ENHANCING THE UTILIZATION OF PRIMARY MENTAL HEALTH CARE SERVICES IN DODOMA, TANZANIA

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DECLARATION

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

This research study aims at enhancing the utilisation of primary mental health care services in Dodoma, Tanzania. Primary health care (PHC) according to the Alma Ata conference 1948 is an essential part of the health care system for bringing health care closer to where people live and work, is people-centred, affordable and achieves better health outcomes, and is considered to contribute to communities' social and economical development. PHC facilities in Tanzania are health centres and dispensaries, which are within five kilometres from where people live. In the 1980s' countries integrated mental health into PHC to improve the mental health status of their people. To facilitate delivery of Primary Mental Health Care (PMHC), Tanzania has formulated a mental health policy and trained PHC workers on mental health. Despite of these efforts, people still go to referral hospitals for mental health care services. However, authors commented that "when comprehensive primary health is implemented fully" it will bring about security, safety and hope to people and therefore, they will continue to fend for health for all.

The main aim was to explore and describe why people go to referral hospitals instead of utilising PMHC services closer to them. A qualitative descriptive clinical ethnographic research design was employed to examine the mental health care-giving within the context of this research. Purposive non-probability sampling was utilised. Sample size was determined by the saturation. Data collection methods were in two phases. Phase one was participative observation on mental health care-giving in the Primary Health Care (PHC) facilities for a period of at least four weeks, and phase two was by use of an in-depth interview with family members at referral hospitals who had passed Primary Health Care facilities.

Data analysis was an open thematic coding. Trustworthiness of the research was established through credibility, dependability, conformability, triangulation and a thick description.

The findings of this research suggested that there is inadequate service delivery at PHC facilities, disrespect of patients and lack of knowledge on available services and on referral systems, which led to not utilising the available Primary Mental Health Care services. In conclusion the researcher expresses the recommendations of this research in the form of strategies.

OPSOMMING

Hierdie navorsing is daarop gemik om die gebruik van primêre geestesgesondheidsorg dienste in Dodoma, Tanzanië te bevorder. Volgens die Alma Ata verklaring van 1948 is primêre gesondheid sorg (PGS) ’n noodsaaklike deel van die gesondheidsorg stelsel ten einde gesondheidsorg nader na mense werkplek en tuistes te neem. PGS is persoons-gesentreerd, bekostigbaar en het beter gesondheids resultate, dit word aanvaar dat PGS bydra tot die sosiale en ekonomoiese ontwikkeling van gemeenskappe. PGS fasiliteite in Tanzanië is hoofsaaklik gesondheidsentra en apteke, wat binne ’n radius van vyf kilometere vanaf mense se woninigs is. Gedurende die 1980’s het lande geestesgesondheid integreer in die PGS stelsel in ’n poging om die geestesgesondheidstatus van mense te verbeter. Ten einde die lewering van primêre geestesgesondheid sorg (PGGS) te verbeter het Tanzanië ’n geestesgesondheidsbeleid geformuleer en primêre gesondheidsorg werkers opgelei in geestesgesondheidsorg. As omvattende primêre gesondheidsorg ten volle implementeer is sal dit bydra tot sekuriteit, veiligheid en hoop en mense sal aanhou veg vir ”gesondheid vir almal”.

Die hoofdoel van hierdie navorsingstudie was ’n ondersoek en beskrywing ten opsigte van die redes waarom mense eerder verwysings hospitale as PGS fasiliteite nader aan hulle besoek. Die navorser het gebruik gemaak van ’n kwalitatiewe, beskrywende kliniese etnografiese studie ten einde geestesgesondheidsorglewering te ondersoek binne die konteks van hierdie studie. Die navorser het doelgerigte nie-waarskynlikheids steekproefneming gebruik en die versadigingsvlak is bereik deur middel van data-saturasie. Data is tydens twee fases ingesamel. Fase een was gekenmerk deur deelnemende observasie ten opsigte van geestesgesondheidsorg lewering in ’n PGS fassiliteite. Tydens fase twee het die navorser in-diepte onderhoude gevoer met famililede van die persoon wat eerder die verwysings hospitaal as PGS fasiliteit besoek het.

Data analise is gedoen deur tematiese, kwalitatiewe kodering te gebruik. Betroubaarheid van die navorsing is verkry deur middel van vertrouenswaardigheid, eerbaarheid, triangulasie en in-diepte beskrywing. Die bevindings van hierdie navorsings studie suggereer die teenwoordigheid van ondoeltreffende diens lewering by PGS fasiliteite, onrespekvolle hantering van pasiënte en gebrekkige kennis rondom die beskikbare dienste en verwyssings stelsel in plek, derhalwe maak pasiënte eerder gebruik van die verwysings hospitale.

Gevolglik beveel die navorser aan dat strategieë gebasseer op die resultate van hierdie navorsings geïmplementeer word.

DEDICATION

I dedicate this thesis to my husband Charles, my daughter Subira and my sons David and Shemu. Thank you for everything. I love you.

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List of Acronyms and abbreviations

BOD	Burden of Disease
CO	Clinical Officer
CHF	Community Health Fund
CPD	Continuous Professional Development
DALY's	Disability adjusted Life Years
DHMT	District Health Management Teams
EN	Enrolled Nurse
HAM	Huduma za Afya ya Msingi
MCHA	Maternal and Child Health Aid
MDG	Millennium Development Goal
MOHSW	Ministry of Health and Social Welfare
NGOs	Non- Governmental Organisations
NHIF	National Health Insurance Fund
NSSF	National Social Security Fund
PHC	Primary health care
PHSDP	Primary Health Service Development Programme
PMHC	Primary Mental Health Care
PMO-RALG	Prime Minister's Office- Regional Administration and Local Government
UNICEF	United Nations Children and Education Fund
WAUJ	Wizara ya Afya na Ustawi wa Jamii
WHO	World Health Organization
WMHD	World Mental Health Day

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Chapter 1

OVERVIEW OF THE RESEARCH

1.1 Background

Primary health care (PHC) according to the definition of Alma Ata conference is the feasible and realistic health care provided within reach of individuals and families at a reasonable cost using simple and available technology (Jenkins & Strathdee, 2000:277). It is an essential part of the health care system and considered to contribute to the lowest level of the communities' social and economical development (Jenkins & Strathdee, 2000:277). Bringing health care close to where people live and work makes primary health care to be universally accessible and affordable. To be more effective this care should include "promotive, preventive, curative and rehabilitative" services (Baum 2007:35).

Hence, PHC is an important approach to the improvement of health systems in many countries following the International Conference of Alma Ata (WHO, 2001b:59). It creates a sustainable health system in both rich and poor countries, it is people-centred, accessible, affordable, and equitable and capable of achieving better health outcomes, and its implementation leads to an effective and more coordinated health system (Baum, 2007:40). Every person is expected to receive health services nearest to where she or he lives (Funk & Ivjibaro, 2008:22). For people living in the communities in Tanzania, the nearest place for services would be within the PHC facilities that include, the health centres and dispensaries (MOHSW, 2006:17).

Baum (2007:40) further urges that "when comprehensive primary health care is implemented fully" it will bring about security, safety and hope to people and therefore leaders and decision makers will continue their efforts to secure health and proper health care for all. Comprehensive mental health care services that include primary, secondary and tertiary prevention can be provided as promotive, preventive, curative and rehabilitative services as an ideal approach to address needs of patients/clients at primary health care level (Uys & Middleton, 2004:67).

It is estimated that in Tanzania 90% of the population is at a distance of about 8 to 10 kilometres from the nearest PHC facilities, which makes it possible for people to access and utilise local services, rather than travel a long distance for services in larger health care institutions (Masaiganah, 2004:136). Based on personal observation, people still do not make use of these PHC facilities. The importance of making use of services in primary health care facilities is supported by Ngoma, Prince and Mann (2003:352) in their statement that 24% of those presenting at primary health care facilities have mental health problems and therefore primary mental health care services cannot be ignored.

To improve people's mental health WHO has recommended that mental health should be integrated into primary health care (Uys & Middleton, 2004:64). Moreover, studies reveal that integration of mental health into primary health care, provides access to mental health services, continuity of care, holistic and cost-effective services, promotes human rights and reduces disease burden (Funk and Ivjibaro, 2008:21, 22; Jenkins & Strathdee, 2000:279). Mental health care service delivered at primary health care facilities is also known as primary mental health care (Baumann, 2008:5).

1.2 Introduction

In the 1980s the World Health Organization (WHO) recommended countries to improve mental health through integration into primary health care (Funk & Ivjibaro, 2008:128). In 1992, the Tanzania Ministry of Health reviewed its PHC strategy, resulting in decentralisation from national to district level (Manongi, Marchant & Bygbjerg, 2006:1). In 2007 a Primary Health Services Development Programme (PHSDP) was launched to speed up provision of quality primary health care services to all by 2012 (MOHSW, 2007:16). Since then several reforms have been made to sustain the PHC strategy in Tanzania. At the 62nd World Health Assembly several issues were discussed, the main issue was being health equalities and improving health for all as a renewal of PHC (WHO, 2009:1).

In support of the WHO recommendation (WHO, 2001a:10), Tanzania is making efforts to ensure that mental health is improved through integrating it into PHC, as it has formulated a mental health policy, is training professionals and front-line health workers on mental health and has recently launched a PHSDP (MOHSW, 2007:16). In 1980 Tanzania was the first

country in Sub-Saharan Africa to incorporate mental health services into PHC. The PHC setting is a place where people with mental health problems can be identified and treated (Funk & Ivbijaro, 2008:17). In Tanzania 90% of the people live within five kilometres from PHC facilities and would therefore have access to such facilities (MOHSW, 2007:12). However, based on personal observation, most people in Tanzania still visit distant referral hospitals for mental health care services.

1.3 Problem Statement and Research Question

1.3.1 Problem statement

Allwood et al. (2001:7) suggest that "mental health services that are to be effective and user-friendly should be within the reach of each individual, all communities even in the most remote, underserved areas, are entitled to equal services." Several efforts have been made by Tanzanian Government to improve the services such as training of health workers, rehabilitation of infrastructure and construction of new facilities. However, a major challenge remains on how to increase access to such quality mental health care to all, to each and everyone, regardless of where he or she lives or where his or her community is situated (WHO, 2001a:10).

It has been observed by the researcher that people living in the communities (more rural or remote) do not utilise mental health services available within the PHC facilities when they experience mental health challenges. Instead of doing so they seek services in referral hospitals, that are distant and more expensive. Adding to this challenge, in spite of the training of health workers in PHC facilities, and the close distance, mental health care users continue to pass the PHC settings. A spontaneous question therefore, arises as stated below:

1.3.2 Research question

What are the reasons for people with mental health challenges to attend distant referral hospitals rather than local PHC services in the Dodoma region, Tanzania?

1.4 Rationale of the research

This research endeavours to enhance the utilisation of primary mental health care in Dodoma Municipality. In the researcher's experience no strategies for enhancing the utilisation of mental health services in the PHC facilities do exist. Therefore, this research is to explore reasons as to why people go to distant referral hospitals, instead of using primary mental health care services closer to them and, accordingly, to develop strategies to enhance the utilisation of primary mental health care services to people with mental health challenges in Dodoma Municipality.

1.5 Research aim and objectives

1.5.1 Research aim

The aim of the research was to accomplish the following:

To explore and describe why people seek assistance at distant referral hospitals, instead of primary mental health care services closer to them. According to the results obtained strategies will be developed to enhance utilisation of primary mental health care services in Dodoma Municipality, Tanzania.

1.5.2 Research objectives

The purpose of the research was to enhance the utilisation of primary mental health care in Dodoma, Municipality. In order to achieve this purpose the objectives of the research included the following:

- To determine availability of mental health care-giving in the primary health care facilities in Dodoma Municipality
- To investigate the reasons why people go to referral hospitals, instead of utilising primary mental health care services closer to them
- To develop strategies to equip communities at large, and more specifically families of mental health care user, with better knowledge and information on primary mental health

1.6 Central theoretical argument

The participative observation of mental health care-giving in the primary health care facilities, and the interviewing of the families of the mental health care users at the referral hospital who preferred the latter to the PHC facility, will lead to the formulation of strategies to empower families of mental health care users about primary mental health care services and inform nurses in primary mental health care about expected mental health care in order to enhance the utilisation of primary mental health care services.

1.7 Theoretical definition of key concepts

For the purpose of this study the following concepts or terms are used as defined below:

- **Mental health**

  Mental health can be defined as a condition when a person has a positive view of himself/herself is able to maintain good relationships with others and able to adapt to changes in his/her environment (Frisch & Frisch, 2006:5). According to another definition (Mero, 2009: para.1) mental health is "a psychological state of someone who is functioning at a satisfactory level of emotional and behavioural adjustment. It is a desirable state for all mankind".

  The concept is further defined by Sadock and Sadock (2007:12) as follows: mental health is when there is successful performance of a person's mental functions, good relationships with others, and an ability to adapt to change and to cope with difficulties. Moreover, mental health can be defined as a state in which a person is simultaneously successful at work, loving and resolving conflicts by coping and adjusting to the recurrent stress of daily life (Uys & Middleton, 2004:753).

Therefore, the definition of mental health in this research is that it is a state of psychological well-being of an individual that influences everything he or she does, such as thinking, feeling and behaving. And also mental health influences how people relate to each other and how they cope with everyday life.

Mental health is the main concern in this research because it is an essential part of health. Health involves emotional, social, spiritual and cultural well-being of the whole community (WHO, 2001b:3). This is supported by a statement according to which "There is no development without health and no health without mental health" (WHO, 2001a:6).

- **Primary health care**

According to WHO (2009a:2) primary health care can be regarded as essential health care based on practical, scientifically sound and socially acceptable health care. It must be accessible to all individuals and families of a community. For such health care to render satisfactory outcomes it would have to be maintained and for this reason cost-effectiveness as well as full participation of all those involved would be necessary. To secure full participation relevant knowledge and information would have to be made available. Self-reliance and self-determination would be important factors.

In Tanzania there is "an extensive network of health facilities throughout the country", which makes it possible for people to access essential health care services (Mamdani & Bangser, 2004:138). The availability and accessibility of health care in the health facilities in the country concur with the description of primary health care provided above.

- **Primary mental health care**

Primary mental health care would focus on mental aspects and can be defined as mental health care services rendered in a primary health care setting, the first level of

a health care system by primary health care workers. These services are basically preventive and curative (Saxena et al. 2006:182).

Funk and Ivbijaro (2008:15) assert that Primary Mental Health Care cannot but be considered an integrated part of Primary Health Care.

In this research primary mental health care is viewed as the mental health care services that are accessible and available at first level of the health care system, and that would be essential to people with mental health challenges and more specifically so the services that should be rendered at primary health care facilities within Dodoma Municipality for the purpose of improving the mental health status of the people. In Tanzania the first level of the health care system is at dispensary level (see chapter 2, section 2.4).

1.8 Outline of the research study

Chapter 1: Overview of the research

Chapter 2: Literature review for the research

Chapter 3: Research methodology

Chapter 4: Realisation and interpretation of the research and research findings

Chapter 5: Recommendations and Conclusion

1.9 Summary

In this chapter the researcher provided an overview of the research by introducing the concept of primary mental health care and its utilisation. The research question, the objectives, rationale of the research was discussed and the theoretical definitions of key concepts highlighted, namely mental health, primary health care and primary mental health care. Finally the outline of the research study was included by means of a chapter division.

In chapter two the researcher discusses the literature review that provides a broader understanding of the problem through reviewing other studies already conducted on similar challenges.

Chapter 2

LITERATURE REVIEW

2.1 Introduction

The aim of a literature review is to orient the researcher on what knowledge already exists on a problem to be studied and what is not known and then to decide whether the existing knowledge can be applied to the study (Burns & Grove, 2005:145). In this study the researcher conducted a literature review to explore what knowledge on the utilisation of primary mental health services does exist and what is not known so that the existing knowledge could help to generate new knowledge on enhancing the utilisation of primary mental health services. In the following discussion the researcher will focus on conceptualisation of mental health, reasons for promoting primary mental health care, mental health care services, health care delivery system, primary health care, historical background of primary health care, core reasons for integrating mental health into primary health care and primary mental health care. The chapter will be concluded by a summary.

2.1.1 Selecting and reviewing literature

In this section several sources were consulted to gather information for literature review such sources were from the Library and computer search from Stellenbosch University Tygerberg campus and the Ministry of Health and Social Welfare in Tanzania.

2.2 Concept of Mental Health into Primary Health Care (PHC)

2.2.1 Mental health

The reason for highlighting this concept is because it is a core concept that underpins the objectives of the research. For a service provider to enhance PMHC, he or she would need to have clarity about what mental health or mental illness is. The researcher intends to present these concepts in the context of this research. Understanding mental health and mental

functioning is important as mental functioning provides understanding of the development of mental and behavioural disorders as mental health is interconnected with physiological and social functioning that would bring about favourable health outcomes (WHO, 2001b:5).

Mental health and mental illness are not opposite, but are on a continuum with varying mental health challenges along the line. Every one of us may experience such challenges once in life time (Abbo, Ekblad, Waako, Okello, Muhwezi & Musisi, 2008:2). Mental illness is therefore, when there is alteration of physiology and/or brain function causing someone to act and behave abnormally (Allwood, Carllo, Van Wyk & Gmeiner, 2002:14), whereas, mental disorder is a behavioural or psychological syndrome that occurs within an individual and is associated with distress or disability (Uys & Middleton 2004:753). Short periods of abnormal behaviour or one incidence of abnormal mood should not be considered as a mental disorder, unless it is sustained for a period of time (WHO, 2001b:21). Mental illness has a high prevalence rate and affects all populations of the world (WHO, 2001b:23).

In this research understanding the concept of mental health is important as mental health is an essential part of the general health of individuals, and therefore provision of primary mental health services is necessary for a patient's mental health.

2.2.2 Reasons for promoting Primary Mental Health Care

The researcher, in exploring the literature, found several reasons that support the promotion of primary mental health care. These reasons include prevalence and burden of mental disorders.

2.2.2.1 Prevalence of mental disorders

Studies show that mental disorder is the root of about 12% of all health problems in the world (WHO, 2001b:3). About 450 million people in the world have mental disorder (WHO 2001b:23). From the World Mental Health survey done in fifteen countries it shows that the prevalence of any mental illness ranges from 4.3% to 26.4% worldwide, affecting both developed and underdeveloped countries (Kessler, 2004:2585). Also it was reported that 35.5% to 50.3% of patients with serious mental illness in developed countries did not receive

treatment in health care facilities compared to 76.3% to 85.4% in underdeveloped countries (Kessler, 2004:2587).

Tanzania, being among the developing countries has a prevalence of 2.5 million people who suffer from mental health challenges (Mero, 2009, para.7). Occurrence of mental problems differs from place to place in developed and underdeveloped countries. The common conditions are depression, anxiety, substance abuse, schizophrenia, epilepsy, alcohol, mental retardation, panic disorder, and primary insomnia (WHO,2001b:23). These conditions usually prove to coexist with physical conditions as could be observed at health facility places (WMHD, 2009:6).

In Tanzania it is estimated that 24 – 48 % of people attending primary health care facilities present with mental disorders (Mbatia, Shah & Jenkins, 2009: 2). Studies show that many people attending primary health care facilities present with mental problems that include anxiety (panic disorders) and depression, all of which are preventable and treatable. If not treated these conditions may cause severe illnesses, disabilities and deaths (Allwood, Carllo, Van Wyk, & Gmeiner, 2001:4; WHO, 2001b:19). Among these conditions, depression is ranked to be in a fourth position of disorders causing global disease burden (WHO, 2001b: 30). Therefore, a careful assessment with proper recording should be done for better diagnosis and management of these patients (Chetty, in: Baumann, 2007:68).

The above discussions support the fact that mental health services at primary health care facilities can assist in the prevention and treatment of mental disorders and in this way help to reduce disease burden (WMHD, 2009:9). In this research it became evident, noticing the prevalence of mental illness, that primary mental health care has a major role to play in the management of patients with mental health challenges.

2.2.2.2 Burden of mental disorders

In most countries mental health is a neglected part of health care. Even the allocation of funds is low, for example, figures show that out of 46 African countries surveyed 84% have an allocation of merely 1% of the total budget (WHO, 2001a:146). Priority setting of the health budget depends on reliable and realistic information on a disease. In the past the seriousness

of a condition was estimated according to mortality figures, and mortality rates linked to mental health problems were poorly recorded, if at all (Lopez, Mathers, Ezzati, Jamison & Murray, 2006:35). Recently the seriousness of a condition is estimated by a global measurement known as Global Burden of Disease (BOD) which include Disability Adjusted Life Years (DALY) assigned to a certain disease, calculated as a "sum of years lived with disability and years of life lost due to the disease" (Lopez et al., 2006:48; Haagsma, Havelaar, Janssen & Bonsel, 2008:2). In 2000 the burden of disease was 12% and it is projected to increase up to 15% in 2020 (WHO, 2001b: 20).

Mental disorders cause deprivation of economic and educational levels and people who suffer from related diseases may well end up with an accompanying state of poverty (Ssebunya, Kigozi, Lund, Kizza & Okello, 2009:2). Poverty reduction is another strategy of achieving the first Millennium Development Goal (MDG) by the year 2015 for improving quality of life and human development (Ministry of Planning, Economy and Empowerment, 2006:1, 32; Baum, 2007:40). In Tanzania it shows that in order to achieve the MDG of poverty reduction, efforts should be made to ensure that people who are poor and vulnerable receive quality health care with enough resources for better health outcomes, and also it shows that funds are allocated to facilitate services to be taken closer to people. These funds are, however, not enough to secure the necessary positive health outcomes that are envisaged (Mamdani & Bangser, 2004:150). It would be necessary to investigate and understand the burden of disease and the cost it puts on families, patients, and health care facilities. In this research the utilisation of available primary mental health care services are taken into consideration such health services allow for important interventions to ensure that mental disorders are prevented and treated at a lower cost. The burden of management could also accordingly be more evenly spread and the higher burden on referral hospitals alleviated.

2.3 Mental health care services

Mental health care services are the services that include promotion of health, prevention of illness, early detection and treatment and rehabilitation (WHO, 2001a: 27). Such services are provided worldwide and at different levels of a health care system. Below, the researcher focuses on mental health care from an International perspective, an African perspective and the Tanzanian perspective.

International perspective

Mental health care services have been provided in all countries of the world as mental illness is a worldwide challenge for many countries (WHO, 2001b: 23). In the distant past mentally ill patients were badly treated, beaten or even set to fire, and then followed a period of isolation by putting them in lunatics' asylums or mental hospitals. Such practices could also be found in Africa. The hospital conditions were inferior and according to today's standards human rights were violated. Movements for human rights were established and although improvement gradually took place, there still is room for further improvement and hospital conditions are yet satisfactory (WHO, 2001b:50). Following WHO's call mental health has now been integrated into primary health care to member countries of United Nations regardless of such limited resources as they might experience (WHO, 2001a:13).

The United Nations Secretary General emphasised that mental disorders affect all people of all countries and societies and that it is inappropriate to talk about health as such to the exclusion of mental health. Mental health should receive greater attention (WHO, 2001a:6). Efforts are being made to address mental health problems worldwide (World Mental Health Day (WMHD), 2009: 2). The theme of the 2009 World Mental Health Day campaign was "Mental Health in Primary Health care: Enhancing treatment and promoting mental health". This theme aims at making mental health a global priority (WMHD, 2009: 2).

African perspective

The provision of mental health services in Africa existed even before the colonial rule. It was attended to by the traditional and spiritual healers, then followed by asylums for custodial confinement in mental hospitals (Kigozi, 2003:27). This was then followed by decentralisation and integration of mental health into PHC as was recommended by WHO at the Alma Ata conference (Kigozi, 2003:27). After a review of mental health programmes now many countries in Africa have policies and programmes in place and have integrated mental health into PHC as a way of providing equitable and accessible mental health services to people (Saraceno & Saxeno, 2002:42).

Although the implementation of policies and programmes may still be improved and although mental health is still receiving low priority and an insufficient allocation of resources, experience shows that most of the mental health services have moved away from hospitals to lower levels of health care delivery (WHO, 2001b:87). As a result of support and motivation rendered by WHO mental health now is receiving the attention it deserves and it is recognised to be an important public health and development issue in Africa and many countries are working on mental health policies (Saraceno & Saxeno, 2002:40). Smith (in Baumann 2007:45) comments that the primary health care system is the correct way to provide high quality services to people with mental health problems in southern Africa. Wars and conflicts are the cause of most of the mental health problems and yet mental health is poorly funded compared to other health services and in need of better development (WHO, 2001b: 3, 43).

Tanzanian perspective

Traditionally mental health services were neglected and were socially unaccepted, until the World Health Organization recommended countries to decentralise and integrate mental health into primary health care (WHO, 2001a:137). Now there are regional mental health coordinators appointed to coordinate PHC activities, but these coordinators are faced with many problems such as a lack of trained personnel in the districts to train and supervise primary health workers in mental health. This very often is an obstacle to proper implementation of mental health at PHC level (Ministry of Health and Social Welfare (MOHSW), 2006:11). However, the theme of the world health day in 2005 which was "Mental health care" brought hope and was a sign of recognition and good will of mental health care in Tanzania and in the whole world (MOHSW, 2006:12).

As is evident from other countries worldwide much emphasis in primary health care is placed on decentralisation and integration of mental health services as being a preferable way of bringing mental health services closer to people. In this research this approach enjoys the researcher's attention.

2.4 Health care delivery system

In order for mental health workers to attain the goal of assisting patients/clients to uphold and sustain mental functioning, avoid mental problems and develop their mental capacity, mental health care services should be provided in primary health care facilities and other levels of health care delivery systems through a diverse of health care activities (Varcarolis, 2002:83). A Health care delivery system is a structured series of health care facilities arranged in levels according to their roles and responsibilities in provision of health services in the country with their different health workers' professional background at these levels (Funk & Ivbijaro, 2008:16). The researcher focuses on the International, African and Tanzanian perspectives of the health care delivery systems.

International

The World Health Organization arranges the levels in formal and informal health systems. The levels are in a pyramid structure. In the formal health system the first level includes primary care, community-based settings with community outreach teams and ambulatory services with health workers ranging from general practice physicians, primary care workers, community health workers and social workers (Funk & Ivbijaro, 2008:16).

Africa

Countries have adopted the health care delivery system from the WHO, but modified it according to their needs (Jenkins & Strathdee, 2000:280). Most of the countries in Africa have a three-level health care delivery system in which at the first or lowest level are the clinics and dispensaries, with the district level hospitals at secondary level and at the tertiary level are the speciality or referral hospitals with the resources and services generally concentrated at that level (Castro-Leal et al., 2000:66; Alem et al., 2008:54).

Tanzania

In Tanzania the first level is the lowest level in the hierarchy of the health care delivery system and is the PHC level where there are village health workers without health care

facilities, followed by another PHC level which is the second level where the dispensaries are found, and yet another PHC level is the third level where there are health centres (MOHSW, 2006:16). With regard to hospital-related health care there are again three levels, namely level one that includes the district hospitals, level two the regional hospitals, and level three the referral hospitals (MOHSW, 2006:16). Ideally the referral system was for the dispensaries to refer patients to health centres, from the health centres to district, region and referral hospitals. Unfortunately this system is not functioning well, resulting in self-referral and by-passing the referral system (MOHSW, 2007:30).

Comparing the different levels of health care delivery within the context of this research, primary mental health services indicate those services provided at primary health care facilities, specifically at dispensaries.

2.5 Primary health care

Through the previous discussions it became clear that primary health care (PHC) forms an essential part of the health care system and is considered to be the lowest level of the system to serve communities of different social and economic development (Jenkins & Strathdee, 2000:277). In addition PHC is an important setting of the health system for introducing treatment and care for people with mental health challenges (WHO, 2005a:1).

According to the Alma Ata International Conference held in 1978 Primary health care is defined as a feasible and realistic health care provided within reach of individuals and families at a reasonable cost (WHO, 2009a:2). Primary health care services at primary health care facilities are holistic in nature (Funk & Ivbijaro, 2008:21). Other authors add that primary health care services found at primary health care facilities "provide crisis intervention, crisis intervention can prevent the development of full-blown episodes of illness, as well as the deterioration of pre-existing disorders" (WHO, 2005a:3).

In Tanzania the Primary health care facilities are facilities found at community level and would include dispensaries and health centres (MOHSW, 2006:17; MOHSW, 2007:12). The United Republic of Tanzania, which is a union of Tanzania mainland and Tanzania Island-Zanzibar is located in East Africa. Administratively Tanzania Mainland is divided into 21

regions and 113 districts with 135 Councils. Each district is divided into 4 – 5 divisions, which in turn are composed of 3 – 4 wards. Every 5 – 7 villages form a ward and there are a total of about 10,342 villages in the country (MOHSW 2007:10). At the moment there are 4,622 dispensaries which can provide mental health services (MOHSW, 2006:17) and it is estimated that each dispensary should serve 3 - 5 villages which have an average population of 10,000 respectively (MOHSW, 2007:12).

It is also estimated that 80% of the population live in rural areas whereas 90% of this population are at a distance of about 8 to 10 kilometres to the facilities, making it possible for people to visit and utilise the services at primary health care level rather than to travel a long distance of more than 10 kilometres seeking for services in large institutions (Masaiganah, 2004:136). Primary health care facilities are designed to provide health care services in general. These primary health care services are not for primary prevention only but they are comprehensive health care services and holistic in nature in order to include mental health services as well (Uys & Middleton, 2004:42). These facilities have a major role of providing comprehensive, coordinated and focused health services to the population concerned. The facilities are sometimes known as "gate keepers" as they have the role of referring patients who need specialised care to other specialised health facilities (Roland, in: Jones et al., 2005:273).

The primary health care facility is the place of first entry into the health care delivery system, where mental disorders can be identified, diagnosed and managed (WMHD, 2009:4). The move towards utilising the facilities available in the community has drawn the attention of individuals, families and communities. This move assists people to view mental health care as being for the people and not otherwise (WHO, 2001b:52).

2.6 Historical back ground of PHC and I ntegration of mental health into PHC

The first International Conference on Primary Health Care organised by WHO and UNICEF was held in 1978 in Alma Ata (Almaty), Kazakhstan to achieve the goal which was declared as "Health for all by the year 2000". The main focus was to bring health services to people in the community so that it would be easily accessible to everybody. By doing so the health of

the people would be maintained and improved (Baum, 2007:34). It was noted that application of primary health care could relieve people from physical and psychological distresses (Newell, Goumay & Goldberg, 2000:11). At the international conference, all the governments and countries that attended the conference were tasked to formulate principles and guidelines for achieving the primary health care delivery for the people in their countries. Following the Alma Ata declaration countries formulated principles and guidelines for primary health care delivery according to the needs and problems of each country (WHO, 2001a:13).

During the initial phase of PHC at the Alma Ata conference the focus was on improving the health of people by providing general health care. At that time mental health care and, mental health services were not included. This may have been due to underestimation of the magnitude of mental health problems, and lack of knowledge on neurological science (Uys & Middleton, 2004:11). However, it was then recommended by WHO that governments should make sure that mental health is improved through integrating it into each level of the health care system especially at community level with the PHC system (Uys & Middleton, 2004:64).

In 1980 Tanzania was the first country in Sub-Saharan Africa to incorporate mental health services into Primary Health Care by making sure that there would be provision of high quality mental health services which are available to people in the country. In 1980 -1983 a pilot study was done in two regions, namely Morogoro and Kilimanjaro, to see whether primary health care would be applicable in the country. After realising that primary health care could be implemented in the country, (1983) the expansion continued slowly to the other 10 regions, Dodoma region being one of them (MOHSW, 2006:10, 14, & 27). In 1992 the primary health care approach was reviewed by the Ministry of Health and then decentralised from national level to district level with the prediction that decentralisation of care to district level would improve the provision of health care. The process of decentralisation included training of frontline health workers for the purpose of motivating and increasing their knowledge and skills (Manongi, Marchant & Bygbjerg, 2006:1).

Since the Alma Ata conference several reforms have been made to sustain the Primary Health Care strategy. At the 62nd World Health Assembly (2009) several issues were discussed among which was “Primary Health Care, including Health System Strengthening” as a

renewal of PHC (WHO, 2009 b: 1). Countries were recommended to set up plans of action on four policy reforms which were "health and equitable coverage, person-centred care, including health in policies, and provision of inclusive leadership" as described in the World Health Report 2008 for health equalities and improving health for all (WHO, 2008:18). The reforms were to focus on utilisation of mental health services, to be integrated into primary health care as an appropriate way of bringing health services close to where people live and work and therefore to improve their overall health status (Masaiganah, 2004:137).

2.6.1 Integration of mental health into Primary Health Care

Integration of mental health services into Primary Health Care is very crucial for improvement of mental health care at community level (Uys & Middleton, 2004:64). Responding to WHO's call on integration (WHO, 2001a:13), many countries took the idea of integrating mental health services into primary health care, because many people (80%) who can be treated in these facilities are in the community/ rural areas (MOHSW, 2006:15; Thom, in: Baumann, 2008:4). Integration of mental health into primary health care ensures that people are treated in a holistic way, addressing the physical and mental health needs at the same time (Funk & Ivjibaro, 2008:208). But also integration of mental health services into primary health care is supported by different policies, programmes and human rights as discussed below.

To respond to the World Health Organization's recommendation on integration of health services, Tanzania, like other countries in the world had to formulate policies in order to reduce barriers to service provision and to users, as well as to protect the mentally ill patients from being discriminated against and excluded from service. The Tanzania National Health Policy and its mission views mental health and general health both as being important as it stresses provision of proportional, equitable, quality, affordable, sustainable and gender sensitive basic health services to people (MOHSW, 2007:14).

The National Mental Health Policy is a governmental document that stipulates the goals to be attained in order to improve the mental health status in a specific country or area. The main components of the policy are "Advocacy, prevention, promotion, treatment and rehabilitation" (WHO, 2005a:14). The National Mental Health Policy in Tanzania was

formulated and integrated into the National Health Policy in 1990 (WHO, 2005a:489) and then revised in 2006. Its main intention is to support provision of mental health services and to ensure that services reach each individual in the community and that community involvement in health improvement is encouraged (MOHSW, 2006: 24, 26).

The Mental Health Programme is a national plan of action of work which shows what is to be done, who to do it, why, when and how so as to attain the set objectives of mental health services in the country and it is in support of a National Health Policy and supported by the same (WHO, 2005a: 16). This National Mental Health Programme was formulated in 1980, its development was facilitated by WHO and the Danish Development Agency (WHO, 2005a:489).

To ensure that there is achievement in provision of service in the country the Substance Abuse Policy was also established in 1995 for control of substance abuse and use in the country together with the National Therapeutic drug policy and essential drug list (WHO, 2005a: 490). The drug policy and drug list were introduced to ensure that essential drugs which would be in line with WHO's recommended list of essential drugs would be available for use in the country (WHO, 2005a:490). The basic drugs in the list for primary health care facilities are "Phenobarbitone, Amitriptylline, Chlorpromazine and Diazepam" (WHO, 2005a: 22).

2.6.2 Primary Health Service Development Programme (PHSDP)

A 10-year (2007-2017) Primary Health Service Development Programme has been launched in Tanzania to support the integration of mental health services into primary health care by using facilities at the primary care level which will provide quality health services in the country (MOHSW, 2007:16). The MOHSW in collaboration with PMO-RALG is implementing the programme by achieving the following 5 objectives, *i.e.* to improve the quality of primary health care facilities' infrastructure, increase the number of qualified and competent health workers, improve the referral system, ensure that financial allocation is increased for better provision of health services, and to improve the provision of health services by providing equipment, instruments and supplies of high quality to all primary health care facilities in the country. It is expected that this programme will speed up

utilisation of services at community levels, thus improve the health of people in the country (MOHSW, 2007: 16 -17).

2.6.3 Human rights for all clients with mental disorders

Human rights are for every individual whether ill or well. According to the definition of primary health care, it is the right of every individual to access the service regardless of his or her health status (Verschoor, Fick, Jansen, & Viljoen, 2007:35). Human rights are not only for support but also serve as the reason for integration of mental health into PHC.

2.7 Core reasons for integrating mental health into primary health care

There are several reasons for integrating mental health into primary health care and many studies that have been done show that integration bring improvement to patients with mental health problems. The main reasons for integration of mental health into primary health care include the following:

Mental health and **physical health problems can be t reated simultaneo usly and holistically at primary health care facilities,** because mental health problems are likely to influence physical problems and patients with chronic physical health problems are likely to develop mental symptoms, therefore, when diagnosing and treating physical health problems the mental health problems can be identified and treated as well (Funk & Ivjibaro, 2008:21, 28). Mental health and physical health are like mind and body, so there is no need to separate the mind from the body (WMHD, 2009:5). Studies show that integrating physical and mental health services at one setting encourages better and more effective utilisation of the available services (Aisbett, Boyd, Francis & Newhnam, 2007:9).

According to Smith (2004:637), there is a need to integrate mental health into general health care as many of the general health problems stem from psychosocial conditions. Also people with mental health problems are at high risk of having physical problems such as cardiac, respiratory and infectious diseases (Jenkins & Strathdee, 2000:279). So it is at primary health care level patients can best be managed holistically. Integration enables people **access to mental health services** closer to where people live, also help to keep the families together

and maintain their daily activities, although the distance to facilities in some areas may be a problem, but PHC facilities are more accessible than the referral hospitals (Funk & Ivjibaro, 2008:37). Integration also facilitates mental health promotion, provides chances for family and community education, facilitates early diagnosis and treatment and at PHC facility is an entry to services and a point of referral to other levels of a health care system (Funk & Ivjibaro, 2008:37).

Bringing mental health services to the community level encourages good cooperation among people within the community and outside that community as well (Alem, Jacobsson & Hanlon, 2008: 56). Also provision of mental health services at PHC facilities reduce stigma and discrimination as people will not fear to seek services at this level rather than seeking services at a well-known mental institution (WMHD, 2009:2).

To integrate mental health into primary health care **improves the provision of treatment** ; this is because at the primary health care level each person in need of treatment will be able to access it as it is within his or her reach (Jenkins & Strathdee, 2000:279). Studies on efficacy of drugs for mental disorders show that there are drugs that can be used to treat common mental disorders at primary health care setting (Patel & Cohen, 2003:164). There is evidence that most of the mental health problems are preventable and treatable and such treatment interventions can be found at primary health care facilities.

It is estimated that 70% of patients with schizophrenia can be prevented from relapse by use of antipsychotic drugs and family care, 70% of depressed patients can be treated by combining antidepressants and psychotherapy, and 60% - 70% of epileptic patients can be treated by using easily affordable anticonvulsants, but lack of these drugs at primary health care facilities affects utilisation of services as well as leads to the illnesses to become severe and debilitating (WHO, 2001b:65-70).

A study that was conducted by Chinese Americans reported that integration of mental health into primary health care has shown improvement in the treatment of mentally ill patients who attend and receive treatment at the primary health care facility (Yeung et al., 2004:259). A report from a European region shows that there is provision of care and treatment at primary

health care level, although such care and treatment would vary from excellent to no care at all (WHO, 2005a:1).

Mental health disorders cause burden to individuals, family and the nation which also affect the social-economical status of the country (Funk & Ivbijaro, 2008:21). Institutionalisation of mentally ill patients in hospitals brings a burden to families as after admission the family members have to take care of their patients. It is a burden because sometimes a family would have to stop doing productive activities and concentrate on providing care to patients (Hyman, Chisholm, Kessler, Patel, & Whiteford, in: Jamison et al., 2006:621; WHO, 2001b:19).

This **burden can be reduced** by utilisation of mental health services available at primary health care facilities as shown in studies done in some of the African, Asian and Latin American countries where training of health workers in early identification, diagnosis and treatment of mental illness at primary health care level has reduced institutionalisation and has improved patients' mental health status. Similarly at this level patients can receive medical care, community support, family care and rehabilitation, which are important to them (WHO 2001b:59).

Delivery of mental health services at primary health care facilities promotes respect of human rights and therefore it reduces stigma and discrimination towards mentally ill patients (Funk & Ivjibaro, 2008:21). According to the human right of Amnesty International and Universal Declaration of Human Rights, a mentally ill patient has the right to the available mental health services and to be treated equally and without discrimination (Lyons & Rush, 2004:114). The following are social demographic characteristics of the mentally ill patients who receive mental health services at primary health care level without being discriminated by other patients

Age is not a determining factor and facilities are visited by people from all ages. For children and adolescents, it is estimated that globally $^{1}/_{5}$ of children are seen at primary health care facilities with "attention disorders, general and separation anxiety disorders, depressive disorders, conduct disorders, delirium and post-trauma stress disorders". In the USA, estimates of mental disorders among children and adolescents receiving medical care lie

between 15% and 30%. The common conditions are depression and substance abuse (WHO, 2001b:23).

In young adults and middle aged people, the major mental health problems are depression, generalised anxiety, alcohol use and dependence, somatisation, schizophrenia, bipolar disorders and suicide while elderly people aged more than 65 years commonly suffer from depressive disorder, and rarely with dementia and Alzheimer's disease have been attending primary health care facilities for treatment (WHO, 2001b:23).

Patients attend the primary health care facilities regardless of their **gender** status. Reports show that both women and men are vulnerable to emotional and psychological distress only that they differ in prevalence and type of conditions (WHO, 2001b:20).

Studies show that, respect of human rights at different levels of **socio-economic statu s** provides chances for both the rich and poor to utilise health services at primary health care facilities (Mamdani & Bangser, 2004:139, 150), without discrimination. In addition PHC provides people-centred care that is accessible to all, *i.e.* the poor and the rich (Baum, 2007:40).

In primary health care facilities different people seek health services regardless of their levels of **education.** A study conducted in Canada identified all people with different levels of education attend health care facilities, but at different times or stages of illness (Steele, Dewa, Lin & Lee (2007: 102).

The mental health services can easily be reached at the primary health care level at a **reasonable cost compared to the cost of mental h ealth serv ices provid ed in big institutions** because the fee for services are being paid in instalments and not out of pocket. At the primary health care level services can be provided any time to any patient visiting the facility. Access to service at a short distance helps people to spend smaller amounts of money, time and energy. This system minimises fear of visiting the facility for services (Funk & Ivbijaro, 2008:21).

Uys and Middleton (2004:64) suggest that it is good to integrate mental health into Primary Health Care as many people who live in the communities are in need of professional attention and when they are in need of the service they will receive it near to their homes with minimal expenditure of money. Others explain that integrating mental health into Primary Health Care should be considered as many patients with emotional problems need to be attended to in their community, and when they fall ill they seek help within the community, first from the family and neighbours, if no health services are available. If family or neighbours fail to provide them with what they need they move on and seek help from other levels of health care far from where they live (Blignault, Birouste, Ritchie, Silove & Zwi, 2009:9).

Primary health care facilities also provide **continuity of care to mental patients** after discharge. This activity helps to establish collaboration between the primary health care services provided at lower level to other higher levels of health care. It is also true that continuity of care enhances good and maintained mental health to mentally ill patients (Funk & Ivbijaro, 2008:21). It has also been found that the use of the primary health care system prevents patients from waiting long for an appointment in referral hospitals. With health workers at primary care level they can coordinate care to other levels of care thus resulting in patients to be attended to quickly and at the same time preventing complications that might occur due to delays (Jenkins & Strathdee, 2000:287). Although the purpose of PHSDP is to ensure a timely and smooth referral system, the continuity of care will also be ensured (MOHSW, 2007:30).

Many studies have revealed that there is continuity of care and improvement of the health status of people when care is provided by health workers at primary health care level and more so than when care is provided at specialised institutions only (Bodenheimer & Grumbach, 2007:4 – 6). Although it is believed that mental health services are not provided at primary health care facilities, a study done in Tanzania revealed that people have been attending, diagnosed and treated at the primary health care facilities (Mbatia, Shah & Jenkins, 2009:2). Through utilisation of Primary Health Care facilities in Tanzania, mentally ill patients who return to their communities after hospitalisation or institutionalisation will receive continuing mental health care (MOHSW, 2006:15, 27) which will improve their health status. Studies also show that mentally ill patients after discharge from hospitals can be followed by workers from the primary health care facility (WHO, 2001b:59).

To conclude it can be said that mental health care has been provided at different levels of the health care delivery systems worldwide. Integration of the services into primary health care is facilitated by many factors, for example policies and programmes that indicate the commitment of the governments to address mental health issues. The integration has many advantages that result in improved mental health status of the people and the society in general. People should indeed be encouraged to utilise mental health services at the primary health care facilities.

2.8 Primary Mental Health Care

Primary mental health care is part of a comprehensive package of primary health care (Thom, in: Baumann, 2008:2, 4). Comprehensive primary health care motivates health workers to provide a more people-centred, responsive, effective, efficient health care for people in the communities and in the country (Baum, 2007:34). In order to provide quality mental health care to mentally ill patients at primary health care level a comprehensive approach that includes primary prevention, secondary prevention and tertiary prevention is very important (Uys & Middleton, 2004:67).

At primary health care level mental health care is not a part of specialised service but is comprehensive and integrated into the general health care system and is holistic in that it addresses neurological, psychological, physiological and sociological aspects within a bio-psychosocial approach (Smith. In: Baumann, 2008:638). According to Uys and Middleton (2004:76) caring of mentally ill patients physically, socially, psychologically and spiritually is considering a patient as a total human being who also needs a comprehensive care. Therefore, primary mental health care should be comprehensive and holistic but according to the countries' set protocols and guidelines of management of mental health problems (Jenkins & Strathdee, 2000:285). In Tanzania health workers use a WHO primary care guideline for provision of primary mental health care (Mbatia, Shah & Jenkins, 2009:6).

2.8.1 Comprehensive mental health care services

A comprehensive manner of care provided to an individual can be evaluated in many ways. It can be either from before illness to after illness and disability, or can be all along at the lifetime (Uys & Middleton, 2004: 41). Comprehensive services facilitate early detection of disease, diagnosis, treatment and referral (WHO, 2008:48). Comprehensive health care includes primary prevention, secondary prevention and tertiary prevention; these should not be confused by primary, secondary and tertiary levels of health care services (Uys & Middleton, 2004: 42).

It is emphasised that a health service that provides access to health problems should provide a comprehensive combination of curative, palliative and rehabilitative services (WHO, 2008:52). Funk and Ivjibaro (2008:15) add that "Primary care for mental health forms a necessary part of comprehensive mental health care, as well as an essential part of general primary care". Therefore, the comprehensive mental health services are provided in the following ways:

Primary prevention aims at reducing the occurrence of mental health problems in the community and it is mainly focused on health to people so that they can maintain their health status (Uys & Middleton, 2004:42). Promotion activities include creating awareness of mental health problems among members of the community and preventive activities include early identification and intervention with regard to mental health problems and the solving of such problems (MOHSW, 2006:26-36: Allwood et al., 2001: 4-6).

The aim of **secondary prevention** is to decrease the prevalence of mental health problems by early diagnosis and appropriate treatment (Uys & Middleton, 2004:43). The services are provided through curative activities that would include proper diagnosis, treatment, counselling and referrals of unmanageable patients (Belfer, 2005:1; MOHSW, 2006:26-36).

Tertiary prevention aims at improving the functioning of a disabled mentally ill patient in a specific environment or could also mean bringing the disabled person back into the community. This function can best be done at primary health care level (Uys & Middleton, 2004:48). The activities for tertiary prevention are rehabilitative, and that includes providing

of psycho-educational support to individuals, families and the community, as well as provision of continuous care to chronically ill patients (MOHSW, 2006:26-36; Allwood et al., 2001: 4-6). Moreover, provision of comprehensive mental health care is also a holistic approach (Funk & Ivjibaro, 2008:9).

2.8.2 Promotion of holistic health services

The holistic approach in health care is the integration of body, mind and spirit (Cherry & Jacob, 2002:347). Another explanation is that holistic means to focus on physical, emotional, functional and spiritual needs of a person, which is also termed as a psychosocial framework used as an intervention method to meet the needs of people. This framework is suitable at primary health care level (Thom, in: Baumann, 2004:6). The holistic approach is also applicable to the contributing factors mental disorders and this would enhance effective treatment of mentally ill patients. Such factors are biological, psychological and sociological (WHO, 2001b:12). According to Frisch and Frisch (2006: 148) a holistic approach is an integrative framework that makes people aware of their emotions, that is bent on developing positive mental patterns, and that pays attention to physical needs of their body and that is to the advantage of their spiritual relationships.

In mental health care settings physical, emotional, mental and spiritual concepts help in establishing the therapeutic modalities so it is necessary to adopt this holistic approach in our daily activities to improve the health status of the patients (Frisch & Frisch, 2006: 515). It is also supported by Hopton and Coppock (2000:168) who point out that a holistic perspective or model is when anti-oppressive and anti-discriminatory mental health interventions incorporate biological, psychological and social factors that would make it easier to diagnose and manage mentally ill patients. According to them this approach is important as a starting point for interviewing a patient and they are of the opinion that without it there are chances of missing useful interventions.

Dealing with people's health problems is complicated because it would demand an understanding of them in a holistic way *i.e.* physically, socially, emotionally, their past, present and future life and failure to observe and consider these aspects or facet may result in failure to make a proper diagnosis and apply proper management of the patient (WHO,

2008:46). In Tanzania efforts are being made to develop a holistic approach in the health care system to obtain the right balance between physical and mental health care (MOHSW, 2006:21).

From the above discussions it may be gathered that mental health is inseparable from mental illness and mental illness has a high prevalence worldwide and its burden affects the social and economic status of people. Mental health care has a long history since before the colonial era when there was traditional healing up to now when there is provision of comprehensive and holistic care. The care is comprehensive in the sense that care should focus on primary, secondary and tertiary prevention and holistic in the sense that care should consider the wholeness of an individual that is physically, psychologically, socially and spiritually composed, so that a patient can be managed properly without missing useful interventions. These health care services should be provided at all levels of a health care system, especially at primary level for improvement of the people's mental health status.

2.9 Summary

Understanding mental health and mental functioning of an individual is important as it helps in understanding of mental and behavioural disorders (WHO, 2001b:5). Mental disorders have an impact on the socio-economic status of the country and are a threat to the health of the people as well as to the health of the nation (Hyman et al.: in Jamison et al., 2006:621). Therefore, provision of mental health care services at all levels of a health care delivery system is very important for managing mental disorders. Utilisation of mental health services at PHC facilities is possible as mental disorder is a global issue due to its high prevalence worldwide. The countries and governments during the international conference at the Alma Ata conference in 1978 were recommended to implement PHC in their countries. Several countries and governments adopted it and formulated policies to guide the implementation.

More than 31 years have passed since the Alma Ata conference on primary health care and the recommendation on integration of mental health into primary health care that was announced at that time. According to more recent results and reports from various studies on successful improvement of people's health status through use of services at PHC level there had been good reason for integration. In spite of this some people still skip primary health

care settings and request mental health care in referral hospitals. There is a need to find out the reason or reasons behind this problem and a need to find the way to address the problem. Although African countries are faced with many problems of low income, high prevalence of diseases, poor services with inadequate staff, support through WHO initiative has placed mental health in a position of now receiving the attention it deserves (Mero, 2009: para.10).

What remains to be done in Tanzania as a first step in the right direction, is to make the people more aware of the advantages and importance of using the PHC facilities in their vicinity instead of going off to the more distant referral hospitals. Therefore, the government needs to put more effort into creating and building such awareness by including the people, families, communities, health-related professionals, and other stakeholders on the importance of mental health care users to utilise services available at PHC facilities. By doing so not only primary mental health care will be promoted, but also general PHC as well. The facilities need to be well-managed and equipped in such a way that the necessary services can be rendered to mental health care patients and other patients by providing comprehensive health care according to a holistic approach that would pay attention to both physical and physiological problems at the same time.

It was the researcher's intention to investigate the reason or reasons why people do not use the locally available services at the primary health care facilities more effectively. The need for more research on this problem has also been suggested by Ng et al. (2003:617) in their study on preference, need and utilisation of mental health services in Singapore.

In Chapter three the researcher discusses the methodology of the research.

Chapter 3

RESEARCH METHODOLOGY

3.1 Research design

For this research on enhancing the utilisation of PMHC services in Dodoma, Tanzania the researcher used a descriptive qualitative research design. Selected strategies of inquiry for this research were clinical ethnography and qualitative interviews (Creswell, 2009:5). The researcher focused on inductive reasoning, using the data collected to formulate strategies (Thorne, 2000:68). The researcher found that this method was applicable to this research, because data were collected to explore and describe why people do not use mental health services available at PHC facilities. Findings also assisted in the development of strategies to enhance the utilisation of the primary mental health services. The two strategies applied were in two phases *i.e.* phase one included clinical ethnography in the PHC setting and phase two that included qualitative interviews, namely in-depth interviews was conducted at the referral hospital.

3.1.1 Phase one: Clinical ethnography

In phase one the researcher focused on clinical ethnography where she conducted a participative observation at the PHC facility.

Clinical ethnography

Research design is defined as an outline or plan that guides a researcher to carry out a research as it is intended (Mouton, 2008:55). De Vos et al., (2008:268) also describe research design as all methods used by a researcher to conduct a study. In this research a qualitative, descriptive clinical ethnographic research design, was employed. Creswell (2009:229) defines ethnography as "a qualitative strategy in which the researcher studies an intact cultural group in a natural setting over a prolonged period of time by collecting primarily observational and interview data." However, in this research the researcher did not use

traditional ethnography, but chooses a qualitative descriptive, clinical ethnography intended to examine "the human experience of illness or care-giving in an interpersonal context" and the research focused on participative observation in a PHC facility and interviewing at the referral hospital (Kleinman, 1992: in Dean & Major, 2008:1089; Savage, 2000:1401).

The emphasis was on observing the care-giving in PHC facilities and exploring the reasons why people do not utilise PMHC services closer to them. In this research the researcher visited the PHC setting for a period of four weeks, collecting data through participative observation in order to explore the care-giving practice in the PHC setting.

3.1.2 Phase two: Qualitative Approach (In-depth Interview)

In this phase the researcher interviewed families of mental health care users who preferred the referral hospitals to the PHC facilities. Afterwards the researcher developed strategies to inform family of mental health users about PMHC services and inform the PHC workers about the expected mental health care-giving in PHC facilities as defined by WHO (Funk and Ivjibaro, 2008:17).

3.2 Worldview of the research

The research adheres to the advocacy and participatory worldview as it focuses on the needs of mentally challenged people living in the community who are "marginalized and disenfranchised" as stated in Creswell (2009:9). This worldview also focuses on helping mentally challenged people to free themselves from discrimination and stigma and then to help them to integrate with others in the community, to have self-development and self-determination. The researcher respects the four pillars of the participatory worldview, namely that it is focused on transformation or change, empowering individuals to free themselves, facilitating the creation of debates and collaboration with others.

In order to achieve this, the researcher used participative observation where she stayed and worked in the Village for four weeks, observing care-giving behaviour and practices and sometimes having casual talks with health workers and villagers. Moreover, the researcher

used in-depth interviewing to collect data that would help to develop strategies to enhance the utilisation of PMHC, in order to improve their mental health status.

3.3 Research methods

3.3.1 Population, Sampling and Sample

In this section the methodology, the study population, sampling method and sample size are discussed.

Population

According to Burns and Grove (2007:324) population is described as a total set of people eligible to participate in a research study. In this research the population included all adult family members who were looking for mental health services within Dodoma municipality. The assumption was that adult people would be able to express themselves and to provide information on experience of care-giving as they had been seeking health care services, be it for shorter or longer periods of time.

Sampling

Sampling is a method used to select subjects or participants to represent a population under study (Burns & Grove, 2007:29). A portion of a population is selected by using two methods of sampling, one of which is probability sampling, which means that every subject in the population has a chance to be selected. The other is non-probability sampling meaning that not everyone has a chance to be selected (Burns & Grove, 2007:330,337). The researcher employed the non-probability purposive sampling method to select participants. Purposive sampling is a judgemental selection whereby study participants are consciously selected to be included in the study (Burns & Grove, 2007:551).

In this research, participants were purposely selected to obtain information to match with what had been found out during participative observation (Roper & Shapira, 2000:78). In this case the sample would have to include those who had preferred the referral hospitals to the

primary health care facilities. On the days of interview the researcher arranged one of the private room where no interruptions occurred. Then the researcher selected various participants who met the inclusion criteria and after obtaining their consent to voluntarily participation in the research, participants bringing patients seeking for mental health care services in the hospital were sampled because they would be knowledgeable about the phenomenon under study. Mentally ill patients were excluded from interview because they are the vulnerable groups who need special care.

Sample

According to Burns and Grove (2007:324) a sample is a portion of a population selected for a study. The sample size appropriate for qualitative research is usually smaller than in a quantitative research (Burns & Grove, 2007:76). But, the sample size is adequate when saturation of information has been achieved, meaning that it would be unnecessary to add more participants to the sample as no new information would be provided (Burns & Grove, 2007:348). Onwuegbuzie and Leech (2007: 242) suggests that the sample should not be too small because it would then be difficult to achieve data saturation, and neither should it be too large because that would make it difficult to extract thick and rich data. In this research the actual sample size was determined by the saturation of information. Interviews were conducted with 9 participants. These participants were purposively sampled and were interviewed after their patients had received the services.

Inclusion criteria

Inclusion criteria are the characteristics that should be possessed by a person to be a participant in a study (Burns & Grove, 2007:325). The inclusion criteria in this research considering the purpose of the research, allowed for including only adult family members older than 18 years bringing patients to seek mental health services at the referral mental hospital and who were able to communicate well in the Kiswahili language because it is the national and common language spoken in Tanzania.

3.3.2 Research Setting

A setting refers to an environment where a research is carried out and in qualitative research, the study takes place in a natural environment (Burns & Grove, 2007:352). This research was conducted in a selected primary health care facility that is situated within Dodoma Municipality in Tanzania. The United Republic of Tanzania is made up of Tanzania mainland and Tanzania Islands that are located in East Africa. Tanzania mainland is divided into 21 regions, 113 districts and 10,342 villages with 4,622 dispensaries (MOHSW, 2007:10 - 17).

The official capital town of Tanzania is Dodoma. Dodoma is located at the central part of the country. It has 5 districts, 145 wards and 465 villages. Dodoma municipality or Dodoma Urban District has 30 wards and 42 villages with 32 dispensaries (Regional Profile, 2009:1). The setting for this research was one dispensary in one of the villages and the referral mental hospital in Dodoma municipality where patients seek mental health services. It is in this hospital where people who had preferred the referral hospital to their region's local primary health care facilities can be found. Free movement and non-intrusive activities of the researcher around the area facilitated and enhanced data collection and curbed the Hawthorne effect.

3.4 Measuring instruments

3.4.1 Phase one: Clinical ethnography

During participative observation the researcher collected data and made field notes. Videotaping was originally planned as well, but participants refused to be videotaped. However the field notes report was written in a chronological manner to know which information was written first and which later (Arkava and Lane, 1983 in: de Vos et al., 2008:281). The researcher recorded the mental health care-giving in the primary health care facility. This mental health care-giving activity was observed for four weeks.

3.4.2 Phase two: In-depth interviews

The researcher used an interview guide with a central question, which was **"Why did you not make use of your primary health care facility and why did you come to this referral hospital for mental health care services?"** The researcher probed further by using deeper interpersonal communication skills. The interview guide was written in English then translated into Kiswahili for communication with the participants as it is the common language used in Tanzania. After data collection the interview was translated verbatim to English for interpretation (Roper & Shapira, 2000:83). Translation of data from Kiswahili to English was completed through the assistance of a language expert from the University of Dar es Salaam in Tanzania to enhance consistency in translations (see annexure).

3.5 Data collection, management, analysis and recommendations

Data collection is a systematic process of collecting information significant to the research study (Burns & Grove, 2007:41). In this research data were collected through the participative observation and open-ended interviews. The information gained *i.e.* according to the responses during interviews, was then reported in a narrative format (Creswell, 1998. In: De Vos, Strydom, Fouche, & Delport, 2008:268). The data collection activity was undertaken during the months of February and March 2010.

3.5.1 Phase one: Clinical ethnography

In this phase, the researcher used a participative observation which is studying the natural set up and the day to day events taking place at a particular community or situation (De Vos et al., 2008:276). As documented by Reeves, Kuper and Hodges (2008:512) the researcher was involved herself in the area being studied to explore the mental health care-giving behaviour in the real situation. She participatively made observation at the dispensary for one month. The information gained by doing so included more detail about the physical layout of the place, flow processes at the health services setting, people involved, activities performed, interactions, emotions felt and expressed. Such participative observations were continuously documented. The tools used for data collection were from researcher's own professional as well as the expertise' experience.

3.5.2 Phase two: In-depth interviews

In-depth interviews with family members were conducted at the hospital setting. The interviews were conducted in a private room after a common agreement on location with the participant. The interviews were audio-recorded with the permission of the participants. Each interview began by asking one central open-ended question that focused on the research question. As the interview proceeded other questions followed pertaining to clarifying, emerging and recurring themes about participants' knowledge and experiences regarding mental illness and care-giving at primary health care facilities.

As suggested by Rubin and Rubin, (1995) in: De Vos et al., (2008:293) an interview should be built on three kinds of questions, namely the main question, followed by probing questions and then follow-up questions that might be deemed necessary or appropriate. Such questions including "as from your opinion and experience do you think these services are available at the facilities? Collection of data continued to the point of saturation of information, when no more new data would be obtained or when there was repetition of data, namely saturation (De Vos et al., 2008:282). However, the saturated data had to be validated with the literature in order to establish the reliability.

3.5.3 Data analysis and interpretation of phases one and two

Data analysis as according to Burns and Grove (2007: 41) "is conducted to reduce, organize, and give meaning to the data". Another definition is "data analysis is the process of bringing order, structure and meaning to the mass of collected data" (De Vos et al., 2008:333). In qualitative study data analysis occurs in three phases "description, analysis and interpretation" (Burns & Grove, 2007:79). In addition, in qualitative research data analysis begins during data collection that assists the researcher to refine the questions if possible and assist the researcher to remember what has been said or observed (Pope, Ziebland & Mays, 2000:114). De Vos et al., (2008:335); Dean and Major (2008:1089) add that data collection and data analysis go together to have a good flow of data interpretation. The researcher used an open thematic coding process in analysing collected data, which is a qualitative, interpretive process (Corbin and Strauss, 1990a, in: Ward, 2007:7).

In this research, data analysis and interpretation continued according to the process described below.

Planning for recording of the data: In this part of the data analysis the researcher planned to observe the settings, activities performed and people involved. Planned when to use a camera, how to code data collected and where to keep the collected data (De Vos et al., 2008:334). The researcher did not use the camera although it had been planned.

Data collection and preliminary analyses: A preliminary analysis of the collected data was performed while the researcher was still in the field. Data were classified under different sections or headings or clusters of the emerging themes and kept in files (Patton, 2002: in de Vos et al., 2008:335). To have the data available in clustered themes was of importance for the research to proceed.

Managing or organising the data; This step follows the investigation at the site itself after such investigation at the site had been completed. It requires that the data obtained be arranged properly and reproduced and presented in writing in appropriate units. It requires that all information obtained be evaluated and included systematically and it also allows for judging the completeness of the information. The writing can be done electronically or by hand and the completed units would reflect all the results of investigation or research that had been conducted at the site (Patton, 2002. in: De Vos et al., 2008:336).

Reading and writing memos; Because of the nature of the data obtained during the investigation applicable to this research, it was of utmost important to read and re-read the material that had been collected, e.g. and *inter alia* the responses ventured by those who had been interviewed. The researcher used the margin to write down important notes or observations as the reading carried on. On the one hand this assisted in highlighting certain aspects and on the other hand it made easier to find reference again afterwards. In this way the data could be fully explored (Creswell, 1998 as quoted in De Vos et al., 2008:337).

Generating categories, themes and patterns: In order for data to be sensibly interpreted the data would have to be arranged in categories, themes and patterns and doing so was the next step that was taken. Internal convergence as well as external divergence was taken into

consideration as interdependent but different. The process is described "identifies the salient, grounded categories of meaning held by participants in the setting" (De Vos et al., 2008:337). In addition the subthemes were also identified and in this way could be presented in a manageable set of themes written in a narrative format.

Coding the data: Here the researcher indexed or identified categories in the collected data; its purpose was to facilitate the retrieval of data segment by coding category. Coding can be done in different ways such as by highlighting by colours, indexing cards, self adhesive stickers and/or writing in the margins (Burns and Grove, 2007: 82). The researcher coded the collected data by highlighting by colours.

Testing the emergent understandings: In this part the data is tested for usefulness relating to the questions and the phenomenon being studied (De Vos et al., 2008:338). Therefore, the researcher read through the data challenged its usefulness and then linked with questions being asked

Searching for alterna tive explan ations: In this section the searched data for possible explanations are linked among them (De Vos et al., 2008:339). Therefore, the researcher identified and described the same data collected in different ways and searched for the most possible explanations as can be seen in chapter 4

Writing the report: This is the final phase in data analysis and interpretation. The researcher presents what was found in the text by creating a pattern or visual image of the information. The report is organised according to meaningful themes and the themes are broken into categories and sub-categories as sections and sub-sections (De Vos et al., 2008:354). The researcher did the same.

Although the use of software and computer may make the process easier it must be remembered that data analysis and interpretation must be completed by a researcher because computers are not capable of conceptualising, and transforming data into meaningful results (Thorne, 2000:68). For this reason the data analysis was done manually.

3.6 Trustworthiness and validity

According to Lincoln and Guba the trustworthiness of the research is established in credibility, dependability and confirmability (De Vos et al., 2008:346). Reeves, Kuper and Hodges (2008:513) add triangulation and thick description.

3.6.1 Credibility

Credibility in qualitative research is like internal validity in quantitative research. It is to ensure that the participants, setting and the processes are accurately identified and described for the research to be meaningful (De Vos et al., 2008:346). Credibility of the research study can also be achieved by use of a variety of methods of data collection and at prolonged period of time in the setting (Dean & Major, 2008:1089). Therefore, in this research study participants were correctly identified and described by making use of the set criteria. The setting and the process were clearly defined and described to bring meaning to the research. Also, after transcribing the code, the researcher sent the data to other researchers and discussed the data to have inter-coder agreement, such researchers were Masters Degree holders in the field of mental health who made minors corrections. Moreover, to ensure validity of data the researcher had been in the research setting itself for four weeks and had collected data by using a variety of methods with repeating observations on the same situation and setting. The researcher's own experience as employee in the health care delivery system for many years increased the validity of data. Staying in the field for a long time assisted the researcher to familiarize with people's culture and their behaviour and will help setting aside what is known about an experience being studied.

3.6.2 Dependability

According to De Vos et al., (2008:346) dependability is another word for reliability. It is when "the researcher attempts to account for changing conditions in the phenomenon chosen for the study as well as changes in the design created by increasingly refined understanding of the setting". In this research and during the process of data collections and analysis the researcher accommodated changes accordingly, depending on more understanding of the setting to produce meaningful information for the study. In addition Gibbs (2007) in:

(Creswell, 2009:190) states that qualitative reliability is determined by the "researcher's approach being consistent across different researches and different projects." Therefore, dependability in this research was achieved by the researcher allowing cross-checking of codes also known as intercoder agreement by other research experts to see whether these experts would code in the same way as the researcher (Creswell, 2009:191).

3.6.3 Confirmability

Confirmability is when several people or informants view the general findings and confirm the findings as similar with the researcher's findings (De Vos et al., 2008:347). In this research, the researcher sent the findings of the study to experts in mental health and the supervisor to read through and confirm the findings. The throughout checking of data and continuous discussion between experts and supervisor "will ensure the truth value of the data" (Creswell, 2009:199). In this research the supervisor who is an expert in qualitative research and specialist in mental health was constantly consulted.

3.6.4 Triangulation

Triangulation is collection of data related to the subject matter from several sources and these can be from participative observation, interviews and documentation (Roper & Shapira, 2000:24). Reeves, Kuper and Hodges (2008:513) add that triangulation can be achieved by collecting data using different sources, different settings and at different times. In this research the sources for data collection were from participative observation and interviews, with audio-recording and the use of informal conversations after obtaining consent from participants, these were employed to enhance rigour of the research. Then the researcher compared and contrasted what participants had said or the manner in which they had behaved according to the actual situation as observed during the investigation (Reeves, Kuper & Hodges, 2008:513).

3.6.5 Thick descriptions

Thick description is the provision of thorough or in-depth report of the research setting and the study participants in order to increase the quality of the study (Reeves et al., 2008:513).

Dean and Major (2008:1090) add that thick descriptions would include the extensive description of the context using data collection through field notes. In this research, thorough and detailed report of the setting and participants could be prepared by the researcher after data collection from several sources, after being involved in participative observation at the dispensary for four weeks about mental health care-giving behaviour and having interviews with participants who had skipped the PHC facilities and gone to referral hospital instead.

3.7 Ethical considerations

Ethical consideration is an important part in research processes because practising ethics in research and science shows that respect and dignity of participants is maintained (Pera & Van Tonder, 2005:151). In addition this research project went through the approval of the Stellenbosch University's ethical committee in the Faculty of Health Sciences. The researcher was guided by the following ethical principles: permission to conduct research, autonomy, privacy, confidentiality, anonymity and informed consent (Burns & Grove, 2007:212-217; Pera & Van Tonder, 2005:152).

3.7.1 Permission to conduct research

Permission to conduct research was obtained from the Committee for Human Science Research of the Faculty of Health Sciences, Stellenbosch University, the Municipal Director of Dodoma Municipality, the Medical Superintendent of referral mental hospital, the village leaders and the facility incharge of the Dispensary where research was conducted. Obtaining permission from relevant authority shows respect to the authority concerned (see annex 3 and 4). In this sense the institution is equated to a person (Brink, 2001 in: Pera & Van Tonder, 2005:154). Permission on the use of audio-recorded information was obtained from the participants and how the information would be protected was explained.

3.7.2 Right to self-determination or autonomy

Autonomous is when a person is capable of controlling his or her self-destiny, and have freedom to conduct his or her life without force or control (Burns & Grove, 2007:204; Pera

& Van Tonder, 2005:152). Participants were provided with information about the research and its purpose, and without external control, force or exploitation had the right to participate or not to participate and to withdraw from the research at any time. So they were allowed to choose voluntarily whether to participate in the research or not. In this research all participants sampled consented to participate voluntarily.

3.7.3 Right to privacy

Privacy is "freedom to determine the time, extent, and general circumstances under which private information will be shared with or withheld from others" (Burns & Grove, 2007:550). Pera and Van Tonder, (2005:154) said that when confidentialiy, anonymity and the degree of invasion are protected then privacy is maintained. Privacy is also maintained when participants are allowed to share their private information by providing informed consent (Burns & Grove 2001, in: Pera and Van Tonder, 2005:154). In this research voluntary informed consent was obtained for disclosure or sharing of participants' information and also interviews were conducted in a private room to maintain privacy and security of information provided by participants.

3.7.4 Right to confidentiality

Confidentiality in a participant's information is the "management of private data in research in such a way that only the researcher knows the subjects' identities and can link them with their responses" (Burns & Grove, 2007:534). In this research, confidentiality was maintained but not disclosing names and by avoiding reporting long quotes of participants on responses to questions to avoid identifying participants by linking quotes to them. Information was not shared with others without participants' authorisation, and raw data were kept confidentially in a secured place.

Participants' identity was not linked to their responses (Burns & Grove, 2007:212). Also anonymity is maintained when the identity of participants and their research setting are not published by applying false names or changing of events and location (Roper & Shapira, 2000:122). In this research no names appear in publications of the research and report is

published with partcipants' permission. The researcher ensured that informed consent was obtained prior to any procedure.

3.7.5 Informed Consent

Informed consent is "an agreement by a prospective subject to participate voluntarily in a study after he or she has assimilated essential information about the study" (Burns & Grove, 2007:543). The researcher ensured that participants understood the research study and its purpose, and were assured that their participation was voluntary and that they were free to withdraw from the research study at any time. The researcher was did not ask any question which could have distressing the participants and professionalwere mobilized to support participant in case he or she become distressed. No participant withdrew from the research. The researcher's contact particulars were provided to participants so that if they had any questions at any time they could ask. No questions were received from the participants during the research period. Finally a written and oral consent was obtained from all participants (see annex 5).

3.7.6 Summary

In this chapter the process of conducting the research has been presented. In the following chapter, the researcher provides the realistic methods employed in data collection, analysis, interpretation as well as the discussion of the research findings.

Chapter 4

REALISATION AND INTERPRETATION OF THE RESEARCH AND RESEARCH FINDINGS

4.1 Introduction

The researcher discusses the realisation of the research, focusing on the finding as well as the interpretation of the findings. This will be discussed in two phases led by the strategies of inquiry namely, Clinical Ethnography and In-depth Interviews. Phase one, data collection was at the Primary Health Care facility in Dodoma Municipality area. This Primary Health Care facility is a dispensary, it is a government facility. The dispensary level is the first and the lowest level in the hierarchy of the health care delivery system followed by health centres, then district and regional hospitals, lastly is a referral (consultant) hospital. These are also the levels of referring patients, from the dispensary to the referral hospital.

The Clinical Officer in this dispensary has been trained in identification, diagnosis and management of patients who are mentally challenged. In this phase the researcher planned to collect data using participative observation. The researcher was able to be at this site for four weeks working in a dispensary as a nurse, while doing observation from the time of opening of the facility to the time of closing the facility. The data obtained were noted down in a diary and kept in a secured place and could not be reached by people outside the research team and doing so served the purpose of maintaining confidentiality of the data. The researcher entered the observations half hourly.

During phase two, data were collected from the only referral mental health hospital in Tanzania, which is in Dodoma Municipality area where all mentally challenged people are referred for advanced management. Obtaining of data through in-depth interviews was scheduled over a period of six days. Eligible participants were purposively sampled (refer to chapter three, section 3.3.1.2); there were nine participants, three males and six females; none of them was a health service provider. These participants came from different villages within Dodoma Municipality area and were interviewed after they had voluntarily consented to participate and each interview was conducted for 30 to 40 minutes in the language spoken in

that area. During each interview the researcher was able to tape-record the interviews after obtaining permission from the participants. The taped interviews were transcribed verbatim. These verbatim transcriptions were analysed according to the schedule in chapter three (refer to 3.4.2). The data were independently co-coded by a qualitative research expert. A consensus discussion between the researcher and the co-coder took place to finalise the findings.

The themes discussed below emanated from the data after analysis. These themes emanating from the data will be illuminated, followed by direct quotes from the data and literature control or references from the literature review chapter (chapter two). However, in the first phase the process in the PHC setting will be discussed followed by direct quotes from the participative observation diary. Following are the discussions of the findings of the two phases of data collection.

4.1.1 Phase one

Phase one is answering the first objective which is to determine mental health care-giving in the primary health care facilities in Dodoma Municipality. In this phase the researcher observed who was doing what, to whom, when and how. The themes emanating from this phase are role players (who/to whom), health challenges (what), health interaction and service delivery (doing what/how) with sub-themes; facilitating interaction, impeding interaction and a summary, the evaluation of the three main themes.

(i) Role players

The researcher observed that there were two types of role players at the dispensary; *i.e.* health workers working at the dispensary and health-seeking clients who had come there in search of assistance. F**our cadres of health w orkers** are represented at the facility under study and there was also one supporting staff member, namely *one Clinical Officer (CO)* who is in-charge of the facility. She is a professional worker (the lowest level for the cadre of medical doctor), has undergone a two-years training in a recognised training institute in the country, had been trained to manage minor conditions including mental health illnesses at the PHC facility and to refer major conditions. She assesses patients, identifies problems, makes

diagnoses, prescribes treatment and refers patients to another level of health care delivery system for further management where applicable. Being in-charge of the PHC facility she had other duties such as attending village and office meetings and doing other administrative duties. In her absence her duties were carried out by the Enrolled Nurse who then acted as being in-charge.

The Enrolled Nurse (EN) had undergone a four years of training in a recognised nursing training institute in the country, was trained to provide nursing care to patients but, being at the PHC facility she assesses patients and prescribes treatment and also supervises all nursing activities at the dispensary. Another member of the staff at this facility had qualifications in the field of *Maternal and Child Health Aide (MCHA)* and had undergone a two-year training course in a recognized training institute in the country. She acts as an Aide specifically responsible for Reproductive Health services at the PHC facility. The staff also included one *Medical Attendant* who was a non-professional. He assisted in nursing activities and performed cleaning activities. A *security guard* who always worked at night was also among the employees at this facility. All these health workers worked in collaboration. The observations made on these four cadres of health workers were as follows:

"CO arrives, exchanges greetings with all of us"
"Nurse arrives, exchanges greetings with medical attendant"
"MCHA arrives, signs in attendance register"
"Medical Attendant arrives"

It appeared that the number of health workers fell short of the required number for efficiently carrying out the necessary duties and tasks. Sometimes when one health worker was not on duty his/her tasks had to be carried out by another health worker who was already burdened with enough responsibilities to attend to.

However, the researcher also observed different clients that were seeking health care at dispensary. These were representative of all age groups, female and male and of differing socio-economic background. They presented with different needs, e.g. those who needed general health care services, those who needed reproductive health services and a few who

needed mental health care services. This is evidenced by the following observations made about the clients coming to the dispensary:

"An elderly woman arrives....."
"A school boy with his friends arrives...."
"A girl brought by her grandmother arrives....."
"A young lady arrives...."
"An elderly man enters the consultation room....."

All these clients were attended to according to their various health needs, although the number of health workers did not correlate with the number of clients attended to. The health workers were few compared to the patients visiting the dispensary, and these health workers had different roles. From these findings the researcher could derive that there was a need to increase the number of health workers to establish a more balanced worker-client ratio.

(ii) Health challenges

Several health challenges could be observed at the dispensary, including *inter alia* **mother and child, minor ailments, mental health and physical health.** All these health challenges had been attended to by the health workers mentioned above. The workload for each challenge amounted to more or less the same routines to be followed except in the case of mental health where clients came to the dispensary only to collect medication after being discharged from the hospital. To address the health challenges requires a reasonable number of qualified and skilled health workers. From the observation it was noted that there were many health challenges compared to the number of health workers. This problem needs great attention. This is evidenced by the following statements:

"CO attends to a patient with *epilepsy* who came to collect his drugs"
"CO attends to an elderly woman with *diarrhoea*"
"CO attends to the child with *wounds"*
"CO attends to another child with *fever, cough and flu"*
"MCHA attends to *children and women"*
"Nurse attends to four children with *chicken pox*"

"Mothers while waiting for services have casual talks, they say, today the services are carried out slowly"

"Nurse attends to a child with a *nail prick*"

To deal with, such a variety of health problems demands much of the health workers and even more so when the number of health workers is limited. More often than not a situation of overload per worker is the result. It is important to capacitate the PHC facilities with a good number of health workers in order for adequate health service to be rendered

.

(iii) Health interaction and service delivery

The researcher witnessed several health interactions between the providers and the clients and service delivery routines being carried out in the dispensary. These interactions are known as **facilitating inte ractions**. On discussing their experiences of visits to the dispensary clients expressed their appreciation for a warm welcome and great attention. Some clients, however, reported differently, saying that they had experienced little attention and a cold reception. The facilitating interactions were evidenced by the following statements:

"CO explains to the mother 'Continue to give plenty of fluids several times as you have been doing and don't forget to use mosquito nets' "

"Nurse says, '*Pole sana mama* you should give food frequently to your child so that she gains weight' "

"It is better that you came here, we will dress the wound and refer you to regional hospital for further management"

"CO asks, "'how do you feel today?'"

These facilitation interactions are of great contribution to the utilisation of mental health services at the dispensary, because clients feel respected and reassured.

Little attention and a cold reception were **impeding int eractions** experienced by clients. Nobody would benefit by such a way of doing and it causes damage to the facility and its 'name'. Such conduct from providers is neither welcome nor pleasant. It demonstrates poor communication skills, a lack of interest in the clients' health problems, a disrespectful

approach towards those who are already in need of assistance and depending on receiving it. These experiences are quoted as follows:

"Why are you late?"
"Why don't you come regularly for injection?"
"Why didn't you bring the child to the facility?"
"Nurse with *unpleasant voice* says..."
"Nurse talks with a *forceful voice"*

The above quotes demonstrate that health workers in this case have used harsh language to health seeking clients. The word "why" is not a suitable word to clients, it may create anxiety instead of calming them. From this discussion, there is a need for the health workers to have effective health interactions with health care seeking clients if really the need to improve the health of the clients is there. Therefore, health workers should be reminded of the way professional health interactions should proceed and should have skills in effective communication to attract and reassure those who seek health-related advice and assistance.

On the other hand service delivery was also observed as an important aspect on the utilisation of mental health services at the dispensary. The researcher observed health workers delivering services to clients. The common **services deliv ered** were through carrying out activities that included weighing of children for reproductive services, giving vaccinations and attending to mothers needing family planning services. Services for physical conditions included partial assessment of patients, prescribing medications and referring complicated physical cases to hospitals. Very little could be observed on interactions with regard to primary mental health services, as the health workers were mainly attending to patients who had been discharged from the hospital after having 'referred' themselves to referral hospitals, and who consequently came to the dispensary merely to collect medications. Time spent for consultation ranged between three to seven minutes. All these are evidenced by the following quotes:

"Nurse assesses her and prescribes drugs (medicines)."
"MCHA collects children's cards; call one by one, weighs them..... and gives vaccinations."
"CO assesses the child with cough and prescribes drugs (medicines)"
"Nurse writes a referral letter and gives it to the mother"

"I have just come to collect my medicines (for epilepsy), they are about to finish"

This observation reveals that assessment, referrals, prescription of medicines are done and health workers spend time for consultation, but there is little done on assessing the clients, no time for counselling and no specimen collected for investigations. It would appear that health workers are in need of and would greatly benefit by added knowledge so that they would be better equipped with sufficient knowledge to manage clients of all conditions appropriately.

Summary

In summary observations made in phase one, which were on role players specifically on health workers, health challenges, and health interactions and service delivery may be used in rendering a great contribution towards enhancing the utilisation of mental health services at the dispensary level.

Evaluation of the three main themes

An evaluation of the three main themes could be done according to the observation as quoted above. With regard to theme one there is interrole conflict between the CO and the EN, especially for these health workers working at the dispensary. These two cadres assess, diagnose and prescribe medicines. Most patients attending the dispensary are those for reproductive health, minor ailments and physical health services. Only a few turn up for mental health services.

4.1.2 Phase two

Phase two was in response to the second objective *i.e.* to explore why people go to referral hospitals, instead of utilising primary mental health care services closer to them. In this phase the researcher conducted in-depth interviews with family members who sought health care assistance from the referral hospital, without making use of the PHC facilities in their vicinity.

The data collected were arranged into themes. The themes emanating from this phase would be related to reasons for not using the PHC facilities, the reasons for using the PHC facilities and other reasons. Then triangulation of participative observation and in-depth interviews followed, and lastly a summary of the chapter.

(iv) Reasons for not using the PHC facilities

Most participants expressed several reasons for not using the PHC facilities. These reasons were arranged in sub-themes. These sub-themes included inadequate services at the dispensary, lack of medicines, not collecting specimens for further testing of possible conditions, being advised by others even health workers themselves to use referral hospitals instead if they needed treatment. There were also complains about unsatisfactory levels of knowledge necessary for adequate services at the dispensary level. These reasons are evidenced by the following statements:

"No medicines in the PHC facilities, Drugs for mental ill not there completely"
"Services and drugs are inadequate and no investigations at PHC facility"
"We do not know if there are services....."
"We were advised by our relative to go to referral hospital"
".....Told by others to go to referral hospital"
"Doctor (CO) told us to go to referral hospital"
"Even villagers go to town for services because of inadequate services"

People attending the PHC facilities need to be satisfied with the services provided at these facilities and the quality of such services would have to meet their needs and live up to certain requirements and standards (Mash, 2010:335) emphasises patient satisfaction and regards it as a tool that points out indicators and alerts the attention to aspects and expectations that are important to patients and which they want to find at health facilities visited by them, or else they would go elsewhere. Some simply do not know where to seek help and the result is that they go anywhere they are told to go (Snowden, 2001:182). A report from WHO (2001b:54) supports the inadequacy of services in the PHC facilities and marks it as a barrier to the utilisation of services. It is the task and responsibility of higher

authorities to develop and implement policies that would ensure proper health care services at all levels, *i.e.* primary health care included.

(v) Reasons for using PHC facilities

The reasons for making use of PHC facilities varied and included the presence of health workers and a Clinical Officer with mental health knowledge, available mental health treatment at some PHC facilities and good reception and attention at the dispensary. Once again patient satisfaction came into play as people appreciated immediate attention and assistance on arrival at the health facility as well being addressed in pleasant language, all of which in comparison appeared in some cases to be contrary to what they experienced at the referral hospitals. These were among the issues that attracted some patients to seek for mental health services at the dispensary. This was reported by a few participants and is evidenced by the following statements:

".....received treatment"
"At the dispensary the reception is straight forward"
".....receives patients properly at PHC facilities"
"The clinical officer who was there was working well"
"There are health workers"
"At the health centre service is good and the reception is good"
"Here (referral hospital) the language is unpleasant"

The reasons mentioned by the participants are important and have to be taken into account if enhancement of the utilisation of mental health services at the PHC facilities is envisaged. In a report by WHO (2005a: 22) the basic drugs for mentally challenged people are indicated and these should be available at the PHC facilities. Some of the facilities already have the required stock, but the situation still leaves room for improvement. Proper communication skills are important in the sense that they create and establish feelings of reassurance, credibility and trustworthiness and also form basis for sound relationships between providers and clients. Patients will be interested and encouraged to seek mental health services at the dispensary. This concept is supported by Mash (2010:107) who discusses the skills for effective communication as an important aspect in services delivery. According to Saxena et

al. (2006:182) professional health workers are considered as the back bone in PHC facilities and therefore, they are important in making people utilise the mental health services at PHC facilities.

(vi) Other reasons include

The reasons for going to a referral hospital instead of the local facilities included side issues such as that it is *a big hospital* and because a *relative is working there.* These reasons are evidenced by the following statements:

"Here in this hospital there is one of our relative..."
"Referral hospital is a big hospital and have big name"

These findings suggest that people lack knowledge on the referral system, and the referral systems are not strict and selective enough. It is possible for people to refer themselves to these hospitals, so to speak and this practice continues freely without them being questioned. This concurs with the explanations on the referral system in MOHSW (2007:30). And also as suggested by Uys and Middleton (2004:68) that health workers should be skilled to manage patients at PHC facilities. Davis and Ford (2004:50) support the fact that people are not adequately informed, that there is a lack of knowledge among people, that they fail to know where to seek mental health services when in need. Much should be done to improve this state of affairs and to get people better informed about the systems at their disposal. Among the other reasons mentioned for seeking mental health services at the dispensary were the *availability of services near to where people live*, which would make unnecessary for people to travel long distances that would require transportation or related fares and to *reduce overcrowding at the referral hospital.* Another reason which was on both sides was the *fees for services.* All these could be detected among the observations and responses.

The reasons that make people seek mental health services at PHC facilities are evidenced by the following quotes:

"Services are available near to where we live"
"We do not have transport fare"

"No trouble travelling long distance"

"Reduces overcrowding....."

From the above statements it is obvious that people need mental health services near to where they live and work. This statement is supported by Masaiganah (2004:137). Mamdani and Bangser (2004:142) support the fact that the cost of accessing care is a factor when seeking services near to where they live. Also as it is reported by WHO (2005b:2) the reason is to reduce the burden on specialised mental health services. Therefore, it is important to ensure that Primary Mental Health Care services are available to people to utilise it for the improvement of their mental health.

Some participants pointed out service fees as one of the issues with regard to the utilisation of mental health services at PHC facilities. Some said that fees had to be paid at all facilities, but some expressed their concern that the fees at PHC facilities were in comparison higher than those at the referral hospital. However, from the above comments the researcher found that people were willing to pay for services. There was only one participant who claimed to have no money for the fees, but she was nevertheless attended to. Others were exempted from payment because of their status. Others commented that at government facilities rates were low but sometimes you had to buy medicines that were not provided at the facilities. These statements and opinions were derived from the responses as listed below.

"At dispensary payment are higher than at the hospital"

"We pay at PHC facility"

"Payment is to all facilities"

".....I don't have money, nurse says, don't worry you will get free treatment"

"Government facilities' rate is low therefore drugs are inadequate"

"Payment but of low rates in government facilities but you have to buy some of the medicine from the medicine stores"

The issue of paying for services is important as people know that when they pay the quality of services at the health facilities may be improved is supported by Mtei and Mulligan (2007:9). Exemptions are also applicable to vulnerable clients who are unable to pay as also suggested by Mtei and Mulligan (2007:6). The comment that the fees at government facilities were low at the same time pointed out that service might consequently be inadequate,

especially as certain medication items had to be bought elsewhere. This would suggest that medicine supplies at such facilities could not meet the demand. This is contrary to the explanation from Mamdani and Bangser (2004:150). It is important that payment and fee rates should relate to the services provided and it is important that users should understand the relation. A proper system for exemption purposes should be in place as there are those who need to be exempted from payment. Users should be informed and made aware of procedures surrounding the systems of necessary fees and related payment.

4.2 Crystallisation (Triangulation between two qualitative methodologies) of the Participative observation with in-depth interviews

During the discussion of the findings from the participative observation and in-depth interviews some findings were similar, while some did not relate. In the participative observation the researcher observed the mental health care-giving behaviour whereas, in in-depth interviews data were collected through verbal responses.

The relating findings which were similar included, *inter alia*, the following: ***Inadequate service delivery*** at the dispensary with regard to mental health services emerged as one of the aspects. In participative observation it was evidenced by attendance of more patients with physical health problems compared to mental health services where patients for mental health were mainly those who had come to collect medicines. In in-depth interviews the findings were as commented by the participants, see 4.1.1 (iii) and 4.1.2, (iv)

Another similar aspect that surfaced was ***disrespect to clients***. In participative observation it could be witnessed by observing the communication process between the health workers and health seeking clients, whereby the word "why" was being used several times, the word "don't" showed disrespect to people. In in-depth interviews it was noted by unpleasant language used by health workers, see 4.1.1 (iii) and 4.1.2, (v).

Lack of knowledge on the referral system presented during both the participative observation and the in-depth interviews. The lack of knowledge in this regard resulted in people taking matters into their own hands by doing self-referrals. See 4.1.1 (iii) on services delivered and 4.1.2 (vi).

From the discussion the unique theme found was that one participant requested the government to conduct a study to find ways of bringing services to the PHC facilities. Though one participant showed this concern, this is a concern for many people living in the community and who need to have adequate services closer to where they live.

All these findings can contribute to the development of strategies to enhance the utilisation of Primary Mental Health Care.

4.3 Summary

This chapter presented the realisation of the research and interpretation of the research findings. The findings of this research concurred with the content in the literature review (refer to chapter two). The findings also provide information to be used for developing strategies to enhance the utilisation of mental health services in PHC facilities.

In the following chapter, the researcher summarises this research study by providing recommendations of the research as the source for developing strategies to enhance the utilisation of mental health services at the PHC facilities. Lastly the conclusion of the research will be presented.

Chapter five

RECOMMENDATIONS AND CONCLUSION OF THE RESEARCH

5.1 Introduction

In this chapter the researcher plans to focus on factors which facilitate the utilisation of primary mental health services, and barriers on the utilisation of Primary Mental Health Care (PMHC) services, recommendations in the form of strategies to enhance the utilisation of PMHC services and the conclusion of this research. It answers the third objective which is to develop strategies to empower families of mental health care users about PMHC services and to inform the primary health care workers about the expected care in order to enhance the utilisation of PMHC services.

The reason why the researcher introduces the factors that facilitate the utilisation of PMHC services and the barriers surrounding the utilisation of PMHC services is to emphasise the importance of PMHC as well as to address the needs identified in this research.

5.2 Factors facilitating utilisation of primary mental health services

There are several factors that facilitate utilisation of primary mental health services as seen from various studies and sources of literature. ***Development and implementation of Mental Health Policies and Programmes*** is a key factor for facilitating the provision and for improvement of mental health services in the countries (Saxena, Sharan, Cumbrera & Saraceno, 2006: 183). Policies and programmes give direction on how to implement the strategies set for provision of services (WHO, 2001b:77). These concepts are reflected in studies that were conducted after the Alma Ata conference when the governments and countries were recommended to formulate the policies and strategies for implementation of primary health care (Saxena et al. 2006:184). Several countries responded to the call, $^{2}/_{3}$ of the countries have mental health programme in situ and ¾ of the countries have either policies or programmes (WHO, 2001b:77).

Tanzania is one of the countries that have both a Mental Health Policy and a Mental Health Programme (WHO, 2005b:490), and it has also formulated supervision guidelines to be used by District Health Management Teams (DHMT) for supervising the activities at primary health care facilities (Manongi, Marchant & Bygbjerg, 2006:1).

"Mental health professionals form the backbone of a mental health care delivery system" (Saxena et al. 2006:182). The presence of ***adequate and skilled health workers at primary health care facilities*** is a factor that directly influences the utilisation of health services (Mackenzie, Gekoski & Knox, 2006: 580). Primary health care workers at the facility vary from country to country by number and type, but they should include medical doctors, nurses and other clinicians who provide general health care (Funk & Ivjibaro, 2008:9). Studies show that there are health workers who provide services at primary health care facilities in some countries and also people are eager to receive the services at these facilities, such as a study conducted on primary health workers' knowledge, attitudes and practice pertaining to depression (Mbatia, Shah & Jenkins, 2009:6).

In African countries the number of these health workers often is inadequate (Alem, Jacobsson & Hanlon, 2008:56) but they are there. In Tanzania provision of mental health services at dispensary level is facilitated by having a team of health workers. The team members usually consist of the clinical officer, enrolled nurses and midwives, medical attendants and laboratory assistant and other support staff (Jenkins & Strathdee, 2000:278). However, a shortage of health workers has been reported in most of the health facilities in which the government is working (Mamdani & Bangser, 2004:141).

By implementing the new Primary Health Service Development Programme launched in Tanzania the country is expected to have an adequate number of human resources in these facilities within the next ten years (MOHSW, 2007:5). It has been observed that in most of the developing countries "well-trained primary health care workers provide adequate treatment for the mentally ill" (WHO, 2001b:59). Tanzania's primary health care health workers have received basic training in managing of mentally ill patients (Jenkins & Strathdee, 2000:281) and still more are being trained likewise (Mbatia, Shah & Jenkins, 2009:6).

Infrastructure is one of the factors in provision of mental health services, although it is reported that in most African countries basic infrastructure of primary health care does not exist (Alem, Jacobsson & Hanlon, 2008: 56). In a study done on poor people's experiences of health services in Tanzania it has been revealed that there are primary health care facilities in the communities although some of them are not in good working condition (Mamdani & Bangser, 2004:138). Sometimes these poorly equipped or managed physical infrastructures reduce health workers' morale towards work as well as their ability to really live up to what is expected of them (Manongi, Marchant & Bygbjerg, 2006: 6).

In order to provide quality health services in the country and motivate health workers, the government has initiated a programme of establishment, rehabilitation and maintaining the infrastructures of health centres and dispensaries, especially the buildings, by involving the communities to participate (MOHSW, 2007:16). The sustainability of rehabilitation and maintenance of these facilities had been facilitated jointly by PMO-RALG and Development Partners since 2003 (MOHSW, 2007:27).

Fees and payment would be one way of improving provision of quality services at PHC facilities. The funds that are obtained from these fees are used to purchase equipment and supplies for smooth running of these facilities (Funk & Ivjibaro, 2008:54). A fee system, when structured well, encourages people to find a way to access services as many people, especially the poor, cannot pay the fees every time they visit the health care facility. A system of contributing smaller amounts of money monthly or after a certain period would be more acceptable and may in some cases even be unavoidable. There are many people who cannot, or would prefer not to, provide the full sum of money payable once during sickness (Mtei & Mulligan, 2007:3). Many countries have a system of payment for services provided but the methods vary from country to country, for example in US the fee system is by "fee for service payments" *i.e*. the more extended the service the higher the payment (Shih, Davis, Schoenbaum, Gauthier, Nuzum & Mc Carthy, 2008:21). Several studies have reported that there is improvement of the quality of health services provided by using fee for service (Mtei & Mulligan, 2007:9).

In Tanzania several fee or payment systems have been introduced to enable people to access and utilise health services at various levels of health care with exemptions to some vulnerable

people such as those with chronic illnesses including patients with chronic mental conditions (Mtei & Mulligan, 2007:2). In 1993 the user fee system or cost sharing was introduced to improve accessibility of health services at hospital levels, which is still being paid for service provision. This type of system would require the patients to pay for service every time they visit the facility (Mamdani & Bangser, 2004:139).

In 1998 Community Health Fund (CHF) was introduced to health centres and dispensaries and covered at least 42 districts with an aim of improving the availability of health services and to serve the majority of the poor in an equitable way. Exemptions were also introduced to protect the vulnerable with the aim of helping those who are unable to pay (Mtei & Mulligan, 2007:6). Studies show that people are willing to pay only when the quality of care is good. Studies also show that CHF has improved the quality of services provided in these facilities. Although CHF was introduced to serve people, but still the problem remains to the poor people who cannot pay for services and are not exempted from payment (Mamdani & Bangser, 2004:139). Other financing systems include National Health Insurance Fund (NHIF) that has started to operate but this was for civil servants only. Up to date there are more than 1.14 million members of this fund, Micro Health Insurance Fund (MHIF) and National Social Security Fund (NSSF) (Mtei & Mulligan, 2007:6).

Treatment for mental health problems at PHC facilities is a factor in influencing utilisation and improving quality mental health services (Kroenke et al, 2000:39). The necessary treatments can be available as recommended by WHO, but countries need to be proactive in searching for the drugs as listed in the drug list of primary health care (WHO, 2001b:91). Studies show that drugs are more affordable at government facilities but that these very soon run short of the necessary items and that people are then compelled to rely on other or private provision stores where they might not be able to pay the prices charged (Mamdani & Bangser, 2004:140).

Therefore, countries should respond to WHO's recommendation according to which countries should make efforts to secure that the drugs for mental health problems are available at primary health care and that people with mental health problems should be treated at primary health care facilities (Abbo et al., 2008:2).

Education for both health workers and service users is very important. Studies reveal that mental health literacy and education has been identified as important factors that influence mental health care use (Keating & Robertson, 2004:446). The factor of education is related to insight into signs and symptoms of mental disorders and a positive attitude towards treatment. This applies to both providers and users of mental health care. People who are uninformed or poorly informed or with low levels of education will have low insight with regard to symptoms of mental disorders and will unfortunately be the very people less likely to seek mental health assistance and services, far less than those with more information and higher levels of education (Steele, Dewa, Lin & Lee, 2007:103,104). It is very important, therefore, to create awareness among people through educating them so that they would have insight which will make them utilise the mental health care services that they need.

Also for better management of patients at PHC facilities, a health worker should be skilled to identify those that can be helped and those that would need referral to other health care levels (Uys & Middleton, 2004:68). Tanzania has PHC workers with basic training in mental health to provide mental health services at PHC level. These workers also receive continuing education regularly. The training is taken care of by mental health coordinators collaborating with officials from the MOHSW (Jenkins & Strathdee, 2008:281).

Seeking professional help is something which usually comes from within a person. It is undoubtedly related to the level of knowledge and insight someone has on mental illness (Mackenzie, Gekoski & Knox, 2006:575). A person, before seeking health services, has to realise that she or he is ill and has a problem. Only then will follow a decision as to where and when to seek help (Melillo & Huode, 2005:78). Studies show that mentally ill patients attempt to seek help from various sources such as from friends, family members, traditional healers and other alternative therapy before getting to health care facilities (Snowden, 2001:182; Mackenzie, Gekoski & Knox, 2006:577). There are factors that stimulate and influence the decision or action of seeking help. Some of the factors include cultural beliefs and values of the individuals and families, accessibility and availability of services (Ng et al., 2003: 617).

There is evidence that few people with mental health challenges seek mental health services at the PHC facilities. Those who do are usually those with somatic disorders (Yeung et al.,

2004:256; WHO, 2001b:54). A study conducted in an Asian community revealed that people seek mental health services at the PHC facility but sometimes they do not explain to the health workers their mental problems, which sometimes makes the health worker fail to make a proper diagnosis (Wynaden et al., 2005:92). In another study conducted on Knowledge, Attitude and Practice to depression among PHC workers in Tanzania it has been revealed that among all patients attending primary health care facilities 24% - 48% were suffering from mental disorders (Mbatia, Shah & Jenkins, 2009:2), which means that people seek care from health care facilities.

From the discussion above it is evident that mental health care is indeed sought at PHC centres and that improvement with regard to the necessary information as well as the necessary services would come everybody to good stead and would greatly be to the advantage of individuals and of communities at large. PHC is a step towards improving mental health of the people living in the communities (Hyman et al. in: Jamison et al., 2006:620). Also utilisation of these facilities reduces the burden of seeking services in referral hospitals where it is even more expensive (Khe, Toan, Xuan, Eriksson, Hojer & Diwan, 2002: 105).

Family involvement is also a factor because members of a family are directly affected by events pertaining to experiences of well-being or opposite thereof. The family is the smallest unit in the community and the most important when it comes to patient care when one of the members is in need of such care. It has many functions and an important role to play for the sake of their members close to them. Among the functions that the family has to fulfil are provision of financial and emotional support and mobilisation of resources to deal with emerging problems of its members. With proper and informed family support mentally ill patients within the community can be cared for a great extent in order to improve their health and well-being (Malcolm, in: Baumann, 2008:628).

In African communities the majority of families live together as extended families. There are strong ties and greater social support among family members and most patients who are mentally ill live together with their families. There are, however, those who decide to move away because of their illness. Only in rare cases when the condition is extremely uncontrolled patients may be strained or neglected. However, families in these African societies form the

basis of mental health care in traditional societies (Alem, Jacobsson & Hanlon, 2008: 55). This behaviour should be encouraged to maintain the involvement of the families in care.

Community involvement is seen to be an important factor in providing care to mentally ill patients in the communities. Community members need to be sensitised and have anti stigma campaigns regarding mental disorders to increase community involvement in caring of mentally ill patients (Alem, Jacobsson & Hanlon, 2008: 56). A community needs to be encouraged to appreciate and value what they have in their communities so that they can use it to their benefit instead of valuing others' ideas (Alem, Jacobsson & Hanlon, 2008:56). Studies also show that community participation of young people, women and men in care at all levels of health care contributes greatly towards providing care to mentally ill patients (Blignault et al., 2009:13).

Stakeholders' involvement in providing care, support through experience and resources in order to assist mentally ill patients at PHC level is very important (Ng, Herman, Chiu & Singh, 2009:52). Studies show that there is a need to involve churches and NGOs that can reach out to a diverse population and would be able to encourage them to use mental health services and related programmes available in the community (Blignault et al., 2009:13). According to Hyman et al. (2006:620) it has been reported that 93% of African countries have NGOs that are important providers of mental health care. They provide various services, including supportive services, preventive services, rehabilitative services, and housing, research and other programmes.

Other stakeholders who should be involved are village leaders. Village leaders have a very important role to play in that they take strong actions on the needs expressed by the communities. They, too, can easily communicate with their communities on different health issues, can mobilise community to do something and can help to manage community health and health-related problems (Mamdani & Bangser, 2004:145). All these stakeholders are in our communities and it is possible to involve them for improvement of utilisation of mental health services at PHC facilities.

To conclude, studies show that all the factors discussed above are feasible as mental health services have been provided in many areas with positive results despite the challenges they

have. What is required is that the factors are either improved or modified for better provision of quality mental health services at PHC facilities so that people can access and utilise the services available.

5.3 Barriers on utilisation of primary mental health services

Barriers can be described as obstacles towards achieving something, but according to Melillo and Houde (2005: 79) on the content of care model, it shows that there are factors which are barriers on the one hand, but on the other hand can be the facilitating factors to the utilisation of health care services. In this section several barriers to service utilisation are discussed, as based on the studies conducted in various countries.

Stigma, discrimination and shame can be counted among biggest barriers to service utilisation, and even more so in the case of local mental health services. Many studies show that stigma lowers the patient's quality of life and patients are afraid of being stigmatized, the same applies to family members who may feel ashamed and fear for their reputation to be destroyed when one in the family is known to be mentally ill (Newell et al., 2000:17). Stigma leads to discrimination, shame and negligence of the patients. Mentally ill patients may easily fall victim to discrimination with regard to housing opportunities, employment, life partners and other social activities and another result may also be loss of contact and support from family and friends (La Veist, 2005: 104).

A study done on Asian community on factors that influence Asian communities' access to mental health care reported stigma to be a big barrier that caused families to isolate the mentally ill patients because of feelings of shame, a word shame that cannot be explained in other languages to give the real meaning from their perspective, the family did not want the patient to be known to the public in order to protect the family reputation. Due to stigma and discrimination that in turn lead to feelings of shame, families are not seeking mental health services for their patients (Wynaden et al., 2005:90).

In many developing countries mental health care enjoy low priority. Related care is provided in merely a small number of health care facilities that are being described as "usually overcrowded, understaffed and inefficient". The services are available in mental hospitals

that are far to be reached and for this reason people seek help there only as a last resort (WHO, 2001b:52). In these hospitals, laws of admission and discharge, and shortage of qualified professionals contribute to the stigma of people with mental disorders (WHO, 2001b:52). The state of affairs is still the same in most of the hospitals. In Tanzania the only mental referral hospital is Mirembe Hospital where patients are managed in a fenced environment and isolated cells. Sometimes these patients are not treated well, thus stigma to mentally ill patients is still manifested (Santegoeds, 2007, under heading of Mirembe Hospital, Dodoma Tanzania).

Beliefs on the causes of mental illness can be a barrier to the utilisation of mental health services. In East African culture most of the communities have limited knowledge on mental illnesses they associate mental illnesses with cultural beliefs that mentally ill patient possess evil spirits and can be treated by traditional healers (WHO, 2001b: 58; Alem, Jacobsson & Hanlon, 2008:56). Because of fear and shame, and cultural belief that mentally ill patients possess evil spirits that make them behave abnormally, most of people in the rural areas among Chinese patients seek help from traditional healers, but also in contrary cultural beliefs influence other people to make use of health services (Ng et al., 2003:618).

Financial constraints as one of the barriers cannot be conveniently brushed aside. Such a position certainly present as a barrier to access to mental health services in some areas where there is a fee-for-service system. A study done among Mexican Americans shows that people with a low income living in rural communities were most severely affected and ever so often had to resort to informal care due to lack of money for mental health services at health facilities (Vega et al., 1999:932). A study done in rural Vietnam showed that a lack of financial resources counted among the barriers to health services (Khe et al., 2002:105). In Uganda poor people living in remote areas are not able to access mental health services even when these services in the public health facilities are free, simply because of not being able to afford necessary transport (Ssebunya et al., 2009:6). In a study conducted in Tanzania it was revealed that poor women who have no money are faced with problems in accessing health services especially when there is a fee-for-services system and the necessity for out-of-pocket expenses (Mamdani & Bangser, 2004:139).

Social demographic characteristics are some of the barriers in utilisation of mental health services. These factors include age, sex, race, and education as well as a few others as supported by a several studies (Ngoma, Prince, & Mann, 2003:354; Mackenzie, Gekoski & Knox, 2006:580; Snowden, 2001:186). Contrary to the study just mentioned, is another study that was conducted among the communities of Singapore on preference, need and utilisation of mental health services. The latter study reported that social demographic characters such as gender, age and marital status are enabling factors to the use of mental health services (Ng, Fones, & Kua, 2003:613).

Distance between the patients' homes and the nearest health care facilities also poses as a barrier, especially so with regard to some of the communities. A study conducted among African Americans showed that long distances to health facilities presented as a barrier to access services (Davis & Ford, 2004:49). Another study conducted in Tanzania showed that one of the obstacles to access health care was that some people had to walk a distance of 10 kilometres to reach the health facility, though most of them are within reach of health care facilities (Mamdani & Bangser, 2004:141).

Ethical issues would appear to be a more serious barrier than expected. In some cases or at certain facilities it had been observed that ethical issues such as confidentiality, privacy and anonymity are lacking in PHC facilities, resulting in patients' fearing to use the available services at the health care facility in the sense of fear of being publically known to other people (Chipp, Johnson, Brems, Warner & Roberts, 2008:7, 538).

Availability of quality mental health service at primary health care facilities is an important factor, but if no service exists or service is inadequate, it becomes a barrier. In a study conducted among Mexican American it could be seen that less effective as well as inappropriate treatment can be a barrier to services (Vega et al., 1999:933). A report from World Health Organization also supports the concept that there is inadequacy of the services provided at some of the PHC facilities (WHO, 2001b:54).

Attitude of health workers and service users can be a barrier to the utilisation of the PMHC. It has been observed that *health workers have a negative attitude towards mentally ill patients.* In such cases services are not provided as they should be provided and would lack

the quality the services are supposed to have. Studies revealed that 90% to 95% of health workers have a negative attitude towards mentally ill patients. Not only are the health workers guilty of showing a negative attitude towards mentally ill patients, but also members of the public. The root of the problem is very often that they regard mentally ill patients as dangerous to people and they have extraordinary behaviour, thus they make people feel uncomfortable being with them (Uys & Middleton 2004:66).

Ng et al. (2003:617) assert that *attitude of the community towards mental health services* is an important factor in the utilisation of the services and therefore a positive attitude is associated with better utilisation. Another study done within an Asian community revealed that some patients first sought the assistance supplied by other sources and that consequently a lack of collaboration between health professionals and religious/spiritual leaders, led to patients not making use of mental health services at health facilities (Wynaden et al., 2005:92).

Knowledge is a factor that affects utilisation of mental health services at PHC facilities. The knowledge referred to here could apply to patients, community or health workers. A study conducted within an Asian community on factors that influence Asian communities' access to mental health care reported barriers to be, lack of knowledge among people on the causes of mental illness (Wynaden et al., 2005:91). Studies also showed that some mentally ill patients do not know where and how to access mental health services when they need care (Davis & Ford, 2004:50). Sometimes stigmatisation and discrimination are seen among health workers who do not have enough knowledge on mental disorders to view such illnesses objectively. They, too, would then stand in the way of provision of health care services to patients in need (La Veist, 2005: 105).

In conclusion, barriers of utilisation of mental health services that have been discussed above can be grouped in factors as educational, social cultural, economic, ethical, administrative, service and geographical factors, stigma and discrimination being the biggest barrier. In Tanzania some programmes have been developed and continue to be developed in order to overcome these barriers, for example, the PHSDP aims at increasing the number of health workers at PHC level as well as providing training and continuing education on mental health to update and expand knowledge and skills of such workers. Reconstruction and

rehabilitation programmes are being attended to in order to upgrade the infrastructure of health facilities.

5.4 Limitation of the study

In this study only one PHC facility and one referral hospital was sampled for data collection, which could limit generalization of the findings. However, despite the limitations the results yielded important information which could serve as a basis in enhancing the utilization of PMHC services in Dodoma municipality.

5.5 Recommendations

As was mentioned in chapter one, the recommendations of this research will be presented in the form of strategies. A strategy is "a plan designed to achieve a particular long-term aim" (Soanes & Stevenson, 2008:1425). Another definition of strategy by Interwords.com (2010) "is the long-term action plan for achieving a goal" whereas, Dictionary.com (2010) defines a strategy as "a plan, method or series of maneuvers for obtaining a specific goal or result". In this research, strategies are considered to be plans or methods developed to achieve the goal of enhancing the utilisation of PMHC services in Dodoma Municipality, Tanzania.

These strategies were derived from the findings in 4.1.1 and 4.1.2, and they are; ***community information dissemination***, ***continuous professional development***, ***skills for effective communication*** *and* ***sensitising policy makers*** to strengthen the referral system and the mental health services. Such strategies are discussed in the section below.

In facilitating ***community information dissemination*** it includes creating awareness among people living in the community on the available mental health services at PHC facilities. Mackenzie, Gekoski and Knox (2006:575) as well as Melillo and Huode (2005:78) claim that creating awareness help mentally ill patients to know where to seek help. As according to 4.1.2 (iv) above participants commented that services at PHC facilities have many benefits such as to reduce overcrowding at the referral hospital and to facilitate availability of services near to where people live with no need for them to travel long distances. Moreover, participants recommended that, in order for people to be aware of the services, they should be informed by means of posters, banners, meetings and advertisements via radio, broadcasts, television and magazines. Through these medias people will made be aware of the available

services as according to Steele, Dewa, Lin and Lee (2007:103,104). But also community members need to be sensitised using anti stigma campaigns regarding mental disorders to as well as other methods to increase community involvement in caring of mentally ill patients (Alem, Jacobsson & Hanlon, 2008: 56).

The second strategy is ***Continuous Professional Development (CPD)*** which aims at building capacity of health workers at PHC facilities to ensure that their professional competence is maintained, in order to improve the quality of patient care (Mash, 2010:374). In planning CPD to health workers at PHC setting the main concern should be about the management of mentally challenged people and such management would include assessment of patients, identification of mental health problems, management of minor ailments and reference of major mental illness to the appropriate level of health care delivery. According to Jenkins and Strathdee (2000:281), training of health workers should be frequently to update them with new knowledge and skills.

From the findings participants claimed that some health workers are not capable of providing mental health services. When they receive the clients who are mentally challenged they simply suggest that they be taken to the referral hospital without even assessing the client [see 4.1.2 (iv)]. In order to maintain competence of health workers at PHC facility first, there should be identification of learning needs and accordingly learning can be facilitated by making use of methods such as short courses, training, workshops, seminars, lectures and clinical rotations for relevant clinical experience (Villiers: in Mash et al., 2010:375). In addition open and distance learning to update knowledge and skills can also be used (Quinn, 2000:539).

The third strategy is to facilitate ***skills for effective communication*** to health workers at the PHC facilities. This strategy would aim at teaching health workers a new way of communicating effectively to enhance therapeutic communication. “Communicating in ways that help to solve problems while at the same time respecting and honouring human beings will facilitate the healing process” (Davis, 2006:95). On the other hand ineffective communication results in failure to obtain sufficient information for making proper decisions that are best for the patients to identify and solve their problems. In the findings it was observed that participants were asked “why are you late? Or “you don’t want to answer?”

These questions may leave the patients with a variety of thoughts and negative feelings towards health workers and mental health services.
Health workers should use skills for effective communication in order to increase patients' satisfaction and decrease anxiety and distress (Mash, 2005:107). Quinn (2000:496) discusses communication skills as including listening, questioning, encouraging, information-giving, responding, comforting and controlling. However, attentive listening and careful questioning improves the efficiency of health worker-patient communication (Puri, Laking & Treasaden, 2007:57). Therefore, there is a need to conduct in-service training and tailor made courses regularly to equip health workers with the necessary skills in effective communication.

The fourth strategy is to ***sensitise policy makers*** to strengthen the referral system and mental health services at PHC facilities. This is also supported by MOHSW (2006:11) pointing out that mental health is an essential component in the National Health Policy thus, "the Government of Tanzania is committed to the social goal of health for all through the primary health care strategy." The Policies are there and the referral system as exhibited in the hierarchy of health care delivery system is there (MOHSW, 2007:23). Moreover, according to WHO (2001b:77) policies give direction on provision of health services.

From the findings it was revealed that participants were complaining about inadequate mental health services at the dispensary. The complaints included aspects such as health workers that displayed inadequate knowledge of mental health, shortage or lack of medicines and absence of further investigations, for example by specimens or specialised tests. However, training of health workers help to provide adequate health service (WHO, 2001b:59). Saxena et al. (2006:183) assert that policies must be considered a key factor in facilitating provision of adequate mental health care services at PHC level. To sensitise the policy makers the researcher should submit the research report to them and convene a meeting with them so that they can formulate rules and bylaws to strengthen the process of referring patients and restrict self-referrals, to create awareness among people on these rules, and to make sure that mental health services are available in the PHC facilities with adequate resources.

The researcher recommends that these be considered as the strategies to be developed in order to enhance the utilisation of mental health services at the PHC facilities in Dodoma Municipality, Tanzania.

5.6 Conclusion

In chapter one the researcher provided an overview of the research by introducing the concept of primary mental health care and its utilisation. The research question, the objectives, rationale of the research has been discussed and the theoretical definitions of key concepts highlighted, namely mental health, primary health care and primary mental health care. Finally the outline of the research study, as presented in different chapters, was presented.

In chapter two the researcher discusses the literature review that provided the broader understanding of the problem through reviewing other studies already conducted on similar challenges. Understanding mental health and mental functioning is important as it helps towards understanding mental and behavioural disorders (WHO, 2001b:5). Mental disorders have an impact on the socio-economic status of the country if neglected would pose a threat to the health of the people as well as to the health of the nation (Hyman et al. in: Jamison et al., 2006:621). Therefore, provision of mental health care services at all levels of a health care delivery system, specifically at primary health care level, is very important for managing mental disorders. Utilisation of mental health services at primary health care facilities is possible as mental disorder is a global issue due to its high prevalence worldwide. The countries and governments during the international conference in the Alma Ata in 1978 were recommended to implement primary health care in their countries. Several countries and governments adopted it and formulated policies to guide the implementation.

It is now more than 31 years since the Alma Ata conference on primary health care and recommendation on integration of mental health into primary health care was announced. And in spite of the good reasons for integration, the results and reports from various studies on successful improvement of people's health status through use of services at primary health care level, some people still avoid primary health care settings and prefer mental health care in referral hospitals. There is a need to find out what the problem is and find the way to address the problem or problems. Therefore, the government needs to put more effort into creating awareness among the people, families, communities, health-related professionals, and other stakeholders on the importance of mental health care users to utilise services available at primary health care facilities to promote primary mental health care. And to those patients with mental health problems who will seek health services at primary health care

facilities to be well managed by providing comprehensive mental health care in a holistic approach. With the above discussions the researcher therefore, needs to find out why people do not use the available services at the primary health care facilities effectively.

In chapter three the process of conducting the research is presented. In this chapter, the researcher provides the realistic methods employed in data collection, analysis, interpretation and the discussion of the research findings.

Chapter four presented the realisation of the research and interpretation of the research findings. In phase one the themes emerged were role players who are health workers and health seeking clients, health challenges, and health interactions and service delivery, while in phase two the themes that emerged were reasons for not using PHC facility, reasons for using PHC facilities and other reasons. The findings of this research concurred with the content in the literature review (refer to chapter two). The findings also provided information used for developing strategies to enhance the utilisation of mental health services in PHC facilities.

In chapter five the researcher summarises the research study by providing recommendations in the form of strategies to enhance the utilisation of mental health services at the PHC facilities. These strategies referred to community information dissemination, Continuous Professional Development, skills for effective communication and sensitising Policy makers and lastly the conclusion of the research is presented.

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List of Annexures

Annex 1. Phase one: Clinical ethnography - participative observation

Data collection using participative observation conducted for four weeks between February and March 2010 at a selected Primary Health Care facility.

Day one of the first week

8.00 a.m. I arrive at the Primary Health Facility, greets the Nurse, Maternal and Child Health Aider (MCHA) and Medical attendant, they welcome me and give me a chair to sit and I tell them the purpose of the visit.

8.10 a.m. Nurse orients me to the health facility, introduces me to patients and she says "This is our dispensary feel free to ask any question otherwise you can continue with your activities" she adds "For the whole week the Clinical Officer (CO) will not be around she has an emergency trip, will be here from next week"

8.20 a.m. Mothers with their children and other patients arrive. They sit on the floor, others in the corridor, wait for services.

8.40 a.m. MCHA collects children's cards; calls one by one, weighs them, records in the road to health card and gives vaccinations. Then collects women's card calls them one by one and attends to them.

9.00 a.m. A woman with a baby arrives, hands over baby's card to MCHA. MCHA weighs and records the baby's weight and asks "is your baby sick? Woman answers "yes" MCHA says "I think you know the process of attending sick babies? Take her to the nurse for treatment" Woman "thank you" she leaves.

9.05 a.m. Patients sit in a queue, enter one by one to the consultation room. Nurse welcomes patients for services.

9.20 a.m. A woman with a child arrives, enters in the consultation room, nurse welcomes the woman. The woman sits on a chair and unties her child and says while *looking* at the child "My child is very sick she is having diarrhoea and vomiting since yesterday evening and she is weak" Nurse asks "what drugs have you given to her? Woman "no drugs" nurse assesses the child, prepares Oral Rehydration Solution (ORS) in a *hurry*, puts it in a cup and says "give this

solution to your child now and wait for a referral letter to the hospital" nurse writes a letter and gives it to the woman. Woman leaves with her baby *silently*. Time spent for consultation is five minutes.

10.00 a.m. A nurse welcomes a patient; a mother enters the room. Nurse greets her and she answers. Nurse asks "what is the problem? Mother "my child is sick" nurse "where is the child? Mother "outside because she is afraid" Nurse "bring her inside" child comes in while *crying*; nurse assesses her and prescribes drugs. Time spent for consultation is three minutes.

10.10 a.m. An old woman arrives, walking with a stick, nurse welcomes and greets her. Woman says "I am having painful joints and headache since yesterday, I need treatment, but I don't have money" Nurse "don't worry you will get it free, because of your age you are exempted from the payment" woman while forcing herself to *smile* "*ooh* thank you" nurse asks "do you have any other problem? Woman "no" nurse prescribes the drugs. Woman collects drugs and leaves. Time spent consultation is five minutes.

10.20 a.m. Another mother with her child arrives, mother tells the problems of the child to the nurse. Nurse prescribes drugs. Mother collects drugs and leaves. Time spent for consultation is five minutes.

10.45 a.m. A school boy with his friends arrives; nurse asks "are you all sick? Boys "no, is our friend here" nurse "did you come with the register book from the school? Boys "yes" nurse "okay, come in the one who is sick" she attends the boy; the boy collects the drugs and leaves the place. Time spent is five minutes.

10.55 a.m. MCHA collects children's cards; call one by one, weighs them, records in the road to health card and gives vaccinations. Then collects women's card calls them one by one and attends them.

11.10 a.m. A girl brought by her grandmother arrives, grandmother greets the nurse. Nurse offers a chair to sit and asks her "I haven't seen you for a long time where have you been? Grandmother with a *smile* "I went to town to see my children" nurse "how are they? Grandmother "they are fine" nurse "what is the problem of today? The girl answers "I am not feeling well, I have joint pain and body weakness" Nurse assesses the girl and prescribes drugs, grandmother thanks the nurse and leaves." Time spent for consultation is seven minutes.

11.45 a.m. Nurse welcomes a mother and asks the problem of the child. Mother says "my

child is having diarrhoea and fever since yesterday, but also the gums are swollen" nurse asks "gums swollen since when? Mother says "three days now" Nurse examines the child and prescribes drugs and tells the mother "give your child plenty of fluids frequently and the prescribed drugs. Mother *nods* her head and goes to collect drugs. Time spent for consultation is five minutes.

12.00noon A young lady arrives, nurse welcomes and greets her. Nurse asks "what can I help you with? Patient answers while messaging her abdomen "I need treatment I am suffering from abdominal pain since yesterday" Nurse asks her several questions, patient answers them, then she prescribes drugs. Patient thanks the nurse and leaves. Time spent for consultation is five minutes.

12.15 pm. Nurse attends mothers with sick children, assesses them and prescribes drugs.

1.00 p.m. Mother arrives and tells the nurse about her baby's problem. Nurse asks "why didn't you bring her in the morning? Mother does not answer she looks at the nurse. Nurse says with a *forceful voice* "I am asking you" mother *keeps quiet*. Nurse "you don't want to respond, did you go to the farm first? Mother "Yes" nurse says "that is why you don't want to answer" nurse examines the child and prescribes drugs. Time spent for consultation is seven minutes.

1.10 p.m. No patients. Nurse reviews records, MCHA arranges cards and Medical attendants clean the dispensing area.

3.30 p.m. Nurse and MCHA collect equipment, drugs and books keep them in cupboard. Put on home dress. Medical attendant puts on home dress and closes the windows and doors of the facility. All staff leave the place and go home.

Annex 2. Phase two: Qualitative Approach through in-depth interviews

Data collection using in-depth interview was conducted for six days between March and April 2010 at the referral hospital. Family members of the mentally challenged people were interviewed after they had voluntarily consented to participate. The researcher asked the central question to each participant, which was followed by other questions as follows:

Participant number one:

Researcher My fellow participant, as I have explained to you and read the information from the information sheet on the research process I have one central question to ask you, which will produce other questions following your responses. The question is, "why have you skipped the primary health care facilities such as health centres, dispensaries or District hospitals and come to this referral hospital for mental health care services?"

Participant I have done so to collect drugs here, because of one reason. That is, there are no drugs in there and the drugs do not reach there; this is the reason which has brought me here.

Researcher Is there any other reason?

Participant Another reason is that, I think in our areas where we are living patients are there. Because the patients are there, the government and the department concerned should conduct a research to find out the needs of the people and bring the service and drugs to the areas where we are.

Researcher If I have heard properly you said that drugs do not reach there so they are not available although patients are there and you therefore ask the government to do a study. When you say a study can you explain more on the study which you are talking about?

Participant Okay, I think the word research is to find the solution. It means that the government should do a study to find out the challenge and be able to bring the drugs to the areas where we are living so that the drugs should be available there that is all.

Researcher From your explanations if I have understood you, you want a study to be conducted so that the government will be able to bring the drugs there?

Participant Yes, just like other drugs of other illnesses such as fever or malaria also these drugs should be there in the health centre and dispensaries. It is not necessary for us to come to Dodoma. Or else we should know where to get them just like other drugs. So a study should be conducted or a solution should be sorted out to bring the drugs. In other words, if there are patients in a certain village drugs should be sent there.

Researcher You have said that in your area these drugs do not reach there so there are no drugs, How did you know that there are no drugs, because you have not gone there, you came here directly?

Participant I remember when our patient started suffering from this problem we went straight to the dispensary, because we thought it was complicated malaria. After we had failed to get proper treatment, we went to the traditional healer. The traditional healer could not help us as well. Following the failure of the traditional healer we thought that this could be mental problem that is why we came straight here. When we arrived here we were received and the patient was admitted for three months. Thereafter they told us that we have to leave our patient here to continue with treatment and we shall only be coming to see him. Eventually the patient recovered and progressed well. We were told to take him home and that we should be coming to collect the drugs regularly for him. So I usually come to collect drugs for him as he has to take them regularly according to the doctor's instruction that is why you find me here today.

Researcher You said that you took the patient to the facility thinking that was malaria, when you were received what did they tell you?

Participant After receiving us at the Dispensary they failed to treat the patient, we did not know what was going on.

Researcher Did they tell you that they failed to treat the patient?

Participant No, they did not tell us they failed to treat the patient, but after seeing that the treatment had no direction we knew that nothing was continuing there.

Researcher When you say that the treatment had no direction what do you mean?

Participant When I say that the treatment had no direction, it is that if I tell you my problems then you just pass here and there, and then I stay for a long period, hours, days without being attended then even you; you can realize that there is nothing going on.

Researcher That is when you decided to go to the traditional healer? did you get any help?

Participant To the traditional healer it was wasting of time, after that we went to religious faith when our grandmother and my mother told us to turn back to our God so that the demons can be expelled through prayers. Even after that nothing happened. Thanks to God that improvement is shown through these drugs.

Researcher You have said that after going through the whole process from the traditional healer to religious faith the problem was still there, then you decided to come here. When you arrived here how was the reception?

Participant On arrival they assessed the patient and admitted him in the ward. Then he continued with treatment.

Researcher For how long was he admitted?

Participant Was admitted for three months then they said with the drugs he is getting there is no need for him to be in the hospital. He has to be discharged home, and then we shall continue collecting drugs for him.

Researcher How long since he started suffering till now?

Participant It is nine months now.

Researcher How long is it since he started suffering till when you came to the hospital?

Participant Since he started suffering till we came to hospital was one year, because he was at puberty stage.

Researcher So it means that since he started to be sick till when you brought him here you stayed with him at home for one year going here and there. Then after bringing him here he stayed for three months, after three months he improved till now it is nine years. For how long have you been collecting drugs from here?

Participant Since he was discharged till now has not been admitted again, we just collect drugs for him.

Researcher Have you brought him to be seen by the doctor?

Participant No, we just collect drugs and the doctor only asks his condition. It was once when the patient was aggressive and the doctor changed the drugs. The drugs have been changed twice only.

Researcher If I take you back to our conversation you said that the mental health services in the facility is that the drugs are not available. You have talked about drugs only but not any other thing.

Participant You have not yet asked me about other things, if you ask me I will talk about it. Perhaps another thing is the issue of medical examination, which is done there.

Researcher The thing is the drugs are not available and do not reach there, but patients are there, it is for the government to do a study to find out the solution of sending the drugs there. When you brought your patient here he received treatment and the service continued after recovery was taken back home. Since discharge the patient had not been admitted again, you just come to collect drugs for him and the drugs help him.

Participant Yes, he is also working, he goes to the farm, and he is a human being now.

Researcher Does he have a family?

Participant Family! No, he is still young 29 years old now.

Researcher After taking you back to our discussion and talked all the things, do you have any more comments on mental health services in primary health facilities? What should be done or what makes you and others not to go there instead you come here?

Participant My comment is, I am still insisting on bringing the drugs to the areas where we are living and to other hospital which needs these drugs. Just as they bring other drugs for other illnesses, such as abdominal problems etc. these drugs should also be brought, this is my emphasis.

Researcher The absence of drugs there is the government's problem? Or patients' problem because they are not going there, that is why the drugs are not ordered? Whose problem is this?

Participant This problem should be for the government, because it is not that patients do not go to these facilities and don't need these drugs. There was one woman who had the same problem of looking for treatment; she was helped in this hospital. She is the one who tells others if you get such and such a problem you go straight to Mirembe (referral Hospital) for advice. So the government should make effort to solve this problem, because patients are there. As you were surprised for me coming here by a bicycle a long distance of 70 kilometers to collect drugs.

Researcher Even I am touched by the problem of your coming from a long distance that is why I asked you where the problem is. What do you say about the health workers who are there, are they able to provide mental health services?

Participant These health workers can provide mental health services; if they have any problem in provision of services they can be helped. If they can provide services to pregnant women and other patients, and can work day and night as patients rests there for observation and we have been admitted there. It is obvious that if the drugs were there, I don't think that these health workers would not be able to provide the services. The issue is that these nurses are grown up people they are called to provide services.

Researcher You are still insisting that it is possible to provide these services, but the problem is the drugs. If the drugs will be there, will the community members or villagers be able to utilise these services instead of them travelling here?

Participant I agree they can. I remember in 1999 the government distributed drugs for Trachoma, people received the drugs willingly without knowing whether it was true treatment or not. It was brought as a vaccine but people took them.

Researcher How were you sensitised?

Participant We were firstly convinced by attending a seminar, which they told us that you have to take the drugs for the prevention of eye diseases. After swallowing these drugs it will be the end of the eye problems. If we were able to swallow those big tablets what about if someone knows his problem and the drugs are brought for her or him, even if you get these drugs at a distance of four kilometres after one hour to the facility. I don't think a person can be lazy not to go and take the drugs. I hope all will go for the drugs.

Researcher If I have understood you properly in our discussion, you said that if the drugs will be available and the villagers be informed, and the long distance they walk they will use the services, that is what you told me. Therefore, for a summary I am narrating what you have said that you came here to seek services in the referral hospital because drugs are not there, but patients and health workers are there. If drugs will be available they can provide mental health services, the same as they are providing services to pregnant women and other patients and you have also witnessed. So you think when people are informed the service will be provided and so minimise the problem of you walking a long distance. This is what we discussed. Thank for your nice words, and this is the end of our discussion. The way you have volunteered in this discussion; it will help in finding ways of improving services in the facilities. So that people do not avoid these

services. Thank you so much.

Annex 3. Ethical approval

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jou kennisvennoot • your knowledge partner

11 February 2010

MAILED

Ms A Mangula
Department of Nursing
2nd Floor, Teaching building
Stellenbosch University
Tygerberg campus
7505

Dear Ms Mangula

"Enhancing the utilization of primary mental health care services in Dodoma, Tanzania."

ETHICS REFERENCE NO: N09/11/314

RE : APPROVED

At a review panel of the Health Research Ethics Committee that was held on 25 November 2009, the above project was approved on condition that further information is submitted.

This information was supplied and the project was finally approved on 10 February 2010 for a period of one year from this date. This project is therefore now registered and you can proceed with the work. Notwithstanding this approval, the Committee can request that work on this project be halted temporarily in anticipation of more information that they might deem necessary to make their final decision.

Please quote the above-mentioned project number in ALL future correspondence.

Please note that a progress report (obtainable on the website of our Division: www.sun.ac.za/rds should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.
Translations of the consent document in the languages applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239
The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Hélène Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

Fakulteit Gesondheidswetenskappe · Faculty of Health Sciences

Verbind tot Optimale Gesondheid · Committed to Optimal Health
Afdeling Navorsingsontwikkeling en -steun · Division of Research Development and Support
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Approval Date: 10 February 2010

Expiry Date: 10 February 2011

Yours faithfully

MRS MERTRUDE DAVIDS
RESEARCH DEVELOPMENT AND SUPPORT
Tel: 021 938 9207 / E-mail: mertrude@sun.ac.za
Fax: 021 931 3352

Fakulteit Gesondheidswetenskappe · Faculty of Health Sciences

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Annex 4.1 Permission letter - Director of Dodoma Municipality

JAMHURI YA MUUNGANO WA TANZANIA

HALMASHAURI YA MANISPAA DODOMA

(Barua zote zipelekwe kwa Mkurugenzi wa Manispaa)

MKOA WA DODOMA

Tel.: 2324817/2321550
Fax: 2324817/2354817

Ofisi ya Mkurugenzi wa Manispaa
S.L.P.1249
Dodoma
E-mail: dodomamunicipality@yahoo.co.uk

Unapojibu tafadhali taja:

Kumb Na: **HMD/E.10/4/VOL.III/151** 12, Februari, 2010

Afisa Mtendaji,
Kata ya Mkonze,
S. L. P 1249,
DODOMA.

AFISA MTENDAJI WA KATA
KATA YA MKONZE
DODOMA (M) 15/02/2010

YAH: **KIBALI CHA KUFANYA UTAFITI.**

Bi Anna S. Mangula ni Mwanachuo Chuo Kikuu cha Stellenbosch cha Afirika Kusini ambaye kwa muda huu anahitaji kufanya Utafiti.

Utafiti huo utaanza tarehe 15/02/2010 hadi arehe 12/03/2010. kwa utambulisho huu tafadhali mpe ushirikiano atakaohitaji.

Nakutakia kazi njema.

[G. H. Che-mponda]
Kny: **MKURUGENZI WA MANISPAA,**
DODOMA.

Nakala:-
Mkuu wa kitengo cha Wauguzi,
Chuo Kikuu cha Stellenbosch,
AFRIKA KUSINI.

" Bi Anna S. Mangula

Annex 4.2: Permission letter from Medical Superintendent, Mirembe Hospital

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH AND SOCIAL WELFARE

Address Mirembe Hospital
Telephone No.: 2394570
Fax No. 2390364

Mirembe Hospital
P.O. Box 910,
DODOMA.
15th March 2010

Ref. DO/M/91/VOL.II/8

Ms A. S. Mangula (Nurse Tutor)
Mirembe School of Nursing,
Box 595, DODOMA.

RE: REQUEST TO CONDUCT RESEARCH IN MIREMBE HOSPITAL

Refer to your letter of 5th March 2010 as per the above heading.

I am pleased to inform you that permission is given to you to collect data from Mirembe Hospital for research purposes. Data collection will be according to your research proposal. As a Nurse Tutor, we hope you will adhere to all ethical issues as you promised.

I wish you all the best and success in your studies.

Bernada Emmanuel
For Medical Superintendent
Mirembe Hospital – DODOMA.

MUHIMBILI UNIVERSITY OF HEALTH & ALLIED SCIENCES
MIREMBE & ISANGA INSTITUTION
DODOMA

Copy
Medical Officer in charge)
Matron) Please, give her all the necessary support.
Medical records)

Annex 5: Certificate of Consent

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant_____

Signature of Participant _____

Date _____

Day/month/year

If illiterate [1]

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____ Thumb print of participant

Signature of witness _____

Date _____

Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

1.
2.
3.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

Print Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____

Date _____

[1] A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.