thinking process that leads to problem solution and learning. Proponents of this form of education insist that emphases of education should be on the process rather than the content (Brookfield 1985; Cole 1976). It is described as a model that can facilitate students' learning by actively involving them in the learning process, and which can reinforce the notion that student nurses learn to be goal directed and self critical, and become accountable health professionals. Generally students will be expected to make self diagnoses of learning needs, to have the ability to set learning goals, and develop skills in evaluating their own learning achievements and practical performances.

- **Integrated model:** This model regards students' education for psychiatric-mental health nursing as part of their general nursing education. Martin (1985:51) while describing the psychiatric - mental health nursing curriculum in the Bachelors of nursing programmes in the USA observed that students' education for psychiatric - mental health nursing is a part of their general nursing education. As observed by Martin (1985), the integrated undergraduate curriculum is frequently cited as the source of all problems in the speciality. The fallible aspect of this model is that some psychiatric nurse educators believe that, too frequently, the students do not have the required quality and quantity of clinical experiences with truly psychiatric patients. These educators express concerns that because the BSN students are receiving neither adequate theory nor adequate practice for psychiatric-mental health nursing, this could explain why the young

graduates are not electing to work in psychiatric facilities or pursue graduate education in the speciality (Martin 1985).

- **Interdisciplinary Education Model:** This model described by Lough, Schmidt, Swain, Naughton, Leshan, Blackburn, and Mancuso (1996) in a program designed to look for an alternative model to current health professionals' education. The essential feature of this model is interdisciplinary educational experiences through interdisciplinary collaboration with various health and medical professional programmes that provide opportunity for the students from different health disciplines to learn and practise together, during their formative stages of development. The ultimate assumption in this model is that if the students learn and practise together during their formative years, then they will be realistically expected to practise together as professionals, and therefore be able to deliver quality care through an understanding team approach.
- **Mental Health consultation model:** In an apparent concern for the structuring of students' psychiatric nursing practicum in such a way that student self actualisation would be enhanced, self motivation increased and student stress reduced, Sutherland (1995) proposed a mental health consultation model as a framework for structuring the psychiatric nursing practicum of students. The immediate goal of the model is to strengthen the professional functioning of the caregiver, and the model is adaptable to the learning -teaching situation in psychiatric nursing education, as the student is expected to establish and continue an autonomous therapeutic

relationship with one or more patients. The nature of the consultative model implies that there is an instructor-to-student contact, with the instructor acting as a resource person and an advisor. The focus is on problem-solving issues in the student-to-client relationship while the instructor also provides positive reinforcement and redirection based on continuous evaluation of the therapeutic relationship. The process involves the student seeking assistance in order to improve his/her relationship with the patient, and improve the patient's mental health or alleviate the distress of his mental disorder. The instructor and the student thereafter focus on the problems or issues involving the management of one or more of the student's patients. The model assumes instructor availability and ability to assist the student in managing stressful situations, and skill in acting as a resource person and advisor for the student, in addition to providing a forum for problem solving and role modelling therapeutic communication techniques.

- **Professional versus Technical model:** This model allows a kind of bipartite education, to produce psychiatric nurses within the same setting. On the one hand, a professional and on the other hand, a technical nurse is produced. Klein (1981) described a similar situation that labelled the baccalaureate nurses as professionals and the associate degree nurses as technicians. Klein (1981) explained this development in the USA by writing that early suggestions in the USA were that separate and distinct programmes be set up for the professional and the technical nurses. Montag in Klein (1981:28) also reported that, as far back as 1965, the

American Nurses Association had recommended that “the minimum preparation for beginning professional nursing practice at the present time should be the baccalaureate degree education in nursing and that the minimum preparation for beginning technical nursing practice at the present time should be the associate degree education in nursing”. The meaning given to professional nursing education may however vary from one country to another. While in the USA professional status is achieved with a baccalaureate degree, in the UK, the same status is achieved at the certificate level. In Nigeria, the achievement of the professional status is possible at the certificate level; in Botswana, professional status becomes possible only at the diploma level (Adelowo 1989; Selelo-Kupe 1993).

- **Modular approach:** Psychiatric-mental health education may be given in a modular approach, i.e. a defined period of instruction is set aside to integrate theoretical and practical aspects of psychiatric-mental health care. Students may be made to spend one day a week, for example, on theoretical studies, and then practise in the clinical setting for the same speciality for the rest of the week. In the modular approach adopted by the University of Manchester’s undergraduate program in Nursing, described by Smith (1985:70), the students undergo a 40-day period of instruction which seeks to integrate theoretical and practical aspects of care. Students spend one day a week on theoretical studies, and then practise in the clinical setting of the same speciality for the rest of the week. Each module also includes specific written assignments like a case study, which centres on one patient and his individual needs, usually based on a specific nursing model.

- **Interpersonal model:** This centres on the experience of anxiety both within the patient and the nurse. The nurse is expected to establish a close working relationship with the patient on a basis of trust by using the medium of process recordings. The interpersonal relationship established between nurse and patient is viewed as a particular example of relationship in general. Ideally this is then used to examine relationships in a wider context (Smith 1985:70). Proponents of this model believe that the model assists the nurse to provide patients with tools to alter their life situation should this be desired, rather than concentrating on providing solutions to problems.

In general, the operational definition of the model of nursing education adopted in the first chapter of this report would confer model status on many different approaches of educating psychiatric nurses as described above. The same operational definition would allow models to be described in terms of the setting or the venue where the education took place. Descriptions and observations of models would therefore largely vary from one country or institution to another. The above sample descriptions will however suffice as an indicator of different approaches to producing the same result based on the goal of educating professionals capable of giving psychiatric-mental health nursing care to those in need of it. Nurse leaders, at different times and in countries all over the world, have expressed concern about the system of nursing education that continued to stay tenaciously in the shadow of hospital-based and controlled nursing training schools (Searle 1988:169). Others have criticised the content of the curriculum. While some critics may appear to be

concerned with the process, a number of authors have also expressed concern about the status of psychiatric nursing education as exemplified in the reports of Butterworth (1995) for some selected developing and developed member states of the ICN.

### *3.11 Towards a model of psychiatric nursing education*

There will be little doubt from the educational point of view that the model or models used for a programme of instruction, education and /or training will influence the nature of the product. Educationists have confirmed that, apart from the curriculum itself, the educational system, the educational process, the type of school, the teacher socialisation, the structure of the society, the economic conditions, the type of students will all contribute to the final product of an educational programme (Frey, Frei & Langeheine 1989). One can reasonably assume too that there will be little disagreement with the statement that any educational programme must be driven by the goal of that education. Educators have been known to maintain that the goal(s) of education must be congruent with both the needs of the learner as well as the society's (Wu 1979:14). The implication of this is that whatever model is adopted for an educational programme its goal or outcome must be consistent with the needs of the learner and that of the society to which it is directed.

The goal of psychiatric-mental health nursing education cannot be defined totally differently from the goal of nursing education in general. The goal could be seen to have derived from one or more of the multiple conceptions of

nursing. Nursing itself has been conceived as an interpersonal process (Orlando 1990; Travelbee 1971), as supporting the developmental process (Erickson, Tomlin & Swain 1983), as “assisting the individual, sick or well in the performance of those activities contributing to health or its recovery that would be performed unaided” if the necessary knowledge and strength were at hand (Henderson 1966:15). It might have been conceived as a problem solving process (Abdellah, Beland, Martin & Matheney 1973), as supporting the adaptive process (Neuman 1995; Roy 1984), or as maintaining behavioural stability (Johnson 1980). Psychiatric-mental health nursing would be deemed to fall within the scope of Schlotfeldt’s (1972:245) broad declaration for nursing, that “nursing is health care”. Schlotfeldt conceived of nursing as helping individuals and families to attain, retain, and regain health. In this case, health in particular would be mental health. Wu (1979) explained health in this definition further. Attaining health is interpreted to mean that the individual or family is desirous of, or in need of, achieving a higher level of wellness than he or she is currently experiencing. Retaining health is interpreted to mean that the individual or family is desirous of, or in need of, preventing illness or avoiding disability. Regaining health is interpreted to mean that the individual or family is no longer well and needs assistance to regain his or their previous state of health. The role of the nurse in helping the individual or the family to attain, retain, or regain health is achieved by sustaining, supporting and comforting the person and the family. The task of this section is to identify from literature how psychiatric nursing education in different countries has been structured to meet the criteria of nursing with

emphasis on psychiatric-mental health, the needs of the learner, and the educational relevance to the societal health needs. Objectives of nursing education in the selected countries may be similar, but circumstances under which students achieve their goals in these various places could be very different. The type of clinical exposure, course of instructions, method of teaching, types, number and educational preparation of the teachers, infrastructural and technological facilities are some of the various factors that make the difference in achievement of the goals.

### **3.11.1 Integrated programmes**

The curriculum model of most Bachelor of Science in Nursing programmes in the USA is 'integrated'. Integration here applies to the inclusion of all aspects of clinical specialities in the curriculum for the education of the students. The NLN Education in the USA specifically recommended in 1947 that all nursing students should acquire experience in psychiatric nursing. The basic assumption was that all nurses should appreciate and understand the factors influencing human behaviour in health and disease, and should develop the ability to understand the total needs of the patient (Klein 1981). Psychiatric-mental health nursing therefore, from the holistic nursing point of view, is an integral part of nursing. Students' education in psychiatric-mental health nursing became accepted as part of their general nursing education. Reynolds (1984), reporting on a six-week US study tour, funded by the Florence Nightingale Memorial committee, and comparing what he saw in America with his experiences in Scotland, observed that the emphasis in the development of the skilled psychiatric nurse is at graduate level in the USA.

Specialisation could only follow an undergraduate program of comprehensive nurse education in the USA, whereas in Scotland this was possible even at pre-degree and at pre-general nursing registration level.

Generally, the baccalaureate-nursing program in the USA offers a four-year course, which combines professional instruction with a well-rounded liberal arts curriculum. The students are provided with brief clinical exposure to the main specialities of medical/surgical nursing, psychiatry and paediatric nursing. Reynolds further reported that graduate students, after the first degree nursing programme, intending to pursue a career in psychiatric nursing, can gain a masters degree in psychiatric nursing on either a part-time or a full-time basis. A prerequisite for entry into the masters program is the baccalaureate degree earned by the undergraduate student. Carter (1986), however, found flaws in this arrangement. Reviewing the psychiatric nursing education in the USA, he found that though the undergraduate nursing programmes are based on integrated theoretical frameworks in which psychiatric nursing experiences constitute part of the total nursing experience for baccalaureate nursing education, psychiatric nursing components were either limited or unidentifiable in some of the programmes reviewed. It was also established that the students might not even be able to have clinical experiences with truly psychotic patients. Carter also expressed dissatisfaction with the use of teachers who were not specialists in psychiatric nursing in teaching psychiatric nursing concepts. In her opinion, a lack of understanding about the differences between psychosocial aspects of patient care and psychiatric nursing experiences with mentally ill patients would make faculty

without psychiatric speciality believe they were qualified to teach psychiatric nursing skills. According to her, psychosocial nursing interventions should be differentiated from psychiatric nursing because the ability to focus on psychosocial nursing interventions would not necessarily translate into ability to give psychiatric nursing care. The implication of equating psychosocial care with psychiatric care was that in many schools faculty teaching the psychosocial/psychiatric nursing component might not be psychiatric nurse specialists. Reynolds (1984) aptly describes the aim of basic nursing education curricula in the USA as that of producing an analytical individual, with basic nursing skills, who is able to identify those health functions of her clients independently of medical intervention, and who is able to utilise research for quality care. Entry into the nursing profession is usually after a baccalaureate nursing education, though there may still be pockets of the hospital-based diploma and associate degree programmes. The baccalaureate program seeks to develop and promote qualities of intellectual curiosity, human understanding, and the dedication to service required in nursing. At all levels of nursing education in the USA, there is strong emphasis on nursing diagnosis. Students are encouraged to identify those needs of their clients which nurses can treat, and are not as dependent as they would have been if they followed the medical model, when they would have to wait even for nursing care prescriptions (Reynolds 1984).

The pattern of nursing education that invariably derives from the expectations of practice in the USA is therefore a baccalaureate model of nurse generalist preparation. This evolves into a graduate model of clinical specialisation. The

pattern here is also that of a nursing model as opposed to a medical model of practice, and for psychiatric nursing in particular, a psychotherapeutic model because of the role expected for a psychiatric-mental health nursing speciality.

Martin (1985) and Mitsunaga (1982) advocated a curriculum model rich in psychiatric-mental health nursing content and advanced clinical nursing content, such as the incorporation of physical assessment and other primary care knowledge and skills into the psychiatric nursing content, to allow better opportunities for holistic nursing. Wardle and Mandle (1989) analysed conceptual models used by nurses in psychiatric mental health settings in a study of 27 graduate students in the first semester of a one year master's program in psychiatric nursing. They concluded that non-nursing models like those of psychoanalytic, social learning, behavioural, psychodynamic and cognitive theories dominated the clinical practice of these nurses. The thinking thereafter was that since the holistic model is known to have gained credibility over the ages, the concept of facilitating an individual's wholeness could have proved a useful nursing theme. Also, that the social context of health and illness, development, social learning, existential and expressive and interaction models can be encompassed in the holistic model, as can the psychoanalytic and medical models of care. It is believed that the psychiatric nurse should be prepared in a way that he or she will be able to provide comprehensive care consistent with the holistic philosophy of nursing.

Smeaton (1982) writing about psychiatric nursing education maintained that an appropriate model of psychiatric nursing education should be broad and

adaptable in terms of theory and should support the nursing process approach in its clinical applications. She further reiterated that psychiatric nursing education would do well to move in emphasis from the science of things to the science of people, and suggested that psychology, sociology, perhaps philosophy, literature and history might represent the forms of knowledge desirable for the future. First aid to the psychiatric nurse, accordingly, should evoke visions of emotional or behavioural crises, not scalded hands or broken femurs. This, to the writer, does not mean that one should ignore the physical consequences or effects of say severe anxiety, food refusal, acute confusional states in mental health care, but in essence, priority thinking should favour the psychological and social models of health and illness.

In 1985, regulation R425 of the South African Nursing Council (SANC) abolished the three- and three-and-half- year hospital-based nursing programmes, substituting for these a four-year comprehensive basic nursing education (CBNE) programme. Searle (1983:5) advancing the reasons for this move in South Africa claimed that what necessitated the comprehensive approach to nursing education in South Africa was the country's adoption of the comprehensive health care system which was built around the concept that nurses would be the main providers of health care. In the attempt to produce nurses with a varied and comprehensive body of knowledge who should be able to function in broad health care settings, the CBNE provides the nurses with a type of education that ends in professional registration of the graduate of such programme as a General Nurse (RN), a community health nurse (RCHN), a midwife (RM) and a psychiatric nurse (RPN) within a period of 4

years. This programme could be followed as a CBNE diploma programme in Colleges of Nursing or as CBNE degree programmes at universities in South Africa (SANC 1985). This approach gives the graduates of the CBNE programme a legitimate status to practise as 'specialists' in those additional three specialities as well as general nursing.

Part of the growing concern of educators in the field of psychiatric nursing education is the danger inherent in inappropriate education. It is needless to say that manpower production through education must be relevant to and derived from the manpower needs of the society, and education of this nature is also expected to produce relevant life long skills in the areas of practice. Cormack (1976) declared that psychiatric nurses had failed to develop a counselling or psycho-therapeutic role, partly due to inappropriate education, and he later (Cormack 1982) reiterated that nurses in the UK have been slow to develop the psychotherapeutic role because of a lack of initiative in the education of psychiatric nurses. Reynolds and Cormack (1982) highlighted the problem of role confusion experienced by Scottish nursing students in the psychiatric areas, when they described the inability of many students to organise purposeful activity with clients. This was one of the competencies expected in psychiatric nursing. A cited problem of having clinical specialisation built into the initial comprehensive base is that students may not have the extensive clinical experience, or the age to build on. Effectiveness in practice therefore suffers. Melia (1981) pointed out that student nurses in the UK often find it difficult to talk to clients about their illnesses, treatments or personal problems. Students produced under a system of training that does not

insist on relating theory to practice, or where theoretical concepts are not practised in the clinical areas, and where teachers rarely practise nursing are bound to forget the concepts required in practice (Melia 1981; Reynolds, 1984).

A few of the panaceas prescribed towards an idea of developing a more contemporary and professional concept of psychiatric nursing education are given by writers like McBride (1990) and Peplau (1989). Some of the prescriptions amplified the obvious points that training should focus on usual pathologies, presented approaches must be relevant and realistic, and that education should maximise the use of locally available human and material resources. Rawlinson (1993:230) admitted that “an assumption in developing countries that outside ‘experts’ have answers to problems unique to their situation can present difficulties”. He advocated more discrimination in the adoption of foreign models and ideas, and suggested that the idea of importing wholesale curricula, which have been developed elsewhere, particularly in other cultures, should be considerably reduced.

### *3.12 Pathway to psychiatric nursing practice in Botswana and Nigeria*

From available records, prerequisites to practise psychiatric nursing vary between Nigeria and Botswana. In order to practise psychiatric nursing in Nigeria, a nurse is expected to be registered as a psychiatric nurse (RPN), whereas in Botswana registered general nurses without a psychiatric nursing registration can be deployed to work in a psychiatric nursing setting. Figure

3.4 presents the pathway in psychiatric nursing education in Botswana while figure 3.5 presents the pathway to doctoral qualification in Nigeria.

While the basic entry requirements are similar, as secondary school leavers are targeted, options into the nursing profession and in particular into psychiatric nursing vary. In Botswana, before the government directive on phasing out of the enrolled nursing cadre (Presidency 1993), secondary school leavers could enter the nursing programme through the enrolled nursing training of two years or the full time nursing diploma programme of three years. Those who followed the enrolled nursing programme could thereafter upgrade to diploma in one or two years in order to become registered as general nurses, which enabled them to practise in all nursing settings including psychiatric settings. Interested persons with registered nursing certificates could, however, specialise in psychiatric/mental health nursing in a post-basic diploma programme of 12 months, which enabled registration as a psychiatric nurse with the BNC. Educational progression thereafter is through the university more for teaching or administrative purposes than for specialist practices in clinical or community settings.

In Nigeria, on the other hand, in order to practise in a psychiatric setting, a nurse must be registered to practise psychiatric nursing. In order to achieve this status, the secondary school leaver could have entered a psychiatric school of nursing directly for a three-year basic psychiatric nursing education leading to registration as a psychiatric nurse, or might have entered a three-year basic school of nursing to qualify as a registered nurse first and thereafter achieved

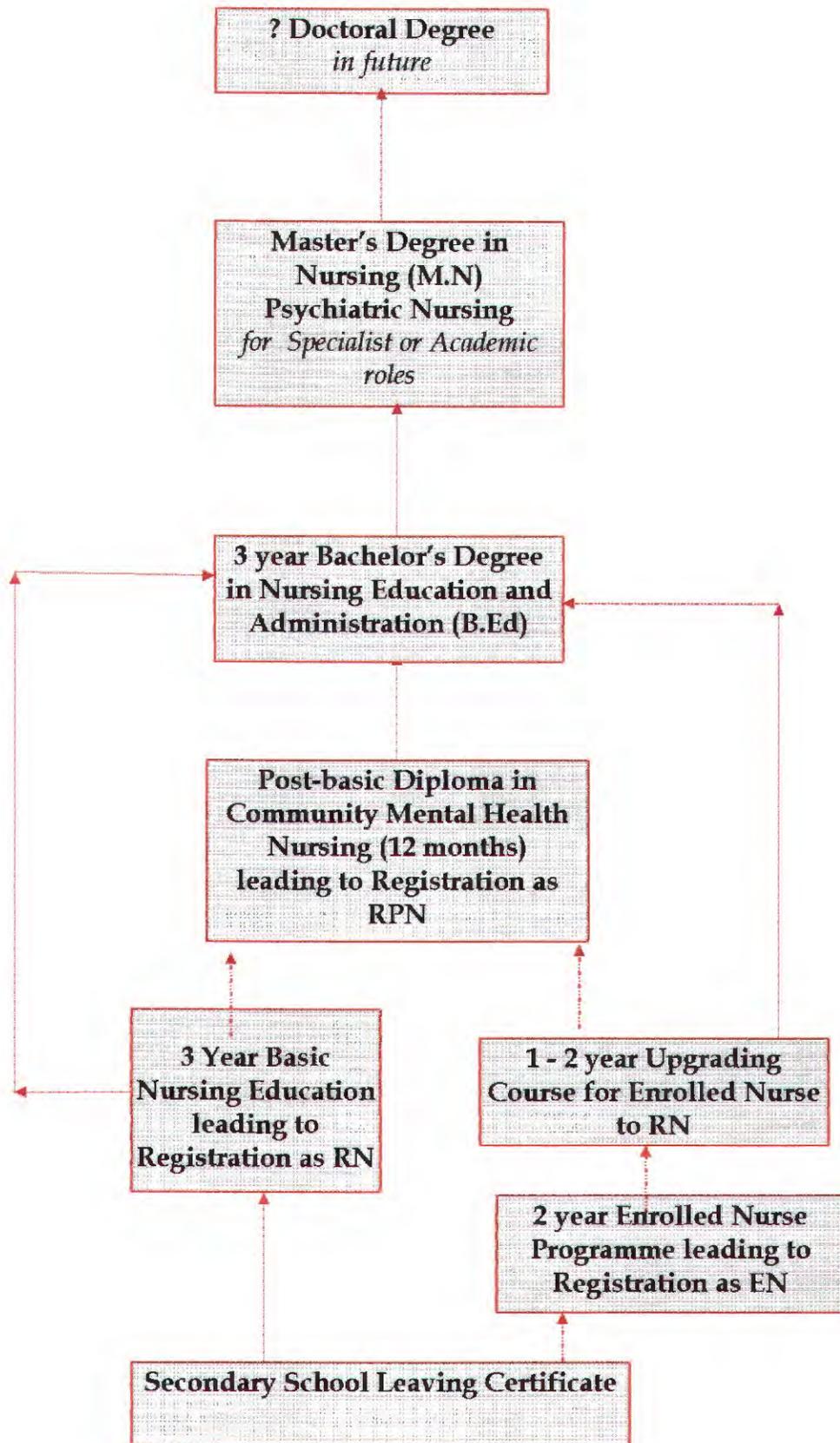


Figure 3.4 An Illustration of Current Psychiatric Nursing Education Pathway in Botswana (1997)

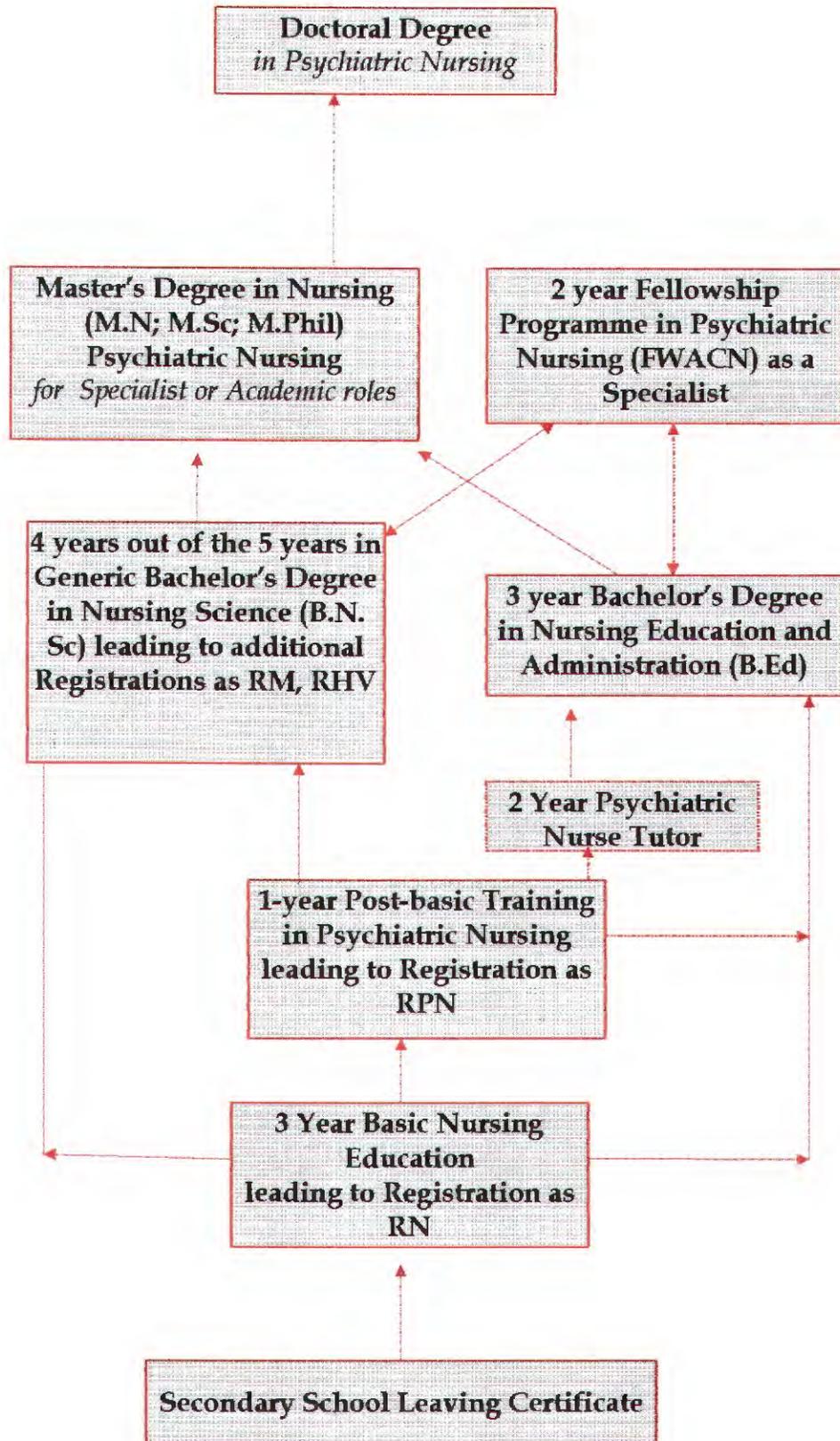


Figure 3.5 An Illustration of Current Psychiatric Nursing Education Pathway in Nigeria (1997)

further specialisation through a post-basic psychiatric nursing programme for a year (12 calendar months) in order to be registered as a psychiatric nurse. One other option is available through a comprehensive baccalaureate nursing education at a university, leading to registration as a general nurse, a psychiatric nurse, a midwife and a public health nurse. Further educational progression in psychiatric nursing from diploma qualification is through university degrees or the fellowship programme of the West African College of Nursing (FWACN). The FWACN programme is based at the University of Ibadan in Nigeria, but is administered through the West African College of Nursing (WACN) secretariat at Lagos in Nigeria. The university graduate and the post graduate degrees are more essentially for teaching and administrative responsibilities than for specialised practice in the clinical or community settings.

### *3.13 Summary*

Attempts have been made in this chapter to look at the historical antecedents to psychiatric nursing education, and the significant influence of this aspect of nursing education development in countries like the USA and the Britain on developing countries like Botswana and Nigeria. Much of the present happenings in the arena of psychiatric nursing education in Botswana and Nigeria can be linked with ideas from Britain and the USA. The concepts of mental health, mental illness, psychiatric nursing, psychiatric nursing education, the psychiatric nursing student and the psychiatric nurse have carried the same meaning as will be described either in Britain or in the USA

for the African countries of Botswana and Nigeria. Much as there appears to be an agreement on the relationship of the system of education and the practice of nursing, the differences in the system of education from schools to schools and country to country do not give the required confidence in pronouncing that the goals of educating relevant psychiatric nurses are being satisfactorily met. Some of the dangers inherent in giving inappropriate education were identified as including inappropriate practice, lack of confidence and inability to develop life long competencies. One concludes therefore that there must be continued concerted efforts by educators, nurse leaders, psychiatric nurses and other relevant people to seek the most appropriate forms of education for those who will be expected to provide psychiatric-mental health nursing services to people.

This research project attempts to examine the training of psychiatric-mental health nurses in Botswana and Nigeria. Lack of systematised information and a clear description of the phenomenon of psychiatric-mental health nursing education in these two countries could create uncertainties as to the direction that could be deemed appropriate for the advancement of mental health of the peoples of the two countries of interest. With the overwhelming problems of mental health in the African continent, knowledge being sought from this research project could provide the lacking baseline information for a number of similar studies for advancement and a clearer perspective in mental health nursing education for Botswana and Nigeria, and for Africa in general.

## Chapter 4

### **Methodology**

#### *4.1 Introduction*

This research is both an exploratory and a descriptive study. It meets the criteria described by Bless and Higson-Smith (1995:42) for exploratory research because it is designed to “gain insight” into a situation. The situation here is about what is happening in the field of psychiatric nursing education of two countries: Botswana and Nigeria. It is also evaluative in the sense that it is assessing the design, implementation and the perceived usefulness of the psychiatric nursing education programmes of these countries. Evaluation here was for the purpose of identifying neglected areas of needs and inappropriate emphasis so as to guide adjustment of the programmes to the particular needs and resources of the communities within which they are situated (Bless & Higson-Smith 1995). The design, choice of sources of data, the participants, instrumentation, approach to data collection and data analysis put into consideration the background purpose of this study.

#### *4.2 Research Design*

The combined exploratory/descriptive nature of the study had important implications for the internal validity of the research process and the design that was selected. A survey design was deemed appropriate for the study since there was no need to manipulate any of the variables. The objectives were

mainly to search for and collect accurate information classifiable as opinions, attitudes, needs or facts (Brink 1996:109) about the phenomenon of psychiatric nursing education in the two selected sub-Saharan African countries. The study data were planned to be collected on a wide range of aspects of psychiatric nursing education from several subjects and from different locations. The method utilised is an amalgam that derived from the etic perspective, i.e. observations made from the perspective of the researcher, and the emic perspective, i.e. the data provided from the perspective of the participants (Seaman 1987:334). This gathering of information would be through indirect observations, questionnaires and interviews which are the usual tools and characteristics of survey studies. Because of the comparison expected in the outcome of the research, however, a causal-comparative design, as described by Wallen and Fraenkel (1991:194), was also adopted with the survey design. A causal-comparative design attempts to determine the differences and possible causes of the differences in groups or phenomena being studied. This approach was necessary to enable a meaningful juxtaposition of information obtained from the two countries being studied.

### 4.3 *Study Subjects*

Nurse educators of all categories involved in psychiatric nursing education programmes in the two countries were targeted as participants in this study. It was expected that because of their experience and involvement in psychiatric nursing education, information obtained from them in relation to psychiatric nursing education would reflect what was happening as well as what might

happen in the future of psychiatric nursing education in the two countries. It was initially difficult to determine the exact number of educators involved in the teaching of psychiatric nursing in the two countries. There was no separate register for psychiatric nurse educators in Nigeria and in Botswana, though the total number of registered nurse educators in Nigeria as at January 1998 stood at 1,634, only a small proportion of this number were likely to possess qualifications as psychiatric nurses. While 94,754 were on the register of general nurses in the same period, only 3,859 were also registered as psychiatric nurses. This is about 4% of the total number of nurses or a psychiatric nurse- general nurse ratio of 1: 25. Guided by the requirements of the NMCN that at least one qualified psychiatric nurse educator must be available for every school of nursing, it was estimated that about one hundred and twenty such nurse educators existed in Nigeria, while Botswana was estimated to have about twenty. This number took into consideration that there were seven (7) schools of psychiatric nursing in Nigeria with an average of 8 psychiatric nurse educators in each school. There were also 64 other institutions for general nursing diploma or degree education that required at least a psychiatric nurse educator as a faculty member in each setting (appendix 2). There is a psychiatric nursing education programme in Botswana with a teaching capacity of 5 nurse educators, and at least one nurse educator for psychiatric nursing is estimated to be present in each of the other 8 basic nursing programmes and the university nursing degree programme in Botswana. In Botswana, as at the time of this study, a total of 4,677 names were on the register of general nurses but only 193 of these were registered as

psychiatric nurses. This is similar to the 4% of the total number of nurses or a psychiatric nurse- general nurse ratio of 1: 25 earlier described for Nigeria.

Criteria for inclusion in the study were that each participant must be teaching a psychiatric nursing course or have been involved in a psychiatric nursing education program in a school of nursing, college of nursing, an institute of nursing, or a university department of nursing in one of the selected countries.

Other participants who serve as sources of data used in this study are senior officials, one each from the NMCN, and the BNC. Others are groups of practising psychiatric nurse leaders at the level of senior nursing officers or senior nursing sisters and above, in Nigeria and Botswana respectively, who are in contact with nursing students deployed to work in their wards or other clinical setting. Methodologically, the use of data from different sources is advantageous as this provides opportunity to triangulate on issues from different directions (Partlet 1981 in Chambers 1988:331).

#### *4.4 Sampling Method*

For Botswana, with only one institute that trains psychiatric nurses, eight other schools of nursing and one university's department of nursing with Psychiatric Nursing components in their curricula, no problem was envisaged in reaching all the subjects. The total population of the psychiatric nurse educators in Botswana was therefore used. The story was, however, different for Nigeria where there were seven (7) schools of Psychiatric Nursing, another sixty one (61) schools of general nursing and three (3) university Departments of

Nursing, producing graduate nurses with psychiatric nursing components in their various curricula giving a much larger population than Botswana. The researcher nonetheless resolved to include all the educators in charge of psychiatric nursing at the 61 schools of nursing and the 3 universities' departments of nursing as well as those teaching at the 7 schools of psychiatric nursing across the country. The total number of psychiatric nurse educators for the two countries were therefore estimated as being approximately 140.

Participants in the focus group discussions were those who consented to participate and were available for the discussions on the appointed dates. These samples combine elements of purposiveness with convenience. This researcher is aware of serious biases inherent in non-probability samples of this nature. The concern of the study dictated that experienced nurses who have had long term contacts with nursing students would be suitable in providing the necessary information. These are nurses in leadership positions in various clinical settings. Their attendance at the discussions were facilitated by heads of nursing services at the institutions used in both countries, since access to these participants was made possible only through the co-operation of the heads of nursing services.

#### *4.5 Procedure for Collection of Data*

The study essentially used a multi-stage data collection approach. Initial data involved an intensive library search for background and historical perspectives, appraisal of the various past and present psychiatric nursing curricula, their origin and processes of implementation. The second stage involved the use of a checklist to assess the present psychiatric nursing education of the two countries (appendix 3).

The third stage involved an opinion survey using a purposely designed self-reporting questionnaire (appendix 4) administered to the psychiatric nurse educators. The questionnaires were either dispatched by postal services or delivered by hand to the participants. In either case, the questionnaire was accompanied by a stamped self-addressed envelope for return of the completed questionnaire by post, because at the time of the data collection the researcher was working as a lecturer at a South African university. Final figures of distributed questionnaires stood at 132. One hundred and sixteen (116) of these were distributed in Nigeria, while sixteen (16) were distributed in Botswana. This shortfall from the initial estimate of 140 came because one of the schools visited by the researcher in Nigeria had only 3 teachers on post as against 7 expected to be present in this school. The questionnaires were dispatched between the months of November and December 1997. In order to facilitate data collection, the researcher personally visited Nigeria and Botswana during December 1997 and January 1998 respectively, and again in July 1998. Time and financial constraints did not allow the researcher to meet

each participant personally. To do so would have required immense finances, unlimited time and grave travel risks, particularly in Nigeria, where transportation by road, rail or air is prohibitively expensive, unsafe and unreliable. This explains why the present means of reaching the participants by mailed questionnaires became imperative. Follow-up contacts were made by letters or telephone calls, as appropriate, through the principals of the nursing schools and colleges, who in all cases facilitated the handing over of the questionnaire to the appropriate staff member targeted for the study.

The fourth stage of the data collection involved interviews of NMCN and BCN officials, and the conducting of two focus group discussions. This approach was considered necessary because, according to Chambers (1988:331), though data may be collected from numerous sources, it is often advantageous to combine techniques for the earlier identified reasons of triangulation. The questionnaire administered to the psychiatric nurse educators nevertheless served as the primary method of data collection, while the psychiatric nurse educators themselves provided the primary source of data for subsequent analysis.

#### **4.5.1 The Instrumentation**

Two instruments purposely designed for this study are used in the collection of the data. These are the checklist for psychiatric nursing education comparison (appendix 3) and the self completing questionnaire (appendix 4). The instruments were developed from the outcomes of the literature review and an examination of the purpose and the questions intended to be answered by the

study. The framework for comparison (appendix 3) identifies 22 curriculum areas for inspection and documentation. This is in line with a goal free evaluation described by Chambers (1988:331) which, unlike a goal directed evaluation, avoids the experimental behavioural approach and examines a programme as a whole, accepting that all data concerning the programme and its context are potentially relevant. This constitutes part of the 'field' earlier described to imply "a totality of coexisting facts which are conceived of as mutually interdependent..." (Lewin 1951:240) in the conceptual framework for this study.

The self-completing questionnaire has 6 sections with a total of 62 items for completion. Sections A, B, C, and D with 20, 10, 6 and 12 items respectively request structured responses on 5-point scales for easy completion. These four sections deal with questions of models in use (section A), quality and quantity of students in the programme (section B), theory-practice gap (section C), and opinion about present and future trends of psychiatric nursing education in the two countries (section D). Section E of the questionnaire is semi-structured to elicit information about nursing or educational models that the participants might be familiar with as well as their present conceptual orientation, so as to determine possible suggestions based on these known premises. Section F contains 9 items of respondents' demographic data. The questionnaire was reviewed by 4 colleagues who also confirmed that it could be completed in 20 - 30 minutes.

#### 4.5.2 Focus Group Discussions

Two focus group discussions (FGD) were held, one for each of the two countries. The groups were made up of experienced psychiatric nurse ward leaders who had been involved in the training of nursing students deployed to the hospital wards or community settings for psychiatric clinical experience. The heads of the respective nursing services divisions in the chosen institutions facilitated access to the participants by suggesting names of participants to be contacted and approving their attendance at the scheduled meetings. Eight participants consented to participate in one psychiatric hospital with community outreach programmes in Nigeria, while only five participants in the same category consented in Botswana. Consent was made explicit by requesting the participants to read and note the implied consent in the invitation letter (appendix 5). This letter gave a guarantee of their right to withdraw from the discussion at any stage if and whenever they felt like doing so, without prejudice or other forms of obligation towards the researcher. The researcher assured the participants that the transcription of the discussions would be made in such a way that contributions would be reported without making it possible to identify the contributor with a specific statement. The guideline used for the discussion is presented as appendix 6. The discussions were tape recorded for ease of transcribing to reduce scribbling during the process of the discussion. Recording also made it easy to check and identify details and particular themes in the discussion at a later stage. Bellenger, cited in Wright (1988:36) pointed out the advantages of this type of focus group discussion. These include synergism - because combined group effort

produces a wider range of information, insight and ideas; snowballing - because random comments may set off a chain reaction of responses that further feed new ideas; stimulation - as the group experience itself may prove exciting and stimulating; security - because individuals may find comfort in the group so that they are able to express their own ideas readily.

#### **4.5.3 Interviews**

The interviews with the officials of the NMCN and the BCN were informal, but the participants were made to understand the purpose of the interviews and how the information provided would be used. Walz, Strickland and Lenz (1991:311) and Brink (1996:158) suggested that unstructured observations and, by implication, informal interviews in exploratory studies allow for flexibility in detecting complexities of the situation. The officials were assured that their specific names would not be provided in the report, and that whatever information was provided would be handled with strict confidentiality. Three interviews were conducted, two in Nigeria because of the greater size of the targeted population there, and one in Botswana. The discussions focused on the current state of and new developments envisaged in the areas of psychiatric nursing education, licensing and practice in their respective countries. A diagrammatic representation of sources and methods of data collected is presented in figure 4.1.

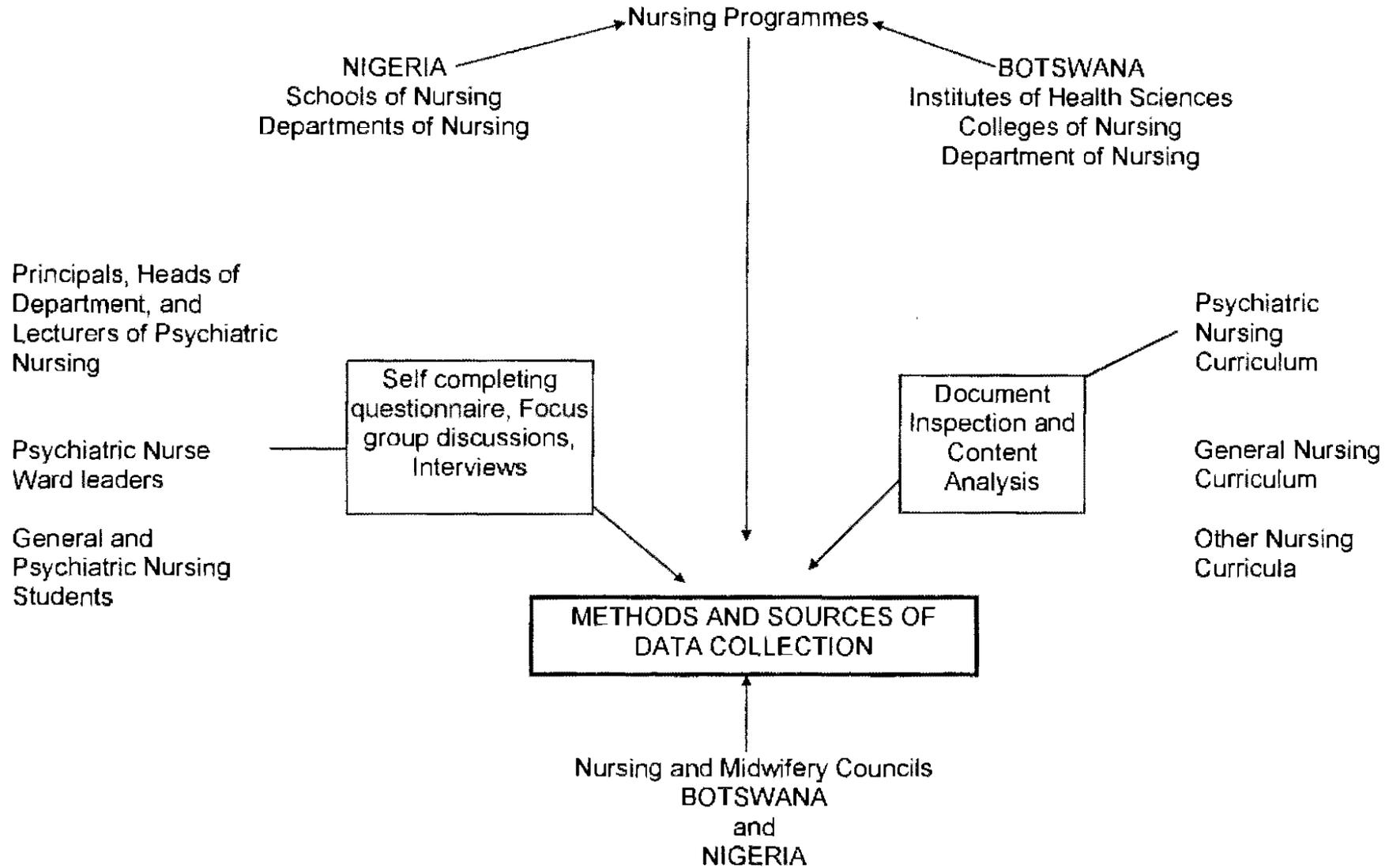


Figure 4.1 Diagrammatic representation of Sources and Methods of Data Collection

#### *4.6 Pilot Study*

A pilot study was conducted to pre-test the data collection methods and in particular to identify items in the questionnaire that might need to be made more explicit. Six lecturers involved with the teaching of psychiatric nursing components in the comprehensive basic nursing education programme of South Africa completed the questionnaire. Responses were consistent among the six respondents except to one question in section E and two questions in section F. These were then modified because of the potential of the respondents to read the questions differently.

#### *4.7 Reliability and Validity*

The nature of this study and the specificity of the area under investigation pose some degree of threat to the validity and reliability of the study. The use of varying methods of data collection, however, provided a means of triangulation as data collected from various sources corroborate each other. Of the three major types of validity - content, criterion-related and construct - the primary concern here was for content validity, that is, the representativeness or sampling adequacy of the range of issues or the domain of information being considered (Kerlinger 1986). The concern for content/face validity of the instruments was pursued with assistance from four colleagues, three of whom are nurse educators and the other is a professor in a faculty of health sciences at the University of Durban-Westville. They all independently reviewed the questionnaire vis-à-vis the research questions and

were all agreed that the items in the questionnaire represented the concern of the study.

Aside from the measures described above, no further statistical proofs of validity or reliability were pursued. This, though not considered of any significant impact on this study, may be a limitation for a study of this nature that is intended to explore the facts of an aspect of the nursing education systems in the selected countries

#### *4.8 Data Analysis*

Four sets of data were analysed. These include:

1. The structure and contents of the six (6) different curricula in use for psychiatric nursing education in the two countries of concern,
2. Thirty six typed pages of transcribed data from the focused group discussions of the senior nursing personnel held in Botswana and Nigeria,
3. Eleven typed pages of transcribed interviews with the Nursing and Midwifery Council officials from Botswana and Nigeria and
4. Data from 91 respondents who completed and returned the questionnaire out of a total of 132 questionnaires distributed to the schools, Colleges and universities in Botswana and Nigeria.

A total of 91 (68.9%) completed questionnaires, 79 from Nigeria (68.1% return rate) and 12 from Botswana (75% return rate) were coded and the

responses were captured with the use of the SPSS computer programme. The data from the questionnaire were subjected to quantitative analysis with the use of the SPSS package. Analyses of qualitative data compiled from two items on the questionnaire and transcribed discussion of the focus groups and the officials of the licensing authorities were done with the use of the NUD\*IST programme. A 68.9% return rate was considered satisfactory enough for a questionnaire that was largely administered by postal services. According to Seaman (1987:284), some social scientists regard a 50% questionnaire return as adequate, 60% as good, and 70% as very good.

The analysis of the psychiatric nursing content of the curricula was based on the Horan et al's model for programme evaluation (Horan et al 1984:320), as described in chapter two of the present report. Identification of the appropriate category and elements in the curriculum is determined by the focus of the evaluative effort. This is largely a matter of judgement on the part of the evaluator (Horan 1984:321). All qualitative data were analysed for content, patterns, categories and themes. The main quantitative statistics were based on frequencies, percentages, ranges of values and means of variable values. Findings from the two countries were compared for differences and similarities. A statistician, conversant with the statistical packages used, assisted with the computer analyses. All analyses were geared to answering the questions raised at the beginning of this study. Results of the analyses will be presented in chapter 5.

#### 4.9 Summary

This chapter described the approach used to gather the relevant data needed to provide the information for analysis in this study. The design, choice of sources of data, the participants, instrumentation, approach to data collection and data analysis took into consideration the overall purpose of this study. This necessitated that the data for the study should be collected on a wide range of aspects of psychiatric nursing education from several subjects and from different locations. The primary source of data was derived from the psychiatric nurse educators. Other sources of data included information from officials of the NMCN and the BNC, and groups of practising psychiatric nurse leaders from both countries. The chapter also highlighted the discovery of shortfalls in the projected number of respondents, which could be described as part of the realities of the situation.

## Chapter 5

# Analysis and Results of findings

## 5.1 *Introduction*

In this chapter, the main results from the data analysed are presented. Details of specific statistical methods, where appropriate, are further explained.

Tables and graphs are used to present the data in clearer perspective. Analysis in this chapter takes cognisance of the fact that results of a study are affected not only by the methods of collecting the data but also by the procedures used to analyse them (Polit & Hungler 1987:503). Efforts have, therefore, been made to make the presentation follow the sequence of the research questions raised at the beginning of this study.

The presented results are the summaries of the information gathered from the four data sources in this study. These sources are the responses to the questionnaire, the analyses of the contents of the curricula, the personal, and the focused group interviews. Quantitative as well as qualitative results have been derived from the data. Findings from the interviews and the analyses of curriculum contents complement the findings from the questionnaire which serves as the primary source of information. These multiple sources enable the researcher to detect consistency and corroboration in the data collected. Lewin's (1951) conceptualisation of 'field', as the totality of mutually interdependent facts that drive or maintain a situation, continue to guide the analysis and presentations of findings in this study. Information derived from

the curriculum contents analysis was organised on the basis of the models of Horan et al (1984), as described in chapter 2 of this report.

## 5.2 *Respondents' characteristics*

The characteristics of the nurse educators who responded to the questionnaire are presented in table 5.1 (page 130). The psychiatric nurse educators whose responses are analysed numbered 91. They were made up of 12 respondents from Botswana and 79 from Nigeria. The number from Botswana was originally overestimated as 20, based on the assumption that the Mental Health Nursing programme located in Lobatse would have as many as 10 nurse educators. It was later found that there were only 4 psychiatric nurse educators in this programme. In the same vein, the initial estimate for respondents from Nigeria was 112. In one of the schools where an estimate of 7 nurse educators was projected, the researcher discovered that only 3 teachers were available as the others had either resigned, retired or were out of the country on approved leave of absence. The initial number expected for Nigeria, therefore, was also overestimated at the outset.

Distribution of the nurse educators by institutional attachment was found to be 7(58.3%) and 43(54.4%) at the RN programmes level for Botswana and Nigeria respectively. At the institutions or programmes for diploma or certificates in mental health nursing leading to registration as psychiatric nurses for Botswana and Nigeria there were 4 (33.3%) and 33 (41.7%)

respectively. One (8.3%) respondent from Botswana and 3 (3.8%) from Nigeria were from university departments of nursing.

There appeared to be more male nurse educators in mental health nursing than female educators. There were 67 (73.6%) male respondents for the two countries, as against 24 (26.4%) female respondents, chi-square ( $\chi^2$ ) = 20.31, df 1,  $p \leq .000$ . No significant difference was, however, noticed when the pattern of gender distribution between the Nigerian respondents and the Botswana respondents was further compared,  $F[1,89]=1.658$ ,  $p=.201$ ,  $>.05$ .

Botswana educators in mental health nursing were significantly older (mean = 44.92, SD = 6.32) than their Nigerian counterparts (mean = 39.51, SD = 6.44). Analysis of variance (ANOVA) yielded  $F[1,89]=7.386$ ,  $p=.008$ ,  $<.01$ . All the respondents from Botswana had RN qualifications while 8(66.7%) were also registered as RPN. The Botswana respondents' highest academic qualifications were a diploma in nursing education for 8(66.7%), a Bachelor's degree in nursing for 3(25%) and a Doctoral degree in nursing for 1(8.3%). Seventy-five (94.9%) of the respondents from Nigeria had RN qualifications, 63 (79.7%) were registered as RPN. The highest educational qualification held by the respondents from Nigeria included a diploma in nursing education held by 53 (67.1%), a Bachelor's degree in nursing by 7 (8.9%), a Bachelor's degree in other disciplines by 12 (15.2%), a Master's degree in nursing by 3(3.8%) and a Master's degree in another discipline by 1 (1.3%).

**Table 5.1: The characteristics of the responding nurse educators**

Description	Botswana	Nigeria
Total Number of Respondents	12 (100%)	79 (100%)
Institutional Sources of Information:		
Respondents from Registered Nursing programmes at Certificate or Diploma levels	7 (58.3%)	43 (54.4%)
Respondents from Institutions offering diploma or certificates programmes in Psychiatric/Mental health nursing	4 (33.3%)	33 (41.7%)
Respondents from University Departments of Nursing	1 (8.3%)	3 (3.8%)
Age Distribution $F[1, 89]=7.386, p=.008, <.01$		
Range	38-54	30-57
Mean	44.92	39.51
Standard Deviation (SD)	6.32	6.44
Gender Distribution:		
Male	7 (58.3%)	60 (75.9%)
Female	5 (41.7%)	19 (24.1%)
Professional qualifications:		
RN	12 (100%)	75 (94.9%)
RPN	8 (66.7%)	63 (79.7%)
Experience in years $F[1,89]=0.0220, p=.8825, >.05, \text{not significant}$		
Mean	9.25	9.50
SD	3.65	5.80
Highest Academic Qualifications:		
Dip. In Nursing Education	8 (66.7%)	53 (67.1%)
B. degree in Nursing	3 (25%)	7 (8.9%)
B. degree in other disciplines	-	12 (15.2%)
M. Degree in Nursing	-	3 (3.8%)
Masters degree in other disciplines	-	1 (1.3%)
Doctoral degree in Nursing	1 (8.3%)	-
Doctoral degree in other disciplines	-	-

### *5.3 Models of psychiatric nursing education in the selected countries*

The respondents rated the extent to which a described model agreed with the model currently in use in their respective country or institution. The mean rating of the respondents for each country on each described model was computed and compared for significant differences. Tables 5.2 and 5.3 present the order in which the models described the current mental health nursing education programmes of Botswana and Nigeria respectively on a mean rating of 1-5.

The rating of 5 represents high agreement with the description and 1 represents strong disagreement with how the models of psychiatric nursing education in the countries would be described by the respondents.

Respondents from Botswana had a tendency to describe their country's mental health nursing education programmes as PHC model or Community Nursing model with a mean rating of 4.8. Mental health nursing education programmes in Botswana were also viewed by the respondents as a Competency based model (mean rating was 4.4) and as a General Nursing model (mean rating was 4.1). Descriptions such as Integrated model, Post general Nursing, and Apprenticeship model received ratings of 3.9, 3.8 and 3.7 respectively from the same respondents.

Respondents from Nigeria tended to see the models of psychiatric-mental health nursing education first as a psychiatric specialisation model with a mean rating of 4.70 among the respondents. They were also likely to describe

their psychiatric nursing education programme as a post-general nursing model with a mean rating on the agreement scale at 4.44.

**Table 5.2: Prioritised order of how respondents from Botswana described their present model of psychiatric-mental health nursing education.**

Described Models	Botswana n=12	
	Mean	SD
1. Primary Health Care model	4.83	.39
2. Community Nursing model	4.83	.39
3. Competency based model	4.42	.90
4. General Nursing model	4.08	1.16
5. Integrated model	3.92	1.62
6. Post general Nursing	3.83	1.75
7. Apprenticeship model	3.67	1.97
8. Problem-based learning	3.58	.79
9. Medical Expressive model	3.25	1.21
10. Diploma model	3.08	1.88
11. Inservice types	2.91	1.0
12. Psychiatric specialisation model	2.75	2.01
13. Degree model	2.67	1.67
14. Post degree model	2.67	1.67
15. Continuing Education model	2.42	1.24
16. Certificate model	2.17	1.80
17. Distance learning model	2.17	1.53
18. Baccalaureate type	2.08	1.16
19. Pre-general nursing	2.00	1.12

Other descriptions such as integrated model, competency based model, certificate model, diploma model, the medical expressive model, received ratings of received mean ratings of 3.75, 3.73, 3.71, 3.61, and 3.59 respectively among the respondents for Nigeria.

**Table 5.3: Prioritised order of how respondents from Nigeria described their present model of psychiatric-mental health nursing education.**

Described Models	Nigeria n=79	
	Mean	SD
1. Psychiatric specialisation model	4.70	.85
2. Post general Nursing	4.44	1.25
3. Integrated model	3.75	1.54
4. Competency based model	3.73	1.6
5. Certificate model	3.71	1.70
6. Diploma model	3.61	1.81
7. Medical Expressive model	3.59	1.55
8. Primary Health Care model	3.53	1.55
9. Community Nursing model	3.35	1.47
10. General Nursing model	3.25	1.79
11. Problem-based learning	3.25	1.67
12. Continuing Education model	3.25	1.84
13. Degree model	2.85	1.73
14. Inservice types	2.72	1.70
15. Baccalaureate type	2.18	1.72
16. Post degree model	2.11	1.53
17. Pre-general nursing	2.05	1.62
18. Apprenticeship model	1.95	1.51
19. Distance learning model	1.39	.99

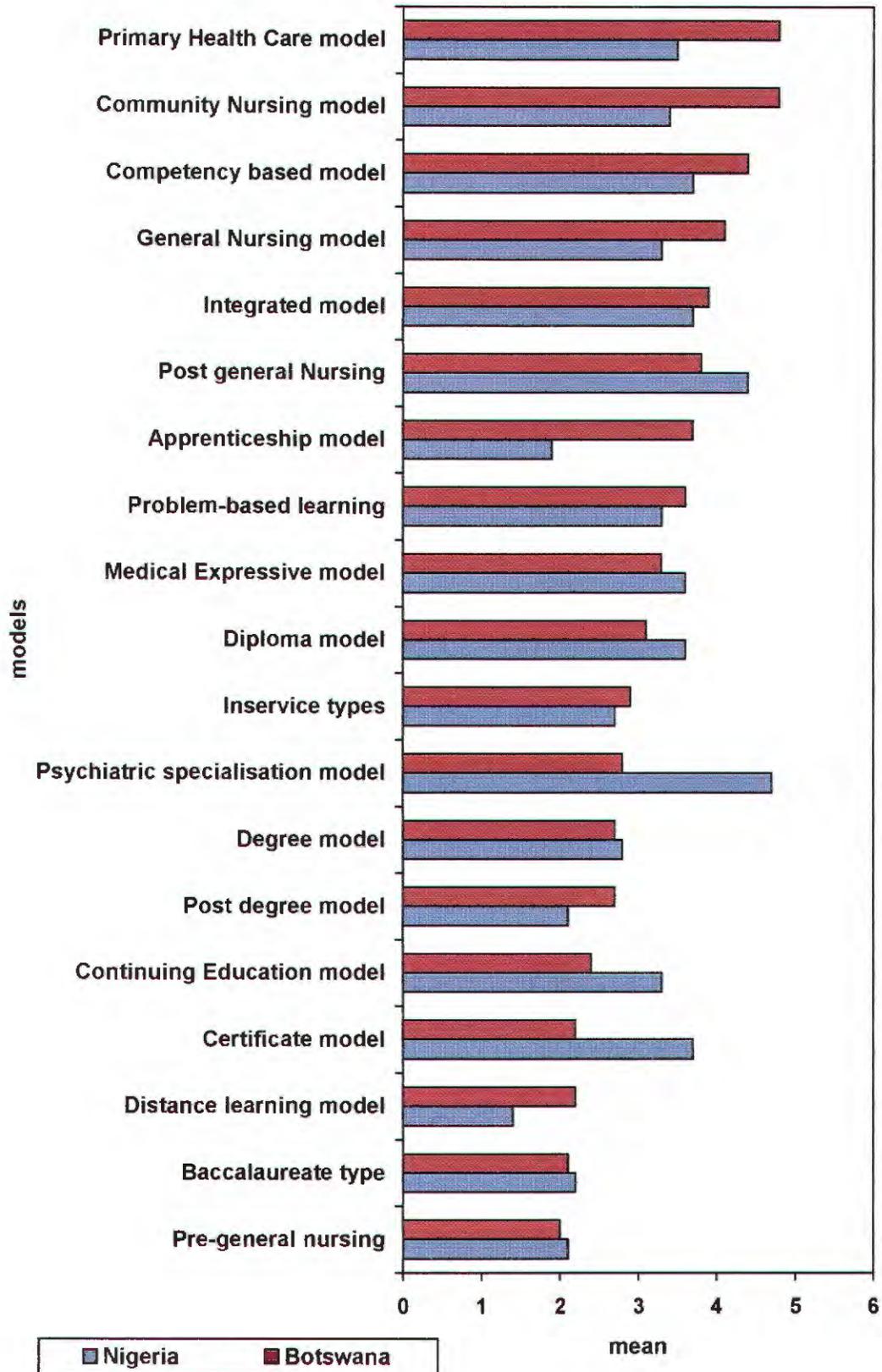
Analysis of variance (ANOVA) revealed significant differences in the means of the groups in the two countries concerning how the respondents would want to describe their psychiatric nursing education programmes. Table 5.4 and figure 5.1 present the results of the comparison of the responses from the respondents from the two countries based on how they would describe their psychiatric nursing education models. These significant differences were noted in the responses to Psychiatric specialisation model ( $F [1, 89] = 34.78,$

**Table 5.4: Comparison of the means for the responses on the models used to describe psychiatric nursing education in Botswana and Nigeria**

Described Models	Botswana n=12		Nigeria n=79		df=1,89	
	Mean	SD	Mean	SD	F	Sig.
1. Primary Health Care model	4.83	.39	3.53	1.55	8.297	.005*
2. Community Nursing model	4.83	.39	3.35	1.47	11.94	.001*
3. Competency based model	4.42	.90	3.73	1.6	2.07	.153
4. General Nursing model	4.08	1.16	3.25	1.79	2.403	.125
5. Integrated model	3.92	1.62	3.75	1.54	.125	.724
6. Post general Nursing	3.83	1.75	4.44	1.25	2.221	.140
7. Apprenticeship model	3.67	1.97	1.95	1.51	12.40	.001*
8. Problem-based learning	3.58	.79	3.25	1.67	.452	.503
9. Medical Expressive model	3.25	1.21	3.59	1.55	.543	.463
10. Diploma model	3.08	1.88	3.61	1.81	.861	.356
11. Inservice types	2.91	1.0	2.72	1.70	.149	.700
12. Psychiatric specialisation model	2.75	2.01	4.70	.85	34.78	.000*
13. Degree model	2.67	1.67	2.85	1.73	.115	.735
14. Post degree model	2.67	1.67	2.11	1.53	1.33	.252
15. Continuing Education model	2.42	1.24	3.25	1.84	2.30	.133
16. Certificate model	2.17	1.80	3.71	1.70	8.41	.005*
17. Distance learning model	2.17	1.53	1.39	.99	5.42	.022
18. Baccalaureate type	2.08	1.16	2.18	1.72	.033	.855
19. Pre-general nursing	2.00	1.12	2.05	1.62	.011	.917

\* indicates significant differences in the response  $p < .05$

**Figure 5.1: Extent to which named models can be used to describe psychiatric mental health nursing education in Botswana and Nigeria**



$p < .0001$ ), Apprenticeship model ( $F [1, 89] = 12.40, p < .001$ ), Community Nursing model ( $F [1, 89] = 11.95, p < .001$ ), Certificate model ( $F [1, 89] = 8.42, p < .01$ ), Primary Health Care model ( $F [1, 89] = 8.30, p < .01$ ), and Distance learning model ( $F [1, 89] = 5.42, p < .05$ ). No other significant difference was noted in the respondents' means on other models used to describe psychiatric nursing models in the two countries. The clustered bars in figure 5.1 compare the mean values of the responses across the groups and the models.

#### 5.4 *The learners*

Section B of the questionnaire was analysed for the respondents' opinions regarding the quality and quantity of students being trained for psychiatric nursing practice in the two countries. The results were compared for differences in the respondents' opinion about the students. Curriculum documents were also inspected for descriptions of or assumptions about the learners in psychiatric nursing programmes. The findings are presented in table 5.5 and figure 5.2.

Significant differences exist between the opinions of the respondents from Botswana and Nigeria about certain aspects of the learners in the two countries. While the respondents in Nigeria view the entry requirements for nurses who would practise psychiatric nursing in Nigeria as adequate (mean is 4.26,  $SD=1.44$  on a rating of 1-5 where 5 indicates a strong agreement, and 1 a strong disagreement), the view of respondents from Botswana on the adequacy of the entry requirements of their nurses practising psychiatric

nursing was significantly lower at a mean of 2.4,  $SD = .76$ ,  $F[1, 89] = 46.39$ ,  $p < .001$ . Respondents from Nigeria also tended to be more satisfied (mean=4.00,  $SD = .99$ ) with their students' age range than their Botswana counterparts were (mean=3.08,  $SD = 1.73$ ),  $F[1, 89] = 7.15$ ,  $p < .01$ . Significant differences were also noted between the two countries in the way the respondents agreed with the students' capability to be self-directed in their learning. The mean for Botswana was 2.41,  $SD = 1.44$ , while that of Nigeria was 3.13,  $SD = .99$ ,  $F[1, 89] = 4.68$ ,  $p < .05$ . When responding to the statement whether students of the calibre being trained in their programmes would do as well as expected of university students if they had to be trained at the Universities or other institutions of higher learning, while the mean for the respondents from Nigeria was 3.8,  $SD = 1.07$ , the mean for the respondents from Botswana was 2.08,  $SD = 1.16$ ,  $F[1, 89] = 26.86$ ,  $p < .0001$ . This difference is statistically significant.

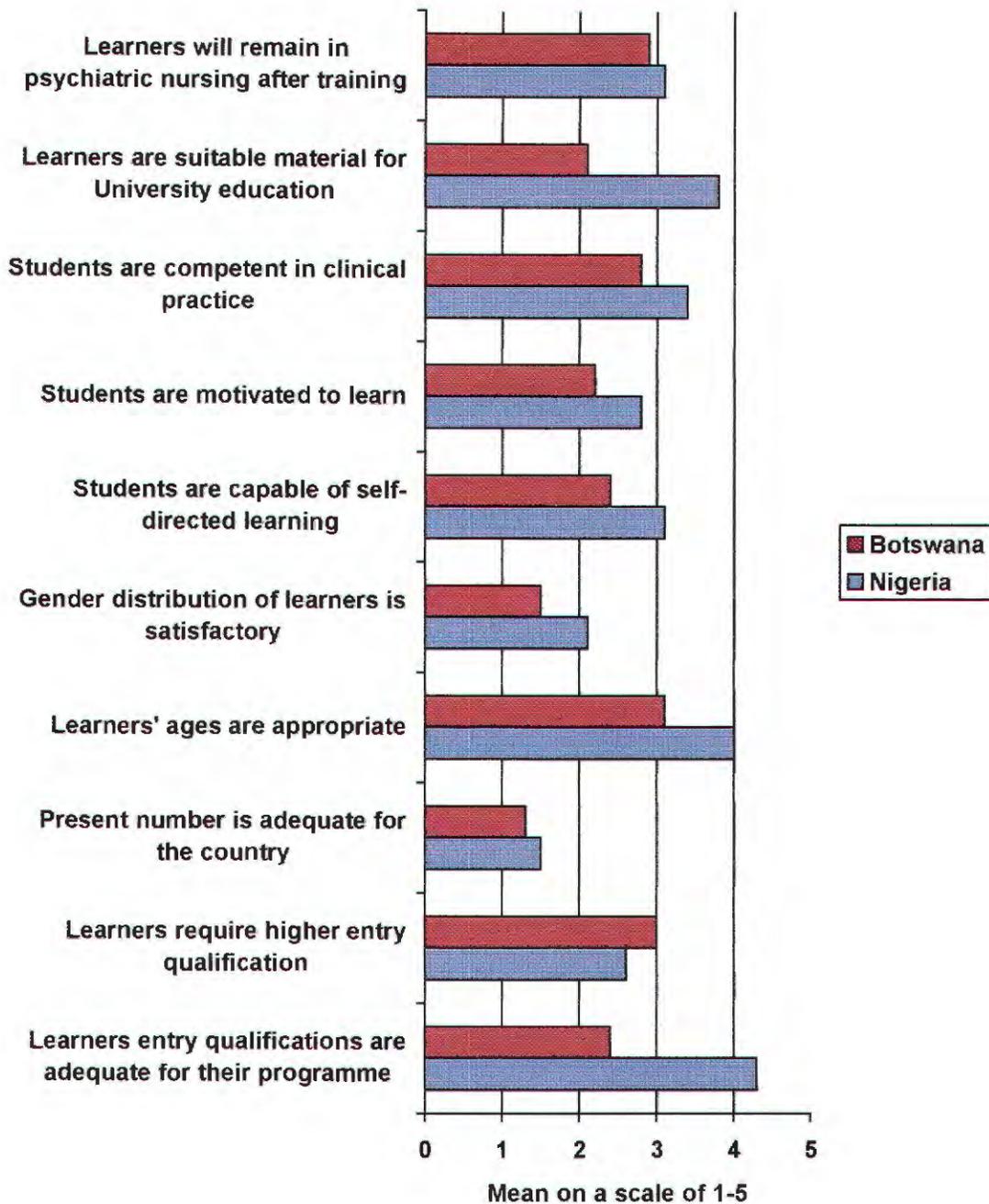
Responses from both countries' groups were not significantly different on the other items that sought to find out how the learners were viewed by the respondents. Learners from both countries were generally not seen to require higher entry qualifications than what they already possess, at the time of the study, to be able to train as psychiatric nurses. The mean for Botswana was 3.00 and for Nigeria it was 2.62. Respondents from both countries were generally not satisfied with the number of students in training for psychiatric nursing. The mean for the response from the Botswana group was 1.25 while that for Nigeria was 1.45. Satisfaction was equally low with the gender distribution of the students among the respondents in the two countries.

**Table 5.5. : Respondents' perception of learners' quality and quantity in psychiatric-mental health nursing for Botswana and Nigeria**

<i>Statements about students' quality and/or quantity</i>	<i>Botswana</i>		<i>Nigeria</i>		<i>F</i>	<i>Sig.</i>
	<i>Mean</i>	<i>SD</i>	<i>Mean</i>	<i>SD</i>		
The entry prerequisite for students who will practise as psychiatric nurses is adequate	2.42	1.44	4.27	.76	46.39	.000
Psychiatric nursing students require higher entry qualifications than now	3.00	1.70	2.62	1.21	.91	.342
Number of students being trained at present is adequate for the country's mental health care needs	1.25	.45	1.46	.78	.78	.377
The students' age range is appropriate for the type of training they are receiving	3.08	1.73	4.00	.99	7.15	.009
The sex distribution of students being trained for psychiatric nursing practice is appropriate, that is, male : female ratio	1.50	.80	2.11	1.03	3.84	.053
Most of the students are capable of being self- directed in their studies	2.42	1.44	3.12	.99	4.69	.033
Students are well motivated to learn psychiatric-mental health nursing	2.17	1.64	2.77	1.39	1.89	.172
Students being trained to give psychiatric care demonstrate as much competence in practice as they do in the classroom	2.75	1.21	3.39	1.08	3.57	.062
The students of the calibre being trained in psychiatric-mental health nursing programmes would do as well as expected of university students if they had to be trained at the Universities or other institutions of higher learning,	2.08	1.16	3.82	1.07	26.86	.000
A large number of the students being trained will presumably stick to psychiatric nursing after training	2.91	1.73	3.05	1.14	.12	.726

SD = Standard deviation; df (degree of freedom) = 1, 89 level of significance  $\leq .05$

**Figure 5.2: Learners as perceived by the respondents in Botswana and Nigeria**



The mean was 1.50 for Botswana and 2.11 for Nigerian respondents.

Respondents from both countries do not seem to agree that the students were motivated to learn psychiatric nursing with a mean of 2.1 and 2.7 for Botswana and Nigeria respondents respectively.

Nigerian respondents tended to regard their students as being capable of demonstrating as much competence in practice as they did in the classroom with a mean response of 3.39,  $SD=1.07$ , while the Botswana counterparts' mean was 2.75,  $SD=1.21$ ,  $F[1,89]=3.57$ ,  $p>.05$ . These responses, however, were not significantly different. Respondents' agreement hovered at a mean of 2.92 and 3.05 for Botswana and Nigeria respectively when the respondents were asked if a large number of the students being trained would presumably stick to psychiatric nursing after training. There was no significant difference in the responses from both countries in this regard.

### *5.5 Congruency between classroom instructions and the realities of clinical practice*

Responses to section C of the questionnaire were analysed for the nurse educators' perception of the congruence between classroom instruction and the realities that students would face in clinical practice. Findings from the two countries were compared and analysed for significant differences. All mean responses were subjected to analysis of variance (ANOVA). Summaries of the findings are presented in table 5.6 and figure 5.3.

**Table 5.6: Respondents' agreement with statements about congruency between practice and theory in the psychiatric nursing education programmes of Botswana and Nigeria**

Statement about congruency between theory and practice	Botswana		Nigeria		F	Sig.
	Mean	SD	Mean	SD		
What students learn in the classroom is what they practise in their clinical areas e.g. the nursing process	3.67	1.30	3.23	1.27	1.23	.269
The clinical experience of the students prepares them well for the challenges of the post qualification practice	4.25	.87	4.11	.99	.20	.652
Students' later practice will depend on available resources rather than on the students' knowledge	3.83	1.19	3.43	1.10	1.36	.247
If a gap exists between theory and practice in psychiatric nursing education, the teachers should be held responsible	3.24	1.51	2.23	1.05	11.82	.001
The students are to blame for whatever gap may exist between theory and practice	2.08	1.44	2.38	1.00	.80	.373
Where gaps in theory and practice occur, the entire responsibility will be that of nurse administrators in charge of the clinical area	3.00	1.13	3.01	1.16	.00	.972

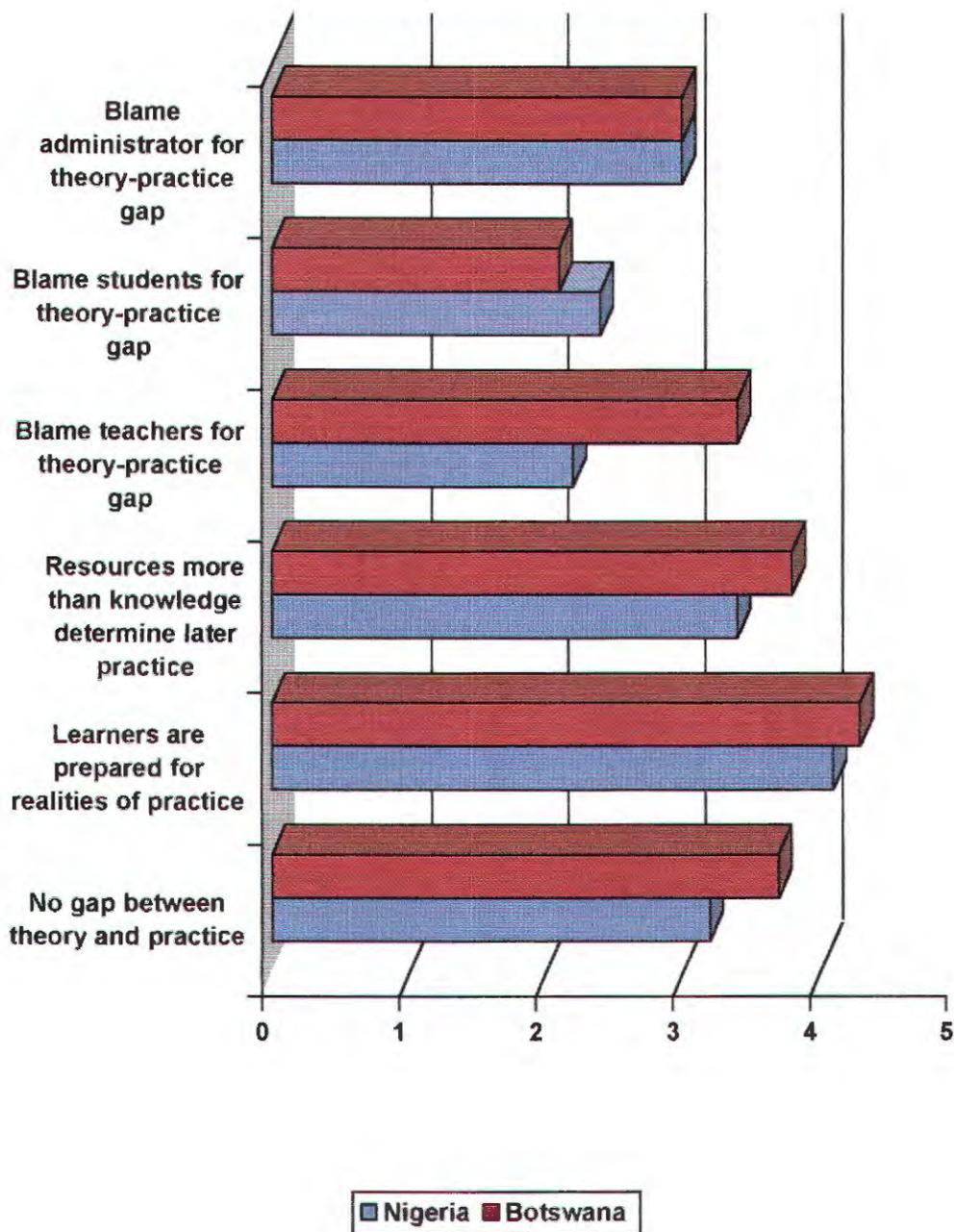
The calculated means were the means of the respondents where 1 represented a strong disagreement, 2 =disagree, 3=undecided, 4=agree, and 5 = strong agreement. Responses of the educators from Nigeria and Botswana were similar when asked whether what students learned in the classroom was what they practised in the clinical areas. The respondents tended to agree, with

mean scores of 3.67, SD=1.30, and 3.23, SD=1.27 for Botswana and Nigerian respondents respectively. This difference is not significant because  $F[1,89]=1.23, p>.05$ . Responses to the statement on whether students' clinical experience prepared them well for the post qualification practice revealed that the educators were in agreement. The means for the responses were 4.25, SD=.87, and 4.11, SD=.99 for Botswana and Nigeria respectively. The responses between the two countries were not significantly different as  $F[1,89]=.20, p>.05$ .

Respondents from both countries also tended to agree with the statement that students' later practice would depend more on available resources rather than on the students' knowledge. No significant difference was observed when the countries were compared. The mean value was 3.83, SD=1.19, and 3.43, SD=1.11 for Botswana and Nigeria respectively,  $F[1,89]=1.36, p>.05$ . On the respondents' agreement with who was to blame if a gap existed between theory and practice, respondents tended to disagree with putting the blame on the students. The mean for this response was 2.08 and 2.37, with SD of 1.44 and 1.00 for Botswana and Nigeria respectively. Differences between the means were not significant because  $F[1,89]=.80, p>.05$ . The means for the response on whether the administrator was to blame for the theory practice gap were 3.00 and 3.01 with SD of 1.12 and 1.16 respectively for Botswana and Nigeria. These responses were also not significantly different as  $F[1,89]=.001, p>.05$ . Botswana respondents, however, tended to want to blame the teachers (mean = 3.42, SD=1.51) if a gap was found between theory and practice, when compared with their counterparts from Nigeria

(mean=2.23, SD=1.05). ANOVA revealed a significant difference between these responses,  $F[1,89]=11.82, p<.001$ .

**Figure 5.3: Perceived theory-practice gap status in psychiatric nursing education with its associated factors**



## 5.6 *Factor analysis:*

The statements about psychiatric nursing education contained in items 1-12 of section D of the questionnaire were factor analysed in order to disentangle the interrelationships among the items so that the responses could be treated as unified concepts (Polit & Hungler 1987:437). According to Norman and Streiner (1986:133), factor analysis explores the interrelationships among variables from the scores obtained on several tests which might actually be reflections of a smaller number of underlying factors. The 12 items in section D were meant to measure the feelings of the respondents on a range of issues about the standard, placement, process and people involved in psychiatric-mental health nursing education in the countries concerned.

The factor analysis utilised the principal component technique. Five (5) factors with eigenvalue  $>1$  were extracted (Norman & Streiner 1986:137; Polit & Hungler 1987:439). The factors were subjected to varimax rotation. Convergence was achieved in 8 iterations. Table 5.5 presents how the items loaded on the five factors. Items 1, 3, 4 and 9 loaded high on factor 1. Items 10 and 11 loaded high on factor 2, while items 6 and 12 loaded high on factor 3. Items 2, 7 and 8 loaded high on factor 4, while item 5 was the only high loading item on factor 5. Factor 1 is named as 'satisfaction with the current academic status' because the items tend to be more concerned with the respondents' support for the present academic status and standard of psychiatric-mental health nursing education for both countries.

**Table 5.7: Factor analysis results for respondents' feelings about the situation of mental health nursing education in the countries.**

	Factor	Loading	Item No
<b>1</b>	<b>Satisfaction with the current academic status</b>		
	• Teachers of psychiatric nursing in schools and colleges are adequately prepared for maintaining the standard expected for the country and the learners.	.823	9
	• General standard of psychiatric nursing education is quite satisfactory and appropriate for the needs of the nation, and the need of the learners.	.660	1
	• It makes no difference to the practice of psychiatric nursing whether the education is at Certificate, diploma, degree or even at post-graduate level.	.595	3
	• Diploma program will still be deemed to be appropriate for specialisation as a psychiatric nurse.	.573	4
<b>2</b>	<b>Multidisciplinary factor</b>		
	• Nurse educators should utilise other teachers from other disciplines like psychology, social and biological sciences in the training of psychiatric nurses.	.849	10
	• Nurse tutors should be sufficiently knowledgeable to do the teaching of psychiatric nursing students without the use of other experts from related disciplines.	-.796	11
<b>3</b>	<b>Professional ideal factor</b>		
	• Psychiatric nursing education in this institution is based on a specified conceptual or theoretical model of Nursing.	.819	12
	• Degree programme appears to be more appropriate in order to specialise as a psychiatric nurse.	.737	6
<b>4</b>	<b>Nurse generalist support factor</b>		
	• Psychiatric Nursing training should actually be integrated into general nursing training, without the need for any other special school for psychiatric nurses.	.801	8
	• Psychiatric nursing education should be part of the general nursing education so that every qualified nurse is able to work with clients that need psychiatric or mental health care.	.684	2
	• Nurses should only be allowed to specialise as psychiatric nurses at the University post- graduate level.	.528	7
<b>5</b>	<b>Support for post-basic nursing model</b>		
	• Psychiatric nursing education should be at the post-basic level of nursing education (post-registration as a qualified general nurse).	.847	5

Factor 2 would seem to be more concerned with teachers' territoriality. It was therefore called the multidisciplinary factor because of its demand for calling

on other disciplines' expertise in the training of mental health nurses. Factor 3 would be more of a 'professional ideal' factor because the items are concerned with the conceptual basis of practice and higher education status for specialisation. Factor 4 showed a disposition to nurse generalist tendency. It was therefore called the 'nurse generalist support factor'. Factor 5 stood alone and was allowed to stay on its own because according to Polit and Hungler (1987:439), the general consensus in determining the number of factors to extract is that 'it is probably better to extract too many factors than too few'.

Responses of the educators from the two countries were compared and analysed for significant differences based on the extracted factors. The factors and how each item loaded on the factor are presented in table 5.6. Analyses of the responses and the levels of significance for the observed differences are presented in table 5.7. In order to provide scores specific to the factors, items that load on each factor were computed and recorded for every participant.

Respondents from Botswana tended to be less satisfied with the current status of mental health nursing education programme (mean = 2.90, SD = .79), though this difference was not significant when compared with the responses from Nigeria (mean = 3.11, SD = .87),  $F[1, 89] = .686, p > .05$ . The differences in the responses between the countries were found to be significant with regard to the use of multidisciplinary teachers. The mean response for Botswana on the multidisciplinary factor was 4.37, SD = .68, while that for Nigeria was 3.48, SD = 1.13,  $F[1, 89] = 7.00, p \leq .010$ .

**Table 5.8: Analysis of the educators' responses to the present situation of mental health nursing education in their countries.**

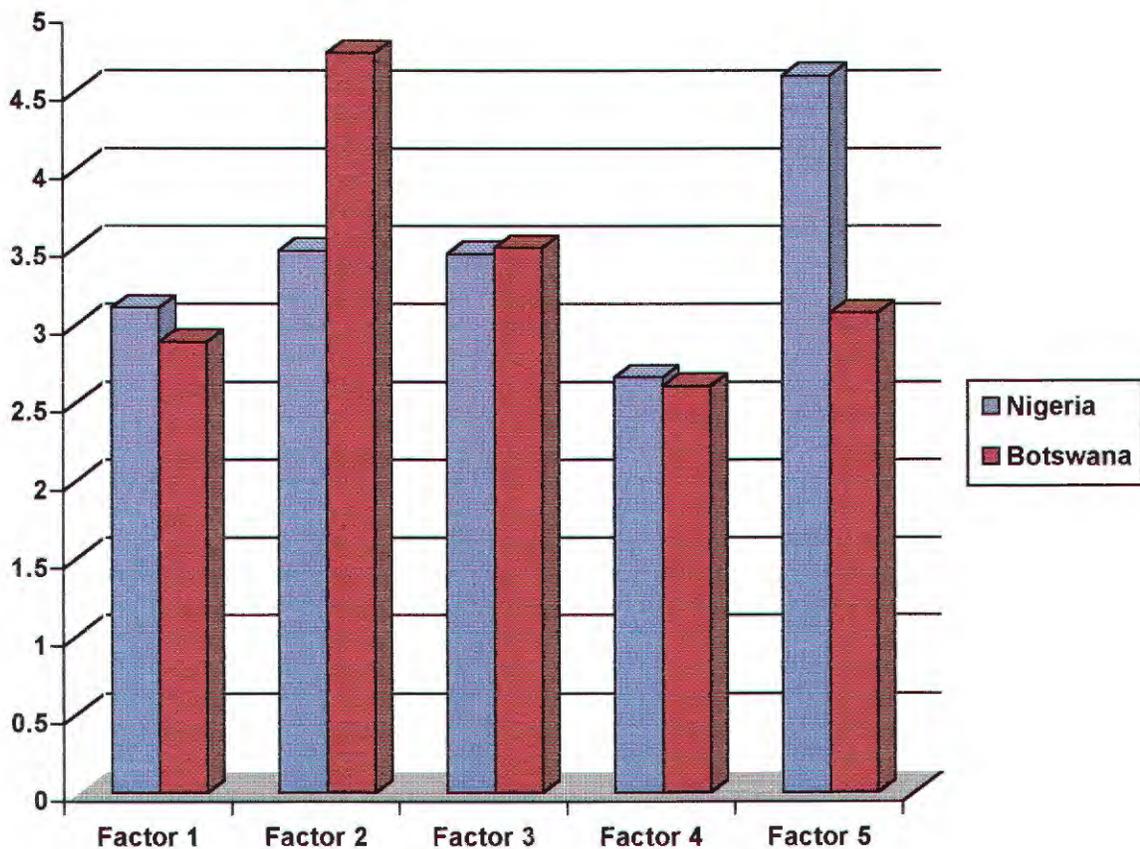
Factor	Botswana		Nigeria		F	Sig
	Mean	SD	Mean	SD		
<b>1 Satisfaction with the current academic status</b>	<b>2.90</b>	<b>.79</b>	<b>3.11</b>	<b>.87</b>	<b>.686</b>	<b>.410</b>
• Teachers of psychiatric nursing in schools and colleges are adequately prepared for maintaining the standard expected for the country and the learners.	2.58	1.44	3.23	1.14	3.09	.082
• General standard of psychiatric nursing education is quite satisfactory and appropriate for the needs of the nation, and the needs of the learners.	2.58	1.38	3.81	1.20	10.48	.002
• It makes no difference to the practice of psychiatric nursing whether the education is at Certificate, diploma, degree or even at post-graduate level.	2.42	1.51	2.23	1.21	.238	.627
• Diploma program will still be deemed to be appropriate for specialisation as a psychiatric nurse.	4.00	1.13	3.20	1.33	3.86	.052
<b>2 Multidisciplinary factor</b>	<b>4.37</b>	<b>.68</b>	<b>3.48</b>	<b>1.13</b>	<b>7.00</b>	<b>.010</b>
• Nurse educators should utilise other teachers from other disciplines like psychology, social and biological sciences in the training of psychiatric nurses.	4.50	.67	3.92	1.13	2.94	.090
• Nurse tutors should be knowledgeable enough to do the teaching of psychiatric nursing students without the use of other experts from related disciplines.*	4.25	.75	3.04	1.42	8.24	.005
<b>3 Professional ideal factor</b>	<b>3.50</b>	<b>1.00</b>	<b>3.46</b>	<b>1.07</b>	<b>.013</b>	<b>.908</b>
• Psychiatric nursing education in this institution is based on a specified conceptual or theoretical model of Nursing.	3.58	1.31	3.56	1.20	.005	.944
• Degree programme appears to be more appropriate in order to specialise as a psychiatric nurse.	3.42	1.00	3.37	1.42	.014	.907
<b>4 Nurse generalist support</b>	<b>3.11</b>	<b>.63</b>	<b>3.18</b>	<b>.80</b>	<b>.085</b>	<b>.771</b>
• Psychiatric Nursing training should actually be integrated into general nursing training, without the need for any other special school for psychiatric nurses.	2.08	1.16	1.77	1.19	.708	.402

\* Coding is reversed for this item so as to indicate the direction of support for multidisciplinary approach to teaching by the respondents.

Factor	Botswana		Nigeria		F	Sig
	Mean	SD	Mean	SD		
<ul style="list-style-type: none"> <li>Psychiatric nursing education should be part of the general nursing education so that every qualified nurse is able to work with clients that need psychiatric or mental health care.</li> </ul>	3.50	1.93	4.00	1.47	1.11	.295
<ul style="list-style-type: none"> <li>Nurses should only be allowed to specialise as psychiatric nurses at the University post-graduate level.*</li> </ul>	3.75	1.42	3.77	1.21	.003	.954
<b>5 Support for post-basic nursing model</b>	<b>3.08</b>	<b>1.51</b>	<b>4.61</b>	<b>.84</b>	<b>27.01</b>	<b>.000</b>
<ul style="list-style-type: none"> <li>Psychiatric nursing education should be at the post-basic level of nursing education (post-registration as a qualified general nurse).</li> </ul>						

As far as the professional ideal factor was concerned, the responses of both groups were not significantly different. Both groups concurred that curricula were correctly based on a conceptual or theoretical model, and that psychiatric-mental health nursing should, from a desirable educational standpoint be placed at the degree level. The mean for this factor was 3.50, SD=1.00, and 3.46, SD = 1.07 for Botswana and Nigeria respectively,  $F[1,89]=.013$ ,  $p=.908$ ,  $>.05$ .

**Figure 5.4: Educators' level of response to aspects of present psychiatric nursing education in Botswana and Nigeria**



The responses in the support for nurse generalist factor revealed no significant difference for both countries. The means were 3.11, SD = .63, and 3.18, SD = .80 for Botswana and Nigeria respectively,  $F[1,89]=.085$ ,  $p=.771$ ,  $>.05$ . The support for psychiatric nursing education at a post-basic nursing model received a higher mean (mean = 4.61, SD = .84) among the Nigerian respondents than among the respondents from Botswana (mean = 3.08, SD = 1.51),  $F[1,89]=27.01$ ,  $p=.000$ .

### 5.7 Curriculum analysis

While the definition of curriculum may vary among different authors, the position adopted here is similar to that of Quinn (1993:233) who views the curriculum as the total learning experience prescribed for the students as a direct result of an involvement with an educational programme. Various nursing educational curricula in Nigeria and Botswana were examined for psychiatric-mental health nursing components, and their differing degrees of emphasis on mental health nursing. The curricula presented in table 5.9 were specifically targeted for analysis and comparison between Nigeria and Botswana. Presence or absence of such curriculum and the chronological antecedents were highlighted in the same table.

The curricula prescribed for nurses intending to seek registration as psychiatric or mental health nurses in Botswana and Nigeria were analysed for detailed structure and content. Comparisons were made of the available curricula in

the two countries, adopting similar reporting strategies for tabulation as used by Keogh and Fourie (1997:31).

**Table 5.9: Curricula with Mental Health Nursing Components in Nigeria and Botswana**

Description	Age of present Curriculum	
	Nigeria	Botswana
Basic Psychiatric/mental health nursing	Approved for use in 1994	Not available in Botswana
Post-basic psychiatric/mental health nursing	Approved for use in 1996	In use since 1982/1983, but a break from 1984-1990
General nursing (Certificate/Diploma)	In use since 1980	Approved for use in 1995
Undergraduate (basic/post-basic)	University of Ibadan -1965 University of Ife -1973 University of Nigeria - 1992	University of Botswana - 1978
Post-graduate	University of Ife – 1988 University of Ibadan - 1992	Not available in Botswana

The comparisons were facilitated with the use of Horan et al's model for the curriculum components. The observations noted in the curricula were further categorised into the findings presented and compared in tables 5.10, 5.11 and 5.12.

### 5.7.1 Intracurricular components

Table 5.10 presents the comparison between the intracurricular components of psychiatric nursing education in the two countries. The intra-curricular components compared include the philosophy of mental health nursing

education of the two countries, the description of the conceptual frameworks, the strands, programme objectives, and other level objectives.

Conceptual frameworks were not described in either the basic mental health nursing or the post-basic mental health nursing programmes of Nigeria. The Botswana mental health nursing education programme, however, described a framework which was intended to guide in the preparation of nurses who would be able to “utilise the primary health care approach in the provision of mental health services” (IHS 1990:6). The Botswana framework specifically mentioned “problem-solving approach (nursing process)” as the main nursing tool in providing assistance to clients with mental health problems.

Both countries include programme objectives and course (subject) objectives in the curricula. Levels and units objectives were, however, not included in the psychiatric-mental health nursing curricula for both countries. The curriculum from Nigeria is hospital-based with primary health care focus, while that of Botswana is community-based with primary health care focus.

**Table 5. 10: Comparison of the intracurricular components of the Mental health nursing curricula of Nigeria and Botswana**

Intracurricular Components	Nigeria	Botswana
Philosophical basis of psychiatric/mental health nursing education	<p>Expressed as statements of beliefs as follows:</p> <ol style="list-style-type: none"> <li>1. Man is a complex biopsychosocial, cultural and spiritual being, whose behaviour patterns develop from genetic inheritance and interaction with the environment.</li> <li>2. Health is a changing biopsychosocial and spiritual level of wellness which the client/patient is assisted to maintain through the utilisation of the Nursing Process.</li> <li>3. Mental Health Nursing is an applied science that employs the intellectual, interpersonal and technical skills of health personnel to assist clients in achieving maximum mental health.</li> <li>4. Mental Health Nursing Education enables the nurse to develop specialised skills in mental health nursing. It also encourages continuous refinement of practice by updating self with current literature and by attending Continuing Education Programmes.</li> </ol>	<p>Expressed as statements of beliefs as follows:</p> <ol style="list-style-type: none"> <li>1. Human being is a biopsychosocial and spiritual individual who has the ability to set his/her own goals, and make judgements, choices and decisions about his/her health in accordance with his/her own needs, values, goals and beliefs.</li> <li>2. Health is, as conceptualised by the WHO, the latent and manifest character of health and illness continuum as a process of adaptive responses to the external and internal environment in order to maintain stability and comfort</li> <li>3. Nursing is a helping and a health profession governed by ethical, legal and professional standards aimed at promoting, maintaining and restoring the health of individuals, families and communities</li> <li>4. Primary health care is the practical approach to making essential health care universally accessible to individuals and families in the community.</li> </ol>

Intracurricular Components	Nigeria	Botswana
	<p>5. To achieve health for all by the year 2000 and beyond, Mental Health Nursing Practices embrace the tenets of Primary Health Care in all its ramifications.</p>	<p>5. The environment is the context in which health occurs. This environment consists of social, psychological, political, economic and physical entities.</p> <p>6. The learner is a self-motivated, self-directed and capable individual. Learning is the responsibility of the individual learner and he/she must assume an active role in determining and fulfilling his/her learning needs.</p> <p>7. The teacher's role is to facilitate the learner's achievement of learning objectives consistent with the goals and aspirations of primary health care.</p>
Conceptual framework	Not described	<p>Described as using Primary Health Care framework (IHS 1990:6).</p> <p>Concepts identified in the Conceptual framework are:</p> <p>Primary prevention</p> <p>Secondary prevention</p>

Intracurricular Components	Nigeria	Botswana
Strands	Hospital care, primary health care.	<p>Tertiary prevention</p> <p>Individual, family and community needs</p> <p>Problem solving approach (Nursing process)</p> <p>Community mental health, primary health care</p>
Curriculum objective	<p>The student, at the end of this Mental Health Nursing Programme will:</p> <ol style="list-style-type: none"> <li>1. Utilise the Nursing Process in providing comprehensive nursing care to individuals and families in primary, secondary and tertiary health care settings.</li> <li>2. Provide a therapeutic environment conducive to re-socialisation and incorporation of the client/ patient to the social norms of the community through inter-sectoral team approach.</li> <li>3. Provide a safe physical setting which minimises the pathological stress related to illness.</li> <li>4. Create an atmosphere of trust which allows for meeting the client/ patient basic emotional needs and</li> </ol>	<p>At the end of the training, each graduate will be able to:</p> <ol style="list-style-type: none"> <li>1. Perform preventive, therapeutic and rehabilitative mental health services for individuals, families, and communities through their active involvement and participation of members of the health team and other sectors.</li> <li>2. Diagnose, treat (or refer) and follow-up clients with a range of emotional or neuropsychiatric disorders.</li> <li>3. Utilise a sound knowledge base in providing mental health care services in the community, psychiatric units/clinics, and mental hospital settings.</li> <li>4. Assist families in fulfilling their preventive, supportive and rehabilitative roles for their own members and other clients with mental health problems.</li> </ol>

Intracurricular Components	Nigeria	Botswana
	<p>changing attitudes.</p> <ol style="list-style-type: none"> <li>5. Encourage individuals to establish opportunities for self-expression, self acceptance and self evaluation which will enable the acceptance of responsibilities commensurate with the changing capacities.</li> <li>6. Assist in providing the necessary corrective experiences for the redirection of negative behaviours to achieve personal growth.</li> <li>7. Display tolerance in the acceptance of maladaptive behaviour of the mentally sick</li> </ol>	<ol style="list-style-type: none"> <li>5. Collaborate with others in rehabilitation and social reintegration of mentally ill clients in all settings.</li> <li>6. Utilise her knowledge of basic psychosocial factors and psychiatric nursing skills to assess, plan, implement and periodically evaluate the nursing care of clients with emotional, neuropsychiatric, drug abuse, and alcohol-related problems.</li> <li>7. Utilise the problem solving approach in the care of individuals and families with mental health problems requiring acquisition and application of knowledge from biological, cultural and psychological sciences.</li> <li>8. Ensure the integration of mental health into all ongoing primary health care activities.</li> <li>9. Conduct activities aimed at creating public awareness of prevailing mental health problems and motivate the public, authorities, non-governmental organisations and other agencies to undertake steps which will prevent or minimise these problems.</li> <li>10. Assume leadership in planning and implementing mental health activities at regional, hospital, and home levels.</li> <li>11. Conduct epidemiological, operational, or health</li> </ol>

Intracurricular Components	Nigeria	Botswana
Level objectives	Taken as basic or post-basic mental health nursing programmes objectives. Objectives for both programmes are the same.	Same as programme objective
Course objectives	Described for each subject	Described for each subject
Unit objectives	Not included	Not included

### 5.7.2 Implementation components:

The implementation components of the curriculum are compared in table 5.11. Nigeria admits candidates with Senior Secondary School Certificates or the equivalent into the basic psychiatric nursing programme. Though a basic psychiatric nursing programme like this does not exist in Botswana, the requirements for entry into the general basic diploma nursing programme at the Institute of Health Sciences or Colleges of Nursing in Botswana are similar. Post-basic psychiatric nursing programmes in both countries admit candidates with RN, but Nigeria allows candidates who may have only RM without RN, with one year post qualification experience.

The learning environment for psychiatric-mental health nursing education in both countries is shared between classroom, hospital, community and other miscellaneous settings. For Nigeria and Botswana, the percentage of classroom time in the total programme is 33% and 44% respectively, hospital time is 34% and 20%, community time is 28% and 26%, miscellaneous activities are 5% and 10%.

The curriculum structure of the basic psychiatric nursing programme of Nigeria has been compared with the basic general nursing programme for Botswana, to determine similarities in content, since graduates of the basic general nursing programme in Botswana are also used for providing psychiatric nursing in the hospitals. All the courses listed in the 3-year diploma nursing programme of Botswana have equivalents in the basic psychiatric nursing programme of Nigeria, except maternal and child health

nursing which is present in the general nursing curriculum of Botswana but absent from the basic psychiatric nursing curriculum which obtains in Nigeria.

The durations of the post-basic mental health nursing programmes for the two countries are 12 months and 18 months for Nigeria and Botswana respectively. In both countries the programmes recognise the need to include aspects of neuro-anatomy and physiology, psychopharmacology, psychology and sociology (behavioural science), psychiatric-mental health nursing, research and statistics. Neuro-endocrinology, perspectives in mental health care, activity therapy, management and teaching are additional courses described in the Nigerian curriculum, while the Botswana curriculum has an added emphasis on epidemiology in relation to research and statistics.

Similar specified teaching strategies in the curricula of both countries include lecture/discussion, patient/client care or case studies and demonstrations. The Nigerian curriculum, however, also lists other assumed teaching-learning strategies. Such listed 'strategies' include clinical practice, clinical rounds, audio-visual aids, projects, field trips, stimulation and tutorials. The Botswana curriculum limits its listed additional strategies to reading/library assignments and clinical observation.

Faculty preparations are specified in terms of professional and academic requirements for Botswana, but the Nigerian curriculum specifies only professional qualification for the teachers. Botswana expects the teachers to be prepared at first degree and Master's degree level. The curriculum for

Nigeria is silent on such recommendations, but suggests a 1:10 staff student ratio for the education programme.

Evaluation methods for the two countries prescribe the use of continuous (formative) as well as end of course assessment (summative). Allocated percentages for both types of assessment vary, for the formative/summative assessment is in a 50:50 ratio in Botswana, while the ratio in Nigeria is 30:70 respectively.

See table 5.11 on the following pages.

**Table 5. 11: Comparison of the implementation components of the Mental health nursing curricula of Nigeria and Botswana**

Implementation components	Nigeria	Botswana
<b>Learners</b>		
1. Usual entry requirements for students to be admitted into the basic mental health nursing program	Candidates must possess the Senior Secondary School Certificate or its equivalent with five credits to include English Language and either Physics, Chemistry, Biology/ Health Science passed at not more than two sittings.	Not available in Botswana
2. Usual entry requirements for students to be admitted into the Post-basic program	Candidates for admission into the Mental Health Nursing Programme of the Nursing and Midwifery Council of Nigeria must possess the "RN" or "RM" certificate with a minimum of one year post qualification experience.	Candidates must possess the basic general nursing diploma or equivalent, with at least one year post registration experience as a Registered Nurse (RN).
<b>Learning Environment</b>	Calculated as % of stipulated total number of hours of exposure in the programme	Calculated as % of stipulated total hours of exposure in the programme
1. Classroom	33%	44%
2. Hospital	34%	20%
3. Community	28%	26%
4. Miscellaneous (e.g. Activity therapy, projects)	5%	10%

Implementation components	Nigeria	Botswana
Curriculum structure		
1. Basic programmes	Basic psychiatric nursing programme	Basic General Nursing programme
1ST YEAR FIRST SEMESTER	Foundations of Nursing I Human Biology I Physics and Chemistry Microbiology Behavioural Science I The Use of English Language Primary Health Care I Community-based Clinical Practice I Seminar in Clinical Practice.	Foundations of Nursing Anatomy and Physiology Applied Physics and Chemistry Microbiology Professional basis for nursing practice
1st year SECOND SEMESTER	Human Biology II Foundations of Nursing II Primary Health Care II Pharmacology I Nutrition Behavioural Science II	Anatomy and Physiology Foundations of Nursing Health Assessment Pharmacology Introduction to Psychology Introduction to Sociology and anthropology

Implementation components	Nigeria	Botswana
2ND YEAR FIRST SEMESTER	Family Health I	
	Hospital-based Clinical Practice I	
	Seminar in Clinical Practice	
	Perspectives in Mental Health Care	Primary health care nursing
	Applied Human Biology	Maternal and child health nursing
	Mental Health Disorders and Treatment Modality I	Community mental health and psychiatric nursing
	Pharmacology	Adult health nursing
	Medical - Surgical Nursing I	
	Behavioural Science III (Applied)	
	Family Health II	
SECOND SEMESTER	Hospital-based Clinical Practice II	
	Seminar on Mental Health Nursing	
	Mental Health Disorders and Treatment Modality	Maternal and child health nursing
	Medical- Surgical Nursing II	Primary health care nursing
	Diseases of the Nervous and Endocrine Systems	Adult health nursing
	Community Mental Health Nursing	Nursing leadership and management
	Statistical Methods	

Implementation components	Nigeria	Botswana
3RD YEAR FIRST SEMESTER	Community-based Clinical Practice II Hospital-based Clinical Practice III (General Nursing experience) Seminar in Mental Health Nursing Research in Nursing Psychopharmacology Primary Health Care III Medical - Surgical Nursing III Activity Therapy Mental Health Disorders and Treatment Modality III Community-based Clinical Practice III Seminar in Mental Health Nursing	Clinical attachments
SECOND SEMESTER	Principles of Management and Teaching Research (Project) Hospital-based Clinical Practice IV Seminar in Mental Health Nursing	Primary health care nursing with Clinical attachment/Internship in Primary health care nursing, maternal and child health nursing, community mental health nursing, nursing leadership and management.  In-patient nursing with clinical attachment/internship in adult nursing, accident and emergency, intensive care, theatre and recovery nursing, nursing

Implementation components	Nigeria	Botswana
Post-basic programme	Duration is 2 Semesters	leadership and management.
1 <sup>st</sup> Semester Courses	Fundamentals of Mental Health Nursing Applied Human Biology Psychopharmacology Perspectives in Mental Health Care Community Mental Health Nursing Behavioural Science Mental Health Disorders and Treatment modality Diseases of the Nervous and Endocrine Systems Hospital-based clinical practice Community-based clinical practice Seminar in Mental Health Nursing	Duration is 3 semesters Neurophysiological aspects of Mental Health Adult and Childhood Psychopathology Psychopharmacology Community Mental Health Psychiatric-mental health Nursing Psychological Aspects of Behaviour Sociological Aspects of Behaviour
2 <sup>nd</sup> Semester Courses:	Activity Therapy Research and Statistical Methods Management and Teaching Community-based Clinical Practice II	Psychopathology of Mental Health Community Mental Health Assessment of Mental Health Psychiatric-mental health nursing

Implementation components	Nigeria	Botswana
3 <sup>rd</sup> Semester Courses	Hospital-based Clinical Practice II Projecting Writing Nil	Community Mental Health Research Epidemiology, and Statistics Psychiatric-mental health nursing
Teaching strategies specified in the curriculum	Lecture Lecture/Discussion Practical demonstration Clinical practice Group Discussion Project Clinical round Field trip Role play Seminar Stimulation Audio visual Aids	Lecture/ discussion Reading /Library assignments Clinical observations Case studies Demonstrations (IHS 1990:15)

Implementation components	Nigeria	Botswana
Faculty preparations (Minimum and maximum available)	<p data-bbox="607 314 1016 617">Group work Patient/Client care study Home/community health round Role modelling Skit Tutorial (NMCN 1991:5)</p> <p data-bbox="607 640 1279 822">Prescribed that the principal <b>must</b> have basic preparation in general nursing and mental health nursing, and a staff student ratio of 1:10 in classroom and clinical areas. List of recommended staff include:</p> <ul data-bbox="607 845 1279 1198" style="list-style-type: none"> <li>• Nurse Educators ( Mental Health Specialisation)</li> <li>• Nurse Educators</li> <li>• Public Health Educators/Primary Health Care Educators</li> <li>• English language Tutors</li> <li>• General Science Tutors</li> <li>• Guest Lecturers for speciality areas</li> </ul>	<p data-bbox="1330 640 2024 822">Prescribed B.Ed Nursing and Masters prepared teachers for ‘tutorial’ (IHS 1995:18), and qualified nurses at basic and post-basic diplomas, basic degree holders and medical practitioners including specialists for the clinical area.</p> <p data-bbox="1330 845 1935 874">Expected teacher:student ratio is not specified.</p>

Implementation components	Nigeria	Botswana
Professional and ancillary supporting	Not described in the curriculum	Not described in the curriculum
Evaluation tools	<p data-bbox="607 409 1077 443">Pretest and post test for each course</p> <p data-bbox="607 463 1294 571">Continuous Assessment forms 30% of final marks, includes projects and all progress examinations and tests.</p> <p data-bbox="607 591 1294 663">NMCN Final Qualifying Examination forms 70% of final marks</p>	<p data-bbox="1330 409 2018 555">Continuous assessment of 2-4 written and practical tests, and 1 – 2 assignments (or projects) for each course taught contribute 50% of final total marks for the course.</p>

### 5.7.3 The outcome components

The identified outcome components in the psychiatric-mental health nursing education programmes of the two countries as described in the basic or the post-basic psychiatric-mental health nursing curricula for Nigeria and Botswana respectively are presented in table 5.12. The expectations in table 5.12 listed 1-9 in the Nigeria column were specifically referred to as competencies in the basic as well as the post-basic psychiatric-mental health nursing curricula for Nigeria. The listed competencies in the basic curriculum were exactly the same as those listed in the post-basic curriculum for Nigeria (NMCN 1991a:2-3, 1991b:3-4). The Botswana curriculum, on the other hand, did not refer to the listed expectations 1-11 under the Botswana column in table 5.12 as competencies in the country's post-basic psychiatric-mental health nursing programme, but as "educational objectives" (IHS 1990:12-13). No other similarly listed expected outcomes were referred to or described as competencies in the Botswana curriculum.

Specific themes were extracted from the listed competencies for both countries. The themes were listed and each theme was matched against relevant competencies from each country. Findings from both countries were compared and presented in table 5.13 in order to identify the similarities and differences between expected outcome components in the curricula of the two countries.

See table 5.12 on the following pages.

**Table 5.12: Comparison of the Outcome components of the Mental health nursing curricula of Nigeria and Botswana**

Outcome components	Nigeria	Botswana
Expected psychiatric nursing competencies of the graduate	<p>The ability to:</p> <ol style="list-style-type: none"> <li>1. Utilise the Nursing Process in meeting the mental health needs of the individual and family.</li> <li>2. Assist the client/ patient to develop an acceptable standard of personal hygiene and good grooming habits.</li> <li>3. Educate families and communities on factors that may contribute to mental health illness.</li> <li>4. Recognise client/ patient verbal and non- verbal communications.</li> <li>5. Prevent client/ patient from constituting danger to self and others in homes, communities and health care settings.</li> <li>6. Plan with individuals and families in meeting psycho- social and spiritual needs through diversional, recreational and occupational therapy.</li> <li>7. Collaborate with members of interdisciplinary and intersectoral team utilising available</li> </ol>	<p>These are given as “educational objectives” (p. 12-13) in the curriculum. They include ability to:</p> <ol style="list-style-type: none"> <li>1. Promote mental health and prevent mental illness by carrying out promotional and primary prevention activities in mental health, by encouraging healthy lifestyles, and conducting anticipatory counselling of mothers, families, schools and other groups in the community about: i) avoiding those factors that predispose individuals and families to mental illness; ii) identifying children, adults, families and groups that are at risk of developing emotional and neuropsychiatric disorders; iii) collaborating with others to initiate specific preventive mental health measures for at risk individuals or groups.</li> <li>2. Teach families, the community and other health workers about: i) possible causes and prevention of mental illness, epilepsy and mental retardation; ii) factors which promote and maintain mental health; iii) stress, stress reduction and management of stress-related disorders; iv) knowledge and skills for</li> </ol>

Outcome components	Nigeria	Botswana
	resources to promote mental health within the community.	early detection and prompt management or referral of mentally ill persons.
	8. Function in a research role by performing relevant investigations in mental health problems and participating in interdisciplinary projects to improve the standard of practice.	3. Collaborate with Family Welfare Educators (FEW), Community Health Nurses, Family Nurse Practitioners and others in all health facilities and communities to assess, screen and manage clients with mental health problems:
	9. Provide primary, secondary and tertiary care aimed at preventing mental ill- health, restoring and maintaining optimum mental health.	<ul style="list-style-type: none"> <li>• Expectant mothers</li> <li>• Children in under-fives-clinics</li> <li>• School-going children</li> <li>• Adolescents (teenagers)</li> <li>• Adults</li> <li>• The elderly</li> <li>• The disabled</li> </ul>
		4. Diagnose and treat common psychiatric disorders by administering a selected range of drugs and other forms of therapy.
		5. Demonstrate the ability to guide, assist and teach other members of the health team, the promotion of

Outcome components	Nigeria	Botswana
		<p data-bbox="1322 309 1995 458">mental health, prevention of mental illness, care and management of individuals and families with mental illness in the community, psychiatric unit, or hospital.</p> <p data-bbox="1274 478 1970 659">6. Demonstrate ability to teach families about the prevention of mental illness among their members and how to support and rehabilitate mentally ill clients within the context of the family and community.</p> <p data-bbox="1274 679 1959 863">7. Collaborate with other health workers in utilising the nursing process in assessing, planning, implementing, monitoring and evaluating the mental health needs of individuals, families and communities:-</p> <ul data-bbox="1322 887 1959 1202" style="list-style-type: none"> <li data-bbox="1322 887 1904 956">• Collecting data on family and community mental health needs in the area</li> <li data-bbox="1322 979 1959 1017">• Identifying prevailing mental health problems</li> <li data-bbox="1322 1041 1915 1110">• Developing objectives for the nursing care interventions</li> <li data-bbox="1322 1133 1893 1202">• Implementing the appropriate nursing intervention to solve identified problems</li> </ul>

Outcome components	Nigeria	Botswana
Licensing	Must seek registration as a Registered Mental Health Nurse (RMHN)	Shall seek registration as a Registered Psychiatric Nurse (RPN)

- Evaluating the effects or impact of this intervention

- Utilise knowledge of the dynamic interaction between mental health, cultural and psychosocial factors to promote community mental health, prevent mental illness, diagnosis, management, follow-up and social rehabilitation of clients with mental illness.
- Demonstrate ability to integrate all aspects of mental health into all ongoing primary health care activities.
- Utilise various communication media to conduct health education aimed at forestalling or alleviating common emotional, neuropsychiatric, drug or alcohol-related problems in Botswana.
- Demonstrate knowledge, skills and attitudes for effective planning, organisation and management of community-oriented mental health care services and specific mental health facilities at secondary and tertiary levels.

**Table 5.13: Comparison of competency themes in the psychiatric-mental health nursing programmes of Botswana and Nigeria.**

Themes	Corresponding Competencies	
	Nigeria	Botswana
1. Health Promotion	7	1, 5, 8, 10
2. Health Education	3	1, 2, 5, 6, 10
3. Prevention of mental illness	3	1, 6, 8, 10
4. Early recognition of mental health problems	3	1, 2
5. Assessment and screening for mental illness	4	1, 3
6. Diagnose and treat mental illness	Nil	4
7. Rehabilitate for mental health	6, 9	6, 8
8. Nursing process and nursing care	1, 2, 5, 6	7
9. Teaching function	3	5, 6
10. Collaboration	7	1, 3
11. Integration in health care services	Nil	9
12. Provide services at primary, secondary and tertiary levels of care	9	5, 11
13. Research role	8	Nil
14. Management role	Nil	11

Altogether, 14 themes were extracted from the combined sets of competencies for the psychiatric-mental health nursing education programmes in both countries (table 5.13). Thirteen of the fourteen (92.8%) themes could be

matched with one or more described competencies in the Botswana programme. The only theme not addressed by Botswana in the listed competencies was that of 'research role' for the psychiatric mental health nurses. It was, however, noted that research content was present in the implementation components of Botswana curriculum (table 5.11) as part of the course 'Research, Epidemiology and Statistics'. Nevertheless, the research role of the psychiatric nurse was not given prominence or appeared to have escaped mentioning in the list of the competencies for the programme in Botswana.

In the case of Nigeria, only eleven of the fourteen (78.6%) competency themes could be matched with the expected competencies listed in the Nigerian programmes. The Nigerian programmes did not address the theme dealing with the psychiatric mental health nurses' ability to 'diagnose and treat common psychiatric disorders'. Two other themes dealing with integration of health services and management of health care services were also not addressed in the Nigerian programmes. Principles of management and teaching, although included in the implementation components of the Nigerian programmes (table 5.11), were not mentioned as a component of the listed competencies.

Findings presented in table 5.12 also showed varying concentrations of the listed competencies for each identified theme. In the case of Botswana, there were concentrations of competencies on the themes of health promotion, health education, prevention and early recognition of mental health problems.

For Nigeria, the only noticeable concentration of competencies appeared to be on the theme that revolved around utilisation of nursing process and the technical nursing care responsibilities. The distribution of the competencies for the themes in table 5.12 would also appear to reflect the degree of attention or the importance accorded each theme by the programmes from the two countries.

### *5.8 Interview data*

Transcribed interviews from Nigeria and Botswana were coded with the NUD\*IST 4 programme for qualitative analysis. It was decided to use a sentence as a text unit for the purposes of this analysis. This decision enabled the researcher to unpack the data in order to get to the depth of every contribution. The entire texts were coded with categories and subcategories developed on the basis of identified meanings and themes. This type of analysis involved extensive forward and backward movements between the raw data and the categorised data in the NUD\*IST programme. This prolonged engagement served as a means of monitoring the relevance, inclusiveness and the appropriateness of the categories and themes derived from the data. Categories and themes derived from this analysis were later compared between the two countries, Nigeria and Botswana.

Arrangement of all the coded responses into categories and subcategories for themes and meanings was made possible with the use of the coding and indexing system of the NUD\*IST. This allowed constant forward and

backward examination of themes, meanings, categories and qualities of the transcribed responses. Information extracted was broadly categorised into:

1. Descriptions of psychiatric-mental health nursing education in these countries;
2. Factors perceived to have been responsible for the present state of psychiatric-mental health nursing education in the two countries;
3. Concerns of the respondents with psychiatric-mental health nursing education in the two countries;
4. Comments and suggestions for the future of psychiatric-mental health nursing education in the two countries.

#### **5.8.1 Description of Psychiatric-Mental Health Nursing Education:**

Emerging patterns in the discussion with respondents from Botswana indicated tendency to view psychiatric-mental health nursing education in this country as having community emphasis, recent development, learners learning on the job, and as a general nursing model. The following statements extracted from the transcribed data are representative of such responses:

*.. we have a community mental health nursing programme attached to the mental health hospital, but training of psychiatric nurses started there not too long ago. Before that time, our people used to train in other African countries like South Africa and Nigeria.*

*....A lot of nurses practising psychiatric nursing are not registered psychiatric nurses. They learn on the job. Our nurses are able to do this because of their knowledge in general nursing. After sometime, they get used to the setting, and are able to do things based on their experience.*

*We have only one mental health nursing programme, though there are 8 or 9 Institutes where registered nurses are trained. I am a product of one of the institutes myself. The institute believe that the mental health nursing aspect of the general nursing programme is enough to work in mental hospitals.*

Descriptions from Nigeria on the other hand tended to focus on the fact that psychiatric nursing education had changed from what it used to be.

Respondents repeatedly referred to the change from being a basic programme to a post-basic programme, with reduction in the duration of the programme.

Respondents also viewed the programmes as having hospital emphasis that resisted advanced practice roles for psychiatric nurses. The following statements represent responses in this category.

*Psychiatric nursing education today is very different from what it was in the past. Many things have changed, and are still changing. The only things that have not changed are the illnesses themselves. Our students are now mainly qualified general nurses, though a lot younger than those general nurses that used to come for post-basic courses in the past.*

*Things have changed but I don't know whether they have changed for the better. Because the students here now are already registered nurses, they are able to do a lot of things on their own. Psychiatric nursing skills is (sic) the only thing they need, and most of them ask very challenging questions. I just take them as colleagues.*

*In the past all these schools were doing (sic) psychiatric nursing for 3 or 3 1/2 years, and if you already have one qualification, then you can do it for 18 months. Nowadays, the nursing council has changed everything. I understand you can only do psychiatric nursing if you have general nursing. But I am sure that will not work in other parts of this country.*

Respondents seem to refer repeatedly to the change in the duration of psychiatric-mental health nursing programme. The following statements represent responses that refer to the duration of the course in psychiatric-mental health nursing, and an indication that the mental health nursing education programme is still focused on care of clients within the hospital and is offered in schools of nursing attached to hospitals.

*Imagine, in those days we spent almost 4 years to become staff nurses with RPN, but today, after 3 years in a school of nursing, you just come in for 12 months and you become a double qualified nurse with general and psychiatric nursing. I agree that it is good to have double qualification (sic), but all these people that come for 12 months of psychiatric nursing training don't practise psychiatric nursing, they just need it to add to their qualification (sic). Very few of them go back to psychiatric nursing in their various hospitals.*

*The course of 18-months to 2 years of the past for post-basic nurses is now 12 months. I think the present system of education teaches the students a lot about hospital care. In the future we shall need more nurses who can work outside the hospitals with patients in the community.*

*What I can say is that today there are more schools of psychiatric nursing than we had in the 70s. In the past we had only one school of nursing for psych (sic), in the whole of the country. We have seven such schools in the country today.*

There are indications that the respondents viewed psychiatric-mental health nursing education as requiring high levels of responsibility and discipline.

The following statement refers to this observation.

*They (students) need to take their education seriously. Psychiatric nursing is really that aspect of nursing that needs good discipline.*

### **5.8.2 Factors associated with the present state of psychiatric-mental health nursing education in the two countries.**

In the discussion of the factors that were deemed to be responsible for the present state of psychiatric-mental health nursing programmes in the two countries, respondents from Botswana tended to focus on issues that were different from those regularly mentioned by the Nigerian respondents.

Reference to the influence of Western countries (Britain and the USA) as well as the influence of home government were, however, common to the responses obtained from Botswana and Nigeria.

The following statement was extracted from the Botswana group discussion with noticeable references to government and the foreign countries.

*The lecturers are mostly foreigners. The World Health Organisation and other foreign countries are responsible for the type of education we have today. But I also feel that the foreign experts study the country and suggest the type of programme.*

*No, I think the issue of nursing education and in particular the mental nursing education has history behind it. Our education system is a legacy from Britain as the former colonial master. It is the same with our nursing education. We don't have our own books, we read their books. We don't have our own teachers, they teach us from their own background, but their background is different from ours. Many things we learn cannot be practised in this country. We always want to copy Britain or America.*

The following responses, however, identified 'planners' of nursing programmes, personnel shortages, as well as policy issues, to be part of the factors that could have influenced the present status of psychiatric-mental health nursing education in Botswana.

*The planners of nursing education are mainly responsible.*

*Botswana relied on expert opinions from outside because of the lack of the necessary human resources. I know that the health policy of the country is based on primary health care and community care. So educational programmes are also driven by this policy.*

On the other hand, there were references to more multiple factors among the Nigerian respondents than were mentioned by the Botswana respondents. The following statement underscored the concern for factors like size and the geo-political structure of the country and the perceived role of the Nursing Council as a body that 'dictates' standard of education and practice.

*Now nursing council (sic) has changed everything. I understand you can only do psychiatric nursing if you have general nursing. But I am sure that will not work in other parts of this country. The country is so big. You cannot force the people in the north to do what you are doing in the south. (Participants may not be pleased with the perceived difference between the standards in some parts of the country). They are still doing the same thing as they do before. Maybe the council will be able to force this in future, but now the situation is not clear.*

The role of the government, the influence of Britain and the USA, intra-and inter- professional conflicts, sources of funding, and an expression of feeling of helplessness could be evident in the following statement.

*Many people also want to dictate to nursing. Nurses themselves cannot get their acts together. There is too much division among the rank and files of nurses, and this affects the education of all nurses, not just the psychiatric nurses. It is true our psychiatric nursing training is a legacy from Britain and America, but these people do not force us to do exactly what they do. But there are other factors here that affect our own type of training. Schools cannot decide to change anything except if directed by the nursing and midwifery council, and who are the members of the council? They have to be controlled also by various interests, state governments, and the politics of the health professions. Everything is dictated by the board or the government. The number of students that can be admitted is even limited by the board. If you admit more than what is speculated, there will be no funding. You cannot have additional tutor (sic), and students cannot be made to pay for their education. Even in the Universities, everything is based on quota system (sic). You have so many people to satisfy with very limited resources. What can anybody do in that situation? You just have to do as you are told.*

The following statements identified possible theory practice gaps, and differences in the objectives of the learners and those of the teachers in psychiatric-mental health nursing education. Learners and teachers were identified to be in mental health nursing education for unrelated reasons. Moreover the participant mentioned the role of the practice in shaping nursing education.

*I think there are some problems with the educators too who read only the theory and think that theory is the same as practice. Nursing education is still controlled by practice, and the sooner the educators realise this the better. Those who go to the Universities and the tutors programmes are all in the school. How do you expect those of us here to understand what is happening in the schools if we do not sit down to discuss things together? One factor that people do not seem to mention is that the objectives of the students are not always the same as that of the school. Some students are only here because of the material benefit, not because they are interested in psychiatric nursing. The whole system of nursing education can do better to identify students with good potential for psychiatric nursing practice.*

Nurses, and males in particular, who opt for psychiatric-mental health nursing education might have done so because of the regulation that precluded males from midwifery education and practice in Nigeria. The following statement exemplifies this factor.

*Nurses don't like to practise psychiatry but the men always want to have general nursing and psychiatric nursing because they are not allowed to do midwifery.*

Factors identified as influencing mental health nursing education included availability or non-availability of the needed resources, and how these resources had been maintained.

*I think this is still a problem because if this continues, we are never going to have enough psychiatric nurses in this country. ... If you look at the present system, things have deteriorated. All those nice things that were available for our training in those days are no more there. I don't know where they moved them, but our practical room in those days was good with many things that you can use for training. These days students don't even have things to practise with.*

National health care delivery structures with attempts to decentralise psychiatric mental health care are factors that further dictate the need to have nurses that are capable of providing mental health nursing care in various health care settings.

*All state hospitals now have psychiatric units in them and this requires psychiatric nurses for staffing. ... What we need in this country is for all health care workers to be familiar with mental health problems, so that this does not become the problem of psychiatric nurses alone.*

The following statement appears to emphasise the issue of territoriality in the health profession and how this might have a major influence on decisions to introduce different mental health educational programmes in the country.

*The advanced practice nurses will be the registered psychiatric nurses who go for further training of one year or more to be able to carry out special skills as nurse therapists or other specialised functions in the clinical setting like psychotherapy, prescribing of drugs and so on. I think this kind of system will work in America. Here, the doctors and nurses themselves will not allow it to work. It will bring too many ill feelings among the health team.*

*Psychiatric nursing in this county in future will be determined by what happens to nursing in general.*

### **5.8.3 Concerns of the respondents with psychiatric-mental health nursing education in the two countries:**

Specific concerns were expressed during the discussions by the respondents.

These concerns were picked up from the exact words used by the respondents.

The concerns fall into the following categories among the respondents from Botswana:

- a. Concern with foreign influence
- b. Non-registered psychiatric nurses in psychiatric nursing practice
- c. The only small number of nurses who are selected for training.

The following extract is an example of statements that relate to concerns (a) and (b) above.

*Our psychiatric nurses of the past, and I think very few of them trained either in other African country or overseas (sic). Up till now, most nurses working in the mental hospital are not registered psychiatric nurses. But some of them really don't like psychiatric nursing. But the ministry post (sic) them there. Once you are posted, you cannot change it so easily. After sometime, they get used to the setting, and are able to do things based on their experience. Remember we also have many nurses who are from other countries on contract...*

The following statement is an example of concern with the number of nurses that could be admitted into the community mental health nursing programme.

*We have only one mental health nursing programme, though there are 8 or 9 Institutes where registered nurses are trained.*

Concerns expressed by the respondents from Nigeria were noted as follows:

- a. Increasing incidence of mental health problems
- b. Shortage of nurses in mental health nursing practice.

One of the respondents remarked about the nurses who only get into mental health nursing programme in order to get a mandatory second nursing qualification, but not because of the interest to practice psychiatric nursing:

*I think this is still a problem because if this continues, we are never going to have enough psychiatric nurses in this country.*

Concern for shortage of nurses is also expressed in the following statement:

*If you look at the number of psychiatric nurses in this country today, they are not even enough for the psychiatric hospitals not to talk of the state hospitals. If nurses are exposed to psychiatric nursing education and practice early enough, more and more nurses would be willing to follow psychiatric nursing path.*

#### **5.8.4 Comments and suggestions for the future of psychiatric-mental health nursing education in the two countries.**

Comments and suggestions from the respondents in relation to the future of mental health nursing education in both countries fall into the following categories listed in table 5.14.

**Table 5.14: Themes in the suggestions put forward by the respondents from Botswana and Nigeria.**

Botswana	Nigeria
Specialisation	support for PHC
Licensing need	family support
Venue of training	new category of nurses
Localisation of resources	Challenge to educators
Increase in numbers	Venue of training
Community relevance	Incentives
Curriculum transformation	Support for polyvalence
Research	Support for basic specialisation
Incentives	
Support for polyvalence	

The following are typical of the comments in the above categories.

*Nurse educators should sit down and look at how the curriculum can be adapted so that all nurses can work as psychiatric or mental health nurses.*

*This proposal should be presented to the government for approval. Our educators and others should continue to research the efficacy of some of the alternative means of mental health care in the community with a view to integrating this in future.*

*The government should encourage more nurses to work in mental health care settings by adding some incentives so that this will make more nurses opt for working in this sector.*

## 5.9 Conclusion

The results presented in this chapter summarised the current situation in the field of psychiatric-mental health nursing education in Botswana and Nigeria. The chapter presented the views of psychiatric nurse educators, and other role players in the field about the psychiatric-mental health nursing education programmes in these two developing countries. The views of the psychiatric nurse educators, the analysis and comparison of the various components of the curricula and the contents of the focus group discussions provided the following highlights:

- i. There are variations and similarities between and within countries in the ways and manners that the psychiatric nurse educators would want to describe the models of their psychiatric nursing education programmes.
- ii. The psychiatric-mental health nursing education programmes of both countries intend to make psychiatric-mental health nursing service available to individuals, family and the community at all levels of care.
- iii. Community strand occurred in the curricula of both countries with varying degrees of emphasis on classroom instruction and clinical placement.
- iv. Though similarities abound in the expected competencies of the graduates of the programme between the two countries, the role functions for these graduates differ between the countries.

- v. Psychiatric-mental health nursing education programmes of the two countries have been influenced at different times by war, colonial history, changing standards of health care delivery, government health policies, economic status of the country, professional status of nursing and the changing standard of education.
  
- vi. The needs of the countries are still not being satisfied by the quantity and the quality of nurses currently being produced by the psychiatric-mental health nursing education programmes of the two countries.

The implications of these findings are discussed in the next chapter

## Chapter 6

# **Discussion, Conclusion and Recommendations**

## *6.1 Introduction*

In this chapter the findings presented in the previous chapter are discussed with a view to drawing conclusions and making recommendations in line with the objectives of the present study. Attempts are also made to explore further problem areas in the light of the presented findings. In the beginning, this study aimed at describing the psychiatric-mental health nursing education programmes of Botswana and Nigeria. The description was to be based on the exploration and the assessment of the areas of commonalties and differences existing in this aspect of nursing education for Botswana and Nigeria.

Educators in Africa and other continents reiterate that nursing education needs to develop a global perspective in the present world of interdependent nations and people (Lindquist 1990; Tlou 1998). In a collaborative study which attempted an international comparison of baccalaureate nursing degrees, French, Anderson, Burnard, Holmes, Mashaba, Wong and Bing-hua (1996:594) have also indicated that increased understanding of similarities and differences between nursing curricula at an international level would be of potential benefit for international co-ordination. The apparent lack of documented information about the status and pattern of mental health nursing education in several countries of Africa today could serve as an impediment to the type of international co-operation being advocated by the likes of

Lindquist (1990), Tlou (1998) and French et al (1996). The subsequent discussions therefore address the main findings that provide further understanding of the mental health nursing education system in the studied countries.

Opinions from other authors will be applied to support the views expressed. Where appropriate, findings are compared or related to the works of other authors in similar fields. Major findings are interpreted and discussed in the light of the models of psychiatric nursing education found in the two countries, the research questions raised, why the countries might have adopted these models, and the appropriateness of the models for the needs of the communities being served. The differences observed and the similarities are also discussed in terms of the geo-political, socio-economic, educational and cultural situations of the countries. The discussion is further geared towards making recommendations for reinforcing strengths observed in the psychiatric nursing education systems of the two countries, or proposing alternative forms or modifications, if necessary, in the form and structure of psychiatric nursing education programmes of the two countries. The recommendations are expected to promote functional relevance of psychiatric-mental health nursing education within the context in which it exists.

## *6.2 Models of Psychiatric Mental Health Nursing Education in Botswana and Nigeria..*

Aspects in common are that psychiatric-mental health nursing education exists in Nigeria and Botswana, and that psychiatric-mental health nursing contents

are mandatorily included in all nursing curricula at basic, post-basic and degree levels in both countries. Findings presented in this study revealed that the manner in which the models of psychiatric-mental health nursing education were described in both countries appeared to vary widely. This variability might have reflected the emphases and perceptions of the practitioners and the stakeholders in this field of nursing. Using the outcome of the enquiry into how the respondents would want to describe the psychiatric nursing education programmes in the two countries to fit the model of psychiatric nursing education in any of these two countries into a predetermined or pre-described model could produce a questionable result.

Primary health care model, community health nursing model, competency based model, general nursing model, integrated nursing model, post-general nursing model, apprenticeship model, problem-based learning model, medical expressive model and diploma model were the top ten ways that the respondents in Botswana tended to describe their models of psychiatric-mental health nursing education. On the other hand, psychiatric specialisation model, post-general nursing model, integrated model, certificate model, diploma model, medical expressive model, primary health care model, community nursing model and general nursing model were the top ten ways that respondents from Nigeria would want to describe their own psychiatric nursing education models (see table 5.4). This hotchpotch perspective of the mental health nursing education models by the respondents in both countries would need to be viewed against the background and the current field of education and practice in these countries as a whole. The inconsistency in the

manners of describing these models might cast doubts on any claim to the use of any single concept to imply an accurate description of the models of psychiatric-mental health nursing education in Botswana or Nigeria.

Table 5.4 (p.134), nevertheless, provided statistically significant evidence that Botswana saw its own programme more as primary health care or community health nursing inclined than did Nigeria. This was further corroborated by the nature of the design and implementation of the community mental health nursing and even the general nursing curricula of Botswana.

The conceptual model of all the nursing curricula in Botswana specifically epitomised the primary health care approach. The mental health nursing education programme in Botswana, from its time of inception, was conceived as a programme meant to provide mental health nursing care in the community (Wankiri 1994:260). The first three objectives of the curriculum, provided in table 5.12 (p.170) of the Botswana mental health nursing programme, made no pretences as to the intention of the programme. It described in detail the expected activities of the graduates of the programme in the community as well as their collaborative responsibilities amongst other members of the health team in the spirit of primary health care delivery. Historical antecedents, the influence of the WHO, and the period when mental health nursing education was introduced into Botswana must have accounted for the strong emphasis on community cum primary health care in the conception and the implementation of the programme in Botswana. The 18-month post-basic mental health nursing programme in Botswana was said to be based on the

belief that a mental health nurse in most developing countries like Botswana “is usually the only professional available to provide most mental health services especially in the rural areas where the majority of people live” (Wankiri 1994:260).

The respondents from Botswana also described their own model as an apprenticeship model significantly more than their Nigerian counterparts. This emphasis needs to be considered in the light of the claims that mental health nursing education in Botswana was also described as a general nursing model, as an integrated model and as a post-general nursing model (see table 5.2, p. 132). Apprenticeship as conceived here might mean that nurses in mental health care settings were made to learn on the job, as this was particularly true of the practice in the mental health nursing service in Botswana. Registered general nurses did not require psychiatric nursing registration to work in the psychiatric-mental health nursing setting. In Botswana, it must have been presumed that the basic preparation received in general nursing programme had an integrated mental health nursing component which would be adequate to enable a registered general nurse to function in mental health care settings. Further skills were acquired on the job, and if desired, a qualified general nurse could opt to do a post-basic diploma programme in community mental health nursing so as to be registered as a community mental health nurse, inappropriately called registered psychiatric nurse (RPN) in Botswana. During the data collection phase of this study, a senior official of the regulating body confirmed that there had been periods that even the head of the nursing services in the mental health hospital

at Lobatse did not have psychiatric-mental health nursing qualification.

Botswana nursing students at basic or post-basic levels of education received stipends or salaries. This situation could further make the respondents see the students as 'learning in-service or on-the-job', a description that fits the concept of apprenticeship.

Why the respondents from Botswana would want to describe their model of psychiatric-mental health nursing education as problem-based was not clear. Throughout the curriculum, there was no indication or even any mention of a problem-based approach to learning. The curriculum did, however, indicate as one of the objectives, that learners would "utilise the problem solving approach in the care of individuals and families with mental health problems requiring acquisition and application of knowledge from biological, cultural, and psychological sciences" (IHS 1990:9). The respondents were therefore likely to have confused the prescribed use of the problem solving approach to provide care, with the problem-based approach to learning. Another possible explanation could be that nurse educators in Botswana interpreted problem-based learning in terms of the intention of the curriculum for mental health nursing in Botswana which was to "address the mental health problems specific to Botswana" (Wankiri 1994:260).

Nigerian respondents tended to see their psychiatric-mental health nursing education programme significantly more as a psychiatric specialisation model as well as a certificate model than did the Botswana respondents (table 5.4 p. 134). Though the Nigerians were apt to use other models like post-general

nursing, integrated, competency based, medical expressive models to the same extent as their Botswana counterparts did, the significant use of psychiatric specialisation and certificate models deserved further consideration. This assertion of psychiatric specialisation status in itself might confuse the international audience who were bound to have a different perception of practice specialisation related to educational levels of qualification. The ICN (1987:74) document on nursing education defines a nurse specialist as:

*... a nurse prepared beyond the level of a nurse generalist and authorised to practise as a specialist with advanced expertise in a branch of the nursing field. Speciality practice includes clinical, teaching, administration, research and consultant roles. Post-basic nursing education for speciality practice is a formally recognised programme of study built upon the general education for the nurse and providing the content and experience to ensure competency in speciality practice*

This definition would make it difficult for nurses prepared through a basic programme to claim a specialist status. First, it would be necessary to clarify that all qualifications leading to registration as a psychiatric nurse in Nigeria were obtained at either a basic or post-basic hospital-based school of psychiatric nursing. These schools of nursing do not award their own certificates or diploma, but only present candidates for the qualifying examinations of the NMCN. Successful candidates in the psychiatric nursing qualifying examination of the NMCN are registered as such by the council to enable them to use the title of a registered psychiatric nurse (RPN). The same NMCN examination is written by candidates seeking basic or post-basic registration as a psychiatric nurse, but once registered, a psychiatric nurse sees himself or herself as a psychiatric nurse specialist!

In Nigeria, the objectives of the basic psychiatric nursing specialisation were not different from the objectives of the post-basic psychiatric nursing specialisation as apparent in the two curricula. Nigeria had no document that described the specialist or advanced practice roles that could be found in other countries like the USA or the UK. Nursing practice in general, as well as psychiatric nursing, was not regulated beyond the first level of practice in Nigeria. In other countries of the world like the USA, the UK and lately in South Africa, frameworks and regulations are being drawn up for higher levels or advanced levels of nursing practice (UKCC 1998). This is in line with the changing health needs of people, the increasing emphasis on delivering care to users in their own locality and the changing nature of the advances in care and treatment in both the developed and the developing worlds. Specialisation claims could be supported, however, if the respondents from Nigeria preferred 'specialisation' to mean "nurses with an in-depth theoretical knowledge and clinical skills in one part of the whole field of nursing" (ICN 1997:22). This support could be based on the assumption that a comparatively greater depth of psychiatric nursing content was covered in the psychiatric-mental health nursing programme than in the general nursing programme.

In Botswana, as in Nigeria, advanced nurse practice roles as described in countries like the UK, the USA and the Netherlands were not included in the expectation and the preparation of psychiatric mental health nurses. It would be possible to identify clearly the expectations of expert or specialist practice in psychiatric-mental health clinical settings in these western countries in relation to educational and academic levels of preparation. Academic levels of

preparation and specialised experience that permit a nurse to take up more independent or autonomous roles which further expand the boundaries of nursing are part of the criteria recommended for use in order to judge specialisation and advanced practice roles (Cronenwett 1995; Davis & Bernhard 1992).

Botswana and Nigeria are examples of countries where national, economic and cultural situations determine how nurses, particularly the psychiatric nurses, assume 'specialist' status. Though the ICN (1992) guidelines on specialisation in nursing clearly recommend post-basic, university diploma or postgraduate education for nursing specialists, economic considerations and their technological level of development might make the developing worlds question the cost effectiveness and the realities of such recommendations. Yet WHO (1994: 12-13) acknowledges the trend that nurses and midwives in many countries of the world today are being educated at university level, and that in some countries the current trend is towards university education for **all** nurses. Moving nursing out of its educational ghetto into mainstream higher education was one of the strategies adopted in Bahrain as a major direction for nursing education into the future (Affara 1990: 157). Arguments of cheaper means of producing health professionals, often used in support of hospital-based schools of nursing, may no more be tenable on a non-scientific assertion. In fact such training might eventually not have been cheaper for the government, but only to the student on the short run, against the unwitting lack of consideration for the long-term effect of a sub-stratum educational exposure. The collegiate education move for the nurses in Nigeria in the eighties (1980s) became

snuffed out of existence through unscrupulous political and economic excuses from the policy makers. The case for higher education for nurses in Nigeria was also not helped by the hostility from the seemingly suspicious professional hegemony within the health care system in the country. Much opposition to collegiate education for nurses at that time came from within the profession itself, particularly from the less educated majority of the members of the profession, who were, themselves, products of the hospital-based nursing schools. They must have felt that moving the education of nurses into the mainstream of the country's educational system, and into higher institutions would deprive them of the existing benefits and would force them to upgrade their certificates to degrees or some other forms of diploma levels. The situation was further worsened by the control that the medical profession had on the nursing profession particularly at the government decision-making levels. Ministers, directors, and most deputy directors who were to make decisions on the fate of nursing were medical doctors. Physicians were almost at that time united in their opinion that nurses would be "overtrained" by educating nurses in colleges, universities and other similar institutions of higher learning. Physicians in Nigeria, like their American counterparts of the 1920s (Ellis & Hartley 1992:60) "were not certain that a sound knowledge base was as important as the acquisition of technical skills and manual dexterity that could be acquired with brief training at the bedside". A cheaper form of training that was achievable in schools of nursing, which were mainly established to meet the service needs of the hospital to which they were attached must have served its purpose in the past. The economic aspect of this

opposition might also be related to the fact that private hospitals, mainly owned by physicians, were the second largest group of employers of nurses after the government. Better education for nurses could therefore mean that the private hospitals would be more expensive to run. This lack of support for nursing education development need not be so if the focus of programmes and services were for the overall benefit and protection of the majority of the people and not just for a section of the population.

The tradition of having nursing schools attached to hospitals in Nigeria, outside the general education system, would further make the suggestion of the ICN (1992) about the pursuit of orderly development of nursing specialities and introduction of advanced nursing practitioners difficult to implement in Nigeria. Psychiatric nursing education in Nigeria has a horizontal relationship to general nursing, while in Botswana psychiatric-mental health nursing education has a vertical relationship to the basic nursing programme. Assumptions of specialisation were therefore easier to make in the case of Botswana than in Nigeria. In the same vein, award of a post-basic diploma from the University of Botswana to the graduates from the Botswana mental health nursing programme provided a more understandable educational credibility than the unclassified certificates of attendance given to graduates from the schools of psychiatric nursing in Nigeria. Psychiatric nursing schools in Nigeria only had affiliations with or were established by hospitals, without any form of academic relationship to universities or other higher institutions as in the case of Botswana.

### *6.3 The Nurse Educators and Psychiatric-Mental Health Nursing in Nigeria and Botswana*

The profile of psychiatric nurse educators in Botswana and Nigeria as presented in table 5.1 (p. 130) conveyed more similarities than differences between the two groups. Gender distribution among the educators was similar as there tended to be more males than females in both groups, probably as a reflection of the usual pattern of gender distribution among psychiatric mental health nurses. Males were known to be more attracted to psychiatric-mental health nursing than females, according to the findings made by Soerlie, Talseth and Norberg (1997:117) on the tendency of males in nursing to adopt roles within nursing that were perceived to be male. This preference might be a more probable reason for the observed number of males among the nurse educators in both countries. The educators in Botswana appeared to be older than their Nigerian counterparts with relatively, but insignificantly, fewer years of experience in psychiatric nursing education. These two characteristics might appear to be in conflict if one expected that the older the educators were, the longer their experience would be in number of years. In fact, psychiatric nursing education in Nigeria predated the programme in Botswana by more than two decades. This chronological history could be used to explain the seeming difference between the educators' experience in Botswana and in Nigeria.

There were similarities in the percentages of Botswana and Nigerian nurse educators whose highest academic qualifications were at the diploma in nursing education level. While the highest academic qualifications of the

psychiatric nurse educators in Botswana were all in the nursing field, the highest academic levels of their Nigerian counterparts could be seen to have spilled into other disciplines like sociology, psychology, public health or even nutrition. None of the Nigerian respondents had the equivalent of a doctoral degree. This picture itself could be a reflection of the academic status of psychiatric-mental health nursing education in the two countries. The affiliation of all formal nursing education programmes, including that of psychiatric-mental health nursing, could have sent signals to the nurse educators in Botswana that further relevant academic qualifications were desirable in nursing. Conway-Welch (1990:139) commented that “the nurse remains the least educated member of the health care team”. The educational preparations of the educators in Nigeria and Botswana could only serve to strengthen such claims. If the majority of the teachers operate at the diploma level, it might be logical to claim that the products would not be able to attain a status beyond that of the educators’ preparation. This limitation of low level academic preparation can become a very potent restraining force when issues of curriculum transformation, academic uplifting, educational restructuring or mainstreaming of nursing professional education get tabled as part of the agenda for nursing education among nurse educators themselves.

One of the factors that has assisted in maintaining the status quo for most of the psychiatric-mental health nursing education at the certificate level in Nigeria today could be traced to the cycle of low academic preparation of the teachers and practitioners of nursing in this setting. Smeaton (1982:80), as a matter of fact, has noted that the mainstream educational scene is impinging

upon the traditional business of nurse training owing to the poor academic preparation of the nurse teachers. This assertion was in particular reference to the inservice certificate or diploma in education courses attended by aspirant nurse teachers as the only additional qualification required to teach in nursing schools, following 3-4 years hospital school of nursing training as a registered nurse. Tutor education will therefore continue to be in the forefront of the conflict between education and practice philosophies. In health care, the common ground for both philosophies is clients' quality care. This common ground would appear to be a strong case for continued call for empirical evidence that can clearly relate levels of educational achievements with standards and quality of care.

The responses of the teachers in table 5.6 (p.141) from Botswana and Nigeria were quite similar in their views on the congruency between their teaching and what the learners would be expected to practise. There was, however, a noticeable difference in one of the items that sought to look at how the respondents would take responsibility for what was learnt or not learnt by the students. It appeared that the Botswana respondents were willing to take more responsibilities for students' learning than would their Nigerian counterparts. While this position agreed with the data presented in table 5.5 and figure 5.2, it had implications for the way that the teachers would view a move towards self-directedness in the learning of students. Some other possible interpretations here might be in terms of commitment and willingness to accept responsibility among the respondents. Either way, the learners were

bound to enjoy varying degrees of freedom to learn based on the perception of these two groups of respondents.

One of the factors that could determine the future trends in the psychiatric-mental health nursing education programmes of the two countries under study might be the nurse educators' views of the present situation of the programme in their countries. In table 5.8 (p. 147), the nurse educators might have been satisfied with the present academic status of psychiatric-mental health nursing programmes in Nigeria and Botswana. While the Botswana respondents might have appeared to be less satisfied, the difference between the two countries was not significant. Satisfaction with the present status could be a maintaining factor in the absence of any more powerful stimuli to change the present status or models for producing psychiatric nurses in these countries. Change would be inevitable where there was an overwhelming perception of need to change. In a situation where the teachers perceived themselves as being adequately prepared for the standard expected in their country, where they were satisfied with their own standard of education, and were prepared to accept specialisation at diploma levels, predicting or prescribing change based on other international standards could prove unwelcome and difficult to motivate.

With the increasing emphasis on multidisciplinary approach to training and education of health professionals, and raging debates on transdisciplinary practice, the Botswana group appeared to be more inclined to embrace the multidisciplinary approach than their Nigerian counterparts. This could be a

manifestation of the levels of primary health care or the community-based emphasis of their respective curricula. In any future plans for psychiatric-mental health nursing curriculum transformation in Nigeria, this aspect would need to be taken into consideration as a possible factor that had a potential of impeding collegial participation in the education of nurses. The glaring exclusion of other professions in the required cadre of teaching staff for the curricula of mental health nursing programmes in Nigeria listed under the requirement for programme implementation (NMCN 1991b:4) appeared to be a subtle manifestation of this bias.

The requirements for the nurse educators in the Nigerian basic and post-basic mental health nursing curricula stated that only the following cadre of staff would be needed in the school of mental health nursing:

- *Nurse educators (Mental Health specialisation)*
- *Nurse educators*
- *Lecturers for speciality areas*

(NMCN 1991:4)

The curriculum failed to specify the qualifications required for these cadres. The same curriculum, also on the same page, did not fail to emphasise that the principal of the school of mental health nursing programme must be a “Registered Nurse Educator who had a basic preparation in General and Mental Health Nursing”. Observers might not be aware of the potency of careful silence on the academic requirements or the educational qualifications expected of the nurse educators. Minimum educational requirements to teach

in a professional nursing programme would seem to be likely to continue to be a contentious issue for a long time in a country like Nigeria.

There was nevertheless a tendency for the nurse educators to want to extol a professional status for psychiatric-mental health nursing. While there was no significant difference in the marginal support given to the generalist model for producing psychiatric nurses, a major move supported by Nigerian nurse educators was to have psychiatric nursing education put at the post-basic nursing level rather than at the basic level. These educators might have realised that pre-registration specialisation in psychiatric-mental health nursing was fast becoming outdated and would continue to confuse the logic of the nursing educational system.

In making a case for a generalist nursing model, Salvage (1993:7) contends that a generalist nurse is not in opposition to or in preference to a specialist nurse, but generalist preparation is intended to meet the need for a sound, broad-based basic education in nursing with a strong emphasis on primary health care. It would then no more be desirable nor cost effective to continue to produce first level or basic specialisation in mental health nursing. If the training of a basic specialist nurse in psychiatric nursing had served any purpose in the past, the purpose had probably been limited to the custodial needs of psychiatric hospitals where such training took place. A basic specialisation must today give way to a post-basic specialisation after a nurse has had a basic or first level generalist preparation in a diploma or a degree awarding institution of learning.

#### *6.4 Nursing curricula and the psychiatric-mental health nursing education in Botswana and Nigeria*

General nursing curricula at the basic or post-basic certificate, diploma or degree levels in the two countries have clearly specified psychiatric-mental health nursing contents. Reasons for inclusion in these curricula were summed up in such objectives for their graduates which expected that at the end of the educational programme a qualified general nurse should be able to provide “comprehensive care to individuals, families, groups and communities...” (IHS/UB 1995:6). Inclusions of psychiatric-mental health nursing components in these curricula were not intended to make specialists out of the learners but to provide basic psychiatric nursing skills for generalist functions. This differs from the approach in at least one other African country, South Africa, where specialist registrations are provided to nurses who have undergone a 4 year comprehensive basic nursing programme (CBNP). The South African 4-year CBNP enables a nurse who completes this programme to register as a general nurse (RN), a psychiatric nurse (RPN), a community health nurse (RCHN) and as a midwife (RM).

Similarities were also noted in the placement of mental health nursing content in the general nursing curricula of the two countries under discussion. The general nursing programmes in both countries currently have a 2<sup>nd</sup> year psychiatric-mental health nursing course be it at the certificate, diploma, and generic or post-basic degree levels. Clinical sites might vary, but a typical course outline for a psychiatric-mental health nursing component in a general nursing curriculum for Nigeria expected that learners would have a total of 88

hours in classroom instructions and 240 hours of clinical experience. The 240 hours of clinical practice were shared between community mental health care (40 hours); psychiatric out patient and psychiatric emergencies (40 hours) and the acute and chronic psychiatric wards (160 hours). This probably demonstrated where the emphasis of clinical experience was placed. With more time spent in the acute or chronic psychiatric wards, learners could not but continue to see mental health problems in terms of hospitalised care.

The corresponding total number of hours spent for classroom instruction in similar programme for Botswana was 80 hours and a total of 168 hours for the clinical experience in the 3-year general nursing programme. In the case of Botswana, 108 hours of the 168 hours for practical experience were devoted to community mental health nursing practice. This would tend to reinforce the expectations that registered nurses in Botswana were expected to function within the frameworks of primary health care which appeared to be the emphasis of the curriculum at the basic and even at the post-basic levels.

Subsequent information revealed in the discussions with practising nurses in the fields of psychiatric-mental health nursing during the course of this investigation did not, however, support the basis of the effort identified for the mental health nursing component of the Nigerian general nursing curriculum. While Botswana would gladly post registered general nurses who were not registered psychiatric nurses to work in psychiatric nursing settings, Nigeria would insist that only registered psychiatric nurses must be posted to work in psychiatric nursing settings. It may be argued that this insistence might result

from the fact that Nigeria started psychiatric nursing education earlier than Botswana, which could have contributed to holding on to the stereotype that only registered psychiatric nurses should be recruited to perform psychiatric nursing functions. Exigencies might have accounted for the fact that long before psychiatric nurses started to be trained in Botswana, the need for psychiatric nursing might have been met by general nurses, who continued to fulfil this same role today. Development of a post-basic community mental health nursing programme in Botswana was only therefore designed to meet a specific health human power problem for Botswana that would cater more for the mental health component of the primary health care.

Botswana through her own programme sought to produce nurses who according to Wankiri (1994:261) could:

- Provide all aspects of mental health and psychiatric nursing as well as render promotional, preventive, therapeutic and rehabilitative mental health services
- Collaborate with community-based frontline colleagues to provide community-oriented mental health services within the framework of primary health care
- Provide mobile consultative services to clients who are referred to them by the general nurses and other professionals

- Train their non-specialised colleagues to identify, manage and follow up mentally ill clients so that only patients with more serious emotional or neuropsychiatric disorders would be referred.

The vertical relationship of the mental health nursing programme of Botswana was therefore easier to conceptualise than it was for the Nigerian mental health nursing programme. First, Nigeria runs a basic psychiatric nursing programme with exactly the same set of objectives as that of their post-basic psychiatric nursing programme. This type of basic mental health nursing programme is understandably non-existent, and has never existed in Botswana. Though basic psychiatric nursing programmes had existed in countries like the UK, Ghana, and South Africa with the same Commonwealth linkage, only a few of such countries would want to retain this kind of specialised basic nursing programme today (Adejumo 1998). Most countries have opted for post-basic mental health nursing curricula. The expectations of such post-basic mental health nursing education are that learners build on the basic skills already developed in general nursing. If the expectations of post-basic mental health nursing education of Botswana and Nigeria were to be judged against the expectations of such education by Peplau (1962, 1987), strong deficits would still exist in the content of their curricula for mental health nursing in these studied countries. Peplau regards the surface type procedures related to mental health nursing like counselling, interviewing skills and interpersonal techniques as what is to be expected of all general nurses at the basic level. She contrasts these basic psychiatric-mental health nursing skills with those arrays of intellectual, interpersonal and in-depth

psychotherapeutic skills specific to the practice of the psychiatric nurse at the post-basic or the graduate level. Neither of the post-basic psychiatric-mental health nursing components for the two countries under study may have achieved this status of developing “in-depth psychotherapeutic skills”. Skills emphasised in the post-basic curricula of the two countries would probably be limited to those identified by Peplau as basic psychiatric-mental health nursing skills.

The mental health nursing component of the basic general nursing curriculum, the basic psychiatric nursing curriculum and the post-basic psychiatric nursing curriculum thus appeared to carry similarities that bordered on duplication of contents. The curricula did not provide hints on depths of coverage of the contents because they were not described in terms of depth. While it is acknowledged that mental health nursing education can vary depending on the identified needs of each country, the contents of the curricula, up to the post-basic level in the two countries, meet with some of the prescribed essential contents for entry into the psychiatric-mental health nursing practice (SERPN 1996). The following basic knowledge and skills were considered essential for entry into mental health nursing practice by the SERPN:

*Knowledge:*

- *Biological and psychological theories of mental health and mental illness*
- *Psychotherapeutic modalities*
- *Substance abuse and dual diagnosis*
- *The care of population at risk*

- *Community milieu as a therapeutic modality*
- *Cultural and spiritual implications of nursing care*
- *Family dynamics in mental health and illness*
- *Psychopharmacology*
- *Legal and ethical factors, including documentation, specific to the care of those with mental illness*

*Skills:*

- *Comprehensive biopsychosocial assessment*
- *Interdisciplinary collaboration*
- *Identification and co-ordination of relevant resources for clients and families*
- *Use of psychiatric diagnostic classification systems*
- *Therapeutic communication*
- *Therapeutic use of self*
- *Psychoeducation with clients and families*
- *Administering and monitoring psychopharmacological agents.*

*(SERPN 1996:30-31)*

As a result of the general system of nursing education and the general educational level of development in countries like Botswana and Nigeria, post-basic psychiatric nursing programme contents might be different from what would be expected for programmes in the university at the Master's level. Though the SERPN content prescription was meant for specialisation at the post-basic degree level, the programme goals of the Botswana post-basic mental health nursing curriculum move close to the expectations of the SERPN's prescribed content for advanced practice nurses. The following

prescriptions by the SERPN (1996:43-35) were more discernible in the Botswana post-basic nursing curriculum than in the Nigerian curriculum.

- *The development, utilisation and evaluation of conceptual frameworks that guide assessment and intervention strategies for underserved populations and population at risk for mental illness.*
- *The development of practicum experiences and sites that reflect multicultural concerns and emerging trends in the delivery of psychiatric care*
- *The expansion of the scope of practice to include a focus on primary prevention in the area of mental health.*
- *The inclusion of educational and collaborative modes of working with clients and their families.*
- *The inclusion of both direct (assessment, intervention) and indirect (consultation, case management, supervision) advanced practice roles.*
- *The inclusion of biological and pharmacological content as fundamental to advanced practice.*
- *The inclusion of mental health aspect and psychiatric complications of physical illnesses.*
- *The analysis of the legal and ethical problems associated with the expansion of the role and scope of practice of the advanced practice nurse.*
- *The analysis of existing mental health policy and participation in the development of new policy initiatives.*
- *The integration of content on cost benefit analysis, fiscal resources, and the impact of economic realities on mental health services.*
- *The expansion of the focus and methodologies of psychiatric nursing research to include outcome and intervention studies.*
- *The collaboration with the consumer groups in the development of curricula for advanced nursing practice.*

The similarities of the above prescribed inclusions with the contents of the Botswana's post-basic community mental health nursing curriculum might be due to its community-based emphasis and as such would be seen to be more relevant to the community needs than if it had been largely focused on hospital

care. While it can be argued that the concept of advanced nursing practice is still very novel to developing African countries, the inclusions prescribed above appear to be still very relevant to the present needs of countries like Nigeria and Botswana. In order for the present psychiatric-mental health nursing curricula of the two countries under study, however, to meet the criteria set out above fully, a restructuring of the mental health nursing components of the curricula for general nursing and for advanced nursing practice in specialised areas like psychiatric-mental health nursing would need to be advocated.

### *6.5 Making psychiatric-mental health nursing education programme locally and internationally relevant in Nigeria and Botswana*

A major task at the outset of this study was to describe what was happening in the field of psychiatric-mental health nursing education in Botswana and Nigeria with a view to making suggestions for the future. While comparisons can be odious, facts that have emerged from the examined documents, the questionnaire and the discussions about the two countries under study do have local as well as international implications in the field of mental health nursing education.

At the local level, it has been recommended that education of health professionals, including those of psychiatric mental health nurses, should be in response to the needs of the people (WHO 1985). This relevance, no doubt, would be concurrently influenced by such factors as identified by the

respondents in the discussion. Such factors as the economy, colonial history, the general educational system, social and cultural factors and interdisciplinary relationships would be found to be at play in determining the situation at the local level. Development of any nursing educational programme, however, cannot be completely isolated from the general global trend of development in the nursing field.

Information from the focused group discussions indicated that a major expected outcome of the education programme for psychiatric-mental health nursing, that of supplying sufficient psychiatric nurses, was not being met for both countries. That such nurses were still in short supply was corroborated by the records available from the registering bodies for nurses in Botswana and Nigeria. As at December 1997, despite commencing training of psychiatric nurses in Nigeria from 1955, there were only 3,859 names on the RPN register which translated to about 4.07% of the total number of nurses when compared with 94,754 names on the RN list. Similarly, Botswana had only 193 names on the psychiatric nursing register, which were about 4.1% of the total number of nurses (4,677) on the RN list. Another African country, South Africa for example, with less than half the total population of Nigeria had 29,483 or about 32.4% registered as psychiatric nurses out of a total of 90,923 names on the general nursing register. It is unlikely that anybody would want to argue that South Africa needs more psychiatric nurses than Nigeria or that South Africa has surplus psychiatric nurses. The point of relevance here was that with this apparent shortage which was also expressed by the respondents, one of the priorities in the psychiatric-mental health

nursing education field in Botswana and Nigeria would be to evolve more creative strategies to increase the supply of nurses who would be competent to provide needed psychiatric-mental health nursing services to the people. Generalist nursing programmes must not be left to pay only lip service to producing nurses who would be capable of providing “comprehensive nursing care to individuals, family and community at the primary, secondary and tertiary levels of care”. Part of the intentions of the curriculum must be to encourage generalist nurses to develop confidence in mental health nursing care, and further encourage those who demonstrate basic competence in psychiatric nursing practice to choose this option as a career. If mental health nursing were made to appeal to general nursing students at the outset of their training, it might become easier to attract and retain nurses for specialist roles in this area of nursing.

The point for a strong psychiatric-mental health nursing component in a general nursing curriculum had been stressed by Rentoul, Norman and Ritter (1991:457). They posited that nursing students need be made to appreciate the fact that a significant number of patients in general nursing settings, both in hospitals and in the community, exhibit mental health problems, particularly in the short-term, that go beyond normal responses to stress. Examples of such patients include parasuicidal patients in medical wards, pathological responses following childbirth, high levels of depression and anxiety that may accompany terminal illness, chronic disability and painful and distressing treatments. Appropriate clinical settings to learn and practice psychiatric-mental health nursing skills must therefore include general hospitals, health

centres and community settings and not just psychiatric hospitals or only community-based psychiatric services.

Dunleavy (1989) also maintained that poor knowledge or lack of understanding of depression and suicide were part of the problems in the care of parasuicidal patients and in the inadequate handling of grief-stricken relatives in general medical care settings. Advanced psychiatric-mental health nursing skills might even be required, for example, in situations where nurses must undertake increased counselling responsibilities as in oncology clinics or wards, or in the establishment of behavioural psychotherapy programmes on elderly care wards.

Another issue to be considered in making mental health nursing education relevant would be the extent to which the programmes were 'responsive to the changing epidemiology' and the 'cultural needs' of the people (WHO 1992:5). Epidemiological facts have indicated that mental illness is a major national health problem in Botswana and Nigeria. A large number of people are known to be suffering from emotional problems severe enough to require treatment. The majority of people who require mental health care will continue to remain outside the hospital, first, because of the nature of the illness and second, because even if continuous hospitalisation were desirable, the available number of beds cannot meet this demand. The persistent nature of mental illness makes continuous rehabilitative care within the community imperative for the mentally ill. The scenario for the mentally ill in Botswana and Nigeria is no different from that commented on by Uys et al (1995:345)

about South Africa, that the “vast majority of psychiatric patients spend the majority of their time outside the hospitals”. In the light of the similarities in the mental health epidemiological characteristics of developing countries, the programme of mental health nursing education would need to prepare more nurses for practice in the community than for the mental or psychiatric hospitals. This view also agrees with the WHO’s global vision for nursing in the 21<sup>st</sup> century. The present curriculum for mental health nursing in Nigeria differs from that of Botswana in this respect. Nigeria’s curriculum is still largely based in hospitals as it had been traditionally designed since this type of training first started at Aro Hospital in 1955, while that of Botswana maintains the community-based emphasis which was the intention of the curriculum from inception in 1982. The vision at Alma Ata in 1978 which gave rise to the intensive pursuit of global primary health care initiatives in the 1980s must have equally influenced the proactive nature of the Botswana mental health nursing programme.

International relevance of the mental health nursing programme will be considered in terms of meeting the general standard that is advocated by bodies like the ICN and regulating bodies from other countries to enable cross mobility of professionals from one part of the world to another. International comparative studies, collaborations and co-operations among institutions and between countries are sometimes designed to fulfil this purpose. ICN (1997:4) reiterated the position of its 1985 Council of Representatives on the regulation that must inform the standard of nursing education among the member countries:

*Programmes of nursing education should generally parallel those for other professions as to setting, level, academic credentials, control and general standards (ICN 1997:4).*

It further sets out the following guidelines to be broadly applicable for institutions educating nurses:

*Setting: within institutions of higher learning: autonomous or independent units for nursing with nurse academic administrators, as appropriate for other professions.*

*Level of education and academic credentials: Generally equivalent to those of other professions within the academic degree structure of the system of higher education. (ICN 1985: 49).*

Cohen (1985) argues that the demand for academic respectability changes the context and as such the method of nursing education. The present arrangements of nursing education in both Nigeria and Botswana will have to adapt in order to meet the above criteria. The difficulties would be greater on the side of Nigeria than Botswana. Botswana might not have satisfied the requirement for the “level of education and academic credentials generally equivalent to those of other professions within the academic degree structure of the system of higher education” (ICN 1985:49) using its present model. The setting for the education of professional nurses in Botswana, however, is mainly within the autonomous Institutes of Health Sciences or Colleges of Nursing that are all affiliated to the University of Botswana. The community mental health nursing programme of Botswana is placed within the Institute of Health Sciences at Lobatse. By virtue of the Nurses and Midwives (Amendment) Act of Botswana 1988 which appeared in the Republic of Botswana Government Gazette No 11 of 1988, the University of Botswana is the validating authority for the courses of instruction and examinations, and is responsible for the award of diplomas or certificates to all graduating nurses

and midwives from the Institutes of Health Sciences (UB/IHS 1993:4). There were strong indications that in the future, the present affiliated health training institutes in Botswana might become one of the Colleges of the University of Botswana with diploma and degree awarding status.

While the ICN (1997) and the WHO (1994) acknowledge that nursing education would in fact depend on countries' policy and their health workforce needs, and that countries could be allowed flexibility in determining how and where best to educate their health professionals, the general trend across the world to move nursing education into the higher education mainstream could isolate countries that do not move along this direction. Psychiatric nursing schools, like other nursing schools in Nigeria, were mainly administered as part of the hospitals within which they were based. There was no document in existence to indicate any form of affiliation or intended affiliation with any of the higher institutions of learning in Nigeria. The government of Nigeria had no policy like that of Botswana, which had directed that the schools of nursing be affiliated to higher institutions. Therefore schools of nursing and schools of psychiatric nursing in Nigeria were not able to award educational certificates that could be equated to any of the certificates that were statutorily recognised as given by an institution of higher learning. This may probably be the reason why the schools of nursing in Nigeria do not on their own award certificates outside the registration provided by the NMCN. There is thus a major disadvantage in the Nigerian type of nursing education system vis-à-vis international recognition despite the similarities in its pre-entry requirements, curriculum

content, length of years of training and practical experience to other international systems.

The International Labour Office (ILO 1986) in Salvage (1993:18)

recommended that candidates for nursing training:

*“...should have completed a full secondary education (which may vary from country to country), and have qualifications for admission that are equivalent to those required by a university or other institution of higher education.”*

This entry requirement is presently met by the two countries and there should be no problem on this basis if a decision is taken to reconcile nursing education with the general education system requirements. Entry requirements into the basic nursing training in Nigeria, as in Botswana, are full secondary school education with good passes or credits in five or more subjects at the Cambridge (in the case of Botswana) or the West African (in the case of Nigeria) School Certificate levels or their approved equivalent. These are the same requirements for admission into the first year levels at the institutions of higher learning like the Universities, Colleges of Education and the Polytechnics in either Botswana or Nigeria. Both countries run a 3-year basic general nursing programme leading to registration as RN with their different regulatory bodies. Registration as a general nurse also happens to be the same entry requirement for the post-basic psychiatric-mental health nursing programme in both countries, or for admission into the post-basic degree programme of the University in Botswana as well as that of any University offering a similar programme in Nigeria. There is an indication therefore that the learners in the nursing programmes for both countries might

not be deficient in the entry requirements for university or higher education. In order to make the education of nurses, and in this case that of the psychiatric-mental health nurses internationally relevant in both countries, alternative systems of nursing education might need to be considered.

## *6.6 Recommendations*

Recommendations made in this study will be based on the present findings and the expectations for the future within the ambits of the prescribed pathways for continuous development and improvement of the nursing profession, with particular reference to psychiatric-mental health nursing education in Nigeria and Botswana. The recommendations will take specific note of aspects of the context of nursing education in the two countries, the influencing factors, the particular shortage of personnel in the field, the curriculum model, and the issue of innovative strategies in health professionals' education for the future. While some of the recommendations might be applicable to both countries, an option of country-specific recommendation will be adopted initially.

### **6.6.1 Specific recommendations for psychiatric-mental health nursing education in Nigeria.**

Psychiatric-mental health nursing education and nursing education in general is expected to have come of age based on the long history of nursing education in Nigeria. While this researcher is aware that basic and post-basic nursing education curricula have within the last couple of years gone through a process of review in Nigeria, manifest outcomes of these reviews are yet to be seen in the areas of how these curricula meet more of the health needs of the country,

and in particular the mental health needs. In view of the apparent realisation that, in developing as well as developed countries, preparing nurses to work only in hospitals is a waste of valuable human resources, responsible authorities must hasten to make psychiatric-mental health nursing education to be more oriented towards primary health care and more community-based than it is at the moment. This can be achieved by ensuring that more time is allocated to community-based experience in the curriculum while reducing the emphasis on hospital-based care.

The shortage of nurses who are able to handle the basic mental health needs of clients in all settings could be overcome by adopting a more liberal attitude to the development of generalist nursing roles. Registered nurses who have demonstrated basic competencies in psychiatric-mental health nursing as a result of their general nursing education should be given the opportunity to practice in psychiatric-mental health nursing settings. Employers have a role to play here by encouraging general nurses to take up positions in psychiatric mental health settings. Nurse educators will also have to encourage general nurses continuously from the start of their training to make the idea of practising in the mental health setting an attractive option. The general nursing curriculum should also be used to make nursing students recognise that all nursing situations require psychiatric-mental health nursing knowledge and skills which should be used to recognise mental health symptoms that could require intervention during general nursing care.

The NMCN, the nurse educators, the nursing professional body, the consumers of nursing services, and the representatives of the ministry of health and the ministry of education in Nigeria need urgently to set in motion a process that would bring nursing education in general into the ambit of the country's higher educational system. This may be a complex process in Nigeria as such a move is bound to involve multi-lateral interests.

Nevertheless, unless this move is made, it will be difficult for the status of nursing education or psychiatric nursing education to develop beyond a sub-diploma level while these systems of education are still being run in hospital-based, ministry-of-health-controlled institutions without any form of affiliation to recognised higher institutions of learning like the universities or the polytechnics in the country. A situation where nursing education continues to be isolated from the country's well-developed higher education system would not augur well for the development of nursing education in the country. The first step must be to affiliate all existing schools of nursing and psychiatric nursing schools to an appropriate university within their zone of location. Nigeria, with over 30 universities and about 20 functioning medical schools, should be able to accommodate all the existing schools of nursing as affiliated institutions, with the prospect of upgrading viable schools into degree awarding colleges of such universities in the future.

Education for specialisation in psychiatric-mental health nursing should therefore be based on a course of liberal general nursing education for nurses. This education would need to be achieved at a collegiate level, preferably

within university departments of nursing, where opportunities are also provided for multidisciplinary learning.

Legislation on nursing education has been made the exclusive responsibility of the ministry of health in Nigeria. This has made it difficult to see nursing education in the light of the general system of education in this country. There may be a need to shift the responsibility of legislating on nursing education to the ministry of education while the health ministry should be left with regulating nursing practice. In the meantime, however, the NMCN as the sole nursing regulatory body in Nigeria has a major role to play in supporting whatever efforts are needed to assist nursing to fulfil the important role of health for all.

#### **6.6.2 Specific recommendations for Psychiatric-Mental Health Nursing Education in Botswana.**

The Botswana programme appears to conform with the current emphasis on primary health care directed at making psychiatric mental health care accessible and available to all within the country. It is therefore recommended that the Botswana curriculum should maintain the emphasis on community mental health care designed to build on the psychiatric-mental health nursing knowledge and skills already acquired from the basic general nursing programme.

It is recommended that competency in data collection and utilisation of research results be included as part of the competencies for these nurses. While it is acknowledged that lack of mention of the research role as an

expected competency in the curriculum for the post-basic mental health nursing might be an error of omission and not necessarily that the learners were not equipped with this skill, specific mention of this role would be able to direct attention of nurses to its acquisition during the programme.

In order to continue to ascertain the effectiveness of the mental health nursing programme of the country, an ongoing assessment of the coverage and competencies of the graduates of the post-basic community mental health nursing programme is recommended. This will assist in programme refinement, and enable Botswana to continue to work towards the objective of meeting the human power requirement for psychiatric mental health in the country.

### **6.6.3 General recommendations for Psychiatric-Mental Health Nursing Education in Botswana and Nigeria as developing African countries.**

The appropriateness of the psychiatric-mental health nursing education in Nigeria and Botswana cannot be considered apart from the future health care needs of the country, the level of general education in the country and the educational patterns of other professions in the health care field, as suggested by WHO (1994:19).

Mental health nursing education in Nigeria and Botswana would also need to be consistent with modern nursing thinking. Therefore, entry into the profession, process of preparation and final outcome of the education must share in the international professional consensus of nursing. The extent to which concensus is achieved will continue to have implications for combined

local and international relevance in the field of nursing education and practice. As a starting point, after due consideration of the present pathway in psychiatric-mental health nursing education for Botswana and Nigeria, and with due consideration to what is globally expected for nursing within the next millennium, a pathway presented in figure 6.1 is proposed for psychiatric-mental health nursing education in both countries.

This model is in line with the developments in several parts of the world in the areas of nursing education. Smeaton (1982:80) remarked that “the survival of a separate and direct-entry psychiatric nurse training might well rest in the hands of those who can make a case for retaining it”. Smeaton (1982) felt that argument supporting such a programme in terms of its utility and cost-return effectiveness or as a viable alternative in terms of educational soundness could not be tenable. It is envisaged in the proposed model (figure 6.1) that the road to registration would be more academic, than hospital-based school of nursing training, and mixed with relevant practice.

In this proposal, the bulk of candidates from both countries would still probably gain entry through the 3-year comprehensive basic nursing programme. Comprehensiveness here refers to a broad based preparation that equips the registered general nurse with a comprehensive basic nursing knowledge and skills in physical, psychiatric-mental health and illness as well as in midwifery within a variety of settings including the community, clinics and in the hospital settings. Institutions for the comprehensive nursing programme will be expected to be affiliated to an existing higher institution of

learning, so that the programme will have at least a diploma status as in the higher education system of both countries. The graduate of the 3-year comprehensive general nursing diploma programme will have the option to continue into a degree programme for 2-3 years, as may be recommended by the university, in order to meet the requirements for the award of a degree and registrations as a psychiatric nurse, midwife and a community health nurse. A candidate from the secondary school who opts for a generic bachelor's degree in nursing would require 4-5 years, with option to exit in the third year for a diploma with RN status, or to complete the programme with the bachelor's degree in nursing and registrations as an RN, RM and RPN. Subsequent progress on the academic and advanced specialisation ladder remains the same depending on choice of speciality for all the candidates after the first degree. All advanced specialisation would be expected to be at post-graduate degree level. Lack of differentiation in the role of the nurse at different levels of preparation is considered to be a major weakness in the field by many people within and outside the profession (WHO 1994:13).

While Nigeria has much catching up to do with this model, particularly in moving education of nurses into colleges that should be affiliated to the higher institutions of learning in the country, Botswana's structure only requires a further expansion of the programme and a possible implementation of the

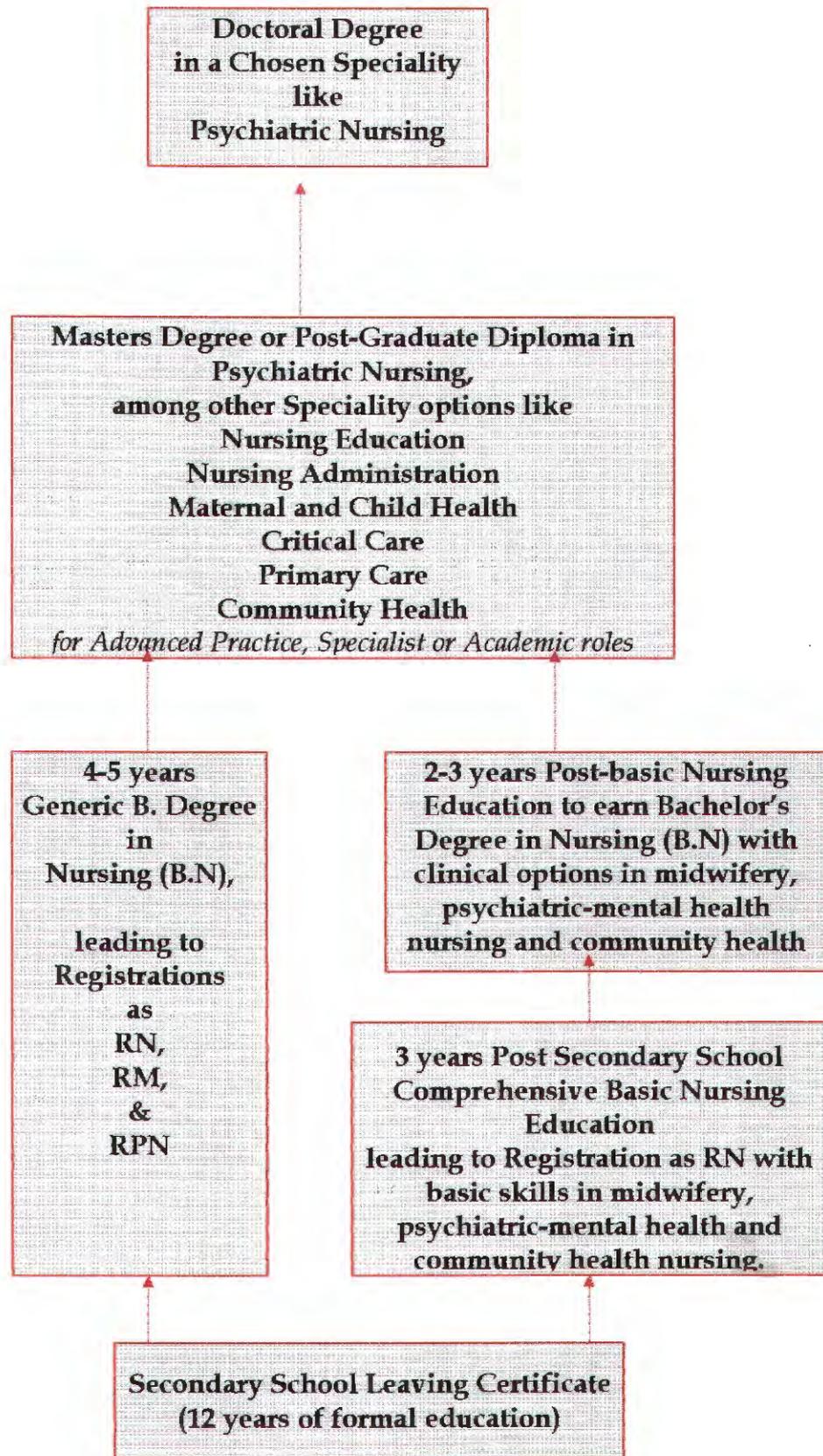


Fig. 6.1: An Illustration of Proposed Psychiatric Nursing Education Pathway for Botswana and Nigeria

plan to upgrade the basic nursing programme to degree level. The community mental health nursing of the Institute of Health Sciences could become a post-graduate diploma or a Masters' level programme in mental health nursing.

More programmes can be developed within the degree programmes that would encourage practising nurses to study towards registration in a clinical speciality like psychiatric-mental health nursing on a part-time basis while working with clients who require mental health nursing services in hospitals and community clinics. Such opportunities provided for serving nurses will encourage more nurses to be available for mental health nursing services. It will also improve the understanding of nurses in the areas of psychiatric-mental health and their willingness to participate in mental health care.

Identifying the mental health needs of the people should be the starting point for curriculum development. Several innovative approaches to learning in contemporary settings make educational outcomes more relevant and more enduring than had hitherto been possible. Nursing education, world-wide, is adopting the recommendation that approaches to teaching and learning should be such that make learners participate more actively in the process of learning with teachers functioning more as facilitators of learning rather than as transmitters of information (Mellish, Brink & Paton 1998:98).

Educators in psychiatric-mental health nursing education for Nigeria and Botswana will need to adopt a more liberal approach to help learners reconcile their learning objectives with the mental health problems that they themselves would be able to see in the real world situation. At colleges or in university

departments of nursing, problem-based learning was recommended by the WHO (1987: 49) to be used in conjunction with the community-based learning approach in the teaching-learning process of health professionals, and nurses in particular. This approach assists in that real life health problems of the community are utilised as stimulus to discover information which could be used to solve existing and subsequent similar health problems of the people. Nursing education in Botswana and Nigeria would therefore need to open up to these approaches that could enable learners to become more active in their field of interest, and, in so doing, develop the ability for life-long learning which could help further to sustain their interest and develop practice. A completely new approach to teaching and learning will have to be adopted in line with the current thinking in the wider education sector. Post-secondary school learners, and more so the adult graduate and post-basic nursing education students must benefit from the new approach to adult learning. This is described as part of the recommendations for nursing education in Salvage (1993:81):

*In essence, the difference between the traditional and the progressive approaches to nursing preparation lies in the difference between education and training, and between educating adults and educating children. The art and science of making adults learn is based on the following assumptions: that an adult's self-concept moves from that of a dependent personality towards that of a self-directing human being; that an adult accumulates a growing reservoir of experience that becomes an increasing resource for learning; that an adult's readiness to learn increasingly focuses on the tasks inherent in her social (and professional) roles; and that an adult's time perspective changes from the postponed application of knowledge to immediacy of application, and accordingly an adult shifts from a concern with subject matter to a concern to use knowledge to solve challenges and problems in their context.*

Learners must be educated and trained but the historical emphasis on 'training' must now shift to 'education' in the new paradigm. The major focus

in the curriculum would therefore be the need to assist the adult learners to learn how to learn and to become self-directed learners.

The proposal also has implications for teachers as well as for preparing teachers. Educators may need to learn new methods of teaching, learning to facilitate rather than to transmit knowledge. The concept of the teacher as the fountain of all knowledge is fast becoming obsolete as the 'nurse tutor' in various settings worldwide is continually being called upon to fulfil more of a facilitatory role in the teaching-learning situation. Nevertheless, the nurse tutor preparation would still continue to be a disparaging measure of the credibility of the educational standard used in the preparation of professional nurses. Career and personal development will need to top the agenda of nurse educators in this era of overwhelming knowledge explosion.

Where appropriate, the existing associations of nurse educators and other groups interested in the education of nurses in Nigeria as well as in Botswana must initiate ongoing discussion in the direction of how to make improvements in the field of nursing education with particular reference here to the psychiatric-mental health nursing for the developing countries.

The educators in Botswana and Nigeria will have to borrow from the injunctions of the WHO (1985:15) guideline to nursing curriculum review in which Salvage states that:

*Educators alone cannot bring about the needed change in schools of nursing or in any educational system. It is also necessary to involve, for example, ministries of health, the legislative or regulatory bodies that set the rules and regulations for nursing education, health professionals and community health consumers. Most important, it is essential that the nursing profession be committed to the need for change in nursing education and practice, and that nurses themselves become more actively involved in the change process. (Salvage 1993:61).*

Tackling the change that is involved in this proposal, however, requires first and foremost the collective will of the educators involved in the programme and of the members of the regulatory body.

In the spirit of collaboration, adopting an international exchange programme between countries like Botswana and Nigeria can facilitate, in the words of French et al (1996:599), greater cognitive and personal development that would enable interest groups, teachers as well as students, to re-examine their own professional and life context.

Nursing students in Nigeria are still part of the work force. The desirability of student status for nurses in training has been a topic of lengthy discussion but has never negated the notion that a nurse must ultimately perform in the role of a professional carer (Smeaton 1982:80). Full student status is recommended for students in the proposed collegiate system whether at basic or post-basic level. Conferment of student status rather than a worker status would be expected to free nursing students and nursing education from the constraint of service needs. This freedom will permit motivated nurse educators to make radical changes in the organisation and content of clinical learning, based on the unfolding challenges of education and health needs of the people.

Another possible advantage of the proposed model for the two countries is that of the likelihood of enhanced career mobility of nursing personnel through formal education. WHO (1994:13) also suggested that higher education status for nursing education might improve the status of nursing and enhance recruitment of able students. It also suggested that education at this level would ensure that all practitioners were broadly educated, mobile, and more able to participate as equal members of health care teams with all the benefits that only higher education could offer.

### *6.7 Summary*

Psychiatric-mental health nursing, from the perspectives of the health needs of the peoples of Africa, and in particular of Botswana and Nigeria, could be seen as a very important component of health care services. This study at the outset made a case for appropriate psychiatric-mental health nursing services in developing countries like Nigeria and Botswana. The study proceeded to explore the field of psychiatric-mental health nursing education and what products emerge from the process of education and training in this field for two developing African countries. Findings from this exploration were mainly discussed in terms of their major implications for the local as well as international relevance of the programmes within the overall educational system for mental health care services.

The findings revealed that similarities existed in the pre-requisites, the content and the process of education for mental health nursing in both Nigeria and

Botswana, but the clinical context of the programme, the conceptualisation of the expected functions of the graduates, curriculum administration and management of the educational outcome varied considerably between the two countries. Various terms described the models for psychiatric-mental health nursing education adopted by these countries, but it would probably serve no useful purpose to attempt to find an all encompassing model to describe the approach of mental health nursing education in Botswana or Nigeria. It was, however, clear that Botswana adopted a more functional generalist basic diploma nursing education approach which encouraged a more advanced post-basic diploma specialisation and practice in community psychiatric-mental health nursing. Nigeria's model leaned more towards a hospital centred basic specialisation with no defined role for the generalist nurse within the psychiatric-mental health nursing care system.

Input into the mental health nursing programme in terms of the learners and the teachers was very similar for the two countries. The points of departure were, however, mainly associated with the educational contexts and outcomes for the two countries. Factors largely responsible for the present state of mental health nursing education in the two countries had been related to colonial history, geopolitics, economic resources, government policies about education and health, professional status of nursing, and the interprofessional relationship of nursing within the health care system. In terms of supplying both quality and quantity of nurses to provide psychiatric-mental health nursing services to the people, neither of the two countries could achieve these with their current models of psychiatric-mental health nursing education.

In both countries, greater efforts were still required towards making education for psychiatric-mental health nursing practice relevant locally as well as internationally. Relevance was explained in terms of adapting the education of the nurses to development of more of the type of knowledge, attitude and skills that would be needed for the care of majority of those who required care, rather than just for the benefit of only a few people. Relevance was also further described in terms of the portability of such education across international borders for the benefit of the global community at large. In the light of these conclusions, recommendations were put forward towards the future of psychiatric-mental health nursing education in the two countries.

Some very specific recommendations were made for Nigeria in particular, largely because, like Bahrain (Affara 1990:157), Botswana had benefited in some ways by making a deliberate choice to build the base of the health care personnel first, postponing physician and apical health personnel education until the basic infrastructure had been strengthened. The researcher emphasised that one key concept that must underlie the development of psychiatric-mental health nursing was the need to create a mental health nursing role that was appropriate to people's health needs rather than the needs of the health care system. The recommendations further emphasised that hospital orientation in psychiatric-mental health nursing education must yield way to a reorientation towards the provision of mental health nursing care with and by the community.

### *6.8 Limitations of the present study*

While reasonable efforts have been made to ensure the validity of the information and the discussions presented in this study, the researcher is fully conscious of certain limitations that must inform the judgement of the readers. Therefore, all deductions and any other interpretations must be made with the following limitations in mind.

1. There is a dearth of literature related to nursing education in general, and psychiatric-mental health nursing education in particular, for countries in Africa. Comparative analysis of materials obtainable from literature was therefore very limited or almost non-existent. Such material might have allowed for a clearer understanding of the past in this field of study in the two countries of concern.
2. The methodological approach used might have excluded some potentially useful participants in this study because of the heavy reliance on postal services, especially for a country like Nigeria where such means of communication can be suspect and unreliable. This aspect, to some extent, was catered for by the triangulation approach to the source of data collected for this study.
3. Several factors continue to impinge on the field of study, therefore changes are not unexpected between the time of data collection and the time of reporting of this study. Such changes will therefore have to be interpreted

along with the findings in this report in terms of the dynamics of change and against the perspectives of time.

4. The nature of this research itself and the location of the researcher at the time of data collection and reporting pose some limitations on the extent of data that could be collected or referred for further verification and validation as in the Delphi technique. This would have required extensive time and money to implement because the researcher relocated to South Africa from Botswana as part of his work demands while the study was still at the advanced stage of data collection.

These limitations notwithstanding, this study still serves as a unique contribution to the field of psychiatric-mental health nursing education in Botswana and Nigeria in particular, and in developing countries of Africa in general. It will provide a frame of reference for further developments in the field of nursing, a basis for comparison, and an impetus to improve the existing programmes in the field of psychiatric-mental health nursing for the countries of concern and a contribution to the scarce literature on psychiatric-mental health nursing in Africa.

### *6.9 Recommendations for further studies*

In view of the fact that this study can be regarded as part of the beginning of efforts to understand and present in-depth documentation on psychiatric-mental health nursing education in Africa, follow-up studies will be necessary to consolidate the gains of information provided in the present study. The

following areas of study which have not been covered by the present study are being suggested for future research.

1. An evidence based study would be necessary in defining the important contribution of psychiatric-mental health nursing education in the improvement of the health status of the people of the two countries through the provision of services within the general health care system.
2. Empirical evidence will also be required to guide nursing education systems in other countries in Africa to modify strategies and develop innovative approaches to meet more of the needs of the people rather than just the need to educate for education's sake.
3. Comparative studies may be required to present empirical evidence on the advantages or disadvantages of using a small core of highly educated nurse and a large number of auxiliary personnel in the psychiatric setting as may often be witnessed in the general care settings of some countries.
4. It is recommended that this research should be conducted in all the African countries, and in particular, where the WHO renders inputs. Such data will not only benefit the nurses of Africa by obviating the need to duplicate previously acquired education, but also the health care providers by saving them unnecessary expenditures in retraining psychiatric nurses moving across countries in African, and the clients in enabling nurses qualified in one country to render the required services in other countries as well.

### *6.10 Conclusion*

Perhaps, the most remarkable achievement of this study is the contribution that is being made to the hitherto unexplored and almost neglected field of psychiatric-mental health nursing education in Africa. This study has brought to the fore, and has compared data about psychiatric-mental health nursing education from two African countries with the view that these data could guide future developments in the field of nursing education and science in the continent. Immediate contribution of this study might be seen in the light of the data presented about Botswana which could be most useful for the current agenda of the East Central and Southern Africa College of Nursing (ECSACON) to establish a common curriculum for nurses in the Southern Africa region. ECSACON's efforts are geared towards facilitating the movements of registered nurses across the borders of Southern African countries. A similar body to ECSACON, the West African College of Nursing (WACN) had from inception been involved with finding ways of developing and harmonising nursing education within the countries in West Africa. Botswana and Nigeria fall within the ECSACON and the WACN regions respectively, the database generated from this study could therefore become the starting point to generate region-wide data for the activities of these two regional bodies.

As most African countries seem to experience a shortage of psychiatric nurses, and as the need for psychiatric and mental health nursing services are likely to increase on the African continent with the continuation of civil and trans-

border armed conflicts, training of more psychiatric-mental health nurses as well as their movements across countries are inevitable. Knowledge about all African countries' nursing education courses should therefore be researched and compared so that informed decisions could be made regarding the cross country accreditation of nursing qualifications. This present study might have contributed as a starting point, and as one vehicle of stimulating cross-country research. The comprehensive comparison table used in this study could be adapted for use in all African countries to establish a continental database for the curricula of the psychiatric nurses of Africa.

The efforts made in this research, the results obtained, and the implications of the findings are aptly described in the words of Johann Wolfgang von Goethe (1749-1832):

*"I find the great thing in this world is,  
Not so much of where we stand, as in what  
Direction we are moving."*

in Stuart & Sundeen (1983:592).

It is, therefore, so very important to evaluate the education of psychiatric-mental health nurses, and it is imperative to continue to do so with a view to steering the course in the right direction particularly within the African context.

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## Appendices

### ***Appendix 1: List of Nursing Institutions in Nigeria as at December 1997***

**List of Accredited Schools by the Nursing and Midwifery Council of Nigeria (NMCN):**

#### ***General Nursing***

1. School of Nursing, Queen Elizabeth Hospital, Umuahia
2. School of Nursing, Mater Mesericordiae Hospital, Afikpo.
3. School of Nursing, General Hospital, Aba.
4. School of Nursing, General Hospital, Yola
5. School of Nursing, St Luke's Hospital, Anua-Uyo.
6. School of Nursing, General Hospital, Ikot-Ekpene.
7. School of Nursing, Immanuel Hospital, Eket
8. School of Nursing, Ituk-Mbang.
9. School of Nursing, Iyi-Enu Hospital, Onitsha.
10. School of Nursing, Our Lady of Lourdes Hospital, Ihiala.
11. School of Nursing, Nkpor.
12. School of Nursing, General Hospital, Bauchi.
13. School of Nursing, General Hospital, Markurdi.
14. School of Nursing, Christian Hospital, Mkar.
15. School of Nursing, University Teaching Hospital, Maiduguri.
16. School of Nursing, General Hospital, Maiduguri.
17. School of Nursing, St Margaret's Hospital, Calabar.
18. School of Nursing, Eja Memorial Hospital, Itigidi.
19. School of Nursing, General Hospital, Ogoja.
20. School of Nursing, State Hospital, Agbor.
21. School of Nursing, Baptist Hospital, Eku.
22. School of Nursing, General Hospital, Warri.

23. School of Nursing, State Hospital, Benin City.
24. School of Nursing, University of Benin Teaching Hospital, Benin City.
25. School of Nursing, Bishop Shanahan Hospital, Nsukka.
26. School of Nursing, University of Nigeria Teaching Hospital, Enugu.
27. School of Nursing, Joint Hospital, Mbano.
28. School of Nursing, General Hospital, Owerri.
29. School of Nursing, Holy Rosary Hospital, Emekuku.
30. School of Nursing, Obowo.
31. School of Nursing, St Mary's Hospital, Amaigbo.
32. School of Nursing, St Luke's Hospital, Wusasa.
33. School of Nursing, Ahmadu Bello University Teaching Hospital, Zaria.
34. School of Nursing, Kafanchan.
35. School of Nursing, St Gerald's Catholic Hospital, Kakuri.
36. School of Nursing, Muritala Mohammed Hospital, Kano.
37. School of Nursing, General Hospital, Katsina.
38. School of Nursing, General Hospital, Obangede.
39. School of Nursing, S.I.M. Egbe.
40. School of Nursing, General Hospital, Ilorin.
41. School of Nursing, Awolowo Road, Ikoyi.
42. School of Nursing, Lagos University Teaching Hospital, Idi-Araba. Lagos.
43. School of Nursing, Military Hospital, Yaba.
44. School of Nursing, General Hospital, Bida
45. School of Nursing, Abeokuta.
46. School of Nursing, State Hospital, Ijebu-Ode.
47. School of Nursing, Akure.
48. School of Nursing, Faculty of Health Sciences, OAU, Ile-Ife.
49. School of Nursing, Obafemi Awolowo University Teaching Hospitals' Complex, Ile-Ife

50. School of Nursing, Obafemi Awolowo University Teaching Hospitals' Complex, Ilesa.
51. School of Nursing, State Hospital, Osogbo.
52. School of Nursing, University College Hospital, Ibadan.
53. School of Nursing, Eleiyeye/Adeoyo Hospital, Ibadan.
54. School of Nursing, Baptist Medical Centre, Ogbomoso
55. School of Nursing, Baptist Medical Centre, Saki.
56. School of Nursing, Christian Hospital, Vom
57. School of Nursing, Murtala Mohammed Hospital, Jos.
58. School of Nursing, General Hospital, Port Harcourt.
59. School of Nursing, General Hospital, Sokoto.
60. School of Nursing, Usman Danfodio University Teaching Hospital, Sokoto.
61. School of Nursing, Suleija, Abuja.
62. School of Nursing, General Hospital, Jalingo

### *Psychiatric Nursing*

1. School of Psychiatric Nursing, Aba.
2. School of Psychiatric Nursing, Eket.
3. School of Psychiatric Nursing, Enugu.
4. School of Psychiatric Nursing, Calabar.
5. School of Psychiatric Nursing, Uselu.
6. School of Psychiatric Nursing, Kakuri.
7. School of Psychiatric Nursing, Aro-Abeokuta.

### *Midwifery*

1. School of Midwifery, Umuahia.
2. School of Midwifery, Aba.
3. School of Midwifery, Abiriba.

4. School of Midwifery, Amachara.
5. School of Midwifery, Yola.
6. School of Midwifery, Anua-Uyo.
7. School of Midwifery, Urua Akpan.
8. School of Midwifery, Ituk Mbang.
9. School of Midwifery, Iquita Oron.
10. School of Midwifery, Ihiala.
11. School of Midwifery, Waterside, Onitsha.
12. School of Midwifery, Iyi Enu.
13. School of Midwifery, Bauchi.
14. School of Midwifery, Markurdi.
15. School of Midwifery, Mkar.
16. School of Midwifery, Maiduguri.
17. School of Midwifery, Calabar.
18. School of Midwifery, Ogoja.
19. School of Midwifery, Obudu.
20. School of Midwifery, Asaba.
21. School of Midwifery, Sapele.
22. School of Midwifery, Afikpo.
23. School of Midwifery, Benin City.
24. School of Midwifery, UBTH, Benin City.
25. School of Midwifery, St Philomena Hospital, Benin-City
26. School of Midwifery, Zuma Memorial Hospital, Irrua.
27. School of Midwifery, Uromi.
28. School of Midwifery, UNTH, Enugu.
29. School of Midwifery, Bishop Shanahan Hospital, Nsukka.
30. School of Midwifery, Adazi.
31. School of Midwifery, Emekuku.

32. School of Midwifery, Aboh Mbaise.
33. School of Midwifery, ABUTH, Zaria.
34. School of Midwifery, Zonkwa.
35. School of Midwifery, Wusasa.
36. School of Health Technology, Kafanchan.
37. School of Midwifery, Kano.
38. School of Midwifery, Katsina.
39. School of Midwifery, Egbe.
40. School of Midwifery, Ilorin.
41. School of Midwifery, Awolowo Road, Ikoyi, Lagos.
42. School of Midwifery, LUTH, Idi-Araba. Lagos.
43. School of Midwifery, Nigeria Army Hospital, Yaba.
44. School of Midwifery, Minna.
45. School of Midwifery, Oba Ademola II Maternity Hospital, Abeokuta.
46. School of Midwifery, Ijebu-Ode.
47. School of Midwifery, Sacred Heart Hospital, Abeokuta.
48. School of Midwifery, Akure.
49. School of Midwifery, Osogbo.
50. School of Midwifery, Wesley Guild Hospital, Ilesa.
51. School of Midwifery, Department of Nursing, OAU, Ile-Ife.
52. School of Midwifery, Yemetu, Ibadan.
53. School of Midwifery, UCH, Ibadan.
54. School of Midwifery, Saki.
55. School of Midwifery, Ogbomoso.
56. School of Midwifery, Catholic Hospital, Oluyoro, Ibadan.
57. School of Midwifery, MMH, Jos.
58. School of Midwifery, Vom.
59. School of Midwifery, L.O.A, Jos.
60. School of Midwifery, Port Harcourt.
61. School of Midwifery, Sokoto.
62. School of Midwifery, Abuja.

***Public Health Nursing***

1. School of Public Health Nursing, Nsukka.
2. School of Public Health Nursing, Owerri.
3. School of Public Health Nursing, Port Harcourt.
4. School of Public Health Technology, Akure
5. School of Health Technology, Benin City.
6. School of Health Technology, Kaduna.
7. School of Hygiene, Kano.
8. School of Health Technology, Calabar.
9. School of Public Health Nursing, Awolowo Road, Ikoyi. Lagos.
10. School of Hygiene, Eleyele, Ibadan.
11. Department of Nursing, Obafemi Awolowo University , Ile-Ife. - 5-year  
BNSc
12. Department of Nursing, University of Nigeria, Nsukka. - 3-year  
BSc

***Orthopaedic Nursing (18 months Hospital programme)***

1. Orthopaedic Hospital, Igbobi, Yaba.
2. Orthopaedic Hospital, Enugu
3. Orthopaedic Dalla Hospital, Kano

***Ophthalmic Nursing***

1. University of Benin Teaching Hospital, Benin
2. Ahmadu Bello University Teaching Hospital, Kaduna

***\* Nurse Anaesthetist***

1. Department of Nursing, University of Nigeria, Nsukka. - 3-year B.Sc
2. University of Benin Teaching Hospital, Benin - 18 months
3. Ahmadu Bello University Teaching Hospital, Zaria - 18 months
4. Lagos University Teaching Hospital, Idi-Araba, Lagos - 18 months

***Perioperative Nursing***

1. University of Benin Teaching Hospital, Benin - 18 months
2. Ahmadu Bello University Teaching Hospital, Zaria - 18 months
3. Lagos University Teaching Hospital, Idi-Araba, Lagos - 18 months

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\* These programmes have been approved by the Council, but has not yet commenced registration of such candidates.

4. University of Nigeria Teaching Hospital, Enugu. - 18 months

**\* Plastic and Burns**

1. National Orthopaedic Hospital, Enugu.

**\* Paediatric Nursing**

2. University of Benin Teaching Hospital, Benin

**\* Accident and Emergency**

***Nursing Education***

3. Department of Nursing, University of Ibadan, Ibadan. -3 -year B.Sc  
 4. Department of Nursing, University of Nigeria, Nsukka. -3 -year B.Sc  
 5. Department of Education, The Polytechnic Calabar, Calabar. -2 -year diploma  
 6. Department of Education, College of Science and Technology, Kaduna. -2 -year diploma  
 7. Federal College of Education , Akoka, Yaba. Lagos -2 -year diploma  
 8. Institute of Management and Technology, Owerri. -2 -year diploma  
 9. Federal Training Centre for Teachers of Health Sciences, UCH, Ibadan. -2 -year diploma

***Midwifery Education***

1. Federal Training Centre for Teachers of Health Sciences, UCH, Ibadan. -2 -year diploma  
 2. Federal College of Education , Akoka, Yaba. Lagos -2 -year diploma  
 3. Department of Education, College of Science and Technology, Kaduna. -2 -year diploma  
 4. Department of Education, The Polytechnic Calabar, Calabar. -2 -year diploma  
 5. Institute of Management and Technology, Owerri. -2 -year diploma

***Public Health Nursing Education***

1. Federal Training Centre for Teachers of Health Sciences, UCH, Ibadan. -2 -year diploma  
 2. Federal College of Education , Akoka, Yaba. Lagos -2 -year diploma  
 3. Department of Education, College of Science and Technology, Kaduna. -2 -year diploma  
 4. Department of Education, The Polytechnic Calabar, Calabar. -2 -year diploma

*Nursing Administration*

1. University of Benin , Benin - 12 months
2. Department of Nursing, University of Ibadan, Ibadan. - 3 -year B.Sc

**Appendix 2: List of recognised Nursing qualifications by the Nursing and Midwifery Council of Nigeria as at December 1997**

**Accredited Nursing Certificates**

**1. Basic Certificate Programmes**

- i. General Nursing
- ii. Psychiatric Nursing
- iii. Midwifery

**2. Post-basic Certificate Programmes**

- i. Public Health Nursing
- ii. Orthopaedic Nursing
- iii. Perioperative Nursing
- iv. \* Nurse Anaesthetist
- v. \* Plastic and Burns
- vi. \* Paediatric Nursing
- vii. \* Accident and Emergency

**3. Post-basic Diploma Programmes**

- i. Nursing Education
- ii. Midwifery Education
- iii. Public Health Nursing Education
- iv. Nursing Administration

**4. Post-basic Degree Programmes**

- i. Nursing Education
- ii. Nursing Administration
- iii. Public Health Nursing

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\* These programmes have been approved by the Council, but has not yet commenced registration of such candidates.

### Appendix 3: Framework for psychiatric nursing education comparison between Nigeria and Botswana

Curriculum Area	Nigeria	Botswana
Age of present Curriculum		
Basic Psychiatric/mental health nursing		
Post-basic psychiatric/mental health nursing		
General nursing (Certificate/Diploma)		
Undergraduate (basic /postbasic)		
Post graduate		
Philosophical basis of psychiatric/mental health nursing education		
Conceptual framework		
Curriculum objective		
Usual entry requirements for students to be admitted into the program		
Basic		
Post-basic		
Expected psychiatric nursing competencies of the graduate		
Curriculum structure		
Number of Courses and duration of program		
How are courses described		
Basic		
Proportion of psychiatric nursing content to other		

<b>general nursing contents</b>		
<b>Organisation of Nursing Content</b>		
<b>Proportion of hours given to classroom instructions versus clinical practice hours</b>		
<b>General nursing skills specified in the curriculum</b>		
<b>Clinical practice area and duration</b>		
<b>Simulation laboratory if present</b>		
<b>Evaluation process</b>		
<b>Pathway for licensing</b>		
<b>Resources available</b>		
<b>Faculty preparations (Minimum and maximum available)</b>		
<b>Students welfare</b>		
<b>Students' status i.e. fee paying, in-service, or free education</b>		
<b>Teaching - learning methods</b>		
<b>Others (Specify)</b>		

**Appendix 4: QUESTIONNAIRE ON MODELS OF PSYCHIATRIC NURSING  
EDUCATION IN DEVELOPING AFRICAN COUNTRIES: A COMPARATIVE STUDY  
OF BOTSWANA AND NIGERIA**

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21 December 1997

Dear Colleague,

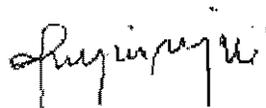
I need your consent and support to be able to carry out a study on Psychiatric Nursing education in two developing African countries: Nigeria and Botswana. Kindly spare a few moment of your time to complete this questionnaire designed for the purpose of this study. I am aware of the possibility that your schedule may be very tight, but I shall forever be grateful to you for consenting to participate in the study and the time you spend in completing this questionnaire. The questionnaire is mailed to educators involved in psychiatric nursing education at any level of nursing programmes in Nigeria and Botswana.

You are not required to disclose your identity, your names are not needed on the questionnaire. Despite this precaution, all responses shall still be treated with the utmost confidentiality.

Please, use the enclosed stamped addressed envelope to mail the completed questionnaire back to me. You may also wish to freely contact me at the address given below for any further questions or information on the present or related study.

Please permit me to say that if you put it away now, to be completed later, the chances of my benefiting from your valued response would have been greatly reduced. I thank you for making me gain from your wealth of experience.

Yours truly,



**Oluyinka Adejumo RN; RPN. Doctoral Student (UNISA)**

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The entire questionnaire will either require you to place a mark (X) on the appropriate choice(s) below, or fill in the appropriate words or figures to complete given statements.

### Section A:

How do the following models fit the description of the type of approach being used in your School or Department of Nursing to educate nurses in order to practise psychiatric-mental health nursing?

Item No	Model	Description	Highly	Almost	undecided	a little	not at all
1	In-Service Education	Not concerned with previous qualification in psychiatric nursing, but train nurses to practise psychiatric nursing by attending specially arranged training sessions in hospitals or in work settings to develop skill and knowledge in psychiatric nursing.					
2	pre-general nursing model	Leading to qualification as a Psychiatric nurse before doing another programme to qualify as a general nurse.					
3	post-general nursing model	Leading to psychiatric nursing qualification only after qualification as a general nurse					
4	baccalaureate specialisation	Leading to psychiatric nursing specialisation at the first degree level in a University or a degree-awarding institution.					
5	degree level model	Psychiatric nursing only taught as part of general nursing at the degree level not leading to specialisation.					
6	post degree level model	Specialisation in psychiatric nursing only after attaining a first degree					
7	medical expressive	Psychiatric nursing education based on the model of diseases and the uses of medical intervention to alleviate symptoms or eliminate illness.					
8	general nursing model	Psychiatric nursing only seen as part of general nursing curriculum at any level					
9	apprenticeship model	Hospital-based training to qualify as a psychiatric nurse by learning-on-the-job while working for the hospital with or without monetary compensation.					
10	psychiatric specialisation model	Training or education that emphasises that a nurse must specialise in psychiatric nursing to be able to practice as a psychiatric nurse.					
11	competency based model	Psychiatric nursing education that specifies certain competencies that must be mastered before an individual is allowed to practice as a psychiatric nurse.					
12	problem-based learning	psychiatric nursing training or education that relies on students					

<i>Item No</i>	<i>Model</i>	<i>Description</i>	<i>Highly</i>	<i>Almost</i>	<i>undecided</i>	<i>a little</i>	<i>not at all</i>
	model	learning through identifying, studying and solving clients' psychiatric problems as they arise in clinical practice.					
13	community nursing model	Psychiatric nursing education that emphasises the location of care of the psychiatric patient in the community to which they belong in order to render more of aggregate, family and community as well as individualised care .					
14	Primary health care model	Psychiatric nursing education that emphasises the practice of psychiatric nursing within the components of the primary health care and integrates the care of the mentally ill in the comprehensive health care of the individual and the community, based on the principles of Primary Health Care.					
15	continuing education model	Short courses in psychiatric nursing education for certificates or credits to enable an individual who is already qualified as a nurse to practise psychiatric nursing.					
16	Distance learning	Psychiatric nursing education obtainable through studying by correspondence or other forms of communication different from attending course of instructions where the school or college is physically located.					
17	Integrated Model	psychiatric nursing education is viewed as a component of basic nursing education, where other components may include midwifery, and community health.					
18	Diploma model	Psychiatric nursing education leads to an award of diploma and professional registration					
19	Certificate model	psychiatric nursing education leads to an award of a certificate for professional registration					
20	Other type not included above (Please specify)	(please describe here)					

**Section B:**

Kindly give your opinion freely regarding the Quality and Quantity of students being trained for psychiatric nursing practice:

Opinion about the quality and quantity of students being trained for psychiatric nursing practice in your Institution						
Item No	Statements about students' quality and/or quantity	Strongly agree	agree	undecided	disagree	strongly disagree
1	The entry prerequisite for students that will practice as psychiatric nurses is adequate					
2	Psychiatric nursing students require higher entry qualifications than now					
3	Number of students being trained at present is adequate for the country's mental health care need					
4	The students' age range is appropriate for the type of training they are receiving					
5	The sex distribution of students being trained for psychiatric nursing practice is appropriate i.e. male : female ratio					
6	Most of the students are capable of being self-directed in their studies					
7	Students are well motivated to learn psychiatric - mental health nursing					
8	Students being trained to give psychiatric care demonstrate as much competence in practice as they do in the classroom					
9	The calibre of students being trained will do as well, even if they were trained in the Universities or other institutions of higher learning					
10	A large number of the students being trained will presumably stick to psychiatric nursing after training					

**Section C:**

The following statements deal with the extent to which you perceive classroom instruction as congruent with the clinical realities the students face when they go for practice.

Item No	Statement about congruency of theory and practice	Strongly agree	agree	undecided	disagree	strongly disagree
1	What students learn in the classroom is what they practice in their clinical areas e.g. the nursing process					
2	The clinical experience of the students well prepares them for the challenges of the post qualification practice					
3	Students later practice will depend on resources available rather than the students knowledge					
4	If a gap exists between theory and practice in psychiatric nursing education, the teachers should be held responsible					
5	The students are to blame for whatever gap that may exist between theory and practice					

Item No	Statement about congruency of theory and practice	Strongly agree	agree	undecided	disagree	strongly disagree
6	Where gaps in theory and practice occur, the entire responsibility will be that of nurse administrators in charge of the clinical area					

### Section D

To what extent do you agree with the following statements about psychiatric nursing education in your institution or country?

Serial No	Statement about Psychiatric Nursing Education	Strongly Agree	Agree	Undecided	Disagree	Strongly dis-agree
1	General standard of psychiatric nursing education is quite satisfactory and appropriate for the need of the nation, and the need of the learners.					
2	Psychiatric nursing education should be part of the general nursing education so that every qualified nurse is able to work with clients that need psychiatric or mental health care.					
3	It makes no difference to the practice of psychiatric nursing whether the education is at Certificate, diploma, degree or even at post-graduate level.					
4	Diploma program will still be deemed to be appropriate for specialisation as a psychiatric nurse.					
5	Psychiatric nursing education should be at the post-basic level of nursing education (post-registration as a qualified general nurse).					
6	Degree programme will appear to be more appropriate in order to specialise as a psychiatric nurse.					
7	Nurses should only be allowed to specialise as a psychiatric nurse at the University post-graduate level.					
8	Psychiatric Nursing training should actually be integrated into general nursing training, without the need for any other special school for psychiatric nurses					
9	Teachers of psychiatric nursing in schools and colleges are adequately prepared enough for the standard expected for the country and the learners.					
10	Nurse educators should utilise other teachers from other disciplines like psychology, social and biological sciences in the training of psychiatric nurses					
11	Nurse tutors should be knowledgeable enough to do the teaching of psychiatric nursing students without the use of other experts from related disciplines					
12	Psychiatric nursing education in this institution is based on a specified conceptual or theoretical model of Nursing					

### Section E: Nursing Models versus Educational Models

1. Nursing educational institutions are sometime known to have specific conceptual or theoretical models of nursing that guide the content of their curriculum. List three (3) of the theories or conceptual models of nursing that you may be familiar with?

- i. \_\_\_\_\_  
 ii \_\_\_\_\_  
 iii \_\_\_\_\_

2. Is your curriculum based on any conceptual model or theoretical model of nursing?  
 Yes  No

3. If Yes, what or whose model(s) of nursing is in use by the curriculum?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. From the available list in **Section A**, choose one or a combination of more than one education model that you consider to be most suitable for psychiatric nursing education in your country.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Section F: Respondent's Personal data

*The personal information in this section is only for data processing and will not be used in anyway to identify the respondent. Please, place a mark (X) on the appropriate choice(s) below, or fill in the appropriate words or figures to complete the statements.*

1. Your age (in years): \_\_\_\_\_ years

2. Your Sex: (mark as appropriate)

- Male  
 Female

3. No of years of your experience at teaching in the training of nurses for psychiatric nursing practice:

\_\_\_\_\_ years

4. Your Present Designation:

- Associate Nurse Tutor  
 Associate Lecturer  
 Nurse Tutor  
 Lecturer  
 Senior Nurse Tutor  
 Senior Lecturer  
 Principal Nurse tutor  
 Principal Lecturer  
 Assistant Chief Nurse Tutor  
 Senior Principal Lecturer  
 Chief Nurse Tutor

- Chief Principal Lecturer
- Assistant Director of Nursing Education
- Director of Nursing Education
- Others (specify) \_\_\_\_\_

5. Your Highest Academic Qualification:

- Diploma in Nursing Education
- First Degree in Nursing
- First degree in other discipline (specify)
- Masters Degree in Nursing
- Masters Degree in other discipline (specify)
- Doctoral degree in Nursing
- Doctoral degree in other area (specify)

6. Your other Professional Qualifications obtained:

- Registered Nurse (RN)
- Registered Psychiatric Nurse (RPN)
- Registered Midwife (RM)
- Diploma in Nursing Administration and Management (DNAM)
- Registered Nurse Tutor (RNT)
- Registered Nurse Administrator (RNA)
- Others (specify) \_\_\_\_\_

7. Number of students being trained for psychiatric nursing in your Institution:

**Pre Nursing Registration:**

Year 1 \_\_\_\_\_ number of students

Year 2 \_\_\_\_\_ number of students

Year 3 \_\_\_\_\_ number of students

Year 4 \_\_\_\_\_ number of students

**Post-Nursing Registration:**

Year 1 \_\_\_\_\_ number of students

Year 2 \_\_\_\_\_ number of students

Others (Specify) \_\_\_\_\_

8. Estimate the Teacher : Student population Ratio in psychiatric Nursing education in your school:

No of Teachers: \_\_\_\_\_

No of Students: \_\_\_\_\_

Teachers to students ratio: \_\_\_\_\_

9. What is the Highest Nursing Qualification attained by the Head of Psychiatric Nursing Education in your Institute:

- Diploma in Nursing Education
- First Degree in Nursing
- Masters Degree in Nursing
- Doctoral degree in Nursing
- Others (specify) \_\_\_\_\_
- Unknown

10. What is the Highest Other Academic Qualification possessed by the Head of Psychiatric Nursing Education in your Institute:

- First degree in other discipline (specify)
- Masters Degree in other discipline (specify)
- Doctoral degree in other area (specify)
- Others (specify) \_\_\_\_\_
- Unknown

**Thank you for completing this questionnaire**

## Appendix 5: SAMPLE LETTER OF INVITATION AND REQUEST FOR CONSENT

Dear Madam/Sir,

You are invited to participate in a focus group discussion concerning psychiatric nursing education in a study of psychiatric nursing education models in two developing African countries. The study is designed to describe the existing models of educating nurses for psychiatric-mental health care and make suggestions for the future.

You are invited as a possible participant in this study because of your experience in the care on the mentally ill and your association with the products of your country's psychiatric nursing education programmes.

In the discussion you will be requested to respond to some open ended questions which focus on the expected roles of psychiatric -mental health nurses in the country, your perception of how the present psychiatric nursing education system is meeting this expectation, and your suggestion for the future of psychiatric nursing education.

The session will be expected to last for about an hour. This will be audio taped (recorded) for transcription which will be coded later and shall not include the identity of the individual participant. All responses shall be treated anonymously and confidentially. Only the investigator shall have access to the audio tapes and the transcribed notes. The audio tapes shall be erased as soon as the data analysis is complete.

You are under no obligation to participate, but you are kindly requested to sign this form as an evidence of your willingness and consent to participate in the discussion. Despite your consent to participate, you shall be free at any point to withdraw from participation before and during the discussion.

Should you wish further information or explanation please feel free to contact me at the supplied address and phone number.

\_\_\_\_\_  
Investigator's Signature

Date:

\_\_\_\_\_  
Participant's Signature

Date:

**Appendix 6: Guide for the Focus Group Discussion**

1. How will you describe the psychiatric nursing education programme in this country today?
2. How satisfactory is the present system of psychiatric nursing education for the health care service in this country?
3. What will you consider to be the main factors responsible for the present state of psychiatric nursing education in this country today?
4. What will be your reaction to the suggestion that nurses train at the basic level as psychiatric nurses as part of the general nursing preparation, but can specialise at advanced practice levels later as an advanced practice nurse in psychiatric nursing?
5. Who do you think should be trained as psychiatric nurses and where and when should this training take place?
6. What effect do you think psychiatric nursing practice of today really have on the total outcome of mental health of the country?
7. What changes will you like to see in the present educational programme for psychiatric nurses in this country?
8. How will you like to see psychiatric nursing in this country in the next 10 years?
9. What will you suggest in order to facilitate the realisation of your vision for psychiatric nursing education at the turn of the century?