AWARENESS, ATTITUDES AND REFERRAL PRACTICES OF HEALTH CARE PROVIDERS TO PSYCHOLOGICAL SERVICES IN BOTSWANA

BY

EMMA JULY

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Supervisor: Dr. D. Elkonin
“When we wake up in the morning, we have two simple choices, go back to sleep and dream, or wake up and chase those dreams.”

The choice is yours........

“Everything that it is, or was began with a dream..”
This thesis is dedicated to my wonderful children, Unaswi, Lechani and Chipo, who had to grow up in the absence of a mother during their crucial developmental stages, and had to learn to be independent in order to survive. It was not easy, but it was worth it.
DECLARATION OF AUTHENTICITY

I hereby declare that: Awareness, attitudes and referral practices of health care providers to psychological services in Botswana is my own work, that all the sources used or quoted have been indicated and acknowledged by means of complete references, and that this treatise was not previously submitted by me for a degree at another university.

Emma July
Signature: _______________

Date: ____________________
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# TABLE OF CONTENTS

DECLARATION OF AUTHENTICITY ........................................................................ iv  
ACKNOWLEDGEMENTS ................................................................................................ v  
TABLE OF CONTENTS ............................................................................................... vii  
LIST OF TABLES ............................................................................................................. xi  
ABSTRACT ...................................................................................................................... xii  

**CHAPTER 1** ............................................................................................................. 1  
Introduction and Problem statement ............................................................................. 1  
1.1. Introduction .......................................................................................................... 1  
1.2. Statement of the problem ..................................................................................... 2  
1.3. Outline of the chapters ......................................................................................... 3  

**CHAPTER 2** ............................................................................................................. 4  
Psychology and Psychological Services in Sub Saharan Africa .................................. 4  
2.1. Introduction .......................................................................................................... 4  
2.2. Definition of psychology ..................................................................................... 4  
2.3. History and development of psychology ............................................................. 5  
2.3.1. Psychology as a science ................................................................................... 5  
2.3.2. Psychology as an academic discipline and a professional career .................... 6  
2.3.3. The history of psychological services ............................................................ 6  
2.4. History of psychology and psychological services in Sub-Saharan Africa ........... 7  
2.4.1. History and development of psychology in South Africa ................................ 10  
2.4.2. History and development of psychological services in South Africa ............. 11  
2.4.3. Psychology and its status in Botswana ............................................................ 12  
2.4.3.1. Training in psychology ............................................................................ 13  
2.4.3.2. Psychological services in Botswana ......................................................... 13  
2.4.3.3. Primary Health Care in Botswana ......................................................... 17  
2.4.3.4. Mental Health Care in Botswana ........................................................... 19  
2.5. Studies on psychological services ...................................................................... 20
2.5.1. International studies on psychological services .................................................. 20
2.5.2. South African studies .......................................................................................... 21
2.5.3. Botswana studies ................................................................................................. 23
2.6. Conclusion ................................................................................................................. 23

CHAPTER 3 .................................................................................................................... 24
Psychological Theories .................................................................................................... 24
3.1 Introduction ................................................................................................................. 24
3.2. Awareness .................................................................................................................. 24
3.4. Referral practices ....................................................................................................... 26
3.5. The consistency model of attitudinal components ..................................................... 27
3.6. The theory of reasoned action .................................................................................... 27
3.7. The use of psychological interventions to improve health care ................................. 28
3.8. Health care consultation ............................................................................................. 29
3.9. The biomedical model ............................................................................................... 29
3.10. The biopsychosocial model ...................................................................................... 30
3.11. Conclusion ............................................................................................................... 31

CHAPTER 4 .................................................................................................................... 32
Research Design and Methodology ............................................................................... 32
4.1. Introduction ................................................................................................................ 32
4.3. Research Design ......................................................................................................... 32
4.4. Methodology .............................................................................................................. 33
4.5. Sampling .................................................................................................................... 35
4.6. Measure .................................................................................................................... 35
4.6.1. Biographical data section .................................................................................... 36
4.6.2. Awareness Section .............................................................................................. 36
4.6.3. Attitudes and Referral Practices Section ............................................................. 37
4.7. Pilot study .................................................................................................................. 37
4.8. Procedure ................................................................................................................... 37
4.9. Data analysis .............................................................................................................. 39
4.10. Ethical considerations .............................................................................................. 39
4.11. Conclusion ............................................................................................................... 39

CHAPTER 5 .................................................................................................................... 40

Results and discussion ................................................................................................. 40

5.1 Introduction .................................................................................................................. 40

5.2. Section A: Biographical Information ....................................................................... 40
    5.2.1. Gender ................................................................................................................. 40
    5.2.2. Age ...................................................................................................................... 41
    5.2.3. Marital Status ...................................................................................................... 41
    5.2.4. Profession ............................................................................................................ 42
    5.2.5. Experience in the profession ............................................................................... 42
    5.2.6. Place of work ...................................................................................................... 43

5.3. Section B: Awareness of psychological services ..................................................... 43
    5.3.1. Section B1: Availability of psychological services ........................................... 44
    5.3.2. Section B2: Awareness of the role of psychological services ........................... 45
    5.3.4. Section B4: Provision of psychological services ................................................ 48
    5.3.5. Summary of the findings on availability and awareness of psychological services ....................................................................................................................................... 50

5.4. Section C: Attitudes and referral practices to psychological services ................. 50
    5.4.1. Section C1: Attitudes towards psychological services ....................................... 51
    5.4.2. Summary of the findings on attitudes towards psychological services ............ 58
    5.5.1. Section C2: Referrals to available psychological services ................................. 58
    5.5.2. Section C3: The frequency of psychological problems ...................................... 63
    5.5.3. Section C4: Actions taken to deal with psychological problems ........................ 65
    5.5.4. Section C5: Referral practices of psychological problems ............................... 67
    5.5.5. Summary of the findings on the referral of psychological problems .................. 71

5.6. Conclusion ................................................................................................................. 71

CHAPTER 6 .................................................................................................................... 72

Conclusions and Recommendations ............................................................................... 72

6.1. Conclusions of the study ........................................................................................ 72

6.2. Recommendations ..................................................................................................... 73
# LIST OF TABLES

Table 1: Psychological services offered in Botswana ....................................................... 14  
Table 2: Gender Distribution of Participants ................................................................. 40  
Table 3: Age Distribution of Participants ..................................................................... 41  
Table 4: Participants’ Marital status ............................................................................. 41  
Table 5: Profession distribution .................................................................................... 42  
Table 6: Years of work experience .............................................................................. 42  
Table 7: Participants’ place of work ............................................................................. 43  
Table 8: Availability of psychological services ............................................................ 44  
Table 9: Participants’ awareness of available psychological services ......................... 45  
Table 10: Provision of psychological service ............................................................... 49  
Table 11: Attitudes towards psychological services ...................................................... 51  
Table 12: Referrals to available psychological services ................................................ 59  
Table 13: The frequency of psychological problems ..................................................... 63  
Table 14: Actions taken to deal with psychological problems ....................................... 66  
Table 15: Referral practices of psychological problems. .............................................. 68
ABSTRACT

The provision of psychological services is vital considering the complex nature of psychosocial issues facing people today. Nevertheless, the provision and utilization of psychological services has not been given due recognition in most African countries, including Botswana.

Botswana is one of the countries faced by the challenges of the HIV/AIDS pandemic and other mental health problems, as well as poverty and unemployment. To date statistics on the magnitude of the HIV/AIDS epidemic in Botswana, published annually by the National AIDS Coordinating Agency (NACA) reflect an increased rate of mental illness and psychosocial problems. Considering the complex nature of issues that impact negatively on people in Botswana, there is a need for awareness and the provision of psychological services in the primary health care system.

There is little research on the place of psychology and psychological services in Botswana. The availability of such information is crucial for the planning of effective community-based psychological services. The present study employed a quantitative research method to explore and describe awareness and attitudes towards psychological services and referral practices in relation to psychological problems, of health care providers in Botswana. The participants in the study were chosen, based on a non-probability, purposive sampling method. The sample consisted of ninety-six persons and constituted medical doctors, nurses, psychiatrists, psychiatric nurses and clinical social workers from governmental and non-governmental institutions from Gaborone and Francistown in Botswana. Data were analyzed by means of descriptive statistics in order to identify the mean, ranges and standard deviations. Frequency counts and percentages of the participants’ responses were computed. The results of the study revealed an awareness of available psychological services, positive attitudes towards psychology and psychological services and a reasonable percentage of referrals to psychological services. The results also revealed that available psychological services were limited and not easily accessible to patients. There was also an indication of a shortage of trained professionals to offer psychological services in health care centres, which resulted in psychological problems being referred to social workers.

Key words: awareness, attitudes, referral practices, psychological services, Botswana.
CHAPTER 1
Introduction and Problem statement

“When I see a community, I try to understand their distress in a number of ways. I try to comprehend it in terms of the particular pattern of events in their individual lives to date, but I also try to locate each person’s experiences within a wider ‘atlas’. These atlases will contain maps of families and maps of the social subsystems within which individuals make most of their interpersonal interactions. There will also be containing maps of broader resources and professionals to help them cope with stressful life events.”

Ben-Tovin, 1987 (p.31)

1.1. Introduction

There is evidence that psychosocial factors have considerable negative effects on individuals, and there is a need for the availability of and accessibility to psychological services at primary health care levels. In the developed nations of the world, the importance and role of psychological services have been well understood in a complex world. Eze (1991) states that there is a general recognition among the developed nations that psychology touches almost every aspect of individuals’ lives, such as intelligence, cognition, emotions, motives, attitudes, perceptions, personality, memory and behavioural styles. He further states that this awareness of psychological dynamics has led to the development of psychological services to help individuals deal with everyday situations. The recognition of the vital role of psychological services has resulted in the psychology profession being given a prominent place in the educational, industrial, judicial and health care systems of the developed nations (Eze, 1991).

However, Brown and Lent (2000) have pointed out that there is a common lack of recognition and understanding of the role of psychology and psychological services in Sub-Saharan Africa, in spite of the recognised need for such services. According to Akin-Ogundeji (1991), psychological services have become vital today, more so than ever before, considering the nature of issues facing the social population, ranging from HIV/AIDS, psychosocial problems, psychological assessment, mental disorders, career counselling and job training, and placement assessment. Ben-Tovin (1987) noted that psychological problems and maladaptive behaviours arise because family members and the community within a social system do not provide sufficient support and stability.
when an individual is faced with stressful life events. Vogelman (1990) emphasized the need for the provision of enhanced psychological services for supporting individuals under stress or suffering incidences of psychological disturbances, that need psychological intervention. According to Dawes (1985), programmes, procedures and structures that offer psychological services have not been given much recognition in most countries in Sub-Saharan Africa. This includes Botswana, which is the focus of this study.

1.2. **Statement of the problem**

The government of Botswana, with the help of non-governmental organizations, is committed to the improvement of health care service delivery in the country. Placed within this broad spectrum of improvement was the incorporation of psychological services within the primary health care system (Manual of Health Service, 1992). Modie, (1993) in a report on commencement practices in Botswana, pointed out that the effectiveness of existing psychological services may not be significant since the provision of psychological services has not previously been clearly defined in primary health care settings and the roles of health professionals, such as medical doctors and social workers, are also not clearly defined in terms of the provision of psychological services. Since the incorporation of psychological services into the health care system in 1992, little research has been done to evaluate the effectiveness of the delivery of psychological services within the health care system. The existing research focuses on the success of the integration of mental health care into the primary health care system (Modie, 1992), but there is not much literature on the relative success of the provision of psychological services in primary health care.

The general aim of this study was to explore and describe the awareness of and attitudes towards the available psychological services, and referral practices in relation to the psychological problems, of health care providers in Botswana. The study is aimed at contributing to a body of knowledge that is relevant for psychological intervention in Botswana.
The aims of the study are:
(i) to explore and describe the awareness of available psychological services, of health care providers in Botswana;
(ii) to explore and describe the attitudes of health care providers towards psychological services in Botswana;
(iii) to explore and describe referral practices utilised in relation to psychological problems, of health care providers in Botswana.

1.3. Outline of the chapters

The following is a brief outline of the layout of the study. Chapter 1 provides a brief introduction to the topic, a statement of the problem and an outline of the study. Chapter 2 provides a comprehensive literature review of the development of psychology and psychological services in Sub-Saharan Africa, South Africa and the study country Botswana. The chapter also provides a brief review of studies relevant to the current topic.

Chapter 3 gives brief definitions of the constructs of awareness, attitudes and referral practices. The consistency model of attitudinal components and theory of reasoned action relevant to the constructs of attitudes and referral practices are also reviewed. The chapter further discusses the use of psychological intervention to improve health care service delivery, as well as the importance of health care consultation amongst health care professionals. The biomedical and bio-psychosocial models of health are reviewed to assist the understanding and to explain the relationship of psychological problems and physical illness. Chapter 4 sets out the aims of the study and provides a breakdown of the methodological considerations and procedures used in this study. The development of the measure and the pilot study of the measure used in the study are also outlined here.

Chapter 5 provides the results obtained and a discussion of these results. Chapter 6 concludes the study, as well as suggesting possible recommendations that could help formulate policies to improve psychological services in Botswana. The limitations of the study are also explained. The method of dissemination of the results to relevant departments is also here outlined.
CHAPTER 2

Psychology and Psychological Services in Sub Saharan Africa

2.1. Introduction

Experts in the field of medicine, sociology and other related fields share a common concern over an alarming intensity of stress experienced in daily activities, which in turn leads to a wide range of psychological problems and problem behaviours (Koinage, 2006). In many African countries, the subject of psychological wellbeing has long been one of major concern. There are many critical events characteristic of Africa that contribute to psychological problems. These among others include political turmoil, poverty, large numbers of refugees, infectious diseases, including HIV/AIDS, along with the world perception of Africa as the begging bowl of the world (Koinange, 2006).

The current study explores awareness of available psychological services, attitudes of health care providers towards psychological services and the referral practices in relation to psychological problems of health care providers to psychological services in Botswana. This chapter therefore aims to contextualize the study by briefly defining psychology, exploring the history and development of psychology and psychological services with particular reference to Sub-Saharan Africa. The status of psychology and psychological services in Botswana will also be explored. Then, in order to place the present study within the context of the practice of psychology, international, South African and Botswana studies on the provision of psychological services will be reviewed.

2.2. Definition of psychology

According to Louw and Edwards (1993), attempts to define psychology have led to the birth of literally hundreds of definitions. The following are some of the definitions that emerged in this process: Psychology is the scientific discipline that focuses on human cognition, emotion and behaviour. The discipline studies the relative influences of inherited and environmental factors on human development and behaviour throughout the lifespan and within specific situational contexts (Seedat, Duncan & Lazarus, 2003); psychology is the scientific study of behaviour and mental processes (Peterson, 1998); psychology is the study of behaviour and experience (Mann, 1987). Louw and Edwards
(1993) further state that, though there are different ways of defining psychology, all the definitions have a common factor in that psychology is the scientific study of human behaviour.

2.3. History and development of psychology

2.3.1. Psychology as a science

Psychology as a science originated in Europe in 1879, when Wundt set up the first psychology laboratory. According to Azuma (1984), psychology as a science primarily developed in Europe and America based on the behavioral data of western people who grew up in western culture. After the Second World War, America forged ahead as the leader in the field of psychology (Carr & Schumaker, 1996), and has since continued to dominate the field, although there is growing interest in psychology in far eastern countries. Carr and Schumaker (1996) further state that the majority of scientific journal articles in the field of psychology are published by European and American researchers, which suggests that psychology remains a Euro-American enterprise. This western domination has limited the applicability of psychology in developing countries.

Psychology as a science investigates both normal and abnormal behaviours and applies its knowledge in various contexts, such as mental health and research. As a science directly concerned with behavioural and social processes, psychology might be expected to provide intellectual leadership in the search for new and better personal and social arrangements (Louw & Edwards, 1993). Psychology, as a new science, is often misunderstood, especially in developing countries, and common beliefs and public opinions about psychology often do not reflect its scientific nature. Since people were, and to a large extent remain, ignorant of the scientific nature of psychology, psychologists are often misconstrued in developing countries as fortune tellers, palm readers and mind readers (Leung & Zhang, 1995).
2.3.2. Psychology as an academic discipline and a professional career

Psychology as a profession developed in the late 1800s with Sigmund Freud’s interest in psychological wellbeing and his method of psychoanalysis. This method focused on the individual, and his basic premise was that emotional disturbances developed as a result of negative past experiences (Seedat et al, 2003). According to Benjamin (1986), psychology at its inception in the 1880s was mostly concerned with its own public image. That is, how the public felt about it and so did the psychologists; and what the public knew about psychology and what the psychologists knew were not necessarily the same. This concern was initially coupled with the identity crisis which the discipline itself went through during its early years of existence – something that can be viewed as quite normal when a new discipline seeks to establish itself and to avoid being neglected. Benjamin (1986) further states that as psychology became better established, the concern shifted from one of its survival to one of its ability to achieve one of its most cherished goals, that is, the improving of human welfare through its application of psychological service to various human endeavours, such as mental health, education and industry.

Psychology began as a field of study mostly at universities. As knowledge advanced and was used in various ways, more and more psychologists worked full-time in the application of psychological knowledge and skills (Louw & Edwards, 1993). Louw and Edwards (1993) further stated that, as psychologists applied their expertise in different areas, specialist bodies of knowledge were built up in specific applied areas and gradually emerged as professional sub-disciplines such as Clinical Counselling, Industrial, Educational and Research psychology.

2.3.3. The history of psychological services

According to Schmidt et al. (1990), there has been a bias in offering psychological services generally. The almost exclusive emphasis has been upon assessing and modifying the behaviour, emotions and cognitions of individuals. As psychology evolved, there was a recognised need for more holistic interventions. The focus which developed was to correct this individualistic bias by considering people within the context of their social settings and the systems of which they are part.
According to Orford (1992), people’s subjective experiences and emotional problems are generated by the conditions that they live under, such as poverty and unemployment. Therefore, it is very crucial to consider psychological and social factors in the provision of psychological assessment and intervention, as there exist mutual relationships between people and their environments.

According to Schmidt et al. (1990), the role of psychology and psychologists in the field of health care has been undergoing a gradual, but important change. He stated that traditionally, the role of a psychologist was to provide mental health care only to individuals suffering mental health problems. This orientation resulted in psychologists seeing only a small portion of people needing mental health care. Those presenting with physical complaints resulting from psychological or social problems, consulted a physician and not a psychologist. Like psychiatrists, most psychologists have defined their role as that of specialty care for psychological wellbeing within the health care system service delivery. This is supported by Schlebusch (1990) who asserted that health care delivery service should substitute “skills for pills” with approaches which recognise that people function as part of a system and that patients should be viewed holistically in the management of their psychological problems. He recommended that medical health care should become more holistic in health care service delivery. He further argued that an effective health care service delivery requires a comprehensive understanding of psychosocial issues. Schmidt et al. (1990) stressed that adoption of a biopsychosocial model approach is necessary in the management of medical problems, as diseases emanate from biological, psychological and social factors.

2.4. History of psychology and psychological services in Sub-Saharan Africa

Psychology was introduced in Sub-Saharan Africa during colonisation in the context of anthropological research. Its theories and methods where and are still western in orientation and its primary focus was on topics that reflect this westernised orientation, thereby neglecting or excluding folk knowledge and local issues (Adair & Kagitcibasi, 1995). The psychosocial experiences of Sub-Saharan African communities compared to those of western European and North American communities are significantly under-represented in current psychological literature. Professional psychology in Sub-Saharan Africa is either non-existent or strongly modelled after practices followed in western
countries (Jones, 2004). In the past, psychology has been internationally criticised for its theoretical perspectives that are based on American individualism, and its approaches to psychological problems which are not relevant to the African context. These individualistic Eurocentric models have been the basis of training for African trainees, thus resulting in alienation from their own traditions, culture and history (Stevens, 2001).

Nsamenang (1995) stated that the historical development of psychology reveals its nascent state in Sub-Saharan Africa. Nsamenang (1995) goes on to explain that psychology has not been recognised as a fully-fledged academic discipline, nor a service domain in Sub-Saharan Africa. This may be due to the marginal status of psychology in academia and the rudimentary but fragmented nature of psychological services in Sub-Saharan Africa, with South Africa being the exception. Belgrave and Allison (2006) identified a series of factors related to the nature, scope, and growth of psychology in Sub-Saharan Africa. These include general economic concerns, the extent to which resources are available for research and curriculum development, job opportunities for psychologists and the degree to which the field is viewed by society as a useful one in terms of society’s needs and goals. Leung and Zhang (1995) discussed systematic factors that influence the development of psychology in developing countries. Such factors include socio-political considerations, influences from other countries and public perceptions of psychology, relationships with other disciplines, the training of psychologists, economic constraints and research constraints.

To trace the practice of psychology in Sub-Saharan Africa, a brief account of the status of psychology and psychological services in Kenya, Zambia and Zimbabwe will be discussed. These three countries were chosen on the basis that there is provision of psychological services in these countries; they are in the same region as the study country and psychology as a professional career within these countries is still undergoing change and development.

Psychology was introduced in Kenya in the 1970s as a result of a perceived need for knowledge of educational psychology in the training of secondary school teachers. With a population of approximately thirty million, Kenya has fewer than three thousand psychologists and professional counsellors, most of whom were trained either overseas or at private universities in Kenya. The majority of these psychologists and professional counsellors are concentrated in towns and cities (Kakiuki, Kimamo & Ginsberg, 2006).
The Kenyan Psychological Association was officially registered in 1997. Membership of the association consists mainly of counselling psychologists, psychology students, and a few educational, clinical and research psychologists, as well as marriage and family therapists. At present there are no licensing or certification requirements that regulate the practice of psychology in Kenya (Koinange, 2006).

Zambia was one of the first African countries to introduce psychology as an academic discipline and a psychology department was established at the University of Zambia in 1965. A Master’s degree is the minimum academic qualification requirement for registration and for being employed as a lecturer in the department, which offers postgraduate courses in occupational, organisational and educational psychology. The department also carries out some research which includes the development of indigenous psychological tests and community-based intervention programmes for the prevention of HIV/AIDS (Mwaba, 1995).

Psychology as a professional career in Zambia was established in the 1970s (Carr & Schumaker, 1996), and psychological services are well established in the civil service. The primary function of the discipline has been in the assessment and placement of manpower and the educational and occupational assessment services are attached to the Ministry of Labour and Social Security. These provide expertise and practical services in matters of occupational assessment and selection into employment, promotion and training (Mwaba, 1995). Psychology units were also established in government hospitals in 1966, but were only officially recognised by the Ministry of Health in 1977. Zambia Consolidated Copper mine which is a non-governmental organisation, has a well-established psychological assessment unit (Mwaba, 1995).

In Zimbabwe, psychologists were first licensed in 1970. After independence in 1980, professional psychology programmes were established at universities. Child psychology was the first area of psychology formally taught at universities in Zimbabwe, and currently the university offers child and occupational psychology at the postgraduate level (Carr & Schumaker, 1996). Psychological services are offered by non-governmental organisations, such as the Institute of Systemic Therapy. The aim of the institute is to offer psychological services to families with a diversity of social problems. It is also involved in training social service and community workers in systemic counselling techniques (Jordan, 1995).
In order to place the present study within the context, the history and development of psychology in South Africa will be discussed in comparison with the study country, in this case Botswana. South Africa has a long history of psychology, and is a useful example of the development of the profession in Sub-Saharan Africa. In Botswana psychology is still in its infant stage when compared to South Africa.

2.4.1. History and development of psychology in South Africa

The history of psychology in the Republic of South Africa shows a resemblance to the historical course of this science in the United States of America, Britain and Europe. The reason for this is that psychology in South Africa also grew out of philosophy as an independent discipline (Louw & Edwards, 1993).

Although there is no date that could be identified as the birth date of psychology in South Africa, there are some important developmental landmarks which have been cited by Edwards and Louw (1993). The South African Psychological Association (SAPA) was founded in the 1960s, but later, due to the language and racial division inherent in the policies of apartheid, the association was split into SAPA and the Psychological Institute of the Republic of South Africa (PIRSA). A period of change resulting from discontent regarding the separate policies of the country at the time ensued for many years. SAPA and PIRSA later reunited as the Psychological Association of South Africa (PASA) in 1983. Subsequent to the formation of PASA, several more organisations grew out of PASA, such as the Organisation for Appropriate Social Services in South Africa (OASSA) which was founded in the middle 1980s and an organization serving black psychologists known as Black Psychological Groupings. In 1992, OASSA and several organisations of doctors and other health workers combined to form the South African Health and Social Services Organisation (SAHSSO). The aim of this multi-racial organisation was to establish a unitary national health services system through policy development and campaigns designed to influence a future government. In 1994 PASA and OASSSA joined together to form a new non-racial Psychological Society of South Africa (PsySSA).

Professional training in psychology is provided at a postgraduate level. Upon completion of a Master’s degree, graduates register in one of the five categories, namely,
clinical, counselling, industrial, educational or research psychology. Each category is defined chiefly by the setting in which one works (Lazarus, 1988). All psychologists are required to register with the Health Professions Council of South Africa (HPCSA) after successfully completing a national Professional Board for Psychology examination. The Professional Board for Psychology, is one of eleven boards functioning under the umbrella of the Health Professions Council of South Africa (HPCSA), and is responsible for monitoring registration, coordinating psychological practices, regulating registration and teaching, and ensuring proper and appropriate professional practice for the discipline in South Africa.

2.4.2. History and development of psychological services in South Africa

According to Dawes (1985), psychological service provision in South Africa has been criticised for many years. In the past, psychological services were centred mainly on working primarily with individuals and families, and doing assessments, counselling, therapy and research. According to Louw and Foster (1991), the first psychologist was appointed by the state in 1923 and the second in 1925. The services rendered by these psychologists primarily entailed psychological assessment, mainly for people with mental handicaps, using intelligence tests. The issues of race and intelligence were rife at that time, and Foster and Louw-Potgieter (1991) point out that intelligence tests of the day were used to determine the relative mentalities of the different races in South Africa. These intelligence tests adapted from overseas for use in the South African context, were used by psychologists as instruments to address social problems.

Over the years, psychologists in South Africa have succeeded in attracting the attention of the public at large. The demand for their services is certain; they are increasingly acquiring respect and have secured a particular status. An increase in the registration of psychologists of different registration categories (clinical, counselling, educational, industrial and research psychology) and the integration of a more holistic approach into the health care system, has resulted in the proficiency of the psychologist as a behavioural scientist gaining recognition far beyond what was first envisaged (Raubenheimer, 1981). The assistance of a Psychologist is now called upon and utilized in numerous spheres of life both public and private, and this has expanded to include psychological services such as psychological assessment, counselling situations, trauma
intervention, marriage and couple counselling and pastoral care, in a variety of settings such as schools, hospitals, the administration of justice, sports, and in the occupational and industrial world (Cooper, 2001).

However, in spite of this growth and development, Pillay and Peterson (1996) pointed out that studies on the provision of psychological services in South Africa have identified problems in current psychology practices and mental health care policies, such as a lack of knowledge of the available psychological services by rural communities, lack of psychological services in rural communities and the effectiveness of psychologists in terms of dealing with social, personal and educational problems of the broader population of the country. They further pointed out that this highlights the importance of collaboration between professionals concerned with psychological wellbeing. Peterson (1998) stated that there was growing concern about the effectiveness and relevance of psychological service delivery systems in meeting the needs of psychological wellbeing. The Government Gazette (White paper, 1997) stated that available mental health services are neither appropriate nor accessible to the majority of the population. Psychological services that do exist are provided through health care services, the education sector, religious organizations and other mental health workers, such as ministers of religion. Stones (1996) points out that most psychological practice in South Africa are privatised and are only available to more affluent service users who mostly comprise the white urban population. Pillay and Peterson (1996) suggest that the nature of psychological services in South Africa needs to undergo changes before such services can be regarded as relevant for the majority of the people of South Africa.

2.4.3. Psychology and its status in Botswana

Botswana does not have a long history of psychology as a profession, as compared with its neighbouring country, South Africa. Psychology is a relatively new discipline in Botswana; therefore there is little published literature. Botswana, with a population of 1.7 million (Central Statistics Office, 2001) has very few practising psychologists or registered counsellors. Those who practice in Botswana were trained either overseas or in the neighbouring countries, such as South Africa and Zambia. In addition, those who are trained in psychology mostly find employment in the areas of
lecturing, working in human resources departments, or other work not related to their areas of clinical training.

In Botswana, psychologists are required to register with the Botswana Health Professions Council (BHPC). The current situation is that the Botswana Health Professions Council (BHPC) Act only recognises and registers clinical psychologists and is silent about other categories (Botswana Health Professions Chapter 61:02). Therefore this indicates that there is an information gap in terms of an understanding of the scope of psychology as a profession in Botswana. There have however, been efforts to bring psychologists together to speak with one voice with regard to issues of credentialing and ethics, as well as lobbying for the recognition of psychology as a profession. After periodic efforts, the Psychological Association of Botswana (PAB) was formed in 2005 and was registered as an association in 2007 (Psychological Association of Botswana Handbook: 2007). Unfortunately the association does not have any powers to regulate and protect the practice of psychology or the provision of psychological services.

2.4.3.1. Training in psychology

In Botswana, training in psychology is provided at an undergraduate level. A psychology department was established at the University of Botswana in January 2004. The department offers two degree programmes at undergraduate level, namely a Bachelors Degree in Psychology (B.Psych) and psychology as a combined major (BA). The aim of the programme is to make students conversant with major areas of psychology and provide a foundation for professional practice and development in the future (University of Botswana Psychology Handbook, 2005/2006). The first cohort of undergraduate psychology students at the University of Botswana graduated in 2008. It is important to note however, that graduates at Bachelor’s level would have to pursue post-graduate study outside of Botswana to become registered psychologists. The university does not currently offer postgraduate degrees in psychology (University of Botswana Psychology Handbook, 2005/2006).

2.4.3.2. Psychological services in Botswana

Botswana is grappling with issues, such as social problems, psychological problems and problem behaviours, HIV/AIDS, as well as the need for psychological
assessment in the workplace. According to Moagi-Gulubane (2007), these issues may have a direct impact on the development and the economy of the country if not handled professionally. Mahatelo and Makgekgenene (2004) stated that, in an attempt to address these issues, the Botswana government introduced and effected health and social welfare structures that provide counselling, psychological assessment and HIV/AIDS voluntary counselling and testing services (VCT). They further stated that the impact of these structures has been inhibited, either by a lack of awareness of such services by the public or underutilization of the services by primary health care providers. The ability of a nation or community to withstand social crises or serious conflicts is directly related to the quality of health, as well as the psychological wellbeing of the nation.

Psychological services that do exist in Botswana are provided through health and welfare structures and the education sector. Other psychological services that exist belong to non-governmental organisations and agencies (Directory of Counselling Services in Botswana, 2001), religious organizations, traditional doctors and family members also play a major role in rural areas. Below is a table from the Directory of Counselling Services in Botswana (2001), indicating some of the government institutions and non-governmental organizations that offer psychological services.

Table 1: Psychological services offered in Botswana

<table>
<thead>
<tr>
<th>CITY</th>
<th>INSTITUTION</th>
<th>COUNSELLING SERVICES OFFERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Francistown</td>
<td>Peer Approach to Counselling by Teens</td>
<td>Equip youth with social skills and relationship management</td>
</tr>
<tr>
<td>Francistown</td>
<td>Young Women’s Christian Association (YWCA)</td>
<td>Youth counselling and peer pressure management skills</td>
</tr>
<tr>
<td>Francistown</td>
<td>Red Cross Blood Donation Programme</td>
<td>Pre-and post-blood donation counselling to blood donors</td>
</tr>
</tbody>
</table>
| Francistown     | Tebelopecle Voluntary Counselling and HIV Testing Centre | Pre-and-post counselling for HIV testing  
Counselling services to individuals directly or indirectly affected by HIV/AIDS |
<table>
<thead>
<tr>
<th>CITY</th>
<th>INSTITUTION</th>
<th>COUNSELLING SERVICES OFFERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gaborone</td>
<td>Bana Consultancy (BANACO)</td>
<td>Provide information and assistance to professionals working with children and their families</td>
</tr>
</tbody>
</table>
| Gaborone| Botswana Family Welfare Association (BOFWA)                                 | Advocate and provide information and education on human growth, reproduction and sexual development  
|         |                                                                             | Advice on pre-marital and marital counselling, family and couple counselling                  |
| Gaborone| Careers and Counselling Centre, University of Botswana                       | Career assessment and counselling                                                            |
| Gaborone| Coping Centre for People Living with HIV/AIDS                                | Counselling services to people living with HIV/AIDS                                         |
| Gaborone| Holy Cross Hospice                                                          | Facilitate and strengthen support groups of people living with HIV/AIDS                      |
| Gaborone| Tirisanyo Catholic Commission                                                | Behavioural change based on Christian teaching  
|         |                                                                             | Provide care and counselling services to individuals living with HIV/AIDS and orphans       |
| Gaborone| Tshepong Counselling Network                                                 | Psychotherapeutic interventions                                                            |
| Gaborone| Guidance and Counselling Division, Curriculum Development and Evaluation    | Career counselling  
|         |                                                                             | Job placement and skills training                                                           |
| Gaborone| Tebelopele Voluntary Counselling and HIV Testing Centre                     | Pre-and-post counselling for HIV testing  
|         |                                                                             | Counselling services to individuals directly or indirectly affected by HIV/AIDS             |
In an attempt to offer psychological services at health centres, government policymakers introduced psychological services at primary health care level. Clinical psychologists are attached to the three main referral hospitals of Botswana, namely Marina and Nyangabwe Referral Hospitals and Lobatse Mental Hospital (Ministry of Health, 2003). Psychological services at community health centres are often offered by medical doctors, nurses and social workers who do not have the relevant training in psychological intervention skills. In an attempt to provide psychological services, these professionals may not be able to give attention to the diverse causes of psychological problems or they may lack the expertise to offer psychological intervention.

At school level, the guidance and counselling division in the Ministry of Education is charged with the responsibility of providing psychological services in Botswana’s schools, from pre-primary schools to tertiary institutions. Psychological services are offered by trained guidance and counselling teachers who adhere to the ethical principles of counselling. They provide counselling to individuals and groups on a wide range of issues (Ministry of Education, Guidance & Counselling Division, 2007).

As psychology as a profession is a relatively new discipline in Botswana, this may result in the role of a psychologist in the health care setting and the community in general being unclear. The fact that social workers, counsellors and guidance and counselling teachers are charged with the responsibility of offering psychological services, and therefore function as psychologists, adds to the misconception regarding the roles of these professionals.

Botswana has outlined a longer-term vision to be achieved by 2016, including the goal of building a compassionate, just and caring nation that addresses the need to strengthen the health care system and to ensure that Botswana is a healthy nation so that its citizens can contribute meaningfully to the country’s development (Long-Term Vision for Botswana, 2004). This requires a coordinated programme of health promotion and disease prevention services, as well as a functioning primary health system and the provision of high quality health services to those who require secondary and tertiary care (Long-Term Vision for Botswana, 2004). One of the ways to the enhance realization of the goals of vision 2016 with regard to health promotion is to explore the awareness of psychological services within the health care system, to assess the attitudes of health care providers towards psychology and to explore their referral practices with regard to
psychological problems. According to Vogelman (1990), the important ingredients for achieving appropriate service delivery include a multi-disciplinary team approach, preventative interventions and the appropriate use of health professionals.

As psychology is part of the mental health care system which falls under the portfolio of primary health care, a brief structure of the primary health care system and mental health care in Botswana will be explained.

2.4.3.3. Primary Health Care in Botswana

Health care is usually seen as a basic need within a nation’s housekeeping. At independence in 1966, Botswana inherited a largely curative, hospital-based health care system, which left the majority of the population without access to any services. In 1973 – 78 a network of basic health facilities was gradually established throughout the country with the aid of the Norwegian Agency for Development Co-operation (NORAD) and the United Nations International Children’s Emergency Fund (UNICEF) (A Manual of Health Services, 1992). In 1975, a separate Ministry of Health was established which was charged with the responsibility for the improvement of the health of the nation which included mental health care. The Ministry of Health then adopted the fifth National Development Plan (NDP 5) policy on Primary Health Care (PHC) which emphasized that the primary health care services provided must be appropriate, affordable to both people and the government and must also be easily accessible (Manual of Health Care Services, 1992). Subsequent to the adoption of this policy was the adoption of the World Health Organisation (WHO, 1990) which emphasized health for all by the year 2000. During the National Development Plan 6 (NDP 6) in 1985-1991, the policy again focused on Primary Health Care (PHC) and the aim was to integrate preventive, promotive, rehabilitative and appropriate curative services through the participation of community groups at all levels of national health care. The National Development Plan 7 (NDP 7) 1985 -1991 brought a shift towards an integrative approach where mental health forms an integral part of primary health care (Manual of Health Care Service, 1992).

Currently, two health care systems run concurrently in Botswana, namely the western and the traditional forms of health care. Every Botswana citizen has access to both traditional health care and western health care. The selection of which health care system to seek is influenced by the beliefs, customs and values of the people. The
western health care inherited at independence in 1996, as previously stated, was largely curative hospital-based care and most Batswana did not have access to the western health care systems (Mental Health Action Plan, 1997). Seloilwe and Thupayagale (2007) explained that it is for these reasons that health care providers should take into cognizance the operations of these two systems and fully comprehend the belief systems of the people with whom they deal in order to accommodate the two systems. This makes it possible for the users to gain access to both traditional and western forms of health care.

The Botswana health care system is organized at different levels of sophistication and coverage. The lowest level is the outreach level where health care may be provided at a mobile stopping point. The next level is the health post that consists of small structures staffed by a nurse and a family welfare educator. The next level is the clinic, which is staffed by a community nurse assisted by visits from the medical practitioner. The nurses at these clinics offer health service and educative health projects, as well as carrying out immunization programmes. They are also charged with the responsibility of the provision of psychological services. The primary and district hospitals are the next level and they provide a range of services which includes a combination of curative and preventive services. These are staffed by medical practitioners and registered nurses, who mainly provide specialist services. The medical professionals also provide psychological services.

At the apex of the service pyramid are three main referral hospitals. These are the Marina Referral Hospital in Gaborone and the Nyangabwe Referral Hospital in Francistown. These are staffed with medical doctors and nurses, who mainly provide specialist services. Psychosocial service is provided by social workers and clinical psychologists attached to these referral hospitals (Ministry of Health, 2003). The third referral hospital is the Lobatse Mental Referral Hospital. This will be briefly discussed under mental health care.
2.4.3.4. Mental Health Care in Botswana

Mental health care should be seen as a basic need within a nation because of its important contribution to the quality of life of every individual. The government of Botswana, with the help of non-governmental organizations, is committed to the improvement of the mental health status of the Botswana nation. Botswana has a population of 1.7 million people (Central Statistics Office, 2001), and these are served by one mental hospital which is located in the southern part of the country, and serves as the referral hospital for the whole country (Mental Heath Action Plan, 1997). The Lobatse Mental Hospital was opened in 1944 and prior to that, persons with mental illnesses were treated in prison or at home by traditional practitioners. The Lobatse mental hospital cares for persons with a variety of mental illness, including those who are in need of custodial care, forensic patients, persons with developmental disabilities, persons with alcohol and drug problems and others who may be referred for mental status examinations (Mental Health Action Plan, 1997).

Psychological services are provided by psychiatrists, psychiatric nurses, clinical psychologists and social workers. Given the size of the country and the needs of the population, there have been steps to decentralize mental health services, and already more than six community mental health clinics situated across the country are in operation, providing regular outreach services to those people who can be treated in the community.

The World Health Organisation report (WHO, 2001) published a declaration that mental health care should form part of primary health care. The WHO Report (2001) stated that the integration of mental health care into the general health service, particularly at the primary health care level, had many advantages. The advantages include among others, less stigmatization of patients, as mental and behavioural problems will be managed alongside physical health problems, and the improved detection of patients presenting with vague somatic complaints related to mental and behavioural problems. Integration has the potential to improve the treatment of mental health problems associated with physical factors (WHO, 2001). In response to this declaration, the Botswana government developed the National Health Policy on mental health to provide a framework for the incorporation of the objectives of mental health into a general health care system and the integration of mental health care services into the
mainstream of the health care. The policy initiated community mental health care education and psychosocial skills for nurses based at community clinics, and the establishment of family support systems for mentally ill patients (Ministry of Health, 2003).

Integration of Mental Health Services into the general health system is currently practised in many countries in Sub-Saharan Africa. For example, in South Africa the Mental Health Service exists within the health care system, and has been a major component of the main institutional practice of curative care (Freeman, 2002).

Previous studies and research on psychological services have focused on issues related to psychology and its uses. In order to place the current study within the context of psychology and psychological services, related case studies will be briefly discussed.

2.5. Studies on psychological services

2.5.1. International studies on psychological services

Several international studies have focused on a topic similar to the present study. These include research by Morgan and Killoughery (2003) and Constantine, Myers and Moore (2004). Morgan and Killoughery (2003) revisited a study previously conducted by Mayou and Smith in 1986 on hospital doctors’ management of psychological problems and their attitude towards psychology, as well as their referral practices. The survey was conducted at St. George’s hospital in London and the survey results indicated that hospital doctors’ attitudes to psychological factors showed heightened awareness of the relevance of these factors compared with previous studies. There appeared to be a greater desire for and interest in liaison with the field of psychology, as doctors’ time was more constrained and this affected the capacity of the medical doctors to conduct biopsychosocial assessments, despite an awareness of their relevance. The results also reflected that there was a need for hospital doctors to be able to make use of simple psychological methods. Most of the respondents indicated that psychological factors could influence the physical prognosis and should be routinely assessed. In terms of referral practices, the common reason for not referring patients to psychological services was the belief that patients dislike referrals and fear stigmatisation (Morgan & Killoughery, 2003).
Constantine et al. (2004) discussed the cultural relevance of indigenous healing in promoting psychological, physical and spiritual wellbeing in people of colour in the United States of America. According to Constantine et al. (2004), the use of indigenous healing methods depends on culture, acculturation, the affordability of western-based approaches and language proficiency. These issues are related to the formal use of psychological services among people of colour and suggest that some individuals are hesitant about speaking to a psychologist, counsellor, social worker, or psychiatrist. The results reflected that there is a potential stigma associated with seeking formal psychological intervention, and this may cause individuals to resort to other forms of helping and healing that are less stigmatising and more indigenous. Constantine et al. (2004) noted that previous studies reveal that there is a tendency for people of colour to turn to more informal sources of dealing with psychological problems, such as family members, friends and indigenous healers. They view indigenous healers and resources as adjuncts to, rather than substitutes for, western healers. However, because of biases they may have regarding the use of formal psychological services they would rather access psychological intervention. Some people of colour may seek assistance only from indigenous healers to address their psychological problems and problem behaviours (Constantine et al. 2004). The health care system setting in this study is similar to the setting in Botswana, where two health care systems run concurrently, namely the western and the traditional forms of health care systems. The selection of which health care system to use is influenced by beliefs, customs and the values of the people. It may be assumed that the use of traditional forms of healing may affect referral practices of psychological problems to psychological services.

2.5.2. South African studies

There have been several studies conducted in South Africa concerning the public image of psychology and its uses. Such research includes studies by Stones (1996), Lupuwana and Simbayi (1996), and Mokgale (2003).

Stones (1996) conducted a survey on attitudes toward psychology, psychiatry and mental illness in the Central Eastern Cape of South Africa. The sample consisted of university students, psychologists, general medical practitioners, members of the public, psychiatric hospital staff and patients. It was found that marked differences existed
between the different samples and the extent of a person’s knowledge on mental illness, as well as the degree of contact with psychological services. These were all important influences on the attitudes of respondents. The findings reflected that medical practitioners believed psychiatrists to be the most effective in dealing with psychological problems. The results also indicated that when dealing with an emotional or mental crisis, general practitioners favoured psychiatrists, while psychologists favoured clinical psychologists and the general public preferred a friend. The findings that general practitioners favoured psychiatrists over clinical psychologists suggest that most medical referrals are likely to be made to a psychiatrist (Stones, 1996).

Lupuwana and Simbayi (1996) conducted a descriptive-based survey study to establish the awareness, attitudes towards, and practices of the black community of Port Elizabeth with regard to psychology and its uses. The survey revealed that the respondents were aware of psychology. Their attitude towards psychologists and their profession was positive. However, the actual use of psychological services was low. It was recommended that there was a need for the introduction of community-based psychological services (Lupuwana & Simbayi, 1996).

A study conducted by Mokgale (2003) to determine knowledge about and attitudes towards psychological services of the Hebron community, a rural village in South Africa, indicated that there was a reasonable level of knowledge about psychological services and the attitude towards psychological services depended on whether the people had had a positive experience with a psychologist or not. Results also indicated that the community expressed the need for psychological services to be made available in the community and that there should be awareness talks regarding these services.

On the basis of the above studies, there is an indication that there is similarity in terms of the findings on the use of psychology and psychological services. Findings reflect that there is an awareness of the available psychological services and the need for the provision of psychological services. There is no similar study regarding psychology and psychological services in Botswana. Studies conducted in mental health care in Botswana will add relevant information to the study.
2.5.3. Botswana studies

The current study on psychology and psychological services is a new study in Botswana. The only literature available is on mental health care in general. Available literature includes a proposal on the integration of mental health care services into the general health care health care system by Tema (2004) and a journal article on community mental health care by Seloilwe and Thupayagale-Tshweneyagae (2007).

Tema (2004) proposed the integration of mental health care services into the general health care system. Tema’s proposal (2004) pointed out that integration of mental health services without proper training of health care providers could lead to adverse effects for patients because Tema (2004) suggested that medical professionals could find it difficult to deal with psychiatric patients due to insufficient skills and training in mental health care. Tema (2004) emphasized that the success of integration of mental health care into the general health care system could be accomplished through the training of medical professionals in mental health care and psychosocial skills. These have been found to be essential for health care providers.

A journal article by Seloilwe and Thupayagale-Tshweneyagae (2007) reviewed developmental trends in community mental health care in Botswana. The Botswana National Health Policy on mental health care was developed to provide a framework for the integration of mental health service into the mainstream of health care service delivery system. According to Seloilwe and Thupayagale-Tshweneyagae (2007), the implementation and success of the policy faced some difficulties and challenges. These included among others shortage of trained professionals in mental health care skills and the availability of mental health care support services in the community.

2.6. Conclusion

This chapter has briefly reviewed the literature on the development of psychology and psychological services focusing on Sub-Saharan African. The status of psychology and the provision of psychological services in Botswana was explored to determine the state of provision of psychological services in general health care. It is evident from the literature that no studies on psychology and psychological services have been done in Botswana, there is only limited information on the provision of psychological services.
CHAPTER 3
Psychological Theories

3.1 Introduction

This chapter explains psychological theories with regard to the constructs of awareness, attitude and referral practice, focusing on the consistency model of attitudinal components and the theory of reasoned action on which the research is based. The chapter also outlines the use of psychological interventions in health care service delivery and briefly discusses biopsychosocial and biomedical models in view of the management of psychological problems.

3.2. Awareness

Awareness, for the purpose of the study, refers to knowledge of or familiarity with a subject or object and an understanding of it. According to Seedat et al. (2003), the knowledge that we have as human beings does not exist in isolation; rather there are factors that affect our knowing. He further outlines an important assumption about the nature of knowledge, namely, that it can be replaced or corrected in the ordinary course of experience. Thus, as we learn more about issues we can correct our ideas, thoughts and beliefs about them. Stones (1996) also emphasized the importance of knowledge and the fact that this knowledge changes with experiences. In this case, we may assume that awareness of psychological services by health care providers may result in the utilization of the available psychological services.

3.3. Attitudes

The concept of attitudes has been regarded as the central concept in the field of social psychology and has been difficult to define, as very different views on attitudes are still prevalent. Each of the traditional definitions of attitudes contains a slightly different concept of what an attitude is or it tends to emphasise a different aspect of it (Foster & Nel, 1991). Foster and Nel (1991) further explain that there is contemporary debate about attitudes between the American “individualistic” perspective and the European perspective. The American “individualistic” perspective locates an attitude regardless of how complex it is, in the head of the individual and this is then assumed to cause or direct behaviour, while the European perspective adopts a more “social” approach which states
that social representations are not evaluative stances towards objects, but are social in that they are shared by many people, provide a social code for naming and classifying objects and assist in establishing a social order which enables individuals and groups to orient themselves. The individualistic conception of attitudes has become the dominant approach, due to the dominance of American social psychology. However, several strands of thought have remained common in the definition of attitudes. These include one where an attitude is seen as directing or “causing” subsequent behaviour; secondly, an attitude is viewed as a state of response which cannot be observed directly, but rather has to be inferred from a behavioural response. It is therefore a hypothetical measure which cannot be measured; and thirdly, an attitude is learnt and is located either mentally or neurally in the individual (Foster & Nel, 1991).

Foster and Louw-Potgieter (1991) define an attitude as “a mental state of readiness, organised through experiences, exerting a directive or dynamic influence upon the individual’s responses to all objects and situations with which it is related” (p.124). They further explain that the attitudes that people have are influenced by factors, such as information and the manner in which it was gained, contact with and exposure to that situation or object. They further state that individuals’ attitudes do not exist in isolation, but rather depend on meanings which are contextually and culturally shared (Foster & Louw-Potgieter, 1991).

Research on attitudes has led to the development of two main theoretical stances in the field of attitudes studies. These are the functionalist and the structuralist paradigms. The functionalist approach examines the functions of attitudes. The structuralist theories of attitude state that attitudes are held because of a need for consistency with other elements, or because they are derived from sets of beliefs (Foster & Nel, 1991). Examples of structuralist theories include the cognitive consistency theory, expectancy theory and the theory of reasoned action (Astbury, 1995). The theory of reasoned action is relevant to this study; it will be reviewed briefly.

It is evident from the research on attitudes, that they are important in understanding the individual’s behaviour towards an object or subject. The beliefs, attitudes and attributes that individuals hold are important in explaining and predicting their behaviour. Therefore the assumption is that if health care provides positive attitudes
towards psychological services, there is likelihood that they will utilise psychological services.

3.4. **Referral practices**

These are defined as sending somebody who needs professional help to a person who can provide professional assistance (Hornby, 2000). These can also be explained in terms of the interaction between two or more professionals. According to Gottlieb and Olfson (1987), psychological service referral practice is a process and goes through stages. They identified three stages of the referral process as: the identification of the psychological problem, the decision to refer and the selection of the treating professional. The referral process depends on an organizational structure that is the stipulated referral protocol to be followed before involving other professionals. Gottlieb and Olfson (1987) outlined the following factors that shape and define referrals: the health care practitioner’s ability to recognise and define the psychological problem; the practitioner’s perception towards psychological services; inter-practitioner’s relations; the availability of psychological services; and the patient’s attitudes towards the referral.

Stones (1996) mentions that an individual’s education and exposure to professional service determines how positive or negative they are about the profession. From this he concludes that more knowledge leads to more positive attitudes and the desire to have more contact with the profession will follow. Therefore, the assumption is that if health care providers are aware of the effects of psychological factors in the management of physical illness, and are aware of available psychological services, they are more likely to refer psychological problems to psychologists.

There are many theories available to explain and predict behaviour. In order to provide a context for understanding the present study, the Consistency model of attitudinal components and the theory of reasoned action relevant to the constructs of awareness, attitude and referral practices will be reviewed.
3.5. The consistency model of attitudinal components

The study is couched in the consistency model of attitudinal components, which states that an attitude is a consistent system of beliefs, emotions and behaviours organised about the particular object (Middlebrook, 1988). This theory suggests that beliefs about a particular object can dictate emotional reactions towards that object and in turn result in behaviour or action. According to Marteau (1989), the cognitions of health professionals have not been the focus of much research because it is implicitly accepted that the behaviour of health professionals is based on medical knowledge, which is an empirically derived set of shared beliefs. Thus their beliefs and behaviour are assumed to be independent of the context. However, Taylor, Peplau and Sears (1994) assert that there is much variation in the practice of health professionals because much medical knowledge is ambiguous and few services are absolutely essential. The practice of health professionals may be influenced by their beliefs and attitudes. Based on this reasoning, health professional’s beliefs and understanding of the role of psychological factors in the management of physical illness may lead to greater referral of patients to psychological services for psychological assessment. Hewstone and Stroebe (2001) maintain that an individual’s attitude towards something depends on the subjective values or utilities attached to the possible outcomes of that action.

3.6. The theory of reasoned action

This theory is based on the assumption that a person’s behaviour is under voluntary control and is therefore greatly guided by intentions (Azjen, 1988). According to Sheridan and Radmacher (1992), an intention towards behaviour is influenced by our attitude towards that behaviour. This attitude is influenced by the strength of the belief that the behaviour will result in a certain outcome, and by the evaluation of the outcome. Intention is also determined by what people believe others think about their ability. This is termed the subjective norm. The theory of reasoned action proposes that attitudes regarding the behaviour and the subjective norm combine to produce an intention, which then leads to the performance of a behaviour (Sarafino, 1990). Based on this reasoning, if health care providers are aware of the role of psychological problems in the management of psychological problems, and acknowledge
that patients need psychological intervention, they will refer patients to psychological services without any stigma being attached to the condition of the patient.

3.7. The use of psychological interventions to improve health care

Bowden and Burstein (1989) emphasized the need for direct access and availability of psychological services at primary health care level for improved health care service delivery. The suggestion was that, primary health care should be carried out by multi-disciplinary professionals. WHO’s policy making body maintained that the main social targets of governments and WHO should be the attainment of a level of health that will allow people to lead a socially and economically productive life (Schmidt et al., 1990). This could only be attained if health care professionals work as a team to promote health, prevent diseases, alleviate unavoidable disease and disabilities, and ensure that all are healthy enough to work productively and to participate in the social life of the community (Bishop, 1994). According to Schmidt et al (1990), more emphasis is always given to physical illness than psychosocial problems, but it is evident that psychological and behavioural problems are widely prevalent, constituting a distressing burden on the community, and are very often brought to the attention of health care providers, but not often adequately assessed and treated. Practically, it is difficult for health care providers to deal with both physical and psychological complaints and the problems of patients since they don’t have sufficient knowledge and skills in psychological intervention (Bowden & Burstein, 1989). Bishop (1994) emphasizes that accuracy in the diagnosis of psychological problems requires that the health professional has well-developed interviewing skills, as well as a basic understanding of the psychological, social, and cultural determinants of the symptoms reported.

Mental health consultation will be briefly discussed now to show the importance of interaction between the health professionals. The biomedical and biopsychosocial models will be outlined to help explain how an increase in the awareness of the complex relationship and multiple dimensions of health and illness, has led to the evolution of the biomedical to the biopsychosocial model of understanding and explaining mental and physical illness (Sheridan & Radmacher, 1992).
3.8. Health care consultation

The term consultation is used in many ways. However, for this study, consultation will be used to refer to the interaction between two or more professionals. Brown and Lent (2000) define consultation as a process of interaction between two or more professionals in which one professional seeks the help of a specialist in a particular area. He further stresses that consultation is necessary amongst care-giving professionals, such as doctors, nurses, psychologists, psychiatrists, teachers, lawyers and welfare workers, to assist them in dealing with both physical and psychological aspects effectively. Bishop (1994), views the consultation relationship as being non-hierarchical. Both professionals are viewed as experts in their own area of speciality.

Brown and Lent (2000) outline the fundamental assumptions that underlie health care consultations. They stress that it is important for medical professionals to consult with psychology professionals as intrapsychic and environmental factors are important in explaining psychological problems and behaviour change. Another assumption is that consultation is important in designing effective interventions, as each professional is embedded in a profession with norms and ethics. They further state that learning and generalization occur when professionals retain the responsibility for their consultations. Lastly, they assume that psychological intervention consultation is a supplement to other physical illness management (Brown & Lent, 2000). In view of this, the availability and the accessibility of psychological services in health care service delivery may result in health care providers being more open to psychological services and will refer psychological problems for psychological intervention.

3.9. The biomedical model

The biomedical model has been the leading model of medical intervention since the nineteenth century, and has governed the thinking of most health practitioners for the last 300 years (Taylor, 1991). It is a medical model which emphasizes the separation of mind and body and emphasizes the physical causation of disease (Bishop, 1994). This model has been strongly influenced by Cartesian dualism. Cartesian dualism defines mind and body as separate substances. Sheridan and Radmacher (1992) explained that within the framework of the biomedical model, only the biochemical factors of illness are considered. Social, psychological and behavioural dimensions fall outside its narrow
framework and are therefore ignored in the management of physical illness. Sheridan and Radmacher (1992) further explained that the narrow framework of the biomedical model does not fit in with the social and psychological influences of today’s health problems. It does not promote prevention, health enhancement or individual responsibility.

Although the biomedical model has undeniably been successful in the fight against disease in the health care system, it is unable to explain why everyone exposed to a disease does not develop the disease, or the influence of psychological and social factors on the development and treatment of the illness and the relationship to the therapeutic outcome. Failure to address these factors has led to the development of the biopsychosocial model which emphasizes that psychological and social factors influence biological functioning and play a role in health and illness. It is for this reason that this study seeks to determine the attitudes of health care providers towards psychological services, as these attitudes will influence their referral practices.

3.10. The biopsychosocial model

The biopsychosocial model is a systems approach that emphasizes the interconnectedness of mind and body and the importance of understanding diseases at all levels (Bishop, 1994). According to Vanker, Carlie and Du Plessis (1990), the biopsychosocial model is the most comprehensive model of health and disease. They maintain that this model provides an approach to the understanding of the development, assessment and management of physical diseases and mental disorders. This model, based on the general systems theory, outlines the biological, psychological or social functioning of a system and views health care in a holistic way (Vanker, et al. 1990). A systems approach emphasizes the mutual dependence of each system within the whole, and suggests that a change in one system will produce changes in the other systems (Bishop, 1994). Within the biopsychosocial model, health care professionals must function as a system for an accurate diagnosis and the appropriate treatment plans. The assumption therefore, is that health care professionals will refer psychological problems to psychologists, as it is necessary to consider factors, such as life changes and social problems, because they provide more insight into the onset and course of physical illness.
This in turn will result in accurate diagnosis and hence adequate intervention in the management of physical health.

3.11. Conclusion

This chapter has briefly defined the constructs of awareness, attitude and referral practices within the context of the study. The consistency model of attitudinal components and the theory of reasoned action relevant to these constructs have also been discussed. The use of psychological intervention to improve health care was briefly outlined. The biomedical model which has governed the thinking of most health practitioners was discussed to determine how it influences their attitudes and referral practice to psychological services. The biopsychosocial model which resulted from the dissatisfaction with biomedical model has also been discussed. The biopsychosocial model emphasises the importance of the assessment of psychological and social factors in understanding illness at all levels; this in turn will result in referring psychological problems to psychologists for a proper diagnosis and treatment. The following chapter will discuss the methodology employed in conducting the study.
CHAPTER 4
Research Design and Methodology

4.1. Introduction

This chapter outlines the aims of the study. The methodology utilized in this study will be described, and this includes an outline of the research design, methodological approaches employed, the research measure utilized and piloting of the research measure. A description of the sample population and sampling procedure will be given. In addition, the chapter discusses the step-by-step process of data collection and analysis which includes descriptive statistics. It concludes with the ethical considerations which were adhered to when conducting the study.

4.2. Aims of the study

According to Vogelman (1990), the important issue for achieving appropriate health care service delivery includes a multi-disciplinary team approach, preventative interventions and appropriate referral to health care professionals. Therefore, the current study aims to:

(i) Explore and describe the awareness of available psychological services, of health care providers in Botswana;
(ii) Explore and describe the attitudes of health care providers towards psychological services in Botswana;
(iii) Explore and describe the referral practices utilised in relation to the psychological problems of health care providers in Botswana.

The information yielded from the study will hopefully be of use in assisting the design and implementation of effective psychological services in Botswana.

4.3. Research Design

This study adopted a quantitative, exploratory-descriptive approach. Data utilized were collected by means of survey questionnaires. Quantitative research seeks to explain the occurrence of a particular phenomenon. The data yielded by quantitative research,
which are usually collected by the use of a standardized instrument, are usually in the form of numbers and graphs which are interpreted in a few short sentences. Quantitative research methods are generally easy to replicate and hence have a high reliability (Aiken, 1997). On the other hand, a disadvantage of quantitative research is that the more structured data collecting approach may cause stress to the participants, thus not showing an accurate reflection of the true results (Neuman, 1997).

An exploratory research approach aims to gain familiarity with a phenomenon. According to Babbie (1990), the purpose of exploratory research is to gain insight into a relatively new and unstudied area. In this study, the phenomena explored are the variables of awareness of, attitudes towards and referral practices of health care providers to psychological services in Botswana. Babbie (1990) further explains that the conclusions drawn are tentative and the value of this type of research lies in the fact that it provides further research topics within the field of the present study. A descriptive research design aims to utilize precise measurements and reports on the characteristics of some population or a phenomenon that is under study. The objective is to explain what is taking place behaviourally, but not to give any causal explanations. According to Neuman (1997), descriptive research provides highly accurate pictures of the phenomenon or behaviour under study.

The exploratory-descriptive approach is used to collect detailed information on the status quo, and to determine any differences between variables. Since the current study adopted an exploratory-descriptive approach, it could motivate other researchers to conduct further investigations, and its findings can inform the Ministry of Health in formulating policies to improve psychological services in Botswana.

4.4. Methodology

One of the strategies for collecting information on public opinion or behaviour is by means of interviews or by questionnaires, which are a form of the survey research (Hewstone & Stroebe, 2001). A survey questionnaire was used to obtain relevant information from the participants. In survey research, questionnaires can be self-administered, where the participants record their own responses. This method of data collection enables the researcher to ask many people numerous questions in a short period of time.
Two national referral hospitals, namely the Princess Marina Referral Hospital and Nyangabwe Referral Hospital, their referring clinics and Social Welfare Departments were identified and approached to take part in this study. The Princess Marina Referral Hospital is in Gaborone which is in the southern part of Botswana. With a population of 186,007, Gaborone city is served by only one referral hospital and thirteen local clinics. Nyangabwe Referral Hospital is in Francistown which is in the northern part of Botswana. Francistown with a population of 83,049 is also served by one referral hospital and thirteen local clinics (Central Statistics Office, 2001). The choice of the two hospitals was based on getting a wider perspective on psychological services in Botswana. In addition, given the vast expanse of the country, it was easy to access the hospitals as well as the referring clinics in the surrounding areas. The clinics are staffed by registered nurses who are trained in the diagnosis and treatment of common diseases. Complicated clinical cases are referred to hospitals. The registered nurses also work in liaison with the social welfare department by referring psychosocial problems and problem behaviours to social workers. National referral hospitals provide specialist clinical services, preventive, curative and rehabilitative services (Manual of Health Services, 1992). There is one clinical psychologist and only a few social workers placed at each of the national referral hospitals, to provide psychological services.

The hospital superintendents of Princess Marina Referral Hospital and Nyangabwe Referral Hospitals were approached to obtain access and identify the participants across the spectrum of health profession disciplines. These comprise medical officers, nurses, psychiatrists, psychiatric nurses and social workers. Nursing sisters-in-charge at the local clinics were approached to obtain access to participants and the Chief Community Development officers were also approached to get access to social workers.

Data were gathered by means of a self-administered questionnaire. The advantage of using questionnaires is that they are cost- and time-effective in terms of administration, easy to score and code. The disadvantages of questionnaires include time and cost implications in designing the questionnaire. Participants are not always honest, and their subjective responses may bear little semblance to reality. Other disadvantages include incomplete responses, the likelihood of misunderstood questions and a low response rate.
In an attempt to overcome some of the disadvantages, participants were provided with the researcher’s contact number in the event of misunderstood items. The researcher personally delivered the questionnaires to the participants and collected the completed questionnaires. This system is preferable to having questionnaires mailed, as response rates are low.

4.5. **Sampling**

The participants were chosen based on a non-probability, purposive sampling method. This sampling method refers to procedures that are directed towards obtaining a certain type of participant (Dane, 1990). Non-probability purposive sampling has the advantage that the researcher has to use his or her own judgment and choose those participants who will best fit the purpose of the study. Its disadvantage is that since the probability that the person will be chosen is unknown, the researcher cannot claim that his or her sample is representative of the larger population (Whitley, 2001).

For the current study, two main referral hospitals in Botswana, that is Princess Marina Referral Hospital and Nyangabwe Referral Hospital, their referring clinics and Social Welfare Department were selected on the basis that medical doctors, nurses, psychiatrists, psychiatric nurses and social workers can be easily accessed across the spectrum of the discipline. Ninety-six health professionals participated in the study. The researcher attended the health professionals report meetings and asked for volunteers to take part in the study. The characteristics of participants consisted of both males and females, with a medical professional qualification and at least one or more years of work experience in the profession and having worked for either government or private hospitals. Participants were excluded from the study if they were psychologists, registered counsellors, occupational therapists, and adherence counselling nurses since they are trained and qualified to offer psychological services.

4.6. **Measure**

The instrument used in this study, is presented as Appendix A, and is a self-administered questionnaire, which the participants completed on a voluntary basis. The questionnaire explored aspects of awareness, attitudes towards and referral practices of health care professionals to psychological services in Botswana. There is no existing
study in psychological services in Botswana, and since this is a new study, the
questionnaire was developed by the researcher based on the relevant literature and in
consultation with experts in the field, so as to cover content validity. To ensure reliability
and validity, a statistician with expertise in item analysis was consulted in the
development process. The questionnaire is written in English, as this is the official
language of communication in Botswana. Considering the level of expertise of the
sample population, translation was not necessary. The questionnaire is divided into three
sections.

4.6.1. Biographical data section
Section A contains biographical data, such as gender, age, marital status,
professional qualifications and years of work experience in that profession and place of
work. Participants were requested to place a tick in the appropriate boxes. The responses
were then coded for scoring purposes. The frequency counts, percentages, means and
standard deviations were computed to describe the sample population.

4.6.2. Awareness Section
Section B covers the participant’s awareness of psychological services and
consists of four questions. Question 1 assessed the availability of psychological services,
and participants placed a tick next to the psychological services available in their health
care centre. Question 2 assessed the awareness of psychological services. Participants
indicated their level of agreement with the provided statement using the 5-point Likert
scale ranging from “Strongly disagree,” “Disagree,” “Neutral,” “Agree” to “Strongly
Agree.” Participants also had an option to write in any psychological services available
but not indicated on the list. Question 3 asked participants to indicate by “Yes” or “No”
whether there was a permanently employed psychologist in their health care centre.
Question 4 asked participants, who had ticked a “No” in question 3, to indicate by a tick
in the appropriate box, who offers psychological services in their setting. Participants
could tick more than one option. The responses were coded and total scores were
computed. The number of responses indicated the available psychological services, and a
few responses indicated the least available psychological services.
4.6.3. Attitudes and Referral Practices Section

Section C covers the participants’ attitudes and referral practices to psychological services, and consists of five questions. Question 1 assessed the attitude towards psychological services. Participants indicated their level of agreement to the statements provided, using the 5-point Likert scale, ranging from “Strongly Disagree,” “Disagree,” “Neutral,” “Agree” to “Strongly Agree.” Question 2 assessed the referrals to psychological services. Participants were asked to indicate from the given options how often they referred to psychological services. Question 3 asked participants to indicate with a tick from the given options how often they dealt with psychological problems. Question 4 asked participants to indicate with a tick from the given options what action they normally took to deal with the psychological problems. Question 5 asked participants to indicate with a tick from the given options, where or to whom they refer for psychological services. Participants also had an option to write in where they refer for psychological services if these options were not one of the given options. The responses were coded and frequency and percentages were then computed.

4.7. Pilot study

A questionnaire needs to be both reliable and valid. In other words, it should measure what it is designed to measure and should do so consistently (Foxcroft, Roodt & Abrahams, 2001). To ensure validity, the questionnaire was piloted to ten health care professionals at Orapa hospital in Botswana. These included five medical doctors, one psychiatric nurse and three registered nurses. The questionnaires were distributed to the participants with the help of the chief medical officer. The participants took ten to fifteen minutes to complete the questionnaire. The comments and questions arising from the pilot study were clarified and the questionnaire was amended accordingly. Piloting also helped the researcher to evaluate the strengths and weaknesses of the questionnaire before the actual study. This is in agreement with Babbie and Mouton (1998) who stated that piloting the instrument is the surest protection against any possible errors.

4.8. Procedure

A research proposal was presented to the academic staff and students of the department of psychology at the Nelson Mandela Metropolitan University. The
presentation garnered feedback that assisted the researcher to add value to the quality of the study. The presentation also served as a springboard for obtaining recommendations for the study. The research proposal was then submitted to the Nelson Mandela Metropolitan University Faculty Research Technology and Innovation Committee (FRTI) to obtain their approval for the study.

Permission to conduct the study in Botswana was applied for from the Ministry of Health and the Ministry of Local Government (Appendix B). After permission was granted by the two ministries (Appendix C), an application was submitted to the Research and Ethics Committees of the institutions of Princess Marina Referral Hospital in Gaborone and Nyangabwe Referral Hospital in Francistown to get approval to commence with the study (Appendix D). Application letters were also presented to the council town clerks and chief community development officers of Francistown and Gaborone in order to get their approval to conduct research in the clinics and social welfare centres (Appendix E).

After getting permission from the two National Referral Hospitals (Appendix F), the researcher then approached hospital superintendents to be introduced to the heads of departments. The researcher then made appointments with these heads of departments to get access to the participants. After permission to conduct the study at the clinic and welfare centres had been approved (Appendix G), the research appointed a Nursing sister-in-charge at the clinics and chief community development officers at the welfare centres to get access to the participants. To access the participants, the researcher was given permission to attend report-taking meetings for different departments, where the researcher explained the nature and purpose of the study and that participation was voluntary. The participants were informed that their responses would remain anonymous and confidential throughout the study. The participants were informed of the time taken to complete the questionnaire. Signed consent forms were obtained from the volunteers who agreed to take part in the study before completing the questionnaire (Appendix H). Questionnaires were then distributed to the participants to complete at their convenience and an appointment was made to collect the completed questionnaires. Completed questionnaires in sealed envelopes were collected from the heads of departments and the nursing sisters-in-charge.
Confidentiality and anonymity was ensured through the coding of each questionnaire with a unique number. This unique number was used for data capturing.

4.9. Data analysis

The data obtained were analysed according to the aims of the study. After the questionnaires had been collected, they were coded and scored for data capturing purposes. Due to the quantitative nature of this study, the Statistical Package for the Social Science better known as SPSS was used to analyse the data obtained with the help of the Nelson Mandela Metropolitan University Mathematical Statistics Department. The data obtained from the biographical section were analysed using descriptive statistics to obtain the profile of the sample. Descriptive statistics were used and the frequency counts and percentages of the participants’ responses for the items were generated.

4.10. Ethical considerations

The research proposal for this study was presented to the Nelson Mandela Metropolitan University Faculty Research Technology and Innovation Committee (FRTI). The ethics approval was granted by the FRTI to complete the study. The research proposal was also submitted to the Health Research Unit in the Ministry of Health and Ministry of Local Government in Botswana. The Research and Ethics Committee of the respective institutions of Princess Marina, Nyangabwe and city clinics and social welfare departments were approached for their approval to conduct the study. Signed consent forms were obtained from the participants. All data collected remained confidential and the participants’ anonymity was protected through the use of codes.

4.11. Conclusion

This chapter has focused on the step-by-step process followed in this study. This included a discussion of the research design applicable to this study, information on the measure used and the pilot study, participants and sampling method, as well as the actual process of the research. The manner in which the data were analysed was also mentioned in this chapter and will be discussed in more detail in the chapter that follows.
CHAPTER 5

Results and discussion

5.1 Introduction

This chapter presents the results and discussion of the study. The aims were: 1) to explore and describe the awareness of the available psychological services of health care providers in Botswana; 2) to explore and describe the attitudes of health care providers towards psychological services in Botswana; and 3) to explore and describe referral practices utilized in relation to the psychological problems of health care providers in Botswana.

The results are discussed below in the same sequence according to the aims of the study and in the order of the survey questionnaire. The chapter starts with the biographical information of the participants; this is followed by a discussion of the descriptive statistics in each section.

5.2. Section A: Biographical Information

5.2.1. Gender

Table 2: Gender Distribution of Participants (N=96)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>n = 34</td>
<td>35%</td>
</tr>
<tr>
<td>Female</td>
<td>n = 62</td>
<td>65%</td>
</tr>
<tr>
<td>Total</td>
<td>N = 96</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 2 shows that 35% (n=34) of the participants were males and 65% (n=62) were females. The helping profession is known to be dominated by females, as it is a nurturing profession, so these findings may be seen as a reflection of the helping professions generally.
5.2.2. Age

Table 3: Age Distribution of Participants (N=96)

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 – 29</td>
<td>n = 22</td>
<td>23%</td>
</tr>
<tr>
<td>30 – 39</td>
<td>n = 40</td>
<td>42%</td>
</tr>
<tr>
<td>40 – 49</td>
<td>n = 24</td>
<td>25%</td>
</tr>
<tr>
<td>50 – 59</td>
<td>n = 9</td>
<td>9%</td>
</tr>
<tr>
<td>60+</td>
<td>n = 1</td>
<td>1%</td>
</tr>
<tr>
<td>Total</td>
<td>N = 96</td>
<td>100%</td>
</tr>
</tbody>
</table>

The results show that the participants’ ages ranged from 25 to 60+ years. Twenty-three percent (n=22) of the participants were within the age range of 25 to 29 years, 42% (n=40) were in the 30 to 39 years age range, 25% (n=24) were in the 40 to 49 years age range, with 9% (n=9) that were in the 50 to 59 years age range, and 1% (n=1) in the 60+ years’ age range.

The results indicate that 99% of the participants are within the age range of 25 – 59 years, which is consistent with the Botswana Public Service Act Chapter 26:01 (1998). This states that people are eligible for employment from the age of 18 and shall retire from the public service on attaining the age of 60 years.

5.2.3. Marital Status

Table 4: Participants’ Marital status (N=96)

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>n = 43</td>
<td>45%</td>
</tr>
<tr>
<td>Married</td>
<td>n = 45</td>
<td>47%</td>
</tr>
<tr>
<td>Divorced</td>
<td>n = 2</td>
<td>2%</td>
</tr>
<tr>
<td>Separated</td>
<td>n = 0</td>
<td>0%</td>
</tr>
<tr>
<td>Widowed</td>
<td>n = 6</td>
<td>6%</td>
</tr>
<tr>
<td>Total</td>
<td>N = 96</td>
<td>100%</td>
</tr>
</tbody>
</table>
The results show that 45% (n=43) of the participants are single, 47% (n=45) are married, 6% (n=6) are widowed and 2% (n=2) have been divorced.

5.2.4. Profession

Table 5: Profession distribution (N=96)

<table>
<thead>
<tr>
<th>Profession</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>n = 25</td>
<td>26%</td>
</tr>
<tr>
<td>Nurse</td>
<td>n = 47</td>
<td>49%</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>n = 1</td>
<td>1%</td>
</tr>
<tr>
<td>Psychiatric Nurse</td>
<td>n = 3</td>
<td>3%</td>
</tr>
<tr>
<td>Social Worker</td>
<td>n = 20</td>
<td>21%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>N = 96</td>
<td>100%</td>
</tr>
</tbody>
</table>

The results indicate that 26% (n=25) of the participants were doctors, 49% (n=47) were nurses, 21% (n=20) were social workers, 3% (n=3) were psychiatric nurses and 1% (n=1) was a psychiatrist.

The study was conducted in two National Referral Hospitals, one Private Hospital and eighteen clinics in Botswana. The clinics are staffed with nurses and the National Referral Hospitals are staffed with specialists, doctors and a few social workers (Manual of Health Services, 1992). The number of participating clinics explains the reason why there are more participants from the nursing profession.

5.2.5. Experience in the profession

Table 6: Years of work experience (N=96)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean</strong></td>
<td>7.00</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>8.34</td>
</tr>
<tr>
<td>Minimum</td>
<td>1.00</td>
</tr>
<tr>
<td><strong>Maximum</strong></td>
<td>30.00</td>
</tr>
</tbody>
</table>
The results presented in Table 6 show that the minimum years of work experience was 1, and the maximum years of experience was 30, with an average mean of 7 and a standard deviation of 8.34. The mean of 7 suggests that most of the participants were experienced. According to Jones (2004), the greater the number of years of work experience, the more professional the individual becomes. The years of work experience indicate that the participants have dealt with psychological problems in consultation and are probably aware of the effect of psychological problems in the context of physical illness.

5.2.6. Place of work

Table 7: Participants’ place of work (N=96)

<table>
<thead>
<tr>
<th>Place of work</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>n = 90</td>
<td>94%</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>n = 6</td>
<td>6%</td>
</tr>
<tr>
<td>Total</td>
<td>N = 96</td>
<td>100%</td>
</tr>
</tbody>
</table>

The results reflected that of the ninety-six (N=96) participants, 94% (n=90) were government employees and 6% (n=6) were from the private hospital. These results reflect the single private hospital located in one of the study areas.

5.3. Section B: Awareness of psychological services

The first aim of the study was to explore and describe the awareness of available psychological services of health care providers in Botswana. According to Stones (1996), the nature of knowledge that we have as human beings, or understanding and familiarity with an object or subject can change our perceptions and beliefs about that particular subject or object. It was for this reason that the awareness of available psychological services was explored.
5.3.1. Section B1: Availability of psychological services

Participants were given a list of psychological services and were asked to indicate the availability of those psychological services at their health care centres. Participants could indicate more than one psychological service. Participants were also allowed to indicate any other psychological services not in the given list but available in their settings. Table 8 shows the respondents’ responses to the availability of psychological services in their settings.

Table 8: Availability of psychological services (N=96)

<table>
<thead>
<tr>
<th>Psychological Service</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Psychotherapeutic intervention</td>
<td>n = 29</td>
<td>30%</td>
</tr>
<tr>
<td>2. Family and Couple counselling</td>
<td>n = 67</td>
<td>70%</td>
</tr>
<tr>
<td>3. Psychological Assessment</td>
<td>n = 39</td>
<td>41%</td>
</tr>
<tr>
<td>4. Career Assessment</td>
<td>n = 12</td>
<td>13%</td>
</tr>
<tr>
<td>5. Crisis Intervention and Management</td>
<td>n = 30</td>
<td>31%</td>
</tr>
<tr>
<td>6. Parent Support groups</td>
<td>n = 18</td>
<td>19%</td>
</tr>
<tr>
<td>7. Peer Approach Counselling</td>
<td>n = 36</td>
<td>38%</td>
</tr>
<tr>
<td>8. HIV/AIDS Voluntary Counselling &amp; Testing</td>
<td>n = 85</td>
<td>89%</td>
</tr>
<tr>
<td>9. Prevention of Mother-to-Child Therapy</td>
<td>n = 79</td>
<td>82%</td>
</tr>
</tbody>
</table>

The results show that 30% (n=29) of the respondents indicated psychotherapeutic intervention, 70% (n=67) indicated family and couple counselling, 41% (n=39) indicated the provision of psychological assessment, while 13% (n=12) indicated career assessment. Thirty-one percent (n=30) of the respondents indicated the availability of crisis intervention and management, 19% (n=18) indicated parent-support groups, 38% (n=36) indicated peer-approach counselling, 89% (n=85) indicated the availability of HIV/AIDS voluntary counselling and testing, and 82% (n=79) indicated the prevention of mother-to-child therapy. Additional information from the participants indicated the availability of trauma counselling, bereavement and grief counselling, home-based care support groups for people living with HIV/AIDS and psychosocial support for orphans.

Responses from the participants reflect that a variety of psychological services are available in their settings. It would be expected that HIV/AIDS voluntary counselling and testing, the prevention of mother-to-child therapy and family and couple counselling
would be available in most health care centres. These psychological services were introduced in an attempt to fight the pandemic disease of HIV/AIDS, as there is evidence that Botswana is one of the Sub-Saharan countries most affected by the epidemic. There are medical doctors and nurses trained in basic counselling skills and the management of HIV/AIDS. These medical professionals are attached to different clinics and are charged with the responsibility for the provision of psychological services to individuals who are directly or indirectly affected by HIV/AIDS (Botswana National Policy on HIV/AIDS, 1998).

5.3.2. Section B 2: Awareness of the role of psychological services

Participants were asked to indicate the adequacy, accessibility and effectiveness of psychological services indicated in section B1 above. Table 9 shows the results of the participants’ responses. Each statement will be discussed below and reference will be made to the Table.

Table 9: Participants’ awareness of available psychological services

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Psychological services available in your setting are adequate</td>
<td>n=23</td>
<td>n=31</td>
<td>n=18</td>
<td>n=19</td>
<td>n=1</td>
<td>n=92</td>
</tr>
<tr>
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<td>25%</td>
<td>34%</td>
<td>20%</td>
<td>21%</td>
<td>1%</td>
<td>100%</td>
</tr>
<tr>
<td>2. Psychological services are easily accessible to patients</td>
<td>n=20</td>
<td>n=30</td>
<td>n=16</td>
<td>n=24</td>
<td>n=1</td>
<td>n=91</td>
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<td>22%</td>
<td>33%</td>
<td>18%</td>
<td>26%</td>
<td>1%</td>
<td>100%</td>
</tr>
<tr>
<td>3. Psychological services which are available are effective</td>
<td>n=11</td>
<td>n=17</td>
<td>n=26</td>
<td>n=29</td>
<td>n=7</td>
<td>n=90</td>
</tr>
<tr>
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<td>12%</td>
<td>19%</td>
<td>29%</td>
<td>32%</td>
<td>8%</td>
<td>100%</td>
</tr>
<tr>
<td>4. If psychological services were readily available, I would refer to them</td>
<td>n=4</td>
<td>n=1</td>
<td>n=4</td>
<td>n=25</td>
<td>n=59</td>
<td>n=93</td>
</tr>
<tr>
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<td>4%</td>
<td>27%</td>
<td>63%</td>
<td>100%</td>
</tr>
<tr>
<td>5. Psychologists have little to offer in health care centres</td>
<td>n=58</td>
<td>n=14</td>
<td>n=5</td>
<td>n=7</td>
<td>n=5</td>
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<td>65%</td>
<td>16%</td>
<td>6%</td>
<td>8%</td>
<td>6%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Statement 1: Psychological services available in your setting are adequate.

Ninety-two participants responded to this statement. Fifty-nine percent (n=54) of the respondents disagreed or strongly disagreed with the statement that available psychological services were adequate. However, 22% (n=20) agreed or strongly agreed that psychological services available were adequate. Twenty percent (n=18) remained neutral.
These results reflect that available psychological services are not adequate. This is a reflection of the literature that Botswana does not have a long history of psychology or psychological services, as this is a relatively new profession. According to Mahatelo and Makgekgenene (2004), the few psychological services that exist are provided through health and welfare structures, the education sector and non-governmental organizations. Religious institutions and family members also play a major role in the provision of psychological support. The Manual of Health Services (1992) Act states that the Botswana national health policy was developed to provide a framework for the incorporation of the objectives of mental health care programmes into existing general health care services. However, the slow process of the implementation of the policy could be attributed to a shortage of trained professionals available to offer psychological services.

Statement 2: Psychological services available are easily accessible to patients.

Ninety-one participants responded to this statement. Fifty-five percent (n=50) of the respondents disagreed or strongly disagreed with the statement which states that psychological services available are easily accessible to the patients. Twenty-seven percent (n=25) of the respondents agreed or strongly agreed with the statement. Eighteen percent (n=16) of the respondents remained neutral.

The results reflect that available psychological services are perceived to be not easily accessible to patients due to the fact that psychologists are only based at national referral hospital and not at the clinical level (The Manual of Health Services, 1992).

Statement 3: Psychological services which are available are effective.

Ninety participants responded to this statement. Forty percent (n=36) of the respondents agreed to strongly agreed with the statement. Thirty-one percent (n=28) of the respondents disagreed or strongly disagreed with the statement, while 29% (n=26) of the respondents remained neutral. A total of 60% (n=54) of the respondents agreed or were neutral about the effectiveness of the available psychological services.

The results reflect that the majority of the respondents indicated that available psychological services are not effective. Mahatelo and Makgekgenene (2004) pointed out that the effectiveness of the welfare structures introduced by the government in health
care centres was not significant, and this has in fact been reflected by the findings of this study.

A similar concern regarding the effectiveness of psychological services in South Africa, the model country, is expressed in a study conducted by Mokgale (2003). Findings indicated that there was growing concern about the effectiveness and relevance of existing psychological service delivery systems in meeting the needs and psychological wellbeing of the community. Psychological services are neither appropriate nor accessible to the majority of the South African population.

Statement 4: If psychological services were readily available, I would refer to them.

Ninety-three participants responded to this statement. Ninety percent (n=84) of the respondents agreed or strongly agreed with the statement that they would refer to psychological services should they be available. Only 5% (n=5) disagreed or strongly disagreed with the statement, with 4% (n=4) being neutral.

The results reflect that the vast majority of respondents are aware of and have the knowledge of the role of psychological services. According to Levinson (1994), the nature of the knowledge that we have, or understanding and familiarity with an object or subject determines our behaviour about that particular subject or object. The fact that respondents are aware of the role of psychology and psychological services in the health care centres should influence their decision to refer to psychological services.

Statement 5: Psychologists have little to offer in health care centres.

To this statement, eighty-nine participants responded. These results reflect that 81% (n=72) of the respondents disagreed or strongly disagreed with the statement that states that psychologists have little to offer in health care centres. Fourteen percent (n=12) agreed or strongly agreed with the statement, while 6% (n=5) remained neutral.

These results reflect that respondents are aware that psychologists have a lot to offer in health care centres, as is reflected in their response that they would refer to psychological services if they were available. Cooper (2001) asserts that awareness helps to understand the meaning that respondents attach to something; in this case awareness of the effect of psychological problems in the management of physical illness influences the understanding of the role of psychological services. These findings reflect an awareness
noted by Bishop’s (1994) argument that psychologists play an important role in primary health care with regard to the accurate diagnosis and the appropriate psychological intervention.

5.3.3. **Section B3: Availability of psychologists to offer psychological services**

In section B3 of the questionnaire, respondents were asked to indicate whether there was a psychologist permanently employed to offer psychological services in their settings. Thirty-five percent (n=34) of the respondents indicated that there was a permanently employed psychologist to offer psychological services, while 65% (n=62) indicated that there was no psychologist permanently employed to offer psychological services in their settings.

The shortage of psychologists who can offer psychological services is a major problem in health care centres in Botswana. It is significant to note that the problem may continue to exist for some time in the future, since there is still a shortage of trained psychologists in the country. This may be exacerbated by the fact that the Botswana Health Professions Council (BHPC) only recognises and registers one category of psychologist, namely clinical psychologists, and is silent about other categories (Botswana Health Professions, chapter 61:02). The provision of psychological services still remains a problem even where there are permanently employed psychologists, due to the small number of clinical psychologists in proportion to the number of patients who require psychological care.

5.3.4. **Section B4: Provision of psychological services**

Respondents who indicated that there was no psychologist permanently employed in their settings were given options from which to choose when it came to who offers psychological services. The respondents could choose more than one option. Respondents were also allowed to indicate other professionals who offer psychological services which were not on the options list. Table 10 shows the results of the responses.
Seventy-four percent (n=46) of the respondents indicated that psychological services are offered by social workers, 71% (n=44) indicated nurses, 61% (n=38) indicated doctors, 40% (n=25) indicated psychiatric nurses and 19% (n=12) indicated psychiatrists.

Psychology is a relatively new profession in Botswana, and the provision of psychological services in health care centres is not yet well established. The findings of this study are a reflection of what is happening on the ground. In the absence of a psychologist, psychological problems are attended to by medical professionals and social workers. These findings reflect the situation established by the Manual of Health Service (1992) which states that clinical psychologists offer psychological services at national referral hospitals, while doctors and nurses are charged with the responsibility of the provision of psychological service at the clinic level. The fact that social workers, nurses and medical doctors are charged with the responsibility of offering psychological services, and therefore function as psychologists, results in the role of a psychologist being unclear to the patients in health centres and adds to the many misconceptions regarding the role of the social workers, nurses and doctors in comparison with those of psychologists. Other information provided by respondents indicated that psychological services are also offered by non-governmental organisations located around their settings.
5.3.5. **Summary of the findings on availability and awareness of psychological services**

The findings of this study reflect that 59% (n=54) of the respondents indicated that psychological services which are available are not adequate, and about 55% (n=50) of the respondents indicated that they are, in any case, not easily accessible to patients. Additional information provided by the respondents indicated that due to the inadequacy of psychological services within the health centres, non-governmental organisations (NGOs) are utilised. The respondents also reflected that available psychological services are not easily accessible and are not effective. Similar findings by Stones (1996) in South Africa indicated that the accessibility and availability of psychological services to the community were also a concern, despite the milestones which have been achieved in the growth and development of psychology as a profession and the delivery of psychological services in general. He pointed out that most psychological services are privatised, and as a result are only accessible to more affluent service users. An overwhelming 90% (n=84) of the respondents indicated that they would refer to psychological services should they be available; and 81% (n=72) of the respondents recognised the role that a psychologist can play in primary health care service delivery. The overall results show that respondents have a very strong awareness of the importance of psychological services. There appears to be a greater desire to liaise with psychological services through referrals, as respondents are aware of the contribution of psychological factors in physical illness.

5.4. **Section C: Attitudes and referral practices to psychological services**

This section deals with the participants’ attitudes towards psychology and psychological services, as well as their referral practices with regard to psychological problems. The results of the findings of the attitudes and referral practices of the participants will be discussed below and reference will be made to the relevant tables. As each table is discussed, parallels will be drawn between the literature and other information provided by the respondents.
5.4.1. Section C1: Attitudes towards psychological services

The second aim of the study was to explore and describe the attitudes of health care providers towards psychological services in Botswana. Participants were given a list of statements pertaining to psychological services and asked to indicate their level of agreement with each of the given statements. Table 11 shows the results of the participants’ responses to attitudes towards psychological services. Each statement will be discussed below and reference will be made to Table 11.

Table 11: Attitudes towards psychological services

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Management of psychological problems is a medical responsibility</td>
<td>n=23</td>
<td>n=23</td>
<td>n=16</td>
<td>n=18</td>
<td>n=12</td>
<td>n=92</td>
</tr>
<tr>
<td></td>
<td>25%</td>
<td>25%</td>
<td>17%</td>
<td>20%</td>
<td>13%</td>
<td>100%</td>
</tr>
<tr>
<td>2. Management of psychological problems is mainly the responsibility of psychologists</td>
<td>n=16</td>
<td>n=22</td>
<td>n=7</td>
<td>n=25</td>
<td>n=22</td>
<td>n=92</td>
</tr>
<tr>
<td></td>
<td>17%</td>
<td>24%</td>
<td>8%</td>
<td>27%</td>
<td>24%</td>
<td>100%</td>
</tr>
<tr>
<td>3. It is important for medical doctors to assess psychological problems</td>
<td>n=5</td>
<td>n=2</td>
<td>n=7</td>
<td>n=48</td>
<td>n=31</td>
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<td>5%</td>
<td>2%</td>
<td>8%</td>
<td>52%</td>
<td>33%</td>
<td>100%</td>
</tr>
<tr>
<td>4. Medical doctors should treat psychological problems</td>
<td>n=15</td>
<td>n=17</td>
<td>n=24</td>
<td>n=27</td>
<td>n=10</td>
<td>n=93</td>
</tr>
<tr>
<td></td>
<td>16%</td>
<td>18%</td>
<td>26%</td>
<td>29%</td>
<td>11%</td>
<td>100%</td>
</tr>
<tr>
<td>5. I frequently discuss psychological problems with patients</td>
<td>n=1</td>
<td>n=4</td>
<td>n=15</td>
<td>n=55</td>
<td>n=15</td>
<td>n=90</td>
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<tr>
<td></td>
<td>1%</td>
<td>4%</td>
<td>17%</td>
<td>61%</td>
<td>17%</td>
<td>100%</td>
</tr>
<tr>
<td>6. Psychological factors are important in the cause of the physical illness</td>
<td>n=1</td>
<td>n=1</td>
<td>n=8</td>
<td>n=34</td>
<td>n=42</td>
<td>n=86</td>
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<td>1%</td>
<td>9%</td>
<td>40%</td>
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</tr>
<tr>
<td>7. When psychological problems appear to be an important cause of the presenting problem, I confine myself to physical treatment</td>
<td>n=38</td>
<td>n=37</td>
<td>n=7</td>
<td>n=6</td>
<td>n=2</td>
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<td>7%</td>
<td>2%</td>
<td>100%</td>
</tr>
<tr>
<td>8. I would like to know more about what psychologists have to offer in the management of medical problems</td>
<td>n=0</td>
<td>n=1</td>
<td>n=4</td>
<td>n=37</td>
<td>n=48</td>
<td>n=90</td>
</tr>
<tr>
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<td>1%</td>
<td>4%</td>
<td>41%</td>
<td>53%</td>
<td>100%</td>
</tr>
<tr>
<td>9. I would like more contact with psychological services through referrals</td>
<td>n=0</td>
<td>n=2</td>
<td>n=6</td>
<td>n=34</td>
<td>n=51</td>
<td>n=93</td>
</tr>
<tr>
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<td>37%</td>
<td>55%</td>
<td>100%</td>
</tr>
<tr>
<td>10. Psychological services should be made available at health care centres</td>
<td>n=0</td>
<td>n=0</td>
<td>n=1</td>
<td>n=21</td>
<td>n=72</td>
<td>n=94</td>
</tr>
<tr>
<td></td>
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<td>22%</td>
<td>77%</td>
<td>100%</td>
</tr>
<tr>
<td>11. It is necessary to have permanently employed psychologists in health care centres</td>
<td>n=0</td>
<td>n=0</td>
<td>n=1</td>
<td>n=24</td>
<td>n=69</td>
<td>n=94</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>26%</td>
<td>73%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Statement 1: Management of psychological problems is a medical responsibility.

Ninety-two participants responded to this statement. Fifty percent (n=46) of the respondents disagreed or strongly disagreed with the statement which states that the
management of psychological problems is a medical responsibility. Thirty-three percent (n=30) agreed or strongly agreed with the statement, while 17% (n=16) were neutral.

Overall results reflected that respondents agree that management of psychological problems is not a medical responsibility. This concurs with Schmidt et al. (1990) who posit that practically it is difficult for medical professionals to deal with both physical and psychological problems, since they don’t have sufficient knowledge and skills in psychological intervention.

Statement 2: Management of psychological problems is mainly the responsibility of psychologists.

Nine-two participants responded to this statement. Results indicate that 51% (n=47) of the respondents agreed or strongly agreed with the statement that management of psychological problems is the responsibility of psychologists. Forty-one percent (n=38) of the respondents disagreed or strongly disagreed with the statement, while 8% (n=7) remained neutral.

Overall results reflected that respondents agreed that the management of psychological problems is the responsibility of psychologists. The results of the study concur with those of Freeman (2002) who stressed that psychological problems are widely prevalent and constitute a distressing burden on any society. He further emphasised the need for psychological problems to be handled by professionals trained in psychological assessment and intervention. The fact that medical professionals and social workers are charged with the responsibility of psychological services in Botswana may result in psychological problems being inadequately assessed and treated, as these professionals are not adequately trained in psychological intervention. According to Bishop (1994), the assessment and management of psychological problems requires well-developed interviewing skills, as well as an understanding of the psychological, social and cultural determinants of the symptoms presented. Lack of such skills may result in psychological problems not being adequately assessed.

The results of the study confirm that the role of psychology and psychologists in the health field has evolved over the years. Most psychologists have defined their role within the health care system as being that of speciality care of psychological wellbeing, within the health care system (Schmidt et al., 1990). As a result, their contribution has
been felt within the medical health care service as one of providing psychological assessment and intervention, acting as consultants to other professionals in the prevention of illness and the promotion of health. Literature has revealed that in South Africa, the demand for psychological service has increased and acquired a particular status. The assistance of psychologists is called upon and utilized in numerous spheres of life, both public and private. There is emphasis of a more holistic approach to the health care system (Cooper, 2001).

Statement 3: It is important for medical professionals to assess psychological problems.

Ninety-three participants responded to this statement. Eighty-five percent (n=79) of the respondents agreed or strongly agreed that it is important for medical professionals to assess psychological problems. Seven percent (n=7) disagreed or strongly disagreed with the statement, while 8% (n=7) of the respondents remained neutral.

Overall results of the respondents reflected that they agree that it is important for medical doctors to assess psychological problems. The results could be influenced by the fact that medical doctors, nurses and social workers are charged with the responsibility of the provision of psychological services in Botswana, and therefore it would be important for them to possess basic assessment skills. The need to assess psychological problems is explained by the fact that physicians are more often consulted with regard to behavioural and psychological problems than are psychologists and other mental health care workers (Schmidt et al. 1990). The need to assess psychological problems was also reflected by a study conducted by Morgan and Killoughery (2003), which reflected that there was a need for hospital doctors to be able to make use of simple psychological intervention skills, as most of the respondents indicated that psychological factors could influence physical prognosis and should be routinely assessed. On the contrary, if medical professionals are fully charged with the responsibility for psychological services, this may result in role confusion and ethical violation of the ethics of psychology with regard to the provision of psychological services.

Statement 4: Medical professionals should treat psychological problems.

Ninety-three participants responded to this statement. The results indicated that 40% (n=37) of the respondents agreed or strongly agreed with the statement that medical
doctors should treat psychological problems, while 34% (n=32) of the respondents disagreed or strongly disagreed with the statement. Twenty-six percent (n=24) of the respondents remained neutral.

The overall results on the treatment of psychological problems by medical professionals seem quite equally divided, a reflection of the reality in Botswana; that is to say, that medical professionals have to treat psychological problems, so they don’t have an option. This situation raises concerns as to whether psychological problems are adequately assessed and treated, since they are not extensively trained in psychological intervention and may lack the expertise to offer psychological services. Furthermore, there is the time factor issue. The medical professional’s time is dedicated to the assessment of physical complaints and they may find it difficult to assess and treat psychological problems. This has been affirmed by Cooper (2001), who asserts that psychological and behavioural problems brought to the attention of medical doctors are often inadequately assessed and treated. He further states that accuracy in the diagnosis and treatment of psychological problems requires well-developed interviewing skills and a basic understanding of the psychological, social and cultural determinants of the symptoms reported. Lack of psychological intervention skills may result in medical professionals not being able to give attention to the diverse causes of any psychological problems experienced.

Statement 5: I frequently discuss psychological problems with patients.

Ninety participants responded to this statement. Of the ninety respondents, 78% (n=70) agreed or strongly agreed with the statement that they frequently discuss psychological problems with patients. Five percent (n=5) disagreed or strongly disagreed with the statement, while 17% (n=15) remained neutral.

Overall results reflected that respondents confirmed discussion of psychological problems with patients and appear to recognise the relevance of psychological problems in physical illness. This may lead to respondents referring the patients to psychological services. This is consistent with the consistency model of attitudinal components which states that beliefs about a particular object can dictate one’s emotional reactions towards that object, and in turn result in behaviour or action. The respondents have a strong awareness of the importance of psychological services, as well as the role of
psychologists. This could influence positive attitudes, resulting in the discussion of psychological problems within a consultation. This is further supported by Hewstone and Stroebe (2001), who maintain that an individual’s attitude towards something depends on the subjective values or utilities attached to the possible outcomes of that action.

Statement 6: Psychological factors are important in the cause of physical illness.

Eighty-six participants responded to this statement. Eighty-nine percent (n=76) of the respondents agreed or strongly agreed with the statement that psychological factors are important in the cause of physical illness, while 2% (n=2) disagreed or strongly disagreed with the statement. Nine percent (n=8) remained neutral.

The overall results reflected that respondents agreed that psychological factors are important in the cause of physical illness. The respondents recognise the role of psychological factors, and are open to this aspect, and therefore may be even more likely to refer to psychological services.

Statement 7: When psychological problems appear to be an important cause of the presenting problem, I confine myself to physical treatment.

Ninety participants responded to this statement. Eighty-three percent (n=75) of the respondents disagreed or strongly disagreed with the statement which states that when psychological problems appear to be an important cause of the presenting problem, they confine themselves to physical treatment. Nine percent (n=8) agreed or strongly agreed with the statement, while 8% (n=7) remained neutral.

Overall results reflected that most of the respondents don’t only confine themselves to physical illness if there is an underlying psychological problem. These results tie in with the results of statement 5, in which respondents indicated discussion of psychological problems with patients. These findings could be a reflection that medical professionals are now moving away from the biomedical model of intervention which has been governing the thinking of most medical health professionals. They now work with the bio-psychosocial model which emphasises an understanding of the development, assessment and management of physical diseases and psychological wellbeing at all levels (Bishop, 1994).
Statement 8: I would like to know more about what psychologists have to offer in the management of medical problems.

Ninety participants responded to this statement. Ninety-four percent (n=85) of the respondents agreed or strongly agreed with the statement that they would like to know more about what psychologists offer in the management of medical problems, while 1% (n=1) of the respondents disagreed or strongly disagreed with the statement. Four percent (n=4) of the respondents remained neutral.

Overall results reflected that respondents would like to know more about the role of psychologists in the management of medical problems. The fact that respondents are aware of the effect of psychological problems in the management of physical illness suggests that they would like to know more with regard to psychological assessment and management, as well as how psychological and social factors can influence physical illness, as it is important to understand disease at all levels. This curiosity could be influenced by the evolution from the biomedical to the bio-psychosocial model. Sheridan and Radmacher (1992) explain that although the biomedical model has been successful in the fight against disease, it was unable to explain the influence of psychological and social factors on the development and treatment of illnesses.

Statement 9: I would like more contact with psychological services through referrals.

Ninety-three participants responded to this statement. Ninety-two percent (n=85) of the respondents agreed or strongly agreed with the statement that they would like more contact with psychologists through referrals. Only 2% (n=2) disagreed with the statement, while 6% (n=6) of the respondents remained neutral.

The overall results reflected that the respondents would like to have more contact with psychological services through referrals. A possible reason for respondents to have interest and more contact with psychological services could be attributed to their positive attitudes towards psychology and psychological services. The respondents have also indicated that if psychological services are available they would refer psychological problems to psychologists. This concurs with Schlebusch’s (1990) prediction that consultation within the health profession is important in order to provide effective health
service delivery. It becomes even more effective when professionals retain responsibility for their referrals.

Statement 10: Psychological services should be made available at health care centres.

Ninety-four participants responded to this statement. An overwhelming 99% (n=93) of the respondents agreed or strongly agreed with the statement that psychological services should be made available at health care centres. No respondent chose the disagree option. 1 percent (n=1) of the respondents remained neutral.

It is evident from the findings of this study that respondents have knowledge of and are familiar with the role of psychological services, as almost all of the respondents indicated the need for the provision of psychological services at health care centres. This reflects that once the psychological services are made available, respondents are more likely to utilise them by referring patients for psychological assessment.

Statement 11: It is necessary to have permanently employed psychologists in health care centres.

Ninety-four participants responded to this statement. Ninety-nine percent (n=93) of the respondents agreed or strongly agreed with the statement that it is necessary to have permanently employed psychologists in health care centres; no respondent disagreed with the statement, and only 1% (n=1) remained neutral.

Overall results revealed that respondents believe that it is necessary to have permanently employed psychologists in health care centres. The results reflect the recognised need to attach psychological service departments at all health care centres in Botswana to reduce the backlog at national referral hospitals. These results concur with Tema’s (2004) proposal on the integration of mental health care services into the general health care system. She proposed that the integration of mental health care into the general health care system should be accompanied by trained mental health care professionals. She argued that due to the shortage of medical staff in primary health care in Botswana, health care providers may find it difficult to provide psychological support to patients.
5.4.2. **Summary of the findings on attitudes towards psychological services.**

According to Foster and Louw-Potgieter (1991), the beliefs, attitudes and attributes that individuals hold are important in explaining and predicting their behaviour. Results show that the respondent’s attitudes towards psychology and psychological services reflect their awareness of the relevance of psychological factors in the management of physical illness. Respondents have indicated the need to know more about the role of psychological services in the management of medical problems and have shown an interest in having more contact with psychological services through referrals. Stones (1996) confirms that people’s knowledge and exposure to psychological services determines how positive or negative they are about these services. This is consistent with the theory of reasoned action which suggests that beliefs about a particular object can dictate emotional reactions towards that object, which in turn result in behaviour or action. The fact that respondents have positive attitudes towards psychology and psychological services suggests that the respondents would refer psychological problems to psychological services. This is further confirmed by Hewstone and Stroebe (2001) who maintain that an individual’s attitude towards something depends on the subjective values attached to the possible outcomes of that action.

5.5. **Referrals**

The third aim of the study was to explore and describe referral practices utilised in relation to psychological problems of health care providers in Botswana. To explore the referral practices, respondents were asked to indicate how often they refer to available psychological services, how often they deal with psychological problems in consultation, actions that are normally taken to deal with those psychological problems, and to indicate where they refer psychological problems.

5.5.1. **Section C2: Referrals to available psychological services**

In section C2 of the questionnaire, participants were asked to indicate from the given options how often they refer to available psychological services that they indicated in section B1 of the questionnaire. The participants were also allowed to indicate other psychological services that they utilize which were not on the given list. Table 12 shows
results on participants’ responses with regard to referrals to available psychological services. However, it should be noted that some participants did not indicate their responses, and as a result, the total number of respondents is not the same for all the psychological services.

Table 12: Referrals to available psychological services (N=96)

<table>
<thead>
<tr>
<th>Psychological Service</th>
<th>Always</th>
<th>Most times</th>
<th>Regularly</th>
<th>Seldom</th>
<th>Never</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Psychotherapeutic intervention</td>
<td>n = 4</td>
<td>n=8</td>
<td>n=10</td>
<td>n=4</td>
<td>n=2</td>
<td>n=28</td>
</tr>
<tr>
<td></td>
<td>14%</td>
<td>29%</td>
<td>36%</td>
<td>14%</td>
<td>7%</td>
<td>100%</td>
</tr>
<tr>
<td>2. Family and Couple Counselling</td>
<td>n=12</td>
<td>n=13</td>
<td>n=14</td>
<td>n=14</td>
<td>n=4</td>
<td>n=57</td>
</tr>
<tr>
<td></td>
<td>21%</td>
<td>23%</td>
<td>25%</td>
<td>25%</td>
<td>7%</td>
<td>100%</td>
</tr>
<tr>
<td>3. Psychological Assessment</td>
<td>n = 9</td>
<td>n=8</td>
<td>n=13</td>
<td>n=4</td>
<td>n=1</td>
<td>n=35</td>
</tr>
<tr>
<td></td>
<td>26%</td>
<td>23%</td>
<td>37%</td>
<td>11%</td>
<td>3%</td>
<td>100%</td>
</tr>
<tr>
<td>4. Career Assessment</td>
<td>n=1</td>
<td>n=2</td>
<td>n=3</td>
<td>n=3</td>
<td>n=2</td>
<td>n=11</td>
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<tr>
<td></td>
<td>9%</td>
<td>18%</td>
<td>27%</td>
<td>18%</td>
<td>18%</td>
<td>100%</td>
</tr>
<tr>
<td>5. Crisis Intervention and Management</td>
<td>n=11</td>
<td>n=5</td>
<td>n=9</td>
<td>n=2</td>
<td>n=1</td>
<td>n=28</td>
</tr>
<tr>
<td></td>
<td>39%</td>
<td>18%</td>
<td>32%</td>
<td>7%</td>
<td>4%</td>
<td>100%</td>
</tr>
<tr>
<td>6. Parent Support groups</td>
<td>n=3</td>
<td>n=3</td>
<td>n=2</td>
<td>n=5</td>
<td>n=2</td>
<td>n=15</td>
</tr>
<tr>
<td></td>
<td>20%</td>
<td>20%</td>
<td>13%</td>
<td>33%</td>
<td>13%</td>
<td>100%</td>
</tr>
<tr>
<td>7. Peer Approach Counselling</td>
<td>n=3</td>
<td>n=12</td>
<td>n=7</td>
<td>n=9</td>
<td>n=0</td>
<td>n=31</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>39%</td>
<td>23%</td>
<td>29%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>8. HIV/AIDS Voluntary Testing Counselling</td>
<td>n=47</td>
<td>n=12</td>
<td>n=13</td>
<td>n=7</td>
<td>n=5</td>
<td>n=84</td>
</tr>
<tr>
<td></td>
<td>56%</td>
<td>14%</td>
<td>15%</td>
<td>8%</td>
<td>6%</td>
<td>100%</td>
</tr>
<tr>
<td>9. Prevention of Mother-to-Child Therapy</td>
<td>n=39</td>
<td>n=11</td>
<td>n=12</td>
<td>n=9</td>
<td>n=3</td>
<td>n=74</td>
</tr>
<tr>
<td></td>
<td>53%</td>
<td>15%</td>
<td>16%</td>
<td>12%</td>
<td>4%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The results show that of the twenty-eight respondents who indicated their responses to psychotherapeutic intervention, 14% (n=4) indicated that they always refer patients for psychotherapeutic intervention, 28% (n=8) indicated most of the time, 36% (n=10) indicated regularly, 14% (n=4) indicated seldom, and 7% (n=2) indicated that they never refer patients for therapeutic intervention. The overall results reflect that 79% (n=22) of the respondents refer patients for psychotherapeutic intervention, while 21% (n=6) seldom or never refer patients. Very few respondents indicated utilisation of psychotherapeutic intervention. This could be explained by the limited availability of these psychological services in the respondents’ settings.
Fifty-seven respondents indicated their responses to family and couple counselling. Twenty-one percent (n=12) of the respondents indicated that they always refer patients for family and couple counselling services, 23% (n=13) indicated most of the time, 25% (n=14) indicated regularly, another 25% (n=14) indicated seldom and 7% (n=4) indicated that they never refer patients for family and couple counselling. The overall results reflect that 69% (n=39) of the respondents refer patients for family and couple counselling, while 32% (n=18) seldom or never refer. The results of this study on the availability of family and couple counselling revealed that the majority (n=67) of the respondents indicated the availability of family and couple counselling services in their settings. Therefore, the availability of this service in most settings is a possible explanation for the high rate of referrals.

Thirty-five respondents indicated their responses to psychological assessment. Twenty-six percent (n=9) of the respondents indicated that they always refer patients for psychological assessment, 23 % (n=8) indicated most of the time, 37% (n=13) indicated regularly, 11% (n=4) indicated seldom, and 3% (n=1) indicated that they never refer patients for psychological assessment. The overall results reflect that 86% (n=30) of the respondents refer patients for psychological assessment, while 14% (n=5) seldom or never refer them. The low utilisation response concurs with the results on availability, as there was an indication from the respondents that it was one of the least available psychological services in the respondents’ settings.

The results of this study have reflected that career assessment was the least available psychological service in respondents’ settings. This is also evident in the responses to the utilisation of career-assessment services. Eleven respondents indicated their responses. Nine percent (n=1) of the respondents indicated that they always refer patients for career assessment, 18% (n=2) indicated most of the times, 27% (n=3) indicated regularly, another 27% (n=3) indicated seldom and 18% (n=2) indicated that they never refer patients for career assessment. The overall results reflect that 54% (n=6) of the respondents refer patients for psychological assessment, while 45% (n=5) seldom or never refer their patients. Less utilisation of psychological assessment could be attributed to the limited number of trained professionals to carry out career assessment in a respondent’s setting.
The results of Table 12 show that of the twenty-eight respondents who indicated their responses to crisis intervention and management, 39% (n=11) indicated that they always refer patients to crisis intervention and management, 18% (n=5) indicated most of the time, 32% (n=9) indicated regularly, 7% (n=2) indicated seldom and 4% (n=1) indicated that they never refer patients to crisis intervention and management. The overall results reflect that 89% (n=25) of the respondents refer patients to crisis intervention and management, while 11% (n=3) seldom or never refer their patients. Once again, less use of the crisis intervention and management service could be attributed to the availability of the psychological services.

Fifteen respondents indicated their responses to parent support groups. Twenty percent (n=3) of the respondents indicated that they always utilise parent support group services, another 20% (n=3) indicated most of the time, 13% (n=2) indicated regularly, 33% (n=5) indicated seldom, and 13% (n=2) indicated that they never utilise parent-support groups. The overall results reflect that 53% (n=8) of the respondents refer patients to parent-support groups, while 46% (n=7) seldom or never refer them. The results of this study on the availability of parent-support groups reflected that this is one of the least available psychological services in respondents’ settings. The results on availability concur with participants’ low responses on referrals to this service.

Thirty-one respondents indicated their responses to peer approach counselling. Ten percent (n=3) of the respondents indicated that they always refer patients to peer-approach counselling, 39% (n=12) indicated seldom, 23% (n=7) indicated regularly and 29% (n=9) indicated that they seldom refer patients to peer approach counselling. The overall results reflect that 72% (n=22) of the respondents refer to peer approach counselling, while 29% (n=9) seldom refer their patients.

Eighty-four respondents indicated their responses to HIV/AIDS voluntary counselling and testing. Fifty-six percent (n=47) of the respondents indicated that they always refer patients for HIV/AIDS voluntary counselling and testing, 14% (n=12) indicated most of the time, 15% (n=13) indicated regularly, 8% (n=7) indicated seldom and 6% (n=5) indicated that they never refer patients for HIV/AIDS voluntary counselling and testing. The overall results reflect that 85% (n=72) of the respondents refer patients for HIV/AIDS voluntary counselling and testing, while 14% (n=12) never refer their patients. The results of this study on the availability of psychological services
reflected that respondents indicated that HIV/AIDS voluntary counselling and testing was available in most of their settings. This explains the high utilisation of this service by respondents.

Seventy-four respondents indicated their responses to the prevention of mother-to-child therapy. Fifty-three percent (n=39) indicated that they always refer patients for prevention of mother-to-child therapy, 15% (n=11) indicated most of the time, 16% (n=12) indicated regularly, 12% (n=9) indicated seldom and 4% (n=3) indicated that they never refer patients for prevention of mother-to-child therapy. The overall results reflect that 84% (n=62) of the respondents refer patients for the prevention of mother-to-child therapy, while 16% (n=12) seldom or never refer their patients.

Other information provided by respondents indicated that respondents also refer patients for trauma counselling, bereavement and grief counselling, home-based care support groups and psychosocial support for orphans. It has been noticed that there are varied results on referrals depending on the availability of psychological services in different settings. The psychological services indicated by respondents as the most available in this study seem to be the ones which received the highest percentage of referrals. This is an indication that once the psychological services are made available, respondents are more likely to utilise them. The respondents who indicated that they never refer patients to psychological services could be a possible indication of what psychological services are available in their settings.

The findings reflect that respondents displayed interest in referring to available psychological services. This is supported by Hewstone and Stroebe (2001), who explained that referral practices of medical practitioners may be influenced by their beliefs and attitudes. This is further supported by Sheridan and Radmacher (1992), who assert that an intention towards behaviour or action is influenced by our attitudes. The respondents displayed good awareness and positive attitudes towards available psychological service and this suggests the possibility of referral to psychological services. This finding echoes that of a study conducted by Morgan and Killoughery (2003) on hospital doctor’s management of psychological problems, their attitudes towards psychology and their referral practices of psychological problems. Findings of the study reflected that medical doctors displayed greater interest in liaison with psychological services for the management of psychological problems.
5.5.2. Section C3: The frequency of psychological problems

In section C3 of the questionnaire, participants were given a list of examples of psychological problems presumed to be the most prevalent in primary health care and requested to indicate from the given options how often they deal with those psychological problems. Participants were also given the opportunity to indicate other psychological problems not on the list that they normally dealt with in consultation. Table 13 shows the results on participants’ responses with regard to the frequency of psychological problems.

Table 13: The frequency of psychological problems (N=96)

<table>
<thead>
<tr>
<th>Psychological Problems</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Less often</th>
<th>Never</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Emotional problems</td>
<td>n = 63</td>
<td>n = 17</td>
<td>n = 5</td>
<td></td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>66%</td>
<td>18%</td>
<td>5%</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>2. Problems of anxiety and stress</td>
<td>n = 62</td>
<td>n = 18</td>
<td>n = 5</td>
<td></td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>65%</td>
<td>19%</td>
<td>5%</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>3. Psychological adjustment to physical illness</td>
<td>n = 38</td>
<td>n = 32</td>
<td>n = 12</td>
<td></td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>40%</td>
<td>33%</td>
<td>13%</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>4. Interpersonal and social problems</td>
<td>n = 53</td>
<td>n = 12</td>
<td>n = 5</td>
<td></td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>55%</td>
<td>13%</td>
<td>5%</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>5. Marital problems</td>
<td>n = 23</td>
<td>n = 39</td>
<td>n = 9</td>
<td></td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>24%</td>
<td>41%</td>
<td>9%</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>6. Educational and occupational problems</td>
<td>n = 12</td>
<td>n = 43</td>
<td>n = 27</td>
<td></td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>13%</td>
<td>45%</td>
<td>28%</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>7. Drug and substance abuse</td>
<td>n = 15</td>
<td>n = 37</td>
<td>n = 30</td>
<td></td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>16%</td>
<td>39%</td>
<td>31%</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>8. Rape</td>
<td>n = 11</td>
<td>n = 36</td>
<td>n = 39</td>
<td></td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>11%</td>
<td>38%</td>
<td>41%</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

The results show that all the participants indicated their responses with regard to dealing with psychological problems in consultation. Sixty-six percent (n=63) of the respondents indicated that they deal with patients experiencing emotional problems weekly, 11% (n=11) indicated monthly, 17% (n=18) indicated less often, and 5% (n=5) indicated that they never deal with patients experiencing emotional problems in consultation. Overall, the results reflect that 95% (n=91) of the respondents deal with patients experiencing emotional problems in consultation, while 5% (n=5) never deal with emotional problems.
Sixty-two percent (n=65) of the respondents indicated that they deal with patients experiencing problems of anxiety and stress on a weekly basis, 11% (n=11) indicated monthly, 18% (n=19) indicated less often, and 5% (n=5) indicated that they never deal with problems of anxiety and stress in consultation. The overall results reflect that 95% (n=91) of the respondents deal with patients with problems of anxiety and stress, while 5% (n=5) never deal with problems of anxiety and stress.

The results show that 38% (n=40) of the respondents indicated that they deal with patients having difficulty in psychological adjustment to physical illness, 14% (n=15) indicated monthly, 32% (n=33) indicated less often, while 12% (n=13) indicated that they never deal with patients having difficulty in psychological adjustment to physical illness. The overall results reflect that 88% (n=84) of the respondents deal with patients having difficulty in adjusting to psychological adjustment to physical illness, while 12% (n=13) never deal with patients having difficulty in psychological adjustment to physical illness.

The results in Table 14 show that 53% (n=55) of the respondents indicated that they deal with interpersonal and social problems cases weekly, 26% (n=27) indicated monthly, 12% (n=13) indicated less often, while 5% (n=5) indicated that they never deal with interpersonal and social problem cases. Overall, the results reflect that 95% (n=91) of the respondents deal with interpersonal and social problems, while 5% (n=5) never deal with interpersonal and social problems.

The results show that 23% (n=24) of the respondents indicated that they deal with marital problems weekly, 25% (n=26) indicated monthly, 39% (n=41) indicated less often, while 9% (n=9) indicated that they never deal with marital problems in consultation. The overall results reflect that 91% (n=87) of the respondents deal with marital problems, while 9% (n=9) never deal with marital problems.

The results show that 12% (n=13) of the respondents indicated that they deal with patients faced with educational and occupational difficulties on a weekly basis, 14% (n=15) indicated monthly, 43% (n=45) indicated less often, while 27% (n=28) indicated that they never deal with patients faced with educational and occupational difficulties in consultation. The overall results reflect that 73% (n=69) of the respondents deal with educational and occupational difficulties in consultation, while 27% (n=28) never deal with educational and occupational difficulties.
The results show that 15% (n=16) of the respondents indicated that they deal with drug and substance abuse cases weekly, 14% (n=15) indicated monthly, 37% (n=39) indicated less often, while 30% (n=31) indicated that they never deal with drug and substance abuse cases in consultation. The overall results reflect that 70% (n=66) of the respondents deal with drug and substance abuse cases, while 30% (n=31) never deal with drug and substance abuse cases.

The results show that 11% (n=11) of the respondents indicated that they deal with rape cases weekly, 10% (n=10) indicated monthly, 36% (n=38) indicated less often, while 39% (n=41) indicated that they never deal with rape cases.

Results on the findings reflect the prevalence of psychological problems that respondents deal with in primary health care which need to be referred to trained professionals. This is an indication that medical professionals are often consulted on psychological problems. This reflects on the assumption of Schmidt et al. (1990) that medical professionals are more often consulted for psychological problems than are the psychology professionals. They pointed out that since medical professionals are not trained to assess and treat psychological problems, this may result in psychological problems being overlooked or not properly diagnosed or treated. The results concur with those of Azjen (1988), who pointed out that there is evidence that psychological problems are prevalent in almost every aspect of our lives and psychological intervention is crucial to enable human beings to become aware of the psychological dynamics and acquire the ability to solve their various complex problems. The findings therefore reflect the need for provision of psychological services in health care centres.

### 5.5.3. Section C4: Actions taken to deal with psychological problems

In this section, participants were asked to indicate from the given options what actions they normally take to deal with the psychological problems indicated in section C3. Some respondents indicated more than one option, while some did not indicate their responses. Therefore the totals for each psychological problem may not be the same. The participants were also asked to write in any other additional information on actions they normally take to deal with psychological problems. The results of the respondents’ responses are presented in Table 14 below.
Table 14: Actions taken to deal with psychological problems (N=96)

<table>
<thead>
<tr>
<th>Psychological Problems</th>
<th>Refer</th>
<th>Medicate</th>
<th>Ignore</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Emotional problems</td>
<td>n = 42</td>
<td>n = 38</td>
<td>n = 0</td>
<td>n = 80</td>
</tr>
<tr>
<td></td>
<td>53%</td>
<td>48%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>2. Problems of anxiety and stress</td>
<td>n = 40</td>
<td>n = 42</td>
<td>n = 0</td>
<td>n = 82</td>
</tr>
<tr>
<td></td>
<td>49%</td>
<td>51%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>3. Psychological adjustment to physical illness</td>
<td>n = 45</td>
<td>n = 26</td>
<td>n = 3</td>
<td>n = 74</td>
</tr>
<tr>
<td></td>
<td>61%</td>
<td>35%</td>
<td>4%</td>
<td>100%</td>
</tr>
<tr>
<td>4. Interpersonal and social problems</td>
<td>n = 58</td>
<td>n = 22</td>
<td>n = 2</td>
<td>n = 82</td>
</tr>
<tr>
<td></td>
<td>71%</td>
<td>27%</td>
<td>2%</td>
<td>100%</td>
</tr>
<tr>
<td>5. Marital problems</td>
<td>n = 57</td>
<td>n = 15</td>
<td>n = 1</td>
<td>n = 73</td>
</tr>
<tr>
<td></td>
<td>78%</td>
<td>21%</td>
<td>1%</td>
<td>100%</td>
</tr>
<tr>
<td>6. Educational and occupational problems</td>
<td>n = 42</td>
<td>n = 8</td>
<td>n = 4</td>
<td>n = 54</td>
</tr>
<tr>
<td></td>
<td>78%</td>
<td>15%</td>
<td>7%</td>
<td>100%</td>
</tr>
<tr>
<td>7. Drug and substance abuse</td>
<td>n = 45</td>
<td>n = 10</td>
<td>n = 0</td>
<td>n = 55</td>
</tr>
<tr>
<td></td>
<td>86%</td>
<td>18%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>8. Rape</td>
<td>n = 33</td>
<td>n = 10</td>
<td>n = 0</td>
<td>n = 43</td>
</tr>
<tr>
<td></td>
<td>77%</td>
<td>23%</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Results show that eighty respondents indicated their actions in dealing with emotional problems. Fifty-three percent (n=42) of the respondents indicated that they refer patients presenting with emotional problems, while 48% (n=38) indicated that they medicate. Eighty-two respondents indicated their actions in dealing with problems of anxiety and stress. Forty-nine percent (n=40) indicated that they refer patients presenting with problems of anxiety and stress, while 51% (n=42) indicated that they medicate the patients. Seventy-four respondents indicated their actions in dealing with patients experiencing difficulty with psychological adjustment to physical illness. Sixty-one percent (n=45) of the respondents indicated that they refer patients, 35% (n=26) indicated that they medicate, and 4% (n=3) indicated that they ignore patients experiencing difficult psychological adjustment to physical illness. Eighty-two respondents indicated their action in dealing with interpersonal and social problems. Seventy-one percent (n=58) indicated that they refer patients presenting with interpersonal and social problems, 27% (n=22) indicated that they medicate, and 2% (n=2) indicated that they ignore such psychological problems.

The results show that seventy-three respondents indicated their action in dealing with marital problems. Seventy-eight percent (n=57) of the respondents indicated that they refer such patients, 21% (n=15) indicated that they medicate, while 1% (n=1) indicated that they ignore such problems. Fifty-four respondents indicated their actions...
in dealing with patients faced with educational and occupational difficulties. Seventy-eight percent (n=42) indicated that they refer such patients, 15% (n=8) indicated that they medicate, while 7% (n=4) indicated that they ignore these problems. Fifty-five respondents indicated their action in dealing with drug and substance abuse cases. Eighty-two percent (n=45) of the respondents indicated that they refer drug and substance abuse cases, and 18% (n=10) indicated that they medicate. Forty-three respondents indicated their actions in dealing with rape cases. Seventy-seven percent (n=33) indicated that they refer, and 23% (n=10) indicated that they medicate rape survivors.

According to Bishop (1994), there is evidence that psychological and behavioural problems are widely prevalent and are usually brought to the attention of health care providers, but not often adequately assessed and treated, due to the fact that health care providers don’t have sufficient knowledge and skills in psychological intervention. The overall results reflect that most of the respondents have indicated referral of psychological problems, as opposed to medication and ignoring them, which suggests the need for trained professional psychologists to offer psychological services at primary health care levels. These results are in line with those of Bowden and Burstein (1989) who assert that it is important for medical professionals to work in liaison with psychology professionals in the management of psychological problems. Medication or ignoring psychological problems could be a possible reflection of a shortage of trained professionals to offer psychological services. Therefore medication could be seen as an instant solution to managing such psychological problems.

5.5.4. Section C5: Referral practices of psychological problems

In section C5 of the questionnaire, participants were asked to indicate from the given options where they usually refer psychological problems indicated in section C4. It must be noted that not all respondents who indicated that they refer in section C4, have indicated their responses in Section C5. Some respondents indicated more than one option or have not responded at all. Therefore, the totals of the respondents who indicated that they refer may not correspond with the totals of responses in this section. Participants were also given the opportunity to indicate other
professionals to whom they refer. Table 15 shows the results of participants’ responses with regard to referral to other professionals.

**Table 15: Referral practices of psychological problems. (N=96)**

<table>
<thead>
<tr>
<th>Psychological problem</th>
<th>Psychologist</th>
<th>Social worker</th>
<th>Church pastor</th>
<th>Traditional Healer</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Emotional problems</td>
<td>n = 14</td>
<td>n = 28</td>
<td>n = 4</td>
<td>n = 1</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>33%</td>
<td>67%</td>
<td>10%</td>
<td>2%</td>
<td>100%</td>
</tr>
<tr>
<td>2. Problems of anxiety and stress</td>
<td>n = 19</td>
<td>n = 19</td>
<td>n = 2</td>
<td>n = 1</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>46%</td>
<td>46%</td>
<td>5%</td>
<td>3%</td>
<td>100%</td>
</tr>
<tr>
<td>3. Psychological adjustment to physical illness</td>
<td>n = 23</td>
<td>n = 17</td>
<td>n = 1</td>
<td>n = 0</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>51%</td>
<td>38%</td>
<td>2%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>4. Interpersonal and social problems</td>
<td>n = 3</td>
<td>n = 49</td>
<td>n = 3</td>
<td>n = 0</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>5%</td>
<td>84%</td>
<td>5%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>5. Marital problems</td>
<td>n = 4</td>
<td>n = 48</td>
<td>n = 10</td>
<td>n = 0</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>7%</td>
<td>84%</td>
<td>18%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>6. Educational and Occupational difficulties</td>
<td>n = 11</td>
<td>n = 25</td>
<td>n = 1</td>
<td>n = 0</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>26%</td>
<td>60%</td>
<td>2%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>7. Drug and Substance abuse</td>
<td>n = 19</td>
<td>n = 27</td>
<td>n = 2</td>
<td>n = 0</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>42%</td>
<td>60%</td>
<td>4%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>8. Rape</td>
<td>n = 11</td>
<td>n = 19</td>
<td>n = 0</td>
<td>n = 0</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>33%</td>
<td>58%</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Forty-seven respondents indicated their responses of referral of emotional problems. Results show that 33% (n=14) of the respondents indicated that they refer emotional problems to psychologists, 67% (n=28) indicated social workers, 10% (n=4) indicated church pastors, and 2% (n=1) indicated traditional healers. The results reflect that most of the respondents refer emotional problems to social workers.

Forty-one respondents indicated their responses of referral of problems of anxiety and stress. The results show that 46% (n=19) of the respondents indicated that they refer problems of anxiety and stress to psychologists, 46% (n=19) indicated social workers, 5% (n=2) indicated church pastors and 3% (n=1) indicated a traditional healer. The results reflect that an equal number (46%) of respondents refer problems of anxiety and stress to psychologists and social workers.

Forty-one respondents indicated their response of referral of psychological adjustment to physical illness practitioners. Fifty-one percent (n=23) of the respondents
indicated that they refer patients struggling with psychological adjustment to physical illness to psychologists, 38% (n=17) indicated to social workers, 2% (n=1) indicated church pastors and there was no indication of referral to a traditional healers. The results reflect that most (51%) of the respondents refer patients struggling with psychological adjustment to psychologists.

Fifty-five respondents indicated their response of referral of interpersonal and social problems. The results show that 5% (n=3) of the respondents indicated that they refer interpersonal and social problems to psychologists, 84% (n=49) indicated social workers, 5% (n=3) indicated church pastors and there was no indication of traditional healers. The results reflect that most (84%) of the respondents refer interpersonal and social problems to social workers.

Sixty-two respondents indicated their response of referral of marital problems. The results show that 7% (n=4) of the respondents indicated that they refer marital problems to psychologists, 84% (n=48) refer to social workers, 18% (n=10) refer to church pastors and there is no indication of any referral to a traditional healers. The results reflect that most (84%) of the respondents indicated that they refer marital problems to social workers.

Thirty-seven respondents indicated their response of referral of educational and occupational difficulties. The results show that 26% (n=11) of the respondents indicated that they refer patients faced with educational and occupational difficulties to psychologists, 60% (n=25) indicated to social workers, 2% (n=1) indicated to a church pastor, and there was no indication of any referrals to traditional healers. The results reflect that most (60%) of the respondents indicated that they refer educational and occupational difficulties to social workers.

Forty-eight respondents indicated their response of referral of drug and substance-abuse cases. The results show that 42% (n=19) of the respondents indicated that they refer drug and substance abuse cases to psychologists, 60% (n=27) indicated to social workers, 4% (n=2) indicated to a church pastor, and there was no indication of referral to a traditional healers. The results reflect that most (60%) of the respondents indicated that they refer drug and substance cases to social workers.

Thirty respondents indicated their responses of referral of rape cases. The results show that 33% (n=11) of the respondents indicated that they refer rape cases to
psychologists, 58% (n=19) indicated social workers and there were no indications of referrals to church pastors and traditional healers. The results reflect that most (58%) of the respondents indicated that they refer rape cases to social workers.

Overall results reflect that most of the respondents refer psychological problems to social workers rather than to psychologists. This is a reflection of what is happening on the ground where psychological problems are referred to social workers due to the limited number of psychologists available to offer psychological services in Botswana. This is in concurrence with the results of this study on the provision of psychological services, where most of the respondents had indicated that psychological services are offered by social workers in the absence of psychologists. The provision of psychological services by social workers is in accordance with the Clinical social work standards of the practice manual (June, 2006). This states that social workers diagnose psychosocial problems; provide intervention strategies to people facing traumatic injury and experiences and are also expected to provide counselling and psycho-education. The standard of practice further states that social workers collaborate and consult with members of the health care team in the management of psychological problems (Clinical Social Work Standards of Practice Manual, June 2006). This explains the high rate of referrals to social workers. There are fewer referrals to church pastors and traditional healers, even though it is reflected that church pastors and traditional healers play an important role in the provision of psychological services in Botswana.

Additional information provided by the respondents indicated that lay counsellors, such as health educators are also utilised in the provision of psychological services at the clinical level. There was also an indication of referral protocol at the clinical level. Most of the respondents at the clinical level indicated that the referrals protocol to be followed requires them to refer psychological problems to the doctors first, before they can be referred to other professionals. This procedure reflects a referral gap in terms of the referral of psychological problems. This could be as a result of the shortage of direct access and the inadequate provision of psychological services. Social workers indicated that even though they were the main source of referral, the assessment and management of psychological problems was beyond their scope of training, since they are only trained in counselling and basic psychological intervention skills.
5.5.5. **Summary of the findings on the referral of psychological problems**

Overall results reflect that respondents carry a greater sense of responsibility for the psychological wellbeing of patients. There is an indication from the respondents of a need for the provision of psychological service within their settings, judging from the indication of the prevalence of psychological problems. The findings reflect a possible interest to refer psychological problems to psychological services, as there seems to be an awareness of the effects of psychological factors in the management of physical illnesses. These findings concur with international studies conducted by Morgan and Killoughery (2003) on hospitals’ management of psychological problems which revealed that there was a greater desire for and interest in liaison with the field of psychology, as doctors’ time was more constrained and this affected the capacity of the medical doctors to conduct psychological assessments, despite the awareness of their relevance.

5.6. **Conclusion**

This chapter has focused on the results obtained in this study. As the results were discussed, parallels were drawn between the literature and other research findings similar to the current study. In conclusion, the findings reflected a good awareness of the availability and the importance of psychological services in primary health care service delivery. Respondents displayed positive attitudes towards psychology and psychological services, as well as an awareness of the relevance of psychological factors in the management of physical illness and the need to refer psychological problems to the relevant professionals. This is in line with Stones (1996), who asserted that knowledge and positive attitudes towards a subject or object lead to more contact with the subject.

The following and final chapter concludes the study by making recommendations for the improvement of the provision of psychological services in Botswana. Limitations of the study are also discussed, as are the suggestions for any future research.
CHAPTER 6

Conclusions and Recommendations

The aim of this study was to explore and describe the awareness and attitudes towards available psychological services, and to look at referral practices in relation to the psychological problems of health care providers in Botswana.

6.1. Conclusions of the study

There is global concern that psychosocial problems impact negatively on mankind. The government of Botswana introduced psychological services at national referral hospitals with the aim of addressing this concern. This was also one of the goals of Vision 2016 which emphasizes the need to strengthen the health care system of Botswana (Long Term Vision for Botswana, 2004). However there is concern that the impact of these structures is not significant and this has been attributed to a lack of awareness of psychological services by the public or the underutilization of these services by health care providers. It is for this reason that the researcher felt the need to conduct this study to explore the public’s awareness of psychological services, attitudes towards psychology and psychological services and the referral practices in relation to the psychological problems of health care providers in Botswana. The research was also influenced by the fact that psychology is a relatively new profession in Botswana and no similar study of this sort has been done before.

In conclusion, the respondents reflected this awareness and their knowledge of the psychological services available; however there was concern regarding the effectiveness and accessibility of these psychological services. The respondents demonstrated positive attitudes towards psychology and psychological services. They acknowledged the relevance of psychological problems in the management of physical illnesses. These were reflected in the desire for and interest in referring psychological problems to psychological services. However, there was a clear indication of a shortage of trained professionals to offer psychological services, and as a result, psychological problems are most frequently referred to social workers. Results also reflected the fact that medical professionals are charged with the responsibility of psychological
assessment and intervention, which could affect their capacity to attend to physical illnesses. The fact that social workers and medical professionals are charged with the responsibility of offering psychological services adds to the prevailing misconceptions regarding the roles of these professionals. There was an indication that lay counsellors, church pastors and family members also play an important role in the provision of psychological services.

The question thus emerges as to what can be done to improve psychological services. The following are some of the possible recommendations.

6.2. Recommendations

Based on the research findings of this study, the following recommendations are made. As there is not much literature that has been published on psychology and psychological services in Botswana, further research should be undertaken on the provision of psychological services. Botswana has outlined a long-term vision of health care service to be achieved by 2016. This emphasizes one coordinated health programme which provides quality health service delivery to promote health. To achieve this goal, it is important that a comprehensive national health policy on the provision of psychological services be incorporated at primary health care level. The findings of the study indicate the need for a multi-disciplinary team effort. Therefore it is recommended that the National Health Policy should make provision for more psychologists to be attached to national referral hospitals and clinics. A forum consisting of all concerned professionals who offer any form of counselling, including lay or professional counsellors and NGOs could be constituted. This would raise the awareness of the importance of psychological services and lobby for the implementation of such services at all levels. Unless such a step is taken, the provision of psychological services will remain the burden of medical professionals and social workers. To address the problem of the shortage of psychologists, it is recommended that the training of psychologists at postgraduate level should be introduced at the University of Botswana and the professional training of psychologists be given priority status. To take away the pressure from the limited number of psychologist at the referral hospitals, it is recommended that registered counsellors be placed at the clinical level to offer basic psychological intervention such as short-term therapy, psycho-education, trauma and debriefing and
career assessment and counselling. The existing psychological service-rendering facilities, such as national referral hospitals and NGOs could raise the awareness with the government on the importance of the role of the psychologist in the delivery of primary health care. Although this study gives insight into the participants’ awareness of psychological services, their attitudes towards psychology and psychological services, as well as their referral practices in relation to psychological problems, certain limitations have also come to light which future researchers need to consider when embarking on similar studies.

6.3. **Limitations**

The study was conducted on a small sample size; therefore the results cannot be generalised to all settings. The study was confined to the two national referral hospitals and their referring clinics in the cities of Gaborone and Francistown, and one private hospital. Participation was voluntary; this could result in a skewed picture of the attitudes and referral practices of the participants. It was also difficult to accurately assess the referral practices of most nurses as their referrals are normally made to the doctors for assessment before referring these to other professionals. The difficulty in assessing referral practices was the same for social workers, as they are the main referral resources. They have to intervene and not refer. The other limitation was that not all the questions were answered by every participant and some of the participants gave more than one response per item or no response at all. This could be ascribed to not understanding the instructions, poor concentration or a possible lack of interest. Limited literature on psychology and psychological services in Botswana and the lack of previous studies also limited this study.

6.4. **Dissemination of the results**

In order to assist policy-making bodies in the planning and implementation of effective psychological services in Botswana, a report of the findings of this study will be provided to the Ministry of Health and the Ministry of Local government, as psychological services fall under the portfolios of these Ministries. Copies will also be sent to the participating hospitals, clinics and the social welfare department.
6.5. Conclusion

Considering the complex nature of issues that impact negatively on mankind, it is evident that psychological services are vital in the provision of an effective health service delivery system. One of the long term-visions of Botswana is to develop and provide a high quality health care service delivery system, and therefore the availability and provision of effective psychological services at health care centres would help realise this vision (Long Term Vision for Botswana, 2004). According to Schlebusch (1990), the provision of an effective health service delivery system requires a multi-disciplinary approach which includes the provision of and direct access to psychological services at primary health care levels.
REFERENCES


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Appendix A
QUESTIONNAIRE

AWARENESS, ATTITUDES AND REFERRAL PRACTICES OF HEALTH CARE PROVIDERS TO PSYCHOLOGICAL SERVICES IN BOTSWANA

Thank you for agreeing to participate in completing this questionnaire. Your response will be kept confidential.

SECTION A: BIOGRAPHICAL INFORMATION

Instructions: please fill in all your details and place ✓ in a box beside the appropriate response.

1. Gender: M [ ] F [ ]

2. What is your age range: 25 – 29 [ ]
   30 – 39 [ ]
   40 – 49 [ ]
   50 – 59 [ ]
   60+ [ ]

3. Marital status:
   Single [ ] Married [ ] Divorced [ ] Separated [ ]
   Widowed [ ]

4. Profession:
   Doctor [ ] Nurse [ ] Psychiatrist [ ] Psychiatric Nurse [ ] Social Worker [ ]

5. Years of experience in current position: ______________________

6. Government: [ ] Private practice: [ ]
SECTION B: AVAILABILITY AND AWARENESS OF PSYCHOLOGICAL SERVICES

SECTION B1: Availability of psychological services

Instructions: please complete the following questions on psychological services by either placing ✓ in a box beside the appropriate response or by writing your response in the provided space.

1. Which of the psychological services are available in your area?

1.1 Psychotherapeutic intervention

1.2 Family and Couple counseling

1.3 Psychological Assessment

1.4 Career Assessment

1.5 Crisis Intervention and Management

1.6 Parent Support groups

1.7 Peer Approach Counselling

1.8 HIV/AIDS Voluntary Counseling and Testing

1.9 Prevention of Mother to Child Therapy

Other:__________________________________________________________
__________________________________________________________
SECTION B 2: Awareness of the available psychological services

2. Please indicate your level of agreement for the statements below by circling the appropriate number:

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Psychological services available in your area are adequate</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2.2 Psychological services are easily accessible to patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2.3 Psychological services which are available are effective</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2.4 If psychological services were readily available I would refer to them</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2.5 Psychologist have little to offer in health care centers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

SECTION B 3: Availability of psychologist to offer psychological services

3. Is there a psychologist permanently employed to offer psychological services in your health centre? □ Yes: □ No:

SECTION B 4: Provision of psychological services

4. If not, who offers psychological services? (Tick all applicable boxes):

4.1. Doctor □
4.2. Nurse □
4.3. Psychiatrist □
4.4. Psychiatric Nurse □
4.5. Social worker □

4.6. Other:__________________________________________
__________________________________________
__________________________________________
__________________________________________
SECTION C: ATTITUDE TOWARDS PSYCHOLOGICAL SERVICES AND REFERRAL PRACTICES OF PSYCHOLOGICAL PROBLEMS TO PSYCHOLOGICAL SERVICES

SECTION C1: Attitudes towards psychological service

1. Please indicate your level of agreement for the statements below by circling the appropriate number:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Management of psychological problems is a medical responsibility</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>1.2 Management of psychological problems is mainly the responsibility of psychologist</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>1.3 It is important for medical professionals and social workers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>1.4 Medical professionals should treat psychological problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>1.5 I frequently discuss psychological problems with patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>1.6 Psychological factors are important in the cause of physical illness</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>1.7 When psychological problems appear to be an important cause of the presenting problem, I confine myself to physical treatment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>1.8 I would like to know more about what psychologist have to offer in management of medical problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>1.9 I would like more contact with psychological services through referrals</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>1.10 Psychological services should be made available at health care centers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>1.11 It is necessary to have a permanently employed psychologist in health care centers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
SECTION C 2: Referrals to available psychological services

2. For those psychological services that are available, to which do you refer to?

<table>
<thead>
<tr>
<th>Psychological service</th>
<th>Always</th>
<th>Most times</th>
<th>Regularly</th>
<th>Seldom</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Psychotherapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2 Family and Couple Counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3 Psychological Assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4 Career Assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5 Crisis Intervention and Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.6 Parent Support Groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.7 Peer Approach Counselling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.8 HIV/AIDS Voluntary Counselling and Testing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.9 Prevention of mother to Child Therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.10 Other, please specify:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION C 3: frequency of psychological problems

3. How often do you deal with the following psychological problems?

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Less Often</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Emotional problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2 Problems of anxiety and stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3 Psychological adjustment to physical illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4 Interpersonal and social problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5 Marital problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.6 Educational and occupational difficulties</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.7 Drug and substance abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.8 Rape</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9 Other, please specify:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION C 4: Actions taken to deal with psychological problems

4. For those problems that you deal with, which of the following action do you usually take?

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>Refer</th>
<th>Medicate</th>
<th>Ignore</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Emotional problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.2 Problems of anxiety and stress</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.3 Psychological adjustment to physical illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.4 Interpersonal and social problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.5 Marital problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.6 Educational and occupational difficulties</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.7 Drug and substance abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.8 Rape</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.9 Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION C 5: Referral practices of psychological problems

5. If you refer, who do you usually refer to for these psychological problems?

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>Psychologist</th>
<th>Social Worker</th>
<th>Church Pastor</th>
<th>Traditional Healer</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Emotional problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2 Problems of anxiety and stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.3 Psychological adjustment to physical illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.4 Interpersonal and social problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.5 Marital problems</td>
<td></td>
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<td>5.6 Educational and occupational difficulties</td>
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<td>5.7 Drug and substance abuse</td>
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<td>5.8 Rape</td>
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<td>5.9 Other</td>
<td></td>
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</table>

6. Please feel free to write any comments on psychological problems you usually encounter in consultations and comment on what strategies you employ to address them:
Appendix B

Nelson Mandela Metropolitan University
Po Box 77000
Port Elizabeth
South Africa

29 September 2008

The Ministry of Health
Research and Development Committee
Private Bag 038
Gaborone
Botswana

Dear Sir/Madam

Re: Application to conduct research at institutions

I am a Psychology Masters student at Nelson Mandela Metropolitan University in Port Elizabeth, South Africa. Part of my degree programme is to conduct research in partial fulfillment of the requirements of a Masters in counseling psychology. The research that I wish to conduct focuses on exploring awareness, attitude and referral practices of health care providers to psychological services in Botswana.

The aims of my research are to:
1. Explore and describe awareness of psychological services.
2. Explore and describe the attitudes of health care providers towards psychological services
3. Explore and describe the referral practice of health care providers in relation to psychological problems

I am requesting permission to conduct research in November 2008 in the cities of Francistown and Gaborone.

Data will be collected by means of questionnaires, which will be administered to medical doctors, nurses, psychiatrists, psychiatrist nurses and social workers. Before completing the questionnaires, participants will be asked to complete consent forms and confidentiality will be maintained at all times. A full report of the findings will be presented to the participating departments.

Attached please find application forms, approval letter from the Nelson Mandela Metropolitan University Faculty Research Technology and Innovation Committee, copy of a full proposal for details, questionnaire, letter to the participant, consent form, my Curriculum Vitae and copy of my I.D.

Yours faithfully
Emma July (Researcher)                        Dr Diane Elkonin (Supervisor)
Appendix B
Nelson Mandela Metropolitan University
Po Box 77000
Port Elizabeth
South Africa

21 August 2008

The Ministry of Local Government
Research and Development Committee
Private Bag 006
Gaborone
Botswana

Dear Sir/Madam

Re: Application to conduct research at institutions

I am a Psychology Masters student at Nelson Mandela Metropolitan University in Port Elizabeth, South Africa. Part of my degree programme is to conduct research in partial fulfillment of the requirements of a Masters in counseling psychology. The research that I wish to conduct focuses on exploring awareness, attitude and referral practices of health care providers to psychological services in Botswana.

The aims of my research are to:
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2. Explore and describe the attitudes of health care providers towards psychological services
3. Explore and describe the referral practice of health care providers in relation to psychological problems

I am requesting permission to conduct research in November 2008 in the cities of Francistown and Gaborone.

The research will be done by means of questionnaires, which will be administered to medical doctors, nurses, psychiatrists, psychiatrist nurses and social workers. Before completing the questionnaires, participants will be asked to complete consent forms and confidentiality will be maintained at all times. A full report of the findings will be presented to the participating departments.

Attached please find approval letter from the Nelson Mandela Metropolitan University Faculty Research Technology and Innovation Committee (FRTI), copy of a full proposal for details, questionnaire, consent form, my Curriculum Vitae and copy of my I.D.

Yours faithfully
Emma July  (Researcher)      Dr Diane Elkonin (Supervisor)
Ms. Emma July
Nelson Mandela Metropolitan University
P. O. Box 77000
Port Elizabeth
South Africa

Dear Madam,

RE: GRANT OF A RESEARCH PERMIT

This serves to acknowledge your application for a research permit in order to do a study entitled “Exploring Awareness, Attitude and Referral Practices of Health Care Providers to Psychological Services in Botswana”.

The permit is valid for a period of three (3) months – beginning today up to January 08, 2009 – and it is granted subject to the following conditions:

1. Copies of the final product of the study are to be directly deposited with the Ministry of Local Government, Ministry of Finance and Development Planning, National Archives and Record Services, National Library Service and University of Botswana Library.

2. The permit does not give you authority to enter any premises, private establishment or protected areas. Permission for such entry should be negotiated with those concerned.

3. You conduct your study according to particulars furnished in application you submitted taking into account the above conditions.

4. Failure to comply with any of the above stipulated conditions will result in the immediate cancellation of the permit.

Yours Faithfully,

L. Kebakile

/For Permanent Secretary- MLG

CC: PS, Ministry of Finance and Development Planning
PS, Ministry of Labour and Home Affairs
Director, National Archives and Records Services
Director, National Library Service
Director, Research and Development, University of Botswana.
REFERENCE No: PPME: PS 13/18/1 Vol IV (5) 11 November 2008

Ms Emma July
P.O. Box 77000
Port Elizabeth
South Africa

Dear Ms July

PERMIT: EXPLORING AWARENESS, ATTITUDE AND REFERRAL PRACTICES OF HEALTH CARE PROVIDERS TO PSYCHOLOGICAL SERVICES IN BOTSWANA

Your application for a research permit for the above stated research protocol refers. We note that you have satisfactorily revised the protocol as per our suggestions.

Permission is therefore granted to conduct the above mentioned study. This approval is valid for a period of one year effective November 11, 2008.

This permit does not however give you permission to collect data from the selected sites without approval from the management. Consent from the identified individuals should be obtained at all times.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Health Research Unit and Development Division in the Ministry of Health for consideration and approval.
Furthermore, you are requested to submit at least one hard copy and an electronic copy of the report to the Health Research Division, Ministry of Health within 3 months of completion of the study. Approval is for academic fulfilment only. Copies should be submitted to all other relevant authorities.

Yours sincerely

P. Khulumani
**For/Permanent Secretary**
Appendix D
Nelson Mandela Metropolitan University
P O Box 77000
Port Elizabeth
South Africa
17 November 2008

The Chairman
Research and Ethics Committee
Princess Marina Hospital
Private Bag 258
Gaborone
Botswana

Dear Sir/Madam

Re: Permission to conduct research

I am a researcher who is interested in psychological services in Botswana. One of the requirements of the Nelson Mandela Metropolitan University is to conduct a research study in partial fulfillment of the Masters degree in counseling psychology. The research that I wish to conduct focuses on exploring awareness, attitude and referral practices of health care providers to psychological services in Botswana. The target population will be doctors, nurses, psychiatrists, psychiatric nurses and social workers.

The aims of my research are to:

1. Explore and describe awareness of psychological services of health care providers.
2. Explore and describe the attitudes of health care providers towards psychological services.
3. Explore and describe the referral practice of health care providers in relation to psychological problems.

The purpose of this letter therefore, is to request permission to undertake the study at your Institution. Attached please find a copy of research permit from Ministry of Health, my proposal, questionnaire, consent form and a letter to the participant.

Your cooperation in this matter will be highly appreciated.

Yours faithfully

Emma July
emma.july@nmmu.ac.za
Appendix D

Nelson Mandela Metropolitan University
P O Box 77000
Port Elizabeth
South Africa

17 November 2008

The Chairman
Research and Ethics Committee
Nyangabgwe Hospital
Private Bag 127
Francistown

Dear Sir/Madam

Re: Permission to conduct research

I am a researcher who is interested in psychological services in Botswana. One of the requirements of the Nelson Mandela Metropolitan University is to conduct a research study in partial fulfillment of the Masters degree in counseling psychology. The research that I wish to conduct focuses on exploring awareness, attitude and referral practices of health care providers to psychological services in Botswana. The target population will be doctors, nurses, psychiatrists, psychiatric nurses and social workers. The aims of my research are to:

1. Explore and describe awareness of psychological services of health care providers.
2. Explore and describe the attitudes of health care providers towards psychological services
3. Explore and describe the referral practice of health care providers in relation to psychological problems

The purpose of this letter therefore, is to request permission to undertake the study at your institution. Attached please find a copy of research permit from Ministry of health, my proposal, questionnaire, consent form and letter to the participant.

Your cooperation in this matter will be highly appreciated.

Yours faithfully

Emma July
emma.july@nmmu.ac.za
The Town Clerk
City of Francistown Council
Department of Public Health
Francistown

ATT: Chief Public Health Officer

Dear Sir/Madam

Re: Permission to conduct research

I am a psychology student at Nelson Mandela Metropolitan University in South Africa and I am interested in psychological services in Botswana. One of the requirements of the Nelson Mandela Metropolitan University is to conduct a research study in partial fulfillment of the Masters degree in counseling psychology. The research that I wish to conduct focuses on exploring awareness, attitude and referral practices of health care providers to psychological services in Botswana. The target population will be doctors, nurses, psychiatrists, psychiatric nurses and social workers.

The aims of my research are to:

1. Explore and describe awareness of psychological services of health care providers.
2. Explore and describe the attitudes of health care providers towards psychological services
3. Explore and describe the referral practice of health care providers in relation to psychological problems

The purpose of this letter therefore, is to request permission to undertake the study at the clinics in Francistown. Attached please find a copy of research permit from the Ministry of Local Government after reviewing my research proposal, questionnaire, consent form and letter to the participant.

Your cooperation in this matter will be highly appreciated.

Yours faithfully

Emma July
Email: emma.july@nmmu.ac.za
The Chief Community Development Officer
Department of Social Work
City of Francistown Council
Botswana

Dear Sir/Madam

Re: Permission to conduct research

I am a psychology student at Nelson Mandela Metropolitan University in South Africa and I am interested in psychological services in Botswana. One of the requirements of the Nelson Mandela Metropolitan University is to conduct a research study in partial fulfillment of the Masters degree in counseling psychology. The research that I wish to conduct focuses on exploring awareness, attitude and referral practices of health care providers to psychological services in Botswana. The target population will be doctors, nurses, psychiatrists, psychiatric nurses and social workers.

The aims of my research are to:

1. Explore and describe awareness of psychological services of health care providers.
2. Explore and describe the attitudes of health care providers towards psychological services
3. Explore and describe the referral practice of health care providers in relation to psychological problems

The purpose of this letter therefore, is to request permission to undertake the study in the institutions in Francistown. Attached please find a copy of the research permit from the Ministry of Local Government after reviewing my research proposal, questionnaire, consent form and letter to the participant.

Your cooperation in this matter will be highly appreciated.

Yours faithfully

Emma July

Email: emma.july@nmmu.ac.za
Dear Sir/Madam

Re: Permission to conduct research

I am a psychology student at Nelson Mandela Metropolitan University in South Africa and I am interested in psychological services in Botswana. One of the requirements of the Nelson Mandela Metropolitan University is to conduct a research study in partial fulfillment of the Masters degree in counseling psychology. The research that I wish to conduct focuses on exploring awareness, attitude and referral practices of health care providers to psychological services in Botswana. The target population will be doctors, nurses, psychiatrists, psychiatric nurses and social workers.

The aims of my research are to:

1. Explore and describe awareness of psychological services of health care providers.
2. Explore and describe the attitudes of health care providers towards psychological services
3. Explore and describe the referral practice of health care providers in relation to psychological problems

The purpose of this letter therefore, is to request permission to undertake the study in the institutions in Gaborone. Attached please find a copy of the research permit from the Ministry of Local Government after reviewing my research proposal, questionnaire, consent form and letter to the participant.

Your cooperation in this matter will be highly appreciated.

Yours faithfully

Emma July

Email: emma.july@nmmu.ac.za
Appendix E

Nelson Mandela Metropolitan University
P O Box 77000
Port Elizabeth
South Africa

13 December 2008

The Town Clerk
Gaborone City Council
Department of Public Health

ATT: Chief Public Health Officer

Dear Sir/Madam

Re: Permission to conduct research

I am a psychology student at Nelson Mandela Metropolitan University in South Africa and I am interested in psychological services in Botswana. One of the requirements of the Nelson Mandela Metropolitan University is to conduct a research study in partial fulfillment of the Masters degree in counseling psychology. The research that I wish to conduct focuses on exploring awareness, attitude and referral practices of health care providers to psychological services in Botswana. The target population will be doctors, nurses, psychiatrists, psychiatric nurses and social workers. The aims of my research are to:

1. Explore and describe awareness of psychological services of health care providers.
2. Explore and describe the attitudes of health care providers towards psychological services
3. Explore and describe the referral practice of health care providers in relation to psychological problems

The purpose of this letter therefore, is to request permission to undertake the study at the clinics in Gaborone. Attached please find a copy of research permit from the Ministry of Local Government after reviewing my research proposal, questionnaire, consent form and letter to the participant.

Your cooperation in this matter will be highly appreciated.

Yours faithfully

Emma July
Email: emma.july@nmmu.ac.za
Appendix F
PRINCESS MARINA HOSPITAL
INSTITUTIONAL REVIEW BOARD

Our Ref: PMH2/08-036

Date: 22\textsuperscript{nd} January 2009

Ms Emma July
P. O. Box 77000
Port Elizabeth
South Africa

Regarding: Exploring Awareness, Attitudes and Referral Practices of Health Care Providers to Psychological Services in Botswana

The Ethics Committee has reviewed your protocol as submitted and has granted approval to conduct the study. We note permission from the Ministry of Health, Research Unit

This approval is on condition that the researcher:

- Seeks permission from the head of the institution/department in which the study will be conducted.
- Resubmits for approval should any changes be made to the protocol.
- Provides both a hard and an electronic copy of the report when the study is finished.

The Committee would like to communicate its support in this very important endeavour. Your continued communication and update is greatly appreciated.

Chakawa Nthomiwa
Secretary
3902526 (office)
71420553 (mobile)
chakawa@orthosurge.co.bw/chakawa@hotmail.com

Please make any submissions via Beauty Khani, PMH Main Theater at 3621420/71537600, beauza2000@yahoo.com
Ethical review of proposed study: "Exploring awareness, attitude & referral practices of health care providers to psychological services in Botswana"

Name of applicant: Ms Emma July; (being a Nelson Mandela Metropolitan University graduate student)
Name of site: Nyangabgwe Referral Hospital (hereafter NRH)
Reviewer: Dr Selemogo
Date & place of decision: 23/12/2008, Nyangabgwe Referral Hospital

Decision

The above named study protocol fulfills all the necessary ethical requirements to give it a go ahead to be carried out at NRH.

- In its overall nature, the protocol may be classified “very low risk” study as it involves no patients (as a vulnerable population group), it is a non therapeutic research which poses no physical risks to the potential participants nor does it involve the use of procedures or devices about which there is limited knowledge. It further targets, as its participant pool, health care workers who are not ordinarily considered a vulnerable study population.
- The protocol also demonstrates the desired sensitivity to the ethical issues which are important to safeguarding the dignity and the rights of its participants particularly by its adequate informed consent procedures. Also notable is its safeguards to protect confidential and identifying participant information.
- Further strengthening its ethical validity is the social & scientific value of the information and knowledge it seeks to generate; information which might enlighten our institution about the usage & referral practices within our psychological services.

Follow-up requirements

The following standard requirements as pertain to the responsibilities of the researcher during the conduct of the study should also be observed:

1. The need to notify the committee in cases of protocol amendments (other than amendments involving only logistical or administrative aspects of the study).
2. The need to notify the committee in the case of amendments to the recruitment material, the potential research participant information, or the informed consent form.
3. The need to report to the HS any serious and unexpected adverse events related to the conduct of the study.
4. In case of a premature suspension/termination of the study, the applicant should notify the committee of the reasons for such suspension/termination.
5. NRH should receive notification from the applicant at the time of the completion of a study.
6. NRH should receive a copy of the final summary or final report of the study.

Signed: [Signature]
Dr Selemogo
Appendix G
GABORONE CITY COUNCIL
Reference no: GCC/H/8

Date: 20-12-2008

Emma July
Gaborone

Dear Sir/Madam,

RE: PERMISSION TO CONDUCT RESEARCH/PRACTICALS IN GCC HEALTH FACILITIES

This serves to let you know that permission is granted for topic:

EXPLORING AWARENESS, ATTITUDES AND REFERRAL PRACTICES OF HEALTH CARE PROVIDERS TO PSYCHOLOGICAL SERVICES IN BOTSWANA

This permits you to go into the health facility but you need to ask respondents for their participation. It should also not disturb the system in any manner during the course of the visit.

The facilities allocated are: ALL HEALTH FACILITIES.

By copy of this letter the Area Matrons and Nurses In-charge of Health facilities are informed of your intentions.

Thank you.

Yours faithfully,

P.O. Mudongo
for Town Clerk
Appendix H