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A Study of Mental Health Requirements among Adolescent School Pupils in Chiredzi District, Masvingo Province

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Abstract

Promotion of mental health for adolescents has become an emerging global concern since its absence brings in a myriad of challenges for adolescents in the form of antisocial behaviour, unwanted pregnancies, abortions, sexually transmitted infections and HIV among other problems. The study examined the need for mental health needs among adolescents in Chiredzi. The study triangulated quantitative and qualitative data. The survey, through the use of a questionnaire, was used to gather information from adolescents. Qualitative data was collected through the use of focus group discussions, in-depth interviews and key informant interviews. It was noted that there was limited emphasis on mental health issues within and among families because of limited resources for adolescents. This was also because of poverty, anxiety, the absence of support from extended family network, cultural initiation ceremonies, siblings and peer pressure. Consequently adolescents find themselves engaged in drug and alcohol abuse and became sexually active at tender ages. The study recommended school policy to support primary carers, that is, parents and communities in the promotion of good mental health for the benefits of adolescents and the nation as a whole. Furthermore the study, calls for the recruitment of school social workers to assist in the guidance and counselling of adolescents.

Introduction

Zimbabwe is one of the developing countries in the Southern African Development Community (SADC). The country has not been spared from economic, social and political challenges which have negatively trickled down to affect individuals and families (Kanyenze et al., 2011; UNICEF, 2003; Chingono et al., 2002). Such challenges resulted in some individual families failing to cope with the effects of economic,

social and political downturn (Watkins, 2000; UNICEF, 2006). The challenges also negatively affected orphans and other vulnerable children and, worse off, child-headed families, as some failed to go to school when donors, who used to assist in the payment of their fees through BEAM, withdrew funding (UNICEF, 2006; Powell, 2006; Felsman, 2006; Mushunje, 2006; Chase et al., 2006). Such hardships created negative effects on the learning abilities of school going pupils. This has led to all forms of mental disorders like adolescents opting for early marriages (UNICEF, 2006; Dhliwayo, 2009), abortions (Ahman & Shah, 2002; WHO, 2004; Dhliwayo, 2009), depression and suicide (Golightly, 2008; Brown et al., 2007; Gilbert 2003), sexually transmitted infections (UNICEF, 2003; Dhliwayo, 2009), and drug and alcohol abuse (Golightly, 2008; Sandhn, 1997; Rosa & Holleran, 2005).

The above studies focused mainly on trends, patterns and the consequences of such behaviours as early marriages, abortions drug and alcohol abuse, depression and suicide. The purpose of this study was to then focus on a holistic approach which emphasises on the promotion and protection of mental health and the prevention and treatment of mental illness or disorders among adolescent pupils in Zimbabwe. The problems included stigmatization, traditional and cultural beliefs, acceptability, accessibility, availability and quality of resources to adolescents. The study disclosed also the lack of information to the general public.

Chiredzi rural is dominated by the Shangaan ethnic group with a few of Venda, Ndebele, Karanga and Zezuru ethnic groups. Though the urban community is composed of all ethnic groups, Shona is the dominant language. Apart from Chivi district, Chiredzi, which is characterised by low rainfall patterns, is the second driest in Masvingo Province.

Mental health

WHO (2013:9) defined mental health as "a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work better productively and fruitfully and is able to make a contribution to her or his community". On the other hand mental illness is referred to as the "suffering, disability or morbidity due to mental neurological and substance use disorders,

which can arise due to generic, biological and psychological make-up of individuals as well as adverse social conditions and environmental factors" (WHO, 2013:9).

Good mental health for individual functioning and well-being can be demonstrated by independent thought and action, pleasure, happiness and life satisfaction (WHO, 2012; Berk, 2000; Rau, 2001). Mental health functioning can also be observed through social surroundings highlighting the opportunity to form relationships whilst being engaged with family members, friends and colleagues. It is only in loneliness, social isolation and difficulties in communication that individual adolescents are at risk in developing mental illness.

Mental well-being is important for a better quality of life. This means that happy and confident adolescents are most likely to grow into happy and confident individuals. These will make meaningful contributions to the nation as well (Rau, 2001).

Adolescents are people who are always viewed as healthy and yet 20% of them experience mental health problems like depression or anxiety (WHO, 2003). It is therefore, important to note that emotional health and well-being among young people have greater implications for self-esteem, behaviour, attendance at school, educational achievement, social cohesion and future health and life chances (Olwens, 1991). Those adolescents with a good mental health have better problem-solving skills, social confidence and a good sense of purpose. Such assets help adolescents to thrive in the face of challenges, and can avoid risk-taking behaviours.

According to World Health Organisation (2013) mental, neurological and substance use disorders exact a high toll, accounting for 13% of the total burden of the disease. Depression alone accounts for 4.3% of the global burden of the disease and is among the largest single causes of disability word wide particularly among women (WHO, 2012). There are over 200 types of mental disorders that affect people worldwide (WHO, 2013). However, the most common ones are a result of factors that include chemical imbalances in the brain, brain damage, emotional and psychological trauma, substance abuse, prolonged physical illness,

genetic factors and distressful events.

The risk factors associated with mental disorders include social exclusion, violence, peer rejection, isolation and lack of family support (Olwens, 1991). Scholars have suggested that strengthening adolescent protective measures in schools, at home and within communities in addition to improvement in quality mental health care will make some contributions to developmental outcomes for the vulnerable adolescents.

Methodology

Study design

The study used a triangulation of both quantitative and qualitative methods. A survey was used for collecting quantitative data. Focus group discussions (FGDs), in-depth interviews and key informant interviews were carried out to collect qualitative data. Adolescents aged 15 – 19 were chosen for the study as these were observed to be affected most from mental health issues (Zimstats, 2012). These are the ones presumed to be involved in risk behaviours and are of school going age.

Data collection methods and tools

Survey

A total of 100 questionnaires were administered to adolescents of school going age from the ages of 15 to 19 years. The idea was to quantify the magnitude of mental health needs of the school going pupils and some possible factors underlying the observed levels.

Sample size determination

To establish the number of respondents in the survey, the following formula was used $N= (Z^2pq)/e^2$, where N = desired sample, Z^2 = the standard normal deviate set at 1.96 which correspond with 95% confidence intervals, p = the proportion in the target population estimated to be aged 15 – 19; q = the estimated proportion of the target population who are not adolescents (1-p); e^2 = desired level of precision and for this study is set at 0.05.

According to the 2012 census, the total population for Chiredzi urban was estimated at 30594, where adolescents aged 15 to 19 years were

3090. Therefore, the following calculations were used to obtain the sample size $(1.96^2 \times 0.05 \times 0.95)/0.05^2 = 66$. However, the sample size was rounded off to 100 as a way of coming up with a better analysis.

Sampling procedure

Respondents were purposively selected from the randomly selected six wards of a total of eight wards of Chiredzi Urban District. The distribution of adolescent population per age group and per ward is shown on Table 1 below.

Table 1

Distribution of Adolescent Population in Chiredzi Urban District

	Age Group					
Ward	15	16	17	18	19	Total
1	126	121	112	209	213	781
3	26	23	22	19	25	115
5	105	93	97	88	217	600
6	126	129	127	109	219	710
7	75	64	62	65	61	327
8	109	98	86	78	186	557
Total	567	528	506	568	921	1183

Source: Zimstats (2012) Provincial Profile Masvingo

Probability proportionate to size sampling using the formula (Nn/N) was used to determine the number of respondents firstly per ward, Nn = number of adolescents in Ward X, N = total number of adolescents in wards and n = sample size. Given that the total number of adolescents in Ward 1 = 781 and total adolescents is 3090, the calculation of adolescents selected in ward 1 was 781/30390 x 100 = 25. The rest of the respondents per each ward are shown in Table 2 below. Probability proportionate to size sampling was used to calculate the number of respondents per age group in each ward, where Nn = total number of respondents in age x, in all wards and n = sample size. The distribution of the sampled population per ward is shown on Table 2.

Table 2

Distribution of the Sampled Population per Ward and Age Group

	Age Group					
Ward	15	16	17	18	19	Total
1	4	4	4	6	7	25
3	1	1	1	1	1	5
5	3	3	3	3	6	18
6	4	4	4	4	7	23
7	2	2	2	2	2	10
8	4	3	3	3	6	19
Total	18	17	17	19	29	100

Households (where respondents were to be drawn) were purposively selected from the Zimstats household units of 2012. If in the household, there were more than one adolescent, each adolescent was assigned a number and then a simple random procedure of assigning numbers to the adolescents and put the numbers in a hat and choose the figure randomly, as a way of selecting the one adolescent was conducted.

Focus group discussion (FGDs)

Four FGDs (using a FGD guide) were conducted for this study. Separate FGDs were carried out with adolescents. One FGD for boys, the other for girls (15-19 age group), one FGD for women and the other for men above the age of 40 years. FGDs were conducted so as to get the community perception of norms and values underlying mental health needs for adolescents and the quality of resources available to adolescents to deal with any form of mental health disorders.

In-depth interviews

Ten in-depth interviews were carried out (using an in-depth interview guide) with ten adolescents from the age of 15-19 years. This was carried out to get their feelings on mental health needs as adolescents.

Key informant interviews

A total of nine (9) key informant interviews (using a key informant guide) were conducted with teachers, psychiatric nurses, police victim friendly unit, a social worker and religious leaders.

The nine key informants were purposively selected for each group, one male and one female from each group. The social worker was the only male figure interviewed as he is the only one in the district. The interviews helped to establish the determinants of promotion of mental health among school going adolescents, appropriate statistics and possible recommendations from the experts in the community.

Data analysis

Survey data was analysed using the statistical package for social sciences (SPSS) version 22.0. The package facilitated the analysis of data through frequency distribution. Thematic frames were used to analyse qualitative data.

Ethical considerations

Permission was sought from Chiredzi Town Council and the Ministry of Education and the Department of Social Welfare. Participants for the study voluntarily participated through their own consent. For children below the age of 18, consent was obtained from their respective parents or guardians. There was full respect for respondents' participation. There was no deception as informed consent was emphasized. The study also adhered to research principles as regards to privacy and confidentiality.

In order to analyse the situation of adolescents in Chiredzi, the researcher utilised the Availability, Acceptability, Accessibility and Quality (AAAQ) Framework as it is presented in the UN International Committee on Economic, Social and Cultural Rights (ICESCR), General Comment Number 14, the Right to the Highest Attainable Standard of Health (UN, 2000). This framework comprised four interconnected and overlapping situations as follows:

Availability: The focus is primarily on the physical aspects of health services (such as hospitals, clinics, trained medical staff, medicines, clean water, sanitation facilities) and whether these would be readily available to adolescents in sufficient quantities. The same framework also include whether there would be health strategies and programmes such as national public plans, preventive health strategies and health promotion activities.

Accessibility with a requirement that health services should be accessible to everyone and having four overlapping dimensions such as non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility (the right to seek, receive and impart information on health).

Acceptability: This implied that health facilities, goods, and services should be gender sensitive and mindful of needs at different stages of life.

Quality required that health care services be sufficiently and medically appropriate, that health professionals be trained and skilled and that

drugs, medicines and hospital equipment be scientifically approved (UN, 2000).

There might be arguments made against using the AAAQ framework for this study, since it was developed in General Comment Number 14 to the ICESCR, a human rights convention that Zimbabwe has not yet ratified and is therefore not legally bound to implement. However, Zimbabwe is a signatory state of the ICESCR implying that the state has an intention to ratify the instrument. Zimbabwe is therefore obliged to "refrain from acts which would defeat the object and purpose" of the treaty (UN, 1969). Zimbabwe is also bound by other treaties that also embrace the right to best attainable physical and mental health (e.g. Convention on the Rights of the Child (CRC), and the African Charter on the Rights and Welfare of Children (ACRWC).

Findings

Socio-economic and demographic characteristics of respondents

The respondents were fairly balanced although the majority were females (52%). The mean age for respondents was 16 years.
All 15-19 year-old respondents were going to school and all of them had at least completed 10 years of schooling.

Table 3
Demographic Characteristics

	SEX		
	Male (%)	Female (%)	Total (%)
Age	47.7	52.3	100
15	18.8	22.0	18.4
16	14.1	20.1	17.1
17	14.3	18.1	16.4
18	17.7	19.1	18.4
19	35.1	21.3	29.7
Total	100	100	100

Table 4
Marital Status

Never Married	97.2	94.6	96.0
Married	2.8	5.4	4.0

Early stress related issues

Stressful situations are proxy to early alcohol abuse. Study results revealed that stressful situations are common among school going adolescents in Chiredzi District. The majority of respondents (94%) agreed that their colleagues had either abused alcohol (90%) or other drugs like cocaine (4%). These are believed to be dangerous drugs especially for adolescents. It was also interesting to note that more males (97%) were more likely to abuse drugs like *mbaje* (marijuana/ dagga) and (3%) cocaine. When asked about their individual experiences, it was observed that the majority of the respondents (87%) noted that they had abused either alcohol (70%) or some drugs like cocaine (17%). Consistent with their friends' experiences, more males (90%) agreed that they had abused alcohol than females (10%). The majority of the adolescent respondents had never married (97.2%) and some (2.8%) were married but were allowed to go to school by their husbands.

Many reasons were suggested as to why school going adolescents had to get into mental health problems at such early stages of their lives. The issues of poverty, lack of adult support and the economic situation affecting the country, the collapse of the extended family system and the need for financial resources from parents or guardians. It was interesting to note that nearly half (45%) females stated the desire for support through financial resources and other favours from parents and well-wishers as compared to paltry (2%) males. The concept suggested was that girls needed to take care of themselves (hygiene) more than boys.

Anxiety was noted among boys as the major drive to consider risk behaviour for males (39%) as compared to females (18%). Peer pressure had more influence on males (24%) resulting in alcohol and drug abuse than females (9%). The rest of the distribution as to why adolescents got into stressful situations was as shown below.

Table 5

Percentage Distribution of Why Adolescent Respondents Are Having Stressful Situations

Reasons why adolescents are stressed	Male %	Female %
Poverty	26.1	15.6
Anxiety	39.2	18.2
Loneliness	3.1	2.1
Peer Pressure	24.4	9.0
Part of Life	1.1	4.6
Lack of counselling services	1.7	3.2
Collapse of the extended family system	2.3	2.2
Financial and other desires	2.1	45.1
Total	100	100

N = 100

Availability

Key informant interviews with a female psychiatric nurse of a local hospital substantiated that girls had a higher percentage of mental health related situations due to their need for financial resources to spend on health issues than boys as she remarked:

> *From the cases of adolescents I have attended to, I have noted that some girls were found in possession of drugs in a bid to commit suicide as they noted that they had no money to buy necessities. Most of these girls admitted that they experienced some loneliness. Some girls hinted that they ended up using rugs which they could pick in bins as a substitute for cotton wool.*

A male psychiatric nurse also bemoaned the need for more psychiatric nurses and doctors and the non-availability of mental health services for adolescents as key in the area. Nurses end up doing the daily work at the hospital without the expertise of physicians. He remarked:

> *There are only four psychiatric nurses for the whole District and no psychiatrists for the whole province. There are also no recreational activities available for adolescents leaving them prone to antisocial behaviours.*

The scarcity of psychiatrists raised the issue of the hierarchical order within medicine and health care institutions, where these physicians would be the only professionals with the status and right to decide on issues regarding medical treatment of patients.

Results revealed that adolescents experience mental health challenges before the age of 16. More than three quarters of the adolescents agreed that they ended up indulging in alcohol and drug abuse before the age of 16 as they experienced some life challenges. When respondents were asked about their personal experiences, 76% reported that they experienced loneliness in their lives. Of the 76%, 80% reported to have had experienced stress related issues in their lives before the age of 16. Analysis by sex revealed that more females (84%) than males (68%) had experienced stress related challenges.

Another challenge was the non-existence of specialised facilities for mental health care. The lack of facilities for children under the age of 16 requiring mental health treatment was so critical in the area. There were also incidences of those who were suffering from multiple diagnoses, especially those who suffered from both substance abuse and mental disability who were highly vulnerable but failed to get appropriate support.

One psychiatric nurse revealed that:

> *We do not provide services to those patients with substance abuse such that we just tell them to go home especially if we have a backlog of patients with other serious problems.*

Adolescents argued that there is lack of information and knowledge concerning the treatability of mental health problems in society. The general public was often not aware of lesser known mental health care services besides visiting traditional healers. Respondents saw this partly as a result of policy makers, politicians and the country's health policies that focus on certain mental problems and not others. According to a key respondent, there was awareness of psychosis as a mental problem in the community that affect men due to substance abuse. This showed itself through aggression and violence by those affected. However, some disorders like anxiety and depression which are more likely to affect women than men, in comparison to psychosis, are less visible to the public. The respondent, a nurse noted:

> *Anxiety disorders, I believe, they are grossly underestimated among adolescents or not diagnosed at all. They only come to the attention of medical profession if they have a panic attack or*

something of that nature. There is a likelihood that there must be literally hundreds if not thousands of adolescents out there with post traumatic stress disorders, the amount of assaults and family violence they usually encounter.

The majority of respondents noted that they normally consult traditional healers in cases of treatment of mental health problems which are regarded as a result of an avenging spirit. One respondent from an FGD noted that:

We really believe that mental health issues are supposed to be treated at health centres but we are also aware that not all of them can be treated there especially those caused by avenging spirits. These cannot be treated using western medicine.

Quality

The decision to incorporate mental health care into primary care in accordance with the Mental Health Act has resulted in some patients incorrectly referred to wrong facilities in the health care system. Admission of patients at primary level care was observed as the main reason for such a challenge. One key informant noted that:

It will only work if a total system; the total primary care is well attended to, well managed, such that people know what they are doing. There needs to be in place the correct skills at all levels. Now very often you find that in primary care, the people are skilled to manage diabetes and hypertension and know how to do a blood pressure, but do they know how to cope or manage a psychotic patient? They do not know how to manage a patient in a multidisciplinary in a holistic context.

Whilst respondents in all FGDs noted that the appropriate age for engaging in drug and alcohol abuse resulting from stress was 19 and 20 for boys and girls respectively, results from this survey showed that the average age for engaging in drug and alcohol abuse was 15. It was also observed that 5% of the adolescents became active abusers of drugs and alcohol as early as 12 years.

Table 6
Percentage Distribution at First Experience of Stress Related Alcohol and Drug Abuse

Age	Percentage
12	4.6
13	3.6
14	2.6
15	69.2
16	5.8
17	8.9
18	3.7
19	1.6
	100

N = 76

Accessibility

Accessibility to information by adolescents was a major challenge in times of need. The fact that adolescents experienced mental health problems as early as 15 years was supported by a female in one FGD who reported that:

> *I have also experienced social isolation from as young as 14 years when both of my parents passed on and I had no-one to turn to for personal and siblings' needs. Because of my huge body, some men were taking advantage of my orphan hood and tried to engage me in sexual activities. Some neighbours had to intervene only to find out that they only wanted to exploit me as well. I had no information as to whom I could turn to for assistance and it resulted in me getting a lot of pressure than what I could afford to absorb. At times adult women could assist.*

Results from multiple response questions of the survey showed that there were a number of factors at play in early mental health related challenges among adolescents indicating a non-availability of support. These included peer and sibling pressure (89%), financial and other material desires (89%), loneliness (94%), lack of counselling and adult support (86%), poverty (85%), and anxiety (88%).

All FGDs reported the need for financial and other material desires as major determinants for adolescent girls' involvement in stressful circumstances. There was an agreement that accessing information by adolescents was also a challenge. Another woman in the 40 year age group indicated above revealed that:

When we grew up, it was a norm that we had to receive support from every other family relations and we were well protected as girls, nowadays girls no longer have that privilege and are susceptible to men who can present to them with financial resources or attractive material possessions which might result in sexual exchange resulting in the girl giving in because she might require the presented items especially money.

Poverty and lack of counselling and adult support were also cited as major factors leading to stressful challenges. It was interesting to note that more females (60%) experienced depression than males (40%).

One female orphan adolescent from an in-depth interview noted that:

Lack of parental guidance or counselling and general adult support has seen us getting into serious stressful challenges. As a result we are always eager to get something to comfort us thereby engaging in drug and alcohol abuse and sexual intercourse at early ages.

This was supported by one male adolescent from an in-depth interview who also noted that:

We used to always hear from our peers and some adults that alcohol releases stress. Actually one of my friends indicated that his first day of taking alcohol was a nice and enjoyable experience. All he remembered was that he found himself at home but never thought of looking for food after the day's drinking. It was like I was in a trance. So who else does not want to have such a taste of an experience? Believe me or not, alcohol is enjoyable and refreshing.

Early indulgence in drug and alcohol abuse seemed to be aggravated by the belief that abusing alcohol relieves psychological and social distress. Respondents in the adolescent FGDs who supported the idea of taking alcohol as a sedative drug for releasing stress argued that alcohol was an answer to release pressure. One male adolescent remarked:

You cannot continue to suffer without any food or support. You can be engaged in cutting sugarcane for a farmer for a weekend

and get your money. This will be enough to buy you alcohol and drink. Once you take it, you forget all the challenges you face on this mother earth. You also forget that you need to go to school.

Therefore, the majority of adolescents (53%) answered in the affirmative that alcohol was a stress reliever. There were fewer girls (40%) than boys (60%) who abused alcohol.

A majority of girls (75%) lured older men for sex for financial support. Of the 25% boys who lured older women for financial support, 45% of them were also engaged in homosexuality.

Traditional and cultural beliefs of the community

According to some respondents, many patients of Shangaan origin would consult with or are taken by their relatives to a traditional healer when they show signs of mental health challenges. This was found to be common if a person was suffering from mental health problems. The reason put forward was either that the individual adolescent was called to become a traditional healer (*nyanga)* or possessed by evil spirits or demons (*tingulube*). However, if such suspicions could not materialise, the patient would be taken to a health clinic. One nurse commented:

Patients go to traditional healers first and what is puzzling to me is that individual families would take a severely ill young person to a traditional healer. The family would get a lag time of two to three years before the patient comes to see you at a health centre for assistance.

Family members take responsibilities for the care of their children and it is difficult for those without family support. Another male adolescent in the FGD supported the idea as he remarked:

If you do not have any relative to take care of you, your only friend who does not reject you in times of need is alcohol or marijuana.

Key informant interviews with teachers emphasized the lack of parental guidance and supervision and the disintegration of the extended family system as major causes of mental ills that take place among adolescents.

All FGDs reinforced that the non-availability of uncles and aunts was a powerful missing link in the socialization process of adolescents. One male respondent in the 40years aged group FGD remarked that:

> *Urbanisation and migration coupled with HIV and AIDS has generally led to the fall of traditional systems of socialization of children and adolescents. Traditionally, grandfathers and uncles had the role of training young boys during men's meeting place (dare). Girls had aunts training them on how to look after themselves and their future families and there was a saying musha mukadzi (A home can only be good because of a woman). The role of the extended family has been eroded paving way for nuclear families. This has led to adolescents to fail to have the rich reproductive and health education necessary for good mental health where adolescents learnt through venting out their social and psychological challenges they experienced The roles of grandparents, aunts and uncles have since been transferred to professional guidance which is also non-available.*

One female adolescent from an in-depth interview also noted:

> *These days as adolescents we lack support from adults, in particular, on the challenges of growing up. Traditionally, aunts and uncles had the mandate to make sure adolescents were well-groomed, but with modernisation, the role has been shifted to parents and for those without parents, it has become a disaster. There is no sex education being taught because parents fear to teach their children the practice which may result in prostitution.*

The concept of sex-education leading to prostitution was well supported by FGDs in 40 years and above age group. One female responded asserted that:

> *It is not proper to give sex education as this would automatically encourage early sexual intercourse resulting in prostitution. There is a tendency for adolescents to practice what they have been taught. It would then result in them trying to establish that which they have been forbidden through sexual intercourse and drug and alcohol abuse.*

One key informant was of the opinion that adult individuals are no longer exercising their full responsibility of caring for children who might not be necessarily their biological children. They were the ones who were the perpetrators of abuse on children and adolescents. One male respondent noted that:

> *It is becoming difficult to train our own children as this should now be the role of teachers and pastors as in the traditional system, it was not the biological parent but uncles, aunts and grandparents.*

Alcohol and drug abuse has been associated with perpetration of violent behaviour among adolescents. One male teacher in a key informant interview acknowledged that:

> *These adolescents have no fear in being engaged in violent activities. They can even attack a teacher without fear, worse still any other member of society. Guidance and counselling in schools at times fail to reprimand them. Even those adolescents with parents fail to supervise their own children.*

One key informant interview with one pastor noted that:

> *We try our level best as servants of God to provide counselling but nowadays adolescents are full of wanting to experiment. It is only in very rare cases when we talk about sexual reproductive issues. We normally talk about drug and alcohol abusers but not always.*

A female teacher acknowledged that the Ministry of Education Sports and Culture has introduced Guidance and Counselling in schools in a bid to cater for issues of stress management among adolescents and some schools have taken this seriously though there is no syllabus for the subject to provide information to adolescents. The subject is not examined come end of year by Zimbabwe Schools Examinations. Each school or each teacher chooses to teach what he or she feels is of importance. One male key informant teacher reiterated that:

> *The course has not been given enough emphasis as one teacher can teach the whole school and in some cases, the Headmaster is the one who teaches it. Therefore, pupils who are depressed are not normally attended to immediately until a serious mental challenge comes to be identified very late.*

The informant gave an example of six boys who were expelled from school after it was discovered that they were taking turns to have sex with a girl in the boys' toilet during lessons.

One male pastor also acknowledged that:

> *I rarely meet adolescents with mental health challenges as those below 16 years; they normally meet as Sunday school pupils. It is also rare that we talk about sex education in our church.*

One female pastor felt it was spiritual poverty and it was the works of the devil which led to mental health related drug and alcohol abuse. During the interview she mentioned that:

> *Adolescents now engage in drug and alcohol abuse because they are dragged by the devil in such practices and they lack direct communication with God whose spirit will be lost in the wilderness. Adolescents' bodies are God's temples which need no defilement at any cost.*

One key informant, a social worker, acknowledged:

> *Adolescents need proper guidance from adult carers. They need to be individualised and never to be blamed for whatever wrong they might have committed. The carer should look at the person-in-situation. This will help them to realise that they are being accepted in society. Blaming the victim perpetuates bed behaviour.*

The social worker advocated on behalf of school adolescents that, just like in developed countries, the Ministry of Education should begin to think about the recruitment of school social workers with the advent of new challenges affecting adolescents in schools.

All FGDs reported that adolescents suffer from depression because they lack family and professional proper support from adult carers. This was supported by Victim Friendly Unit (VFU) Officers who reported that most violent cases reported involved adolescents and cases of rape recorded involved at least an adolescent known to the victim.
As reported by one key informant:

> *Sexual Offences Act is not consistent in its purpose in protecting*

victims especially girls. It protects girls below the age of 16 and boys below the age of 14.

It was reported in all FGDs that poverty and current economic hardships affecting the country since 2000 were the major drives of mental health problems among adolescents in schools. One male key informant teacher reported that:

> *It is becoming difficult for an adolescent to have one meal a day and he or she can decide to find someone who is prepared to provide her or him with something in exchange for sex and deny that offer.*

The teacher also noted that a local NGO which used to provide *maheu* (a traditional non-alcoholic drink) in school has since stopped the support as it was also experiencing financial challenges to fund the programme.

The problem of poverty led to adolescents to steal as one police officer reported:

> *Cases of stealing and shoplifting by adolescents are rampant as adolescents find it difficult to survive just for a day. The majority of the adolescents might have failed to go to school and thereby ending up involved in elicit deals.*

The global technological advancement has brought in a new wave of bullying in schools (Olwens 1991). One male key informant teacher revealed that:

> *Cyber bullying has brought a threat to adolescents in schools as some adolescents are failing to attend classes and some end up committing suicide. The case of communication has helped to move bullying harassment at school playgrounds into cyber space. The media has also become a centre for learning all unnecessary information where children become exposed to all forms of pornography as well.*

In some adolescent FGDs, it was argued that traditional initiation rites have brought about stressful situations in which boys and girls are engaged in traditional training practices of being a proper husband and wife. One male member of the adolescents group noted:

> *You feel like very stressed when August holidays come and you*

are aware that you have not been circumcised. The worst thing is that society emphasizes manhood through cutting the foreskin direct with a knife or razor blade without any medical intervention (anaesthesia).

They also noted that this encouraged early sexual activity because soon after training girls would be free to marry if they were of a marriageable age. One male adolescent respondent in one FGD also argued that:

Once you have successfully gone through the traditional rite, you will be ready for marriage despite your age.

One male key informant teacher also reported that such initiation rites in neighbouring South Africa have turned out to be initiation schools of death. He asserted that:

Out of the six years one tribe has been involved in circumcision rites, 413 lives have been lost, 190 penises have been lost and 5000 boys have been hospitalised. These initiation rites have been turned into initiation schools of death.

Discussion

Promotion of mental health in Chiredzi has proved to be a need as more of adolescents raised issues where there was need for support. The fall of the extended family has been observed to be a challenge for adolescents especially those without living biological parents. This has been found to be consistent with findings by Powell (2006), Mushunje (2006), and Chase et al. (2006) who identified the challenges faced by orphans and other vulnerable children in the absence of their biological parents.

Accessibility

The study has identified lack of staff such as psychiatrists and psychiatric nurses to deal with general mental health issues in Chiredzi. This would result in lack of accessibility to the right to health in Zimbabwe.

Respondents also noted lack of privacy to deal with mental health issues. They noted that in the majority of cases priority is given to other health problems as compared to persons with mental challenges.

There also issues of lack of in-patient facilities for children. This led to children who develop mental health problems to belong to two groups of vulnerable people at the same time as this calls for the situation to be observed from two intersectional perspectives. Taking from the human rights point of view, the lack of treatment facilities for children and the lack of properly trained staff to deal with children's mental health needs is a violation of the right to health as enshrined in the convention on the rights of children.

Respondents also recognised the lack of facilities to cater for the needs of people suffering from multiple conditions such as mental health challenges and drug abuse.

Information availability

Respondents also noted the lack of information on mental health needs. They lack information on the treatability of certain mental health challenges and at times they delay seeking medical help because of lack of information. As a result some respondents believe that some mental health challenges are evoked by avenging spirits and thus may not need the services of medical personnel services.

Respondents also noted that certain cultural practices and beliefs of the Shangaan community have developed peculiar perceptions and understandings of mental health, particularly on psychosis. These have made patients and their guardians inclined to seek help from traditional healers rather than visiting a medical health centre.

The practices of seeking support from traditional healers as associated with cultural perceptions pose an interesting problem from a human rights perspective. According to UN ICESCR's General Comment No. 14 "health services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines' (UN, 2000). At the same time, countries are also obliged to "discourage the continued observance of harmful traditional medical or cultural practices" (UN, 2000). A study by Misisi et al. (2012) in Uganda suggests that "there may be some positive effects for patients with psychosis who combine both biological services and traditional

healing". Kaseke et al. (2012) also noted that though most literature is replete with references to community participation and self-determination, most programmes by both government and non-governmental organisations seldom integrate them with indigenous practices. This has led many governments being criticized for failing to pay attention to the views and practices of local people despite claiming to be highly sensitive to local people and their aspirations. This calls for a proper research to establish the real position of traditional medicines as compared to western medicines in treating mental health challenges.

Poverty has been an issue in calling for support in promoting good mental health among the adolescents in Chiredzi. This is congruent to findings by UNFPA (2003) and UNICEF (2001) in which poverty is recognised as encouraging high risk behaviour of engaging in early sexual activities to deal with its effects. The study noted the need for survival as a priority in which adolescents get engaged in high risk behaviours to deal with the stressful environments.

Lack of proper guidance

The current generation of adolescents growing up have a big challenge in that the extended family network system has collapsed leading to nucleated families in which resources for extended members of the family are limited or non-existent. The absence of grandparents, aunts, uncles and professionals to provide proper socialisation process has seen most adolescents falling into mental health challenges.

The traditional ritual systems which initiated adolescents into manhood and womanhood through socialization processes have since disappeared. The roles have been left to parents and professionals. Parents have also perceived sex education as a taboo. In this study, it has been noted that adolescents lack proper sex education leading them into unprotected sex and acquiring diseases and unwanted pregnancies.

In order to do away with mental health related issues, adolescents end up receiving support from siblings and friends. These have led the adolescents into serious challenges. As shown in this study, adolescents end up practising what their friends encourage them to do as a way of trying to do away with their mental health challenges. The AAAQ

Framework sees the instability and unpredictability of traditional family life as the most destructive force to an adolescent's development (UN, 2000). Therefore, according to the framework, lack of information on mental health issues made adolescents explore other parts of their environment. This would encourage mental disorder for the respective adolescent. The adolescents then aligned themselves with adolescents with antisocial behaviour, and this leads to lack of self-discipline and inability to provide self-direction (Addison, 1992).

Recommendations

In his inaugural address on 20 January 1961, John F. Kennedy once said, "If a free society cannot help the many who are poor, it cannot save the few who are rich" (Henderson, 1995:17). The speech by Kennedy takes cognisance of the findings of this study. The following recommendations, among others, would be imperative in saving the lives of adolescents from further harm:

- Information on mental health issues should be made readily available to adolescents such that they can easily make rational decisions regarding their future.
- The government of Zimbabwe should consider retaining qualified personnel working in the health sector such as psychiatric nurses and psychiatrists to help deal with mental health issues affecting children and adolescents.
- The government should consider employment of social workers to work within the Ministry of Education to work with adolescents.
- The government should, therefore, train and employ more Psychiatric Doctors, Psychiatric Nurses and Social Workers who can work for developing a better health care system for the rest of the society.
- This can then be reinforced by societal values, legislation, and financial resources which should be made available to needy families to function normally.
- Teachers should encourage the full development of the guidance and counselling as a course examinable like other subjects. Teachers and schools are an important component in the development of adolescents' future.
- Schools and teachers should develop a concept of supporting

primary care givers, parents, as this will create an environment that welcomes and nurtures families. The family is the most important component of the adolescent's development. Nutrition, security, health and belief systems are all developed into the adolescent through the family. Therefore pupils who get to schools are a product of different families. Teachers should then be able to deal with the variety of family systems as a way of trying to understand their pupils.

- Adolescents spend most of their time in schools. This means that a relationship developed at school becomes critical for the adolescent's positive development.
- The church should be obligated to take care of adolescents who attend their service. The relationships created outside the family become critical for the adolescent's cognitive and emotional development. The Archbishop of Canterbury, George Carey in 1996 once said "We must recall that the church is always one generation away from extinction" (Carey, 1996).
- The church should be a source of moral and ethical values.
- Religion should be an integral part of culture. The virtues of most religions are the same; love, respect, tolerance and honour. These should be instilled among adolescents.
- The guidance and counselling syllabus should also be based on such virtues and becomes reinforced by positive values from the church and family. These will also create a better world for good metal health for adolescents.

Conclusion

Chiredzi District has demonstrated the need for promoting mental health. There is also need to fight stigma associated with mental disorder. There is need to develop a holistic package which include families, churches, schools community and government in promoting mental health for the benefit of everyone in society. All aspects of society should reinforce the virtues of love, respect, tolerance and honour. The government, through legislation, should make sure mental health needs of adolescents should be availed at affordable costs. Accessibility for mental health needs should be made with qualified personnel made available to everyone who need them.

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