THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
DEPARTMENT OF NURSING SCIENCES

FACTORS CONTRIBUTING TO UNDERUTILIZATION OF MENTAL HEALTH SERVICES IN HEALTH CENTRES WITHIN LUSAKA URBAN

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TABLE OF CONTENTS **PAGE**

CHAPTER ONE

CHAPTER TWO

CHAPTER THREE

CHAPTER FOUR

CHAPTER FIVE

LIST OF TABLES AND FIGURES **PAGE**

Table

Figures

LIST OF ABBREVIATIONS

CHCH	:	Chainama Hills College Hospital
COP	:	Clinical Officer Psychiatry
EPN	:	Enrolled Psychiatric Nurse
IEC	:	Information, Education and Communication
LUDHMT	:	Lusaka Urban District Health Management Team
MCH	:	Maternal and Child Health
MHaPP	:	Mental Health and Poverty Project
MHAZ	:	Mental Health Association of Zambia
MHUNZA	:	Mental Health Users Network of Zambia
OPD	:	Out Patient Department
RMN	:	Registered Mental Nurse
TB	:	Tuberculosis
WHO	:	World Health Organization

APPENDICES

DECLARATION

I hereby declare that the work presented in this study for the Degree of Bachelor of Science in Nursing, has not been presented wholly or in part for any other Degree or is it being currently submitted for any other Degree.

Signed: Mary Lungu Date: 27-05-10

(Candidate)

Approved by: Mr Tolele Date: 28th May 2010

(Supervising lecturer)

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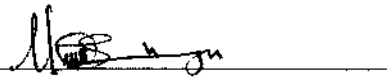
STATEMENT

I hereby certify that this study is entirely the result of my own independent investigation. The various sources to which I am indebted are clearly indicated in the paper and in the reference.

Signed: 

Name: Mary Lungu

Date: 27-05-10

DEDICATION

I dedicate this report to my dear husband and children who tirelessly supported and encouraged me despite the difficulties I encountered as a wife and mother.

ABSTRACT

The objective of this study was to determine the factors contributing to underutilization of mental health services in Health Centres within Lusaka urban. 50 percent of respondents of both males and females from 15 years above were sampled and 10 health workers were also sampled. Literature review showed that mental health care is not being provided at the primary level which requires more advocacy particularly by the stakeholders who include health workers and Non-Governmental Organizations.

For the purpose of this study, a descriptive design was chosen. A systematic random sampling technique was used to select the sample size. A structured interview schedule was used as a data collecting tool for the patient respondents while a self administered questionnaire was used for the health workers. The pilot study was conducted to test the suitability of the methodology. The data was analyzed manually using a calculator and entered on a data master sheet. The findings were presented in the form of pie charts, bar charts and simple frequency tables.

The study revealed that the majority of respondents, 82% were sensitized and had knowledge about mental health services in the Health Centres, 88% had poor accessibility and underutilization, 58% experienced moderately high stigmatization, 78% were not willing to follow traditional beliefs and had good perception on mental illness, and 80% of psychiatric health workers experienced good attitude from the non-psychiatric health workers. The study showed that the respondents were aware of mental health services but preferred to go to Chainama than Health Centres. Most respondents stated that they prefer going to Chainama because of availability of drugs and staff.

The major recommendations made include the following: a similar study should be done on a larger scale, preferably on the entire country to determine the contributing factors to underutilization of mental health services of the country' s population. Health workers and Non-Governmental Organizations such as Mental Health Association of Zambia (MHAZ) and Mental Health User's Network of Zambia (MHUNZA) should intensify advocacy for integration of mental health services into primary health care. Policy makers should also consider integration of Mental Health Services into Primary Health Care (PHC).

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

Zambia is a landlocked country situated in the heart of Central Southern Africa. It is divided into nine provinces and further into 72 Districts. The provinces include: Lusaka, Southern, Central, Western, North Western, Luapula, Northern, Copperbelt and Eastern province. Zambia covers an area of about 752 612 square kilometers, which is 2.5% of the total Africa (CSO, 2000). It shares boarders with eight other countries namely Namibia, Malawi, Angola, Zimbabwe, Botswana, Mozambique, Tanzania and the Democratic Republic of Congo.

According to Central Statistics Office (2000) census, the country had 10.8 million people and 62% reside in the rural area while 38% are found in the urban area. From the country's population, a proportion of 10% (1.080) constitute the persons with disabilities and 17.1% are mentally disabled, the physically handicapped are 38.8%, the hard of hearing 12.4%, the deaf and dump 6.2%, the partially sighted 30.2% and the blind are 5.3%, (CSO, 2000). Below is a table showing the distribution of the disabled persons by province in Zambia, 2000.

Table 1: **Distribution of the disabled persons by Province in Zambia.**

PROVINCE	MALE	FEMALE
Central province	13,114	11,265
Copperbelt	19,314	16,119
Eastern	19,707	17,984
Luapula	12,797	11,872
Lusaka	13,928	12,035
Northern	19,422	17,586
North-Western	8,349	6,614
Southern	15,356	14,048
Western	13,626	13,554
TOTAL	135,613	121,077

Source: CSO, (2000).

The concept of the disease burden, introduced and estimated for the broad range of diseases in the World Bank Report of 2003, illustrates that mental and neurological disorders not only entail high burden than cancer, but are responsible for more than 15% of the total disease burden in developing and developed countries. As a consequence, over the recent past, mental disorders have ranked increasingly highly on the international agenda for health. Many people worldwide are affected by mental disorders. WHO estimates that 154 million people suffer from depression and 25 million people from schizophrenia; 91 million people are affected by alcohol use disorders and 15 million by drug use disorders. As many as 50 million people suffer from epilepsy and 24 million from Alzheimer and other dementias. Around 877 000 people die by suicide every year (WHO, 2004). However, the fact that mental health and nervous system disorders are high on the international health agenda is no means a guarantee that the fate of patients suffering from these disorders in developing countries will improve. In most developing countries the treatment gap for mental and neurological disorders is still unacceptably high (World Bank Report of 2003).

Mental health services in Zambia started as far back as 1924 when the Colonial Administration decided to address the issue of psychiatric patient care. The care in Zambia was custodial type and patients were put in prison like conditions. In 1949, the first mental annex was opened in Ndola and others followed there after. Many more were later opened. Despite these annexes, patients who needed specialized treatment were taken to Zimbabwe's Ingutsheni Hospital. In 1962, Chainama Hills Hospital was built to cater for both the forensic and general psychiatric patients. It was run by the Catholic expatriates. From its inception, psychiatric services at Chainama was to provide promotive, preventive, curative and rehabilitative services to the people of

Zambia in conjunction with the community in accordance with modern psychiatric practice. Community mental health services were commenced in the 1970s when the psychiatric annex was established at Matero Main Clinic by Professor Alan Harworth. Today there are 27 Health Centres in Lusaka urban and all are suppose to offer mental health services (Lusaka Urban District Health Management Team (LUDHMT), 2009). Apart from these Health Centres, the only Psychiatric Referral Hospital for the mentally ill throughout Zambia is found in Lusaka. It is the only tertiary hospital for the mentally ill whole country.

In 1974, Matero Reference Centre was opened and since then the mental heath services have been extended to the rest of the country (Professor Harworth. A, 1987). According to the study done in 2008 by Ministry of Health, statistically Zambia has about 154 mental health workers. About 17 health workers are working in the 27 Health Centres within Lusaka (LUDHMT, 2009).

In 1992, Zambia adopted the Primary Health Care approach which emphasizes on improving the physical, social and mental health standards among the people in the community and reducing the incidence of many diseases including mental disorders in the community by taking the services as close to the families as possible (Zambia Health Reforms, 1992). The Health Centres in Lusaka Province are emphasizing on Primary Health Care delivery in other areas other than mental health services.

In November 2007, Mental Health Association of Zambia (MHAZ) and the Ministry of Health (MOH) held a National Mental Health Conference at Mulungushi International Conference Centre under the theme "No Health Without Mental Health: Time for Action to Meet the Challenges". The overall aim of the conference was to enhance mental health services in Zambia by seeking strategies for prevention of mental and emotional disorders, to promote stronger partnerships and promote mental health. During the same conference, the then Minister of Health (Doctor Brian Chituwo) bemoaned the high levels of stigma and discrimination which people with mental disorders experience in their daily lives. He emphasized that, "the Government of

Zambia is committed to mental health reforms and that the mental health policy and the National Mental Health Strategic Plan for 2007 – 2011 would be implemented in such a way as to strengthen integration of mental health in Primary Health Care, community services, public education, human resource and provision of HIV/AIDS services". A statement read on behalf of the World Health Organisation representative, Dr Peter Songolo called upon the Government to accelerate mental health reforms by implementing the existing mental health policy and updating the mental health legislation for protection of human rights of persons with mental disorders. He also emphasized the need to ensure availability of psychotropic drugs and to develop mental health system (MHAZ & MOH, 2007).

People with disabilities like any other citizens in Zambia need to receive social services from the government. However, the mentally disabled do not utilize the social and health services in the community which could be due to service, client or political related factors. Access to health facilities is calculated in terms of distance away from a health facility (Ministry of Health, 1992). In line with this information, it is estimated that 99% of the urban households in Zambia have access to health services because they live within 5km of a health facility (WHO, 2005). However, the mentally disabled living within 5km of the health facilities do not access the facilities in the Health Centres instead they move kilometers to the tertiary hospital which is Chainama Hills Hospital for services including collection of drugs.

Community approach to mental illness focuses on prevention of the disorders and aim at promoting mental health. Community mental health services are essentially specialized community psychiatric services. Although only some countries will be able to provide the full range of community-based mental health services, a combination of components based on local needs and requirements is essential, (WHO, 1990). In particular, strong community mental health services are essential as part of any deinstitutionalization programme, as well as to prevent unnecessary hospitalization. People receiving good community care have been shown to have better health and

mental health outcomes, and better quality of life, than those treated in psychiatric hospitals, (Funk M et al, 2004).

In the past, discharged patients from Chainama Hills Hospital used to be referred to their nearest Health Centres for follow-up. These clinics included Matero Reference, Chilenje Clinic, Mtendere Health Centre and Clinic 6 at University Teaching Hospital (UTH) to mention but a few. In these Health Centres, psychiatric nurses and Clinical Officer Psychiatrists offered specific follow-up care. They conducted home visits, reviewed the patients, gave mental health talks and monitored drug compliance.

1.2 STATEMENT OF THE PROBLEM

Over the years, mental health care has been regarded as being important because it assists the individuals with mental disorders to achieve their optimal capacity in responding to demands of daily living so that they may achieve a better quality of life.

Access to health care services is crucial for everyone. The concept of primary health care (PHC), adopted by the government in 1992 is aimed at addressing the crucial aspect of health care delivery. Its main focus was to provide health services as close to the family as possible (Ministry of Health, 2000).

However, the mentally disabled are not benefiting from the PHC concept. In a survey carried out by Mwanza in 2007. It was indicated that there were no psychiatric patients seen at health centres which have mental annexes, that is, Chelston, Mtendere, Matero, and Chawama. Meanwhile the members of staff who have done psychiatry are doing other general activities. Another survey conducted by Mental Health and Poverty Project (2008), showed that only one health centre had Largactil drug in stock which is not taken by all patients with mental disorders (MHaPP, 2008).

It has been shown even on electronic media where people are sensitized on reproductive, HIV/AIDS, diabetis mellitus, hypertension and many other health issues

that mental health is not among them. This has made the mentally disabled and the community to be non beneficiaries of PHC making it difficult for them to understand mental illness, the care and rehabilitation programmes in the community.

In Lusaka urban, although the patients live within 5km radius, of the Health Centres, the mentally ill are not utilizing these health facilities. According to the surveys done within the Health Centres within Lusaka urban, there are a few mentally ill patient being attended to and yet the Out–Patient Department (OPD) at Chainama Hills Hospital had seen an average of 812 attendances / reviews per month in 2007, 846 in 2008 per month and 712 per month in 2009, (Chainama Medical Records, 2007 -2009). Most of these could have been seen at their nearest clinics. According to LUDHMT, 79 mental patients were seen in all the 27 Health Centres in 2009 while in a survey done by Ministry of Health 2008, Chainama Hills Hospital had seen 2,880 patients.

It may be assumed therefore that several factors could contribute to the underutilization of mental health services in Health Centers and the community in Lusaka such as the shortage of mental health staff, shortage of drugs and community stigma to mention but a few. The purpose of this study is to determine factors that contribute to underutilization of the services. It is hoped that the findings will be used by Chainama Hospital in revamping community psychiatry and also influence the policy makers as they review the policies.

1.3 FACTORS CONTRIBUTING TO THE PROBLEM

1.3.1 SERVICE RELATED FACTORS

1.3.1.1 Shortage of drugs at the Health Centers

Shortage of psychotropic drugs may be attributed to non-integration of the mental health care in the Primary health care leading to non-supply of the psychotropic drugs to Health Centers by the Government. When patients go to the Health Centre for reviews and find that there are no drugs, they develop

negative attitudes to using such facilities and start to prefer to go to an institution where they always find drugs.

1.3.1.2 **Shortage of Mental Health Workers.**

This may be attributed to the brain drain, retirement, deaths without replacement and also the discontinued Enrolled Psychiatric Nursing training course in 1990 at Chainama. Most of the registered mental health nurses trained have left the country for greener pastures. Patients may have no health providers to attend to them and offer them services or may have delayed services. The shortage of workers may lead to work overload leading to low service standard provision especially when they are many programmes to attend to. This may lead to long waiting hours which discourage patients from using the services and will prefer a place where they are attended to on time.

1.3.1.3 **Inadequate community sensitization**

Another factor could be inadequate community sensitization by health providers about the services in the Health Centers and the community. The patients may not be aware of availability of these services at the Health Centre level leading to under utilization or non utilization of the services and the patients will continue going to Chainama Hills Hospital because they have no information. It is also observed that even at national level mental health is not being publicized. There are many health programmes on radio and television: Health Matters and programmes in local languages which are used to sensitize the nation on different conditions such as diabetis mellitus, HIV/AIDS, hypertension, tuberculosis, reproductive health, except for mental health / illness and the care given to such people. Inadequate sensitization may lead to lack of support and encouragement by the family and community to the patient in the use of the health services found at the Health Centres. They may go to Chainama Hills Hospital for services despite the distance or they may opt not to seek the services.

1.3.1.4 **Long waiting hours and poor reception**

Long waiting hours and poor reception may be as a result of shortage of psychiatric workers in the Health Centres who may not be able to review the psychiatric patients on time. It may also be due to negative attitude by members of staff and these experiences may create unwillingness for patients to use such Health Centres, instead they may prefer going to Chainama Hills Hospital for reviews and consultations.

1.3.2 POLICY RELATED FACTORS

1.3.2.1 **National Policy**

This could be another factor that may affect utilization of mental health services in Health Centres. The Government may due to inadequate funds fail to implement the concepts of Primary Health Care in psychiatry which emphasizes on taking health services as close to the family as possible. The inadequacy in trained Psychiatric Health Workers in Health Centres and at national level may also lead to poor advocacy in Mental Health.

1.3.3 SOCIAL CULTURAL AND ECONOMIC FACTORS

1.3.3.1 **Social stigma by the community and other Health Providers attached to mental illness.**

Stigma may be attributed to patient having low self-esteem because of how he/ she's treated by the family, friends and community at large. The patient may develop fear of being seen at the health centre by those who know him who may in turn label him as a 'mad' person who cannot lead a normal life. The community may also segregate the mentally ill and label them instead of helping them meet their daily needs to improve their lives. When patients are neglected, they may prefer to go and seek for medical advice from where they

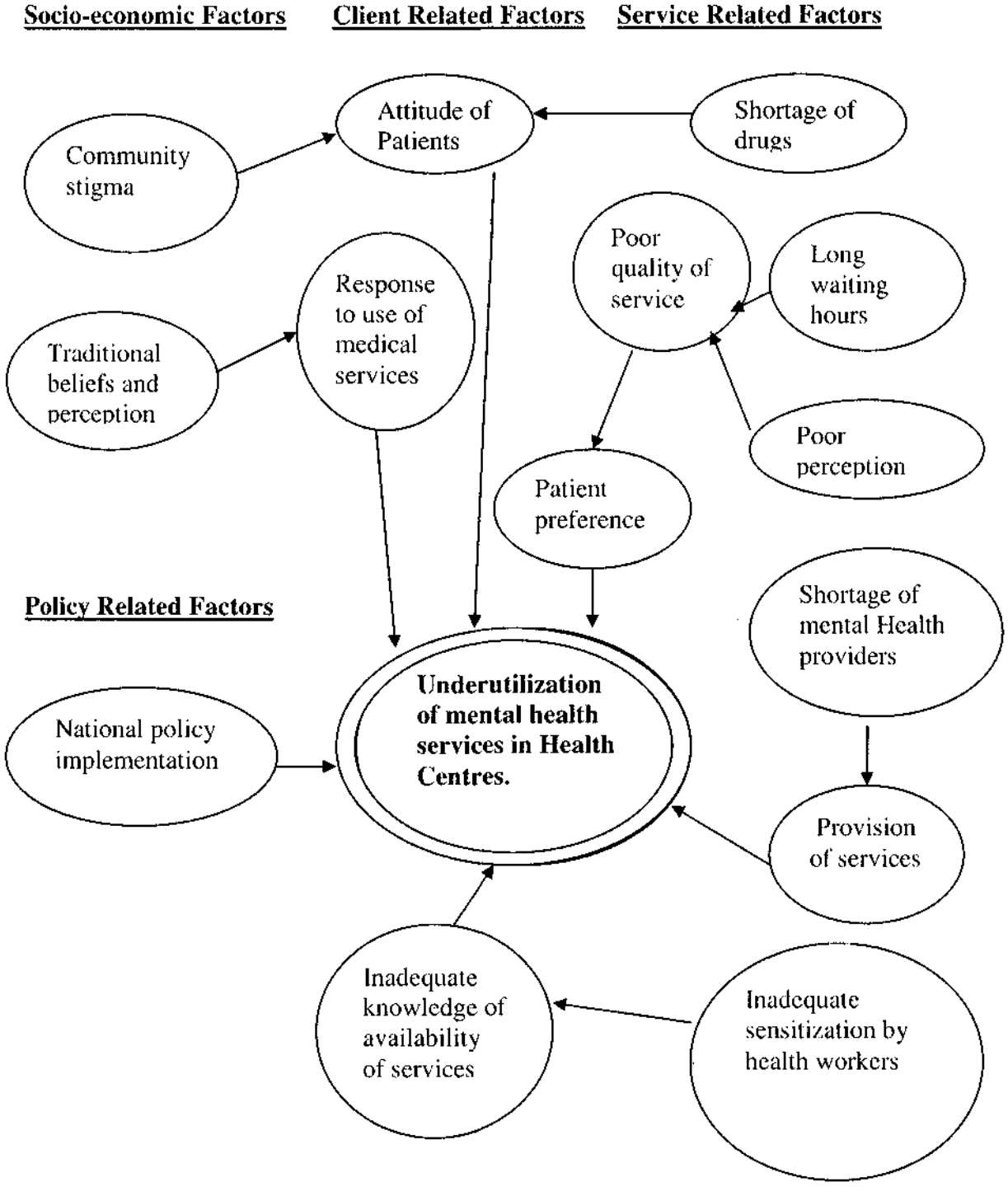
are accepted despite the distance. The stigma may also be attached to the mental health institutions and mental health workers and the members of staff may shun their work because they do not want to be associated with mental illness. The few members of staff available at the Health Centres are usually seen concentrating on patients with physical complaints. This may lead to poor quality of services given to the mentally disabled and patients may prefer not to go to such institutions.

1.3.3.2 **Traditional beliefs and perception**

This may also contribute to low utilization of health services. The patient may not seek contemporary medical treatment if they believe that mental illness is due to a curse after doing something wrong or a person possessing special gifts bestowed by the gods or being demonic. It may also be due to the belief that the mentally ill cannot lead a normal life because once one is diagnosed with a mental problem, they cannot get cured. The community does not know that a chronic disorder can be stabilized and a patient can be able to live a normal life if supported. The family may decide to use traditional medicines instead of seeking for modern treatment.

FIGURE 1

DIAGRAM OF PROBLEM ANALYSIS



1.4 JUSTIFICATION OF THE PROBLEM

Mental health issues in most countries have long been marginalized and stigmatized. According to wikipedia, (2009), mental health programmes have been confined to a lower social standing or under-classified rendering individuals or national groups powerless (http://www.en.wikipedia.org/wiki/Maginalised). This in turn has lead to lack of leadership, adequate evidence, resources and services. In many countries, services have been centralized, institutionalized, professionalized and depersonalized (Global Forum for Health Research, 1999).

Despite the community being empowered to master their own health affairs within the community through the health reforms, mental health has lagged behind. According to the 1992 Health Reforms, the vision is to provide all Zambians with equity of access to cost-effective, quality health care as close to the family as possible (Ministry of Health, 1992). In case of mental health the patients move long distances leaving the nearest Health Centres to be reviewed. This is shown by the number of patients seen at Chainama Hills Hospital (Chainama Medical Records, 2008), while the clinics are not seeing patient with mental disorders (Mwanza, 2007).

In order to meet the health related United Nation`s Millennium Development Goals in Zambia, the problem of underutilization of mental health services in Health Centers need to be addressed. This study aims at finding out the factors leading to underutilization of mental health services in Health Centres so as to find solutions to these problems. The Slogan, "Health For All by 2010" need to be met in all areas under the PHC concept including mental health.

The results of this study could be used by policy makers, Non Governmental Organizations and health providers to make health facilities more accessible for the mentally ill patients and their families. It will also help Chainama Hills Hospital revamp community psychiatry and strengthen community partnership in preventive and promotive programmes planned for in the Action Plan of 2009 to 2011.

1.5 OBJECTIVES

1.5.1 GENERAL OBJECTIVES

To determine factors contributing to underutilization of mental health services in Health Centers within Lusaka.

1.5.2 SPECIFIC OBJECTIVES

1. To find out how community stigma influences underutilisation of mental health services in Health Centres.
2. To determine whether traditional beliefs and perception on mental health has effect on how the mentally ill utilises conversional / modern mental health services.
3. To determine whether the attitude of psychiatric workers influence under-utilization of mental health services in Health Centres.
4. To assess the patient's patient's knowledge on availability of mental health services and how they affect utilization of the services in the Health Centres..
5. To make recommendations to the policy makers and other organizations concerned with the care of the mentally ill patients.

1.6 HYPOTHESIS

1. Inadequate psychotropic drugs influence underutilization of mental health services in Health Centres.
2. Community stigma towards the mentally ill influence underutilization of mental health services at Health Centres.
3. Inadequate knowledge on availability of mental health services in Health Centres influence underutilization of these services.

1.7 OPERATIONAL DEFINITION OF TERMS

Underutilization

When many psychiatric patients can not fully access mental health services at the Health Centres such as reviews, Information, Education and Communication (IEC) and curative care.

Mental Health Services

Health services offered to a mentally ill at the Health Centre reviews, IEC and home visits to maintain the mental health state.

Health Workers

Refer to the trained staff providing health care to the mentally ill patients and these include Nurses, Clinical Officers and Psychiatrists.

Disorder

An ailment affecting one's mental, social, psychological and spiritual well being.

Reviews

Refers to when the patient is assessed by health workers and advised on how to continue taking treatment at home.

1.8 VARIABLES AND CUT OFF POINTS

1.8.1 DEPENDENT VARIABLES

a). Underutilization of mental health services

1.8.2 INDEPENDENT VARIABLES

a) Stigmatization by the society.

b) Accessibility of health services.

c) Attitude of non-psychiatric health workers towards the psychiatric health workers and the mentally ill.

d) Community sensitization on availability of mental health services at Health Centres

e) Traditional beliefs on mental illness and it's treatment.

Table 2: **VARIABLES AND CUT OFF POINTS**

No.	VARIABLE	GRADING	CUTOFF
1	Accessibility and utilization of health services	Very Accessible and utilized always	15-20
		Moderately accessible and utilized sometimes	8-14
		Poorly accessible and under utilized	0-7
2	Stigmatization by the society	Very high	17-20
		Moderately high	9-16
		Low	0-8
3	Attitude of psychiatric health workers rendering services	Good	7-9
		Average	1-6
		Poor	0
4	Sensitization and knowledge of health services	Very good	17-23
		Average	8-16
		Poor	0-7
5	Traditional beliefs on mental illness and treatment.	Willing to follow with poor perception	20-26
		May be willing with fair perception	10-19
		Not willing with good perception	0-9

CHAPTER TWO

2.0 LITERATURE REVIEW

Many countries are undergoing a degree of mental health reform, moving from traditional institutional care or patient neglect, to care which is local, needs-based and in as unrestricted an environment as the well-being of the patient, their family and the public will allow (Alarcon & Aguilar-Gaxiola, 2000).

2.1 GLOBAL PERSPECTIVE

Utilization of mental health services in Health Centres and the community has been studied world-wide. Many countries have been trying to organize mental health services in a manner that avoids isolation, stigmatization and discrimination. The approach of utilizing all the available resources has the attraction of empowering individuals, families and communities to make mental health an agenda of people rather than of professionals (WHO-World Health Report, 2001).

Despite the fact that many countries have been trying to organize mental health services to avoid stigma, it still exists at international, national and local levels (Global Forum for Health Research, 1999). Lack of political support, inadequate management, overburdened health services and, at times, resistance from policy-makers and health workers has hampered the development of services (WHO, 2003). Instead, many countries are still relying on outmoded psychiatric hospital-based approaches to treatment, which are largely ineffective and fraught with human rights violations. Many low- and middle-income countries do not have even basic primary care infrastructure and services, which undermines the success of mental health integration (Jenkins et al, 1998a).

The global neglect of mental health is well-documented (Jacob et al, 2007). In most countries, mental health issues are neglected within health care policy and planning.

The neglect of mental health issues continues despite documentation of the high prevalence of mental disorders, the substantial burden these disorders impose on individuals, families, communities and health systems when left untreated. The neglect also continues despite scores of studies that have shown effective treatments exist and can be successfully delivered in primary care settings (WHO, 2005).Limited resources are allocated to mental health services (WHO, 2005). Moreover, the scant resources that are dedicated to mental health are often inappropriately deployed: most mental health resources are spent on expensive care in psychiatric hospitals rather than on primary care, community care or hospital care near to where people live (Funk M. et al, 2004).

However, WHO (1990), reported that even in countries with well established services, fewer than half of those individuals needing care make use of available services. WHO stated that this is related both to the stigma attached to individuals with mental and behavioral disorders and to the inadequacy of the services provided. The organization also mentioned that despite the major differences between mental health care in developing countries and developed countries, they share a common problem: poor utilization of available psychiatric services (WHO, 1990).

Despite having sixty-eight percent (68%) of psychiatric beds worldwide in psychiatric hospitals, many countries are however trying to de-institutionalize the mental health services while others still neglect them (WHO, 2001a). In a report by Mohit (1999), on the integration of mental health with general health care in the Eastern Mediterranean Region, he demonstrated that the approach to utilizing all available community resources has the attraction of empowering the individuals, families and communities. He emphasized that community approach will help stimulate the organization of mental health care in developing countries and he saw it as a reflection of the opportunity to avoid stigmatization (Mohit, 1999).

In 1992, an important mental health policy was established in Australia that changed the approach of mental health care from an institutional to a community-oriented service. Australia integrated mental health care for older people in general practices of

Sydney. General practitioners provide primary care for mental health, with the advice and support of community psychogeriatric nurses, psychologists, and geriatric psychiatrists. The key to the model is supported, collaborative, and shared care between primary care, community services, and specialist services, which include community-aged care, geriatric medicine, and old age psychiatry. Over time, general practitioners have required less advice and support, and achieved better outcomes in terms of maintaining continuity of care (Whiteford, 1994).

In a study done in Argentina, Neuquen Province, Patagonia Region by Collins (1999), it was established that primary care physicians lead the diagnosis, treatment and rehabilitation of patients with severe mental disorders. Patients receive outpatient treatment in their communities. Psychiatrists and other mental health specialists are available to review and advise on complex cases. A community-based rehabilitation centre provides complementary clinical care and serves as a training site for general medicine residents and practising primary care physicians. The programme has increased demand for mental health care and allowed people with mental disorders to remain in their communities and socially integrated. Because psychiatrists are used sparingly and institutional care is avoided, costs are lower and access to needed services is enhanced.

A report by Ministry of Health Belize (2006), showed that Belize had introduced a nationwide district-based mental health care. Psychiatric nurse practitioners conduct various primary care activities, including home visits and training of primary care workers. Their introduction has facilitated numerous improvements: admissions to the psychiatric hospital have been reduced; outpatient services have increased; and community-based mental health prevention and promotion programmes are now in place.

Another study conducted in Brazil by Lacoponi et al (1989), indicated that integrated primary care for mental health in the city of Sobral enabled the practitioners to conduct physical and mental health assessments for all patients. They treat patients if they are

able, or request an assessment from a specialist mental health team, who make regular visits to family Health Centres. Joint consultations are undertaken between mental health specialists, primary care practitioners, and patients. The model not only ensures good-quality mental health care, but also serves as a training and supervision tool whereby primary care practitioners gain skills that enable greater competence and autonomy in managing mental disorders. Over time, primary care practitioners have become more confident, proficient and independent in managing the mental health problems of their patients. Sobral has been awarded three national prizes for its approach to integrating mental health into primary care. In addition, the free and ready availability of psychotropic medications in the clinics has enabled patients to receive treatment in their communities, thus greatly reducing expenses and time spent travelling to hospitals.

In another study done by Kessel, (1988), it was revealed that mental health professionals cannot carry full responsibility for treatment and rehabilitation regardless of the country or whether they are in rural or urban. Citizens mainly relatives and friends are often the primary care- givers.

In the Philippines, restricted budget, stigmatizing attitudes and the lack of community trained personnel have led to the recognition that psychiatry will have to use native healers in addition to families and other community support in order to help the mentally ill, (Benbow, 2007).

Inadequate financial and human resources also contribute to the lack of adequate mental health care and the large gap between the number of people in need and those that receive care. This is especially true in low- and middle-income countries, where most nations devote less than 1% of their health expenditure to mental health. In Africa, there are only 0.04 psychiatrists, 0.20 psychiatric nurses and 0.05 psychologists per 100 000 population compared with a far more desirable 9.8, 24.8, and 3.1 respectively in Europe (http://www.world-mental-health.net) Accssed on 21-07-09.

Additional information about the number of mental health professionals around the world is displayed as below:

Region	**Psychiatrists**	**Psychiatric nurses**	**Psychologists**
Africa	0.04	0.20	0.05
Americas	2.00	2.60	2.80
Eastern Mediterranean	0.95	1.25	0.60
Europe	9.8	24.8	3.10
South-East Asia	0.20	0.10	0.03
Western Pacific	0.32	0.50	0.03
World	1.20	2.00	0.60

Source: *Mental Health Atlas 2005*, Geneva, World Health Organization 2005.

Other health system factors include lack of adequate insurance or Government reimbursement for mental health treatments, poorly structured or fragmented mental health systems, absence of facilities for vulnerable and special needs populations (Abas et al, 2003) and pharmaceutical patent laws (Hirschfield et al, 1997).

In 2001, not only did the WHO devote its World Health Day to mental health, but the World Health Assembly held a special session on mental and the WHO's annual World Health Report was devoted exclusively to mental health (WHO, 2001b). The high visibility of mental health at present should be seen as a window of opportunity for the concerted action of all those devoted to improving mental health worldwide, particularly in developing countries.

2.2 REGIONAL PERSPECTIVE

Africa is a large continent, prone to strife, especially south of the Sahara. Most of its countries are characterized by low income, high prevalence of communicable diseases, malnutrition, low life expectancy and poorly staffed services (WHO, 2004). Mental health issues come last on the list of priorities for policy makers. Where mortality is still mostly the result of infectious diseases and malnutrition, the morbidity and disablement due to mental illness receive very little attention from the government. Health in general is still a poorly funded area of social services in most African countries. Compared to other health areas mental health services are poorly developed. A survey done by the African Region of the World Health Organisation reviewed that despite some modest achievements, the situation of mental health programmes in most countries was found to be unsatisfactory (WHO, 2003).

The WHO 2001 reported that in South Africa, integration of primary care services for mental health in the Ehlanzeni District, Mpumalanga Province uses two distinct service models. In the first model, a skilled professional nurse sees all patients with mental disorders within the primary care clinic. In the second model, mental disorders are managed as any other health problem, and all primary care workers treat patients with mental disorders. Importantly, clinics have tended to adopt the model that best accommodates their available resources and local needs. WHO also reported that by 2002, half the clinics in the district were providing mental health services, and by early 2007, more than 80% of clinics were delivering services. Primary care nurses and patients are generally satisfied with the integrated approach. While the need for interventions for traumatized communities remains an imperative, mental health promotion and prevention programmes strive towards transforming the structural and material bases of mental ill-health. The WHO (2001) suggests that the challenge for middle-income countries such as South Africa is to increase access to mental health care for the entire population through integration into the PHC system, as well as schools and workplaces.

In the study done by Uznanski , (1997) in the Western Cape Province in South Africa, general primary care nurses provide basic mental health services in the primary health clinic, and specialist mental health nurses and a psychiatrist intermittently visit the clinic to manage complex cases and provide supervision to primary care nurses. Because patients are seen within the same clinic, access to mental health care is improved and potential stigma is reduced. Primary care practitioners are generally satisfied and they appreciate the regular visits by the mental health nurse and the psychiatrist, who provide ongoing in-service training as well as support for complex cases. Uznanski mentioned that this is being examined at a provincial and national level for possible implementation in parts of the country with similar characteristics.

In Uganda, Kigozi (2007), illustrated that with integrated primary care for mental health in the Sembabule District, primary care workers identify mental health problems, treat patients with uncomplicated common mental disorders or stable chronic mental disorders, manage emergencies, and refer patients who require changes in medication or hospitalization. Specialist outreach services from hospital- level to primary health-level facilitate ongoing mentoring and training of primary care workers. In addition, village health teams, comprising volunteers, help identify, refer and monitor people with mental disorders. Mental health treatment in primary care, compared with the previous institutional care model, has improved access, produced better outcomes, and minimized disruption to the affected people.

In 2002, The World Psychiatry Association (WPA) recognized a number of constraints to the development of mental health programmes in Africa as being due to lack of awareness of the magnitude of the problem, lack of reliable information system. Information on the efficiency and cost of various forms of interventions is needed to permit enlightened planning and allocation of resources. The constraint isolated was that there is insufficient human and financial resources, shortage of personnel, absence of national mental health policies, civil strife and violence. http://www.healthlink.org.za/publications/203. Accessed on 15-06-09.

2.3 NATIONAL PERSPECTIVE

According to the Health Reforms (1992), the vision of Zambia is to provide all Zambians with equity of access to cost effective quality health care as close to the family as possible with a slogan of "Health For All By 2010" (Ministry of Health, 1992). The government empowered the community to master their own health affairs except in mental health.

A study conducted by Ministry of Health (2008) in Livingstone to determine the screening of mentally ill patients for Tuberculosis, revealed that since the time Livingstone psychiatric unit was gutted 12 years ago, the Ministry of Works and Supply has not recommended the way forward for the unit. Though the unit has been integrated within the confines of Batoka General Hospital where two side wards have been allocated as admission side wards, the Ministry of health reported that community mental health services are not available. Many patients are roaming the streets. The rehabilitation centre that was to be funded by Norwegian Development Agency (NORAD) is at stand still as the local council has threatened to repose it (Ministry of health, 2008). It also reported that there is only one clinical officer who is brought in from Kafue and an Enrolled Psychiatric Nurse. The Ministry also reported that the District Health Management Team has managed to build the children's and T.B annexes few hundred meters away but have not rehabilitated the psychiatric unit.

In the same report by Ministry of health (2008), it was indicated how Chainama Hills Hospital is being over-utilized. The Ministry compared the number of patients seen at Chainama Hills Hospital to those seen at the Provincial Health Centres in the districts. Below is a table showing the number of patients seen in 2008.

Table 3: **Number of patients seen in the Mental Health Centres country-wide in 2008.**

Centre	Admissions	Patients seen
Chainama Hills Hospital	140	2, 880
Provincial Mental Health Centres	150	480
TOTAL	290	3,360

Source: Ministry of Health-(Hospital Records-2008).

According to statistics by LUDHMT (2009), 79 mental patients were seen from all the 27 Health Centre in Lusaka urban while an average of 712 patients are seen per month by Chainama Hills Hospital in 2009.

In a study to determine Knowledge, Attitude and Practice towards mental illness among families with mentally ill relatives in Ndola rural, Sakuwaha observed that community support to the families with mentally ill patients was inadequate. He recommended that there should be a well defined referral system from hospital or psychiatric units to Health Centres for the purpose of follow-ups and easy management at the local Health Centre and encourage community based mental health services.

In another study undertaken by Ngelezi, (1984) to find out why schizophrenic patients stop taking their medication, it was found that many patients preferred to go to UTH for reviews because it was easy to get a supply of psychotropic drugs than at the Health Centres where drugs were out of stock. The other reason she found was that patients found doctors at UTH and Chainama to attend to them than in the Health Centres.

Meanwhile, in a survey done by Mwanza, (2007) to determine utilization of mental health services in the Health Centres, revealed that mental health services in the community and Health Centres were almost lacking. He also observed that liason between Chainama Hills Hospital as a major health institution and specific Health Centres is not there. He revealed that a few mental health providers found in a few clinics were doing general nursing other than mental health care.

According to a survey done by Mental Health and Poverty Programme, (2008) to assess Knowledge, Attitude and Practices of health workers towards mental illness in the Health Centres in Lusaka and Mumbwa found that almost all clinics had no mental health services and only one clinic had Largactil in stock.

On the other hand, the study done by Akalala (1992), to determine factors contributing to readmissions to Chainama Hills Hospital, suggested that more nurses and clinical officers should be trained in community mental health because those in the Health Centres felt that it is not their duty to follow up patients since they are not specialized. However she emphasized the need for comprehensive monitoring system within the community through community mental health nursing and participation.

2.4 CONCLUSION

In conclusion, the literature review has shown that there is need for continuity of care in the community to prevent deterioration through integration of mental health in Primary Health Care. Care in the community is also said to be cheaper than hospital care. Sometimes the mentally disabled fail to utilize services in Health Centres due to various reasons. These include the following factors like stigma, bad experiences, national policies and lack of drugs in the Health Centres. It has also reviewed that integration of mental health services into primary health care in Zambia need to be done to promote mental health care as close to the family as possible.

CHAPTER 3

3.0 METHODOLOGY

3.1 Research Design

According to Uys and Basson (2000), a research design is the structural framework or blue print of the study. It guides the researcher in the planning and implementation of the study, while optimal control is achieved over factors that could influence the study. The researcher used a descriptive research design in this study. This design involves systematic collection and presentation of data to give a clear picture of a particular situation, individual or group. The study design also discribes what exists. The design was therefore used to explore factors contributing to underutilization of mental health services in Health Centres within Lusaka. It was considered to be appropriate because this type of study will give an insight in the nature and causes or clear picture of a certain problem or situation.

3.2 Research setting

Research setting is the physical location and conditions in which data collection takes place in the study (Pilot and Hungler, 1997). The study was conducted in three (3) different settings and these were: Lusaka urban clinics, University Teaching Hospital (UTH) and Chainama Hills Hospital.

Lusaka urban Health Centres were among the settings because 27 clinics offer mental health services at primary level. This setting was chosen because it has the Enrolled Psychiatric Nurses, Registered Mental Health Nurses and Clinical Officers who offer services to the mentally ill.

Another study setting was Chainama Hills Hospital psychiatric unit. The hospital is located along Great East Road in Munali Constituency on a hilly terrace. It's the only referral psychiatric hospital in Zambia. The setting was chosen because most psychiatric patients go there for their reviews and it was convenient for the researcher

to reach the target patient population for the study. The setting was also chosen because this research has never been done before at this hospital.

The University Teaching Hospital (clinic 6) was one other setting chosen for a pilot study because it is a psychiatric clinic which handles the mentally ill patients as at Chainama the main study setting. The setting was also suitable because it was far from the main study setting to distort the information collected at Chainama Hills Hospital or affect the study results.

3.3 Study population

Dempsey and Dempsey (2000), defined the study population as the total group of individuals or things meeting the designated criteria of interest to the researcher. The study population consisted of Nurses and Clinical Officers in Health Centres in Lusaka urban. The study population also included patients and their relatives who escorted them for reviews at the Out Patient Department / filter clinic at Chainama Hills Hospital.

3.4 Sample selection, approach and size

Sample selection is a process of selecting a portion or subject of the designated population to represent the entire population (LoBiondo-Wood and Haber, 2002). This is a critical part of the research process because the selected sample must be representative of the entire population under study. The study Health Centres and respondents were selected using different sampling methods. The probability sampling method was used to select the study units. This sampling method involves random selection procedure to ensure that each unit of the sample has an equal chance of being included in the sample. A simple random sampling was used to select the study unit. A total sampling size comprised of 50 respondents who were mentally disabled between the age of 15 and 60years. The investigator used the filter clinic appointment book at Chainama Hills Hospital to find the sampling frame. A list of 300 patients attending reviews during the investigator's time of data collection at Chainama Hills Hospital was made. The sample excluded health workers to prevent biasness. 50 respondents were

picked randomly. The sample for health workers was selected from the 6 Health Centres in Lusaka urban. These Health Centres were randomly selected from the 27 that offer mental health services. A list for Health Centres was first made, then the researcher selected those for the study.

After selecting the Health Centres, however, a non-probability sampling method was used. This type of method does not require a sampling frame. In this study, the researcher used this method due to the scarce mental health workers in the Health Centres and inadequate funds for the study. A convenient sampling was used to select 10(60%) mental health workers for the study. In this type of sampling, the investigator selected study units available in Health Centres at the time of data collection for the sample.

3.5 **Data collection technique and tools.**

A data collection tool is a device that is used to collect information (Pilot and Hungler, 1997). He also defines data collection technique as a procedure of collection of data needed to address a research problem. The researcher used the semi-structured interview schedule consisting of both open and closed-ended questions to obtain specific information through probing and clarification of unclear questions and responses. An interview schedule is a questionnaire that is read to the respondent and it is appropriate when informed about the facts and situations involved. The technique was chosen by the researcher because the subjects consisted of both those who are able to read and write and those who can not. The advantages include the following:

- The interviewer is certain that all the questions will be answered,
- The interviewer is able to clarify questions not understood by the interviewee,
- The researcher is able to observe the non-verbal responses,
- The response rate is high,

- The interviewee answers questions systematically because he / she does not look ahead to other items as often occurs in self administered questionnaire (http://www.qmu.ac.uk/psych/rtrek/foundation/f10.htm).

Disadvantages

- Interviewee's answers may be influenced by the presence of the researcher.
- It is time consuming and expensive,
- Interviewers need to be trained,
- Non-verbal behaviours may be interpreted differently by interviewers,
- Some responses may be difficult to quantify,
- Analysis may be difficult and time consuming (ibid).

The Investigator used the self- administered questionnaires to obtain data from health workers and it consisted of both open and close-ended questions. The advantages of self administered questionnaires are that:

- It is rapid and efficient in terms of time,
- Respondents remain anonymous,
- Respondents have time to contemplate on each question before answering it,
- Respondents respond to same questions (ibid).

Disadvantages

- Respondents may not answer all questions,
- No chance of clarifying questions by respondents and researcher clarifying answers,
- Some questionnaires may not be returned or submitted back (ibid).

3.6 **Pilot study**

According to LoBiondo-Wood and Haber, (2002), a pilot study is defined as a small sample study, conducted as a prelude to a large-scale study which is designed to acquaint the researcher with problems that can be corrected in preparation of the larger research project. A pilot study was conducted for both the health workers and patients. Five patients and 2 health workers were interviewed at UTH clinic 6.

The purpose of the study was to identify any ambiguous, unclear or irrelevant questions. After the pilot study, the researcher made modifications to the questionnaires before the actual study.

3.7 **Ethical and cultural considerations**

Polit and Hungler, (1997) defines ethics as a system of moral values that is concerned with the degree to which research procedure adhere to professional, legal and social obligations to the study participants. The researcher had sought permission from the following:

- The Head of Department from the University of Zambia, School of Medicine, Department of Nursing Sciences
- The Director of Lusaka District Health Management Team
- The Executive Director of Chainama Hills Hospital
- The Managing Director at UTH
- Nurses in charge of selected Health Centres
- Individual research participants

The respondents were assured of anonymity, privacy and confidentiality during data collection.

CHAPTER FOUR (4)

4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.1 INTRODUCTION

The study sought to determine the factors contributing to Under-utilization of mental health services in the Health Centres within Lusaka urban. The data was collected from respondents using a structured interview schedule on the patients and a self administered questionnaire on mental health workers. Sixty (60) respondents participated in the study of whom 50 were patients from within Lusaka Urban while 10 were health workers from the Health Centres. In this chapter, the investigator discusses the analysis and presentation of findings of the study.

4.2 DATA ANALYSIS

After collection of data from both the patients and health workers, it was edited for completeness and the interview schedules were numbered. Responses were coded using numbers and open responses were categorized and coded. All data processing was done manually and then entered on a data master sheet.

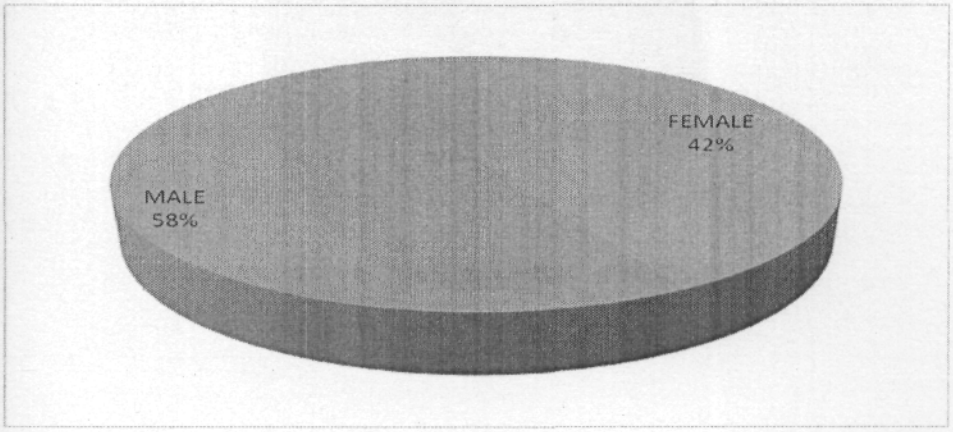
4.3 PRESENTATION OF FINDINGS FROM PATIENTS

Data from the master sheets was presented in charts, graphs, and frequency tables and cross tabulations. These methods were used because they summarize the results in a meaningful way and enhance understanding of the findings, in relation to the intentions of the study.

DATA ANALYSIS ON PATIENTS

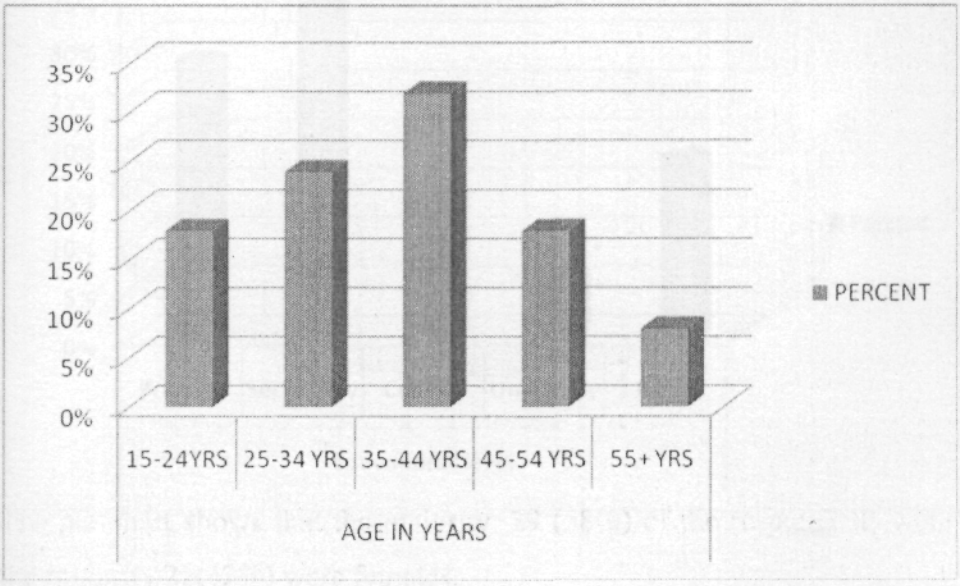
SECTION A: SOCIAL –DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE (N=50)

Figure 4.1: **Frequency distribution of Respondent's Sex**



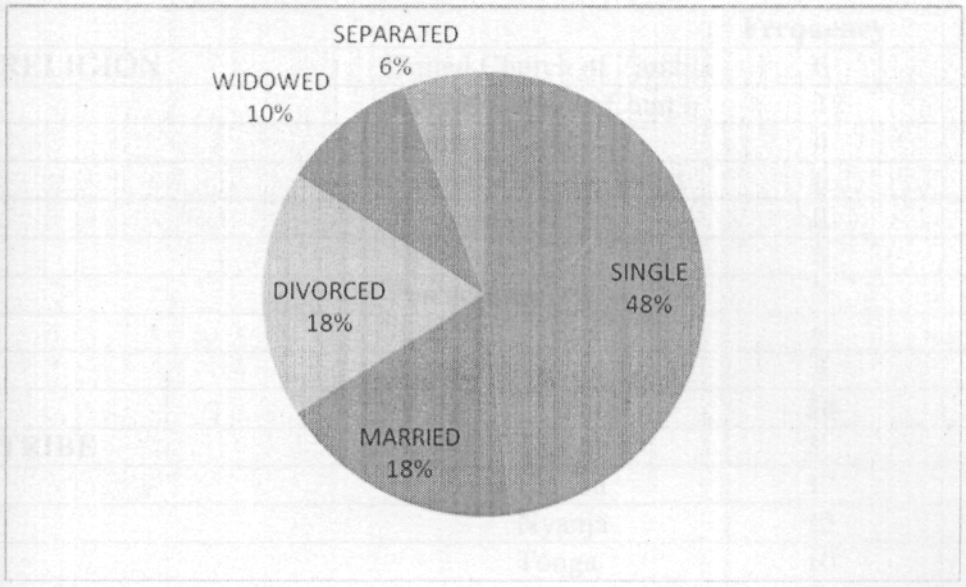
The pie chart shows that the majority, 29 (58%) of the respondents were males while the minority 21(42%) were females.

Figure 4.2: **Frequency distribution of Respondent's Age**



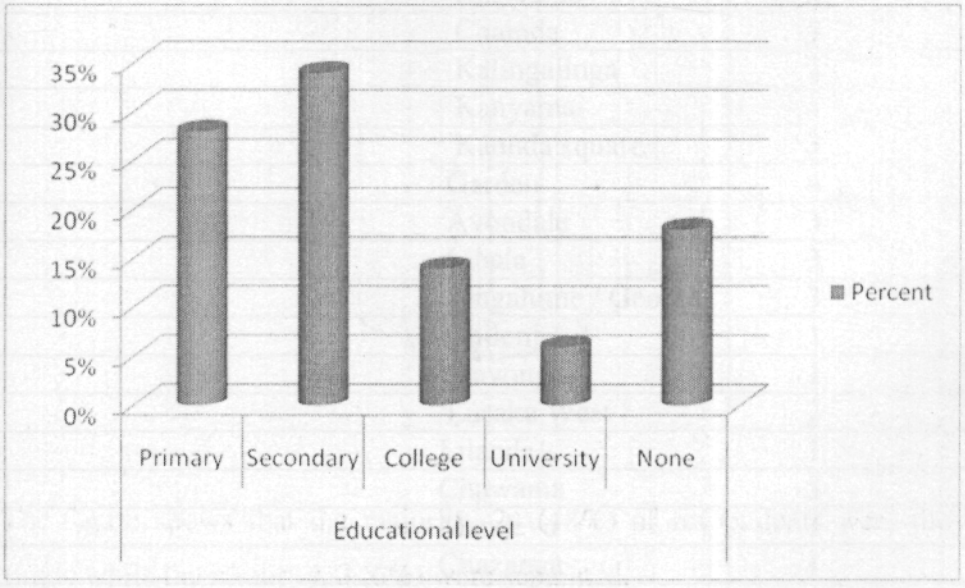
The figure shows that the majority, 16 (32%) of respondents were between the age range of 35-44 while the minority, 8 (16%) were those of 55 years and above

Figure 4.3: **Frequency distribution of Respondent's Marital Status**



The figure shows that the majority, 24 (48%) of respondents were those who were single while the minority, 3 (6%) were separated.

Figure 4.4: **Frequency distribution of Respondent's Educational Level**



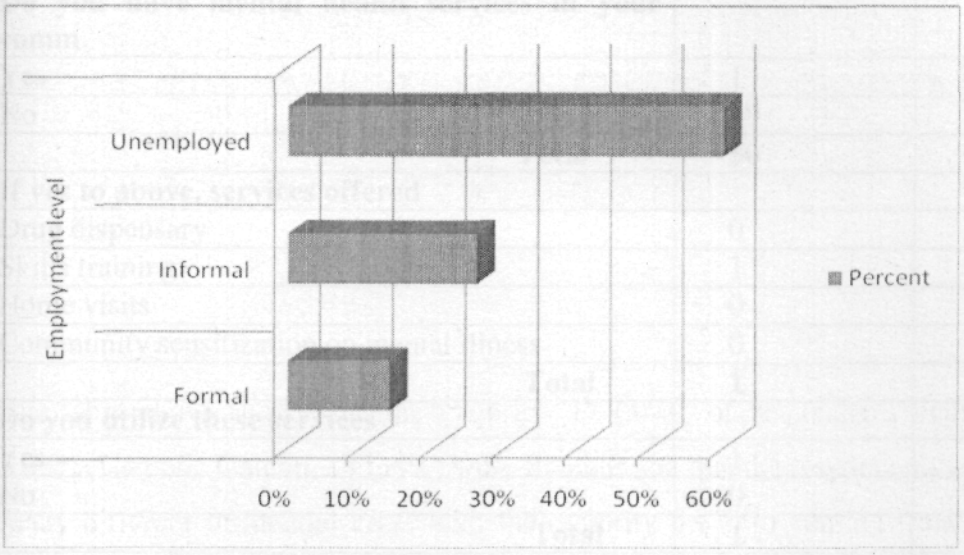
The figure above shows that the majority of 17 (34%) respondents had attained secondary education while the minority of 3 (6%) had gone to university.

Table 4.1: **Social demographic characteristics of sample (N=50)**

		Frequency	Percentage
RELIGION	United Church of Zambia	6	12
	Roman Catholic Church	17	34
	Baptist Church	4	8
	Seventh Day Adventist	6	12
	Jehovah's witness	2	4
	New Apostolic	6	12
	Pentecostal	3	6
	Zion	1	2
	Salvation	3	6
	Total	**50**	**100**
TRIBE	Luvale	3	6
	Bemba	17	34
	Nyanja	13	26
	Tonga	10	20
	Lozi	5	10
	Lenje	2	4
	Total	**50**	**100**
RESIDENTIAL AREA	Misisi	3	6
	Chawama	1	2
	Matero	5	10
	Mtendere	5	10
	Chelstone	4	8
	Chainda	3	6
	Kalingalinga	2	4
	Kanyama	1	2
	Kaunda square	3	6
	Garden	4	8
	Avondale	3	6
	Libala	3	6
	Zingalume / George	3	6
	Chilenje	1	2
	Siavonga	1	2
	Lusaka West	2	4
	Lilanda	1	2
	Chawama	3	6
	Mandevu	1	2
	Chazanga	1	2
	Total	**50**	**100**

The table above shows that the majority, 17 (34%) of respondents belonged to the Roman Catholic Church, 17 (34%) were Bembas and that the respondents came from many different residential areas with the majority 5 (10%) coming from Matero and Mtendere respectively.

Figure 4.5: **Frequency distribution of Respondent's Employment**



The figure shows that the majority, 30 (60%) of respondents were unemployed while 7(14%) were in formal employment.

SECTION B: SENSITIZATION AND KNOWLEDGE OF HEALTH SERVICES (N=50)

Table 4.2: **Frequency distribution of Respondents' Sensitization and Knowledge**

	Frequency	Percentage
What patients know about community mental health services.		
Services offered to improve individual's mental health status in the community.	44	88
Patient's support by families, churches and friends	40	80
Linking patients to skills training centres in the comm.	28	56
Sensitising people on mental illness	47	94
Don't know	0	0

How patients leant about CMHS	**Frequency**	**percentage**
Through friends	23	46
Through health workers	41	82
Through community health workers	0	0
Through radio and television	12	24
Through MHUNZA and MHAZ	7	14
Reading books	6	12
Through churches	4	8
Do you have mental health services in your comm.		
Yes	1	2
No	49	98
Total	**50**	**100**
If yes to above, services offered		
Drug dispensary	0	0
Skills training	1	100
Home visits	0	0
Community sensitization on mental illness	0	0
Total	**1**	**100**
Do you utilize these services		
Yes	1	100
No	0	0
Total	**1**	**100**
If no, please explain		
No respondent answered	0	0

The table above shows that the majority, 47(94%) of respondents knew that community mental health services (CMHS) is sensitizing on mental illness while none 0(0%) did not know, the majority 41(82%) learnt about CMHS through health workers and none by the community health workers, the majority 49(98%) denied having community services while 1(2%) accepted and 1(100%) received and utilized community services.

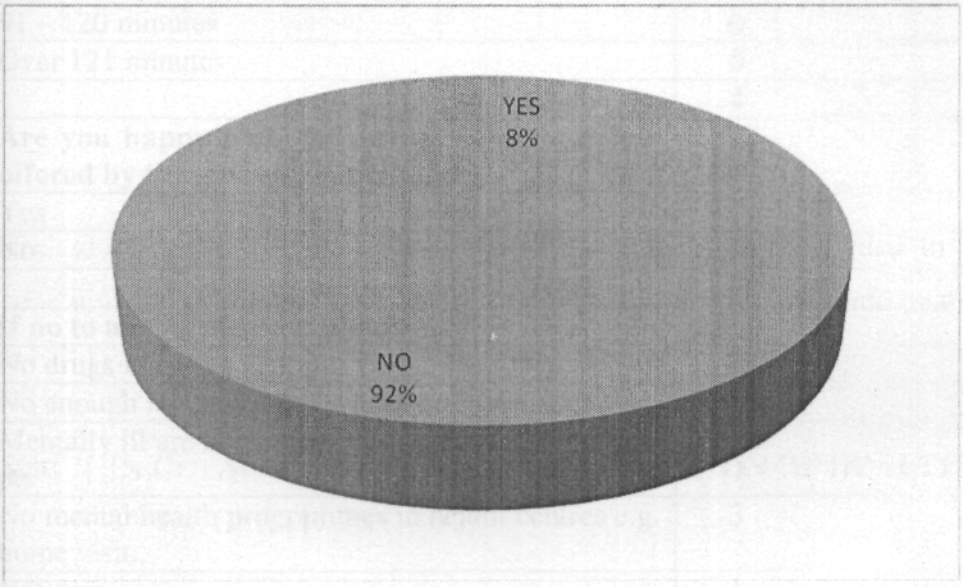
Table 4.3: **Frequency distribution Patient Recommendations to the Government**

Recommendations to government and stakeholders about improving community services.	**Frequency**	**Percentage**
Community sensitization to be done by health practitioners	50	100
Community sensitization by CHW	42	84
Community sensitization through radio and television	50	100
Start skills training for the mentally ill	5	10
Churches to be sensitizing the community	6	12

The table above shows that the majority, 50(100%) recommended to have mental community sensitization done by health practitioners, radio and television while 5(10%) recommended initiation of skills training in the community.

SECTION C: ACCESSIBILITY AND UTILIZATION OF HEALTH SERVICES (N=50)

Figure 4.6: **Frequency distribution of availability of follow-up services at nearest Health Centres.**



The pie chart shows that the majority, 46 (92%) of respondents refused having follow-up services at their nearest Health Centres while the minority, 4(8%) said that they had.

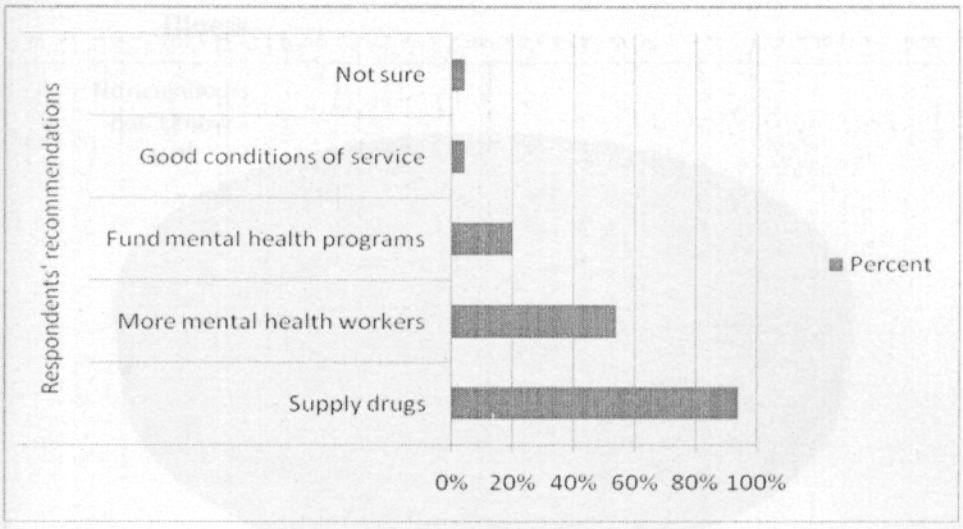
Table 4.4: **Frequency distribution of Respondents' Accessibility and Utilization of health services**

	Frequency	Percentage
How often are these services offered?		
Once per week	1	25
Twice per week	1	25
Three times per week	0	0
All days of the week	2	50
Total	**4**	**100**

Treatment by health workers at the health centres	**Frequency**	**Percentage**
Nicely	4	100
Ignored	1	25
Kindly	4	100
Respectfully	4	100
Listen to my problems	1	25
Welcoming	1	25
Time spent before being attended to at health centre		
0 - 30 minutes	1	25
31 – 60 minutes	3	75
61 - 90 minutes	0	0
91 – 120 minutes	0	0
Over 121 minutes	0	0
Total	**4**	**100**
Are you happy with the mental health services offered by the government clinics?		
Yes	2	4
No	48	96
Total	**50**	**100**
If no to above, please explain		
No drugs in health centres	39	81.25
No enough mental health workers	15	31.25
Mentally ill are neglected compared to HIV and TB pts	14	29.16
No mental health programmes in health centres e.g. home visit.	3	6.25
Not sure	1	2.08

The table above shows the majority, 4 (100%) being treated nicely, kindly and respectfully by health workers at the Health Centre, 3 (75%) spent 31 – 60 minutes waiting, 48(96%) were not happy with the services offered at Government clinics and 39(81%) complaining of not having drugs at Health Centres.

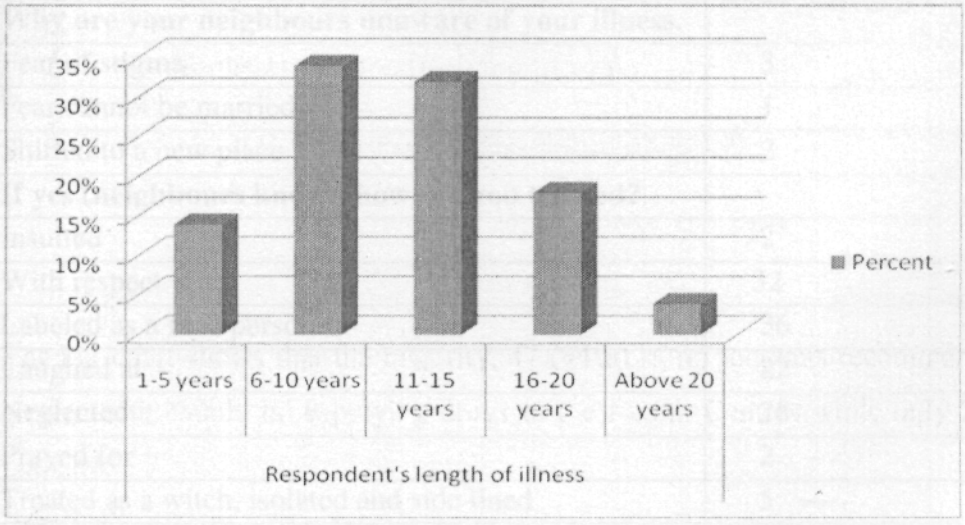
Figure 4.7: **Frequency distribution of Respondents' Recommendations**



The bar chart shows that the majority, 47 (94%) of respondents recommended that the government should be supplying drugs to the Health Centres while only 2 (4%) were not sure.

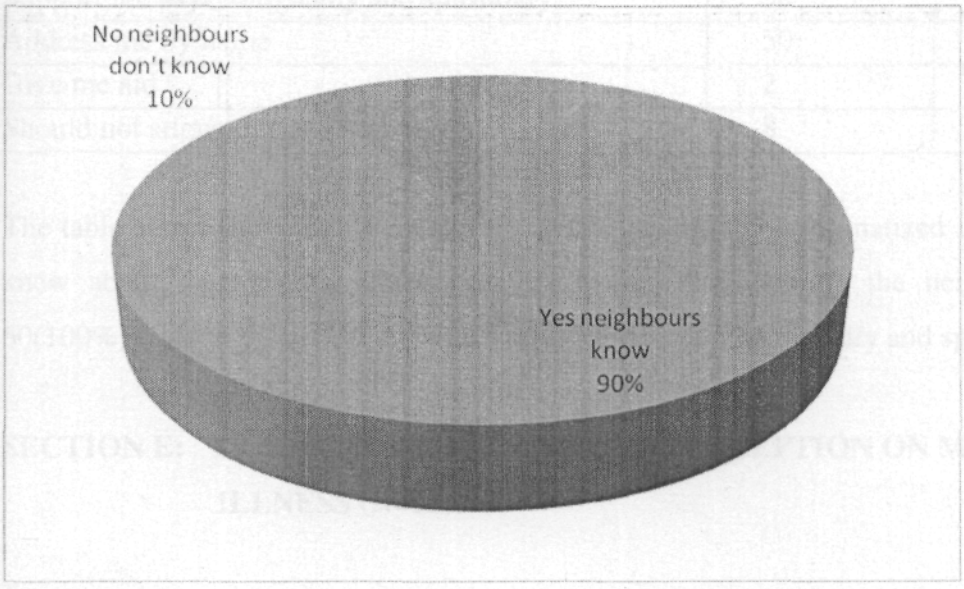
SECTION D: STIGMATIZATION (N=50)

Figure 4.8: **Frequency distribution of Respondents' Period of illness in years**



The figure shows that the majority, 17 (34%) of respondents were between the range of 6-10 years while the minority, 2 (4%) were above 20 years of age.

Figure 4.9: **Frequency distribution of neighbours' awareness of Respondents' Illness**



The pie chart shows that the majority of 45 (90%), respondents' neighbours were aware that they were mentally ill while 5 (10%) did not know.

Table 4.5: **Frequency distribution on Respondents' Treatment by Community.**

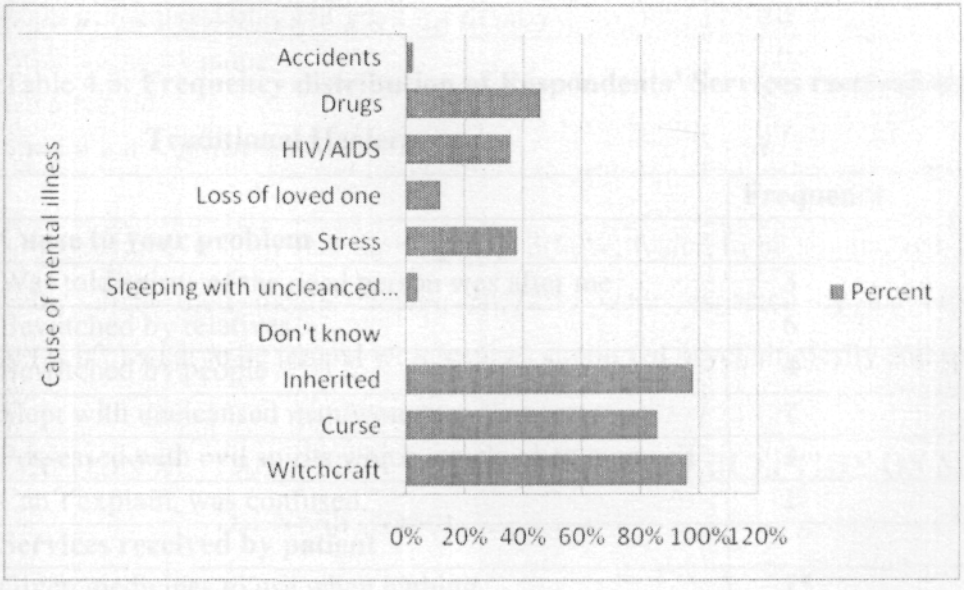
	Frequency	**Percentage**
Why are your neighbours unaware of your illness.		
Fear of stigma	3	60
Fear cannot be married	1	20
Shifted to a new place	2	40
If yes (neighbours know), how are you treated?		
Insulted	2	4
With respect	32	64
Labeled as a mad person	36	72
Laughed at	22	44
Neglected	28	56
Prayed for	2	4
Treated as a witch, isolated and side lined	5	10
Given aid	5	10
Family counseled to be strong	1	2
Gossip about my illness	3	6

How would you like the community to treat you?	Frequency	Percentage
With respect	50	100
Support me psychologically and spiritually	50	100
Address me by name	50	100
Give me aid	2	4
Should not stigmatize and fear me	8	16

The table above show that the majority, 3(60%) feared to be stigmatized if neighbours knew about their mental illness, 36(72%) were respected by the neighbourhood, 50(100%) want to be treated with respect, supported psychologically and spiritually.

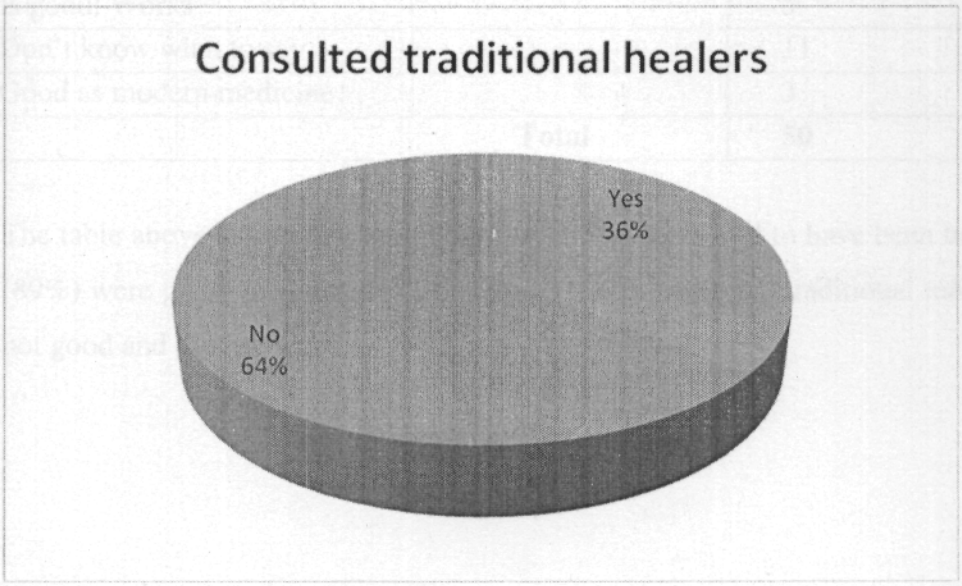
SECTION E: TRADITIONAL BELIEFS AND PERCEPTION ON MENTAL ILLNESS (N=50)

Figure 4.10: **Frequency distribution of Respondents' Knowledge on cause of mental illness**



The figure shows that the majority, 49 (98%) of respondents said that mental illness is by inheritance and none (0%), said that they do not know.

Figure 4.11: **Frequency distribution of Respondents' Consultation on Traditional Healers**



The pie chart shows that 32 (64%) have never consulted the traditional healer while 18 (36%) have consulted the traditional healer before.

Table 4.6: **Frequency distribution of Respondents' Services received from Traditional Healers.**

	Frequency	Percentage
Cause to your problem		
Was told spirits of the dead person was after me	3	17
Bewitched by relatives	6	33
Bewitched by people	4	22
Slept with uncleansed man/woman	1	6
Possessed with evil spirits which attack when annoyed	3	17
Can't explain, was confused.	1	6
Services received by patient		
Given medicines to use when bathing	15	83
Was admitted	3	17
Was given medicines to drink	16	89
Prayed for	4	22
Tattooed	8	44
Covered under boiled herbs	1	6
Referred to health centre	1	6
Given prayed for water to drink	1	6

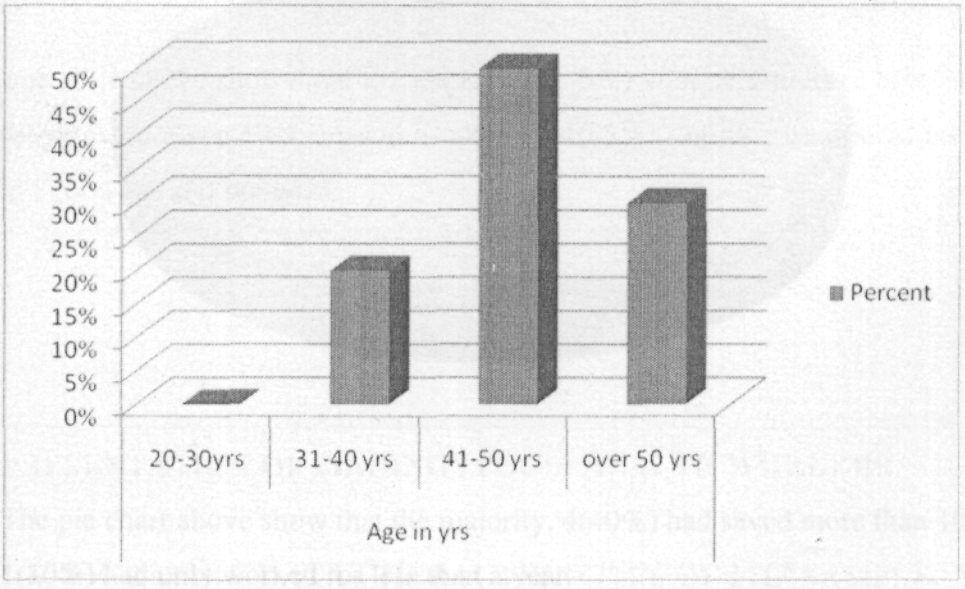
Comment on the use of traditional medicine	Frequency	Percentages
Not good. Do not work	31	62
Is good. Works	5	10
Don't know what to say	11	22
Good as modern medicine	3	6
Total	**50**	**100**

The table above shows that the majority 6 (33%) were told to have been bewitched, 16 (89%) were given medicines to drink and 31(62%) said that traditional medicines were not good and did not work.

PRESENTATION OF FINDINGS FROM HEALTH WORKERS

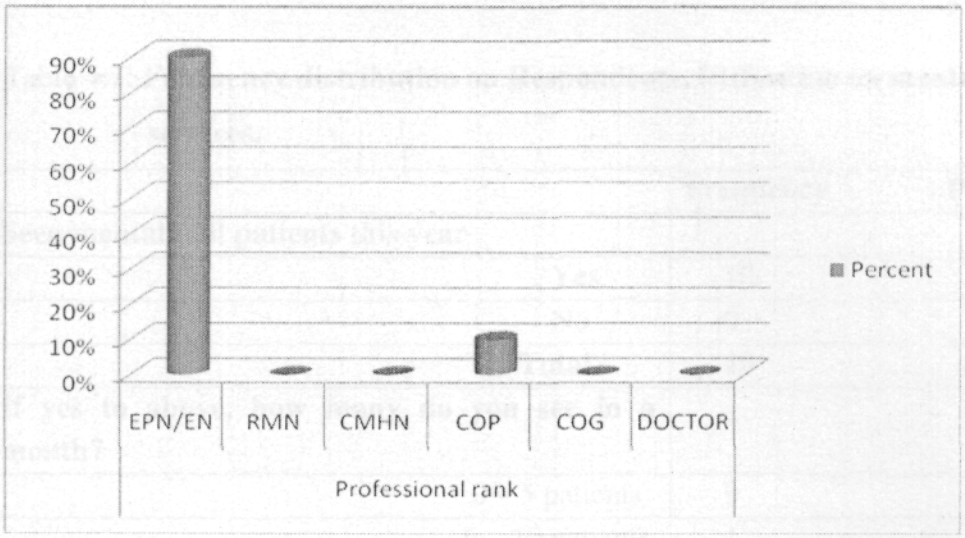
DEMOGRAPHIC DATA CHARACTERISTICS OF THE SAMPLE (N=10)

Figure 4.12: **Frequency distribution on Age of the Health Workers.**



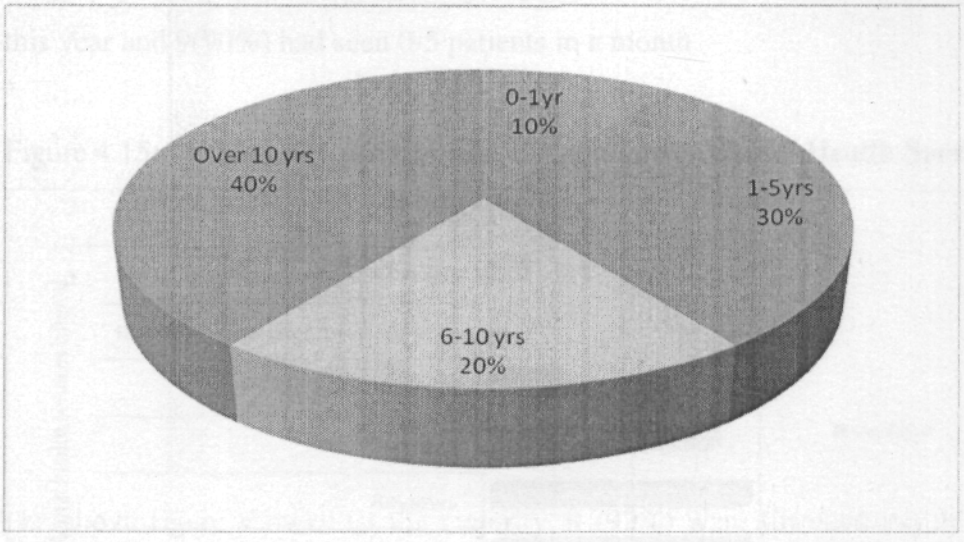
The figure above shows that the majority 5 (50%) of health workers were between 41-50 years while none (0%) were between 20-30 years.

Figure 4.13: **Frequency distribution of Respondents' Professional Qualifications.**



The above figure shows that the majority, 9 (90%) were Enrolled Psychiatric Nurses while 1(10%) was a Clinical Officer.

Figure 4.14: **Frequency distribution on Respondents, Serving Period.**



The pie chart above show that the majority, 4(40%) had saved more than 10 years while 1(10%) had only worked for less than a year.

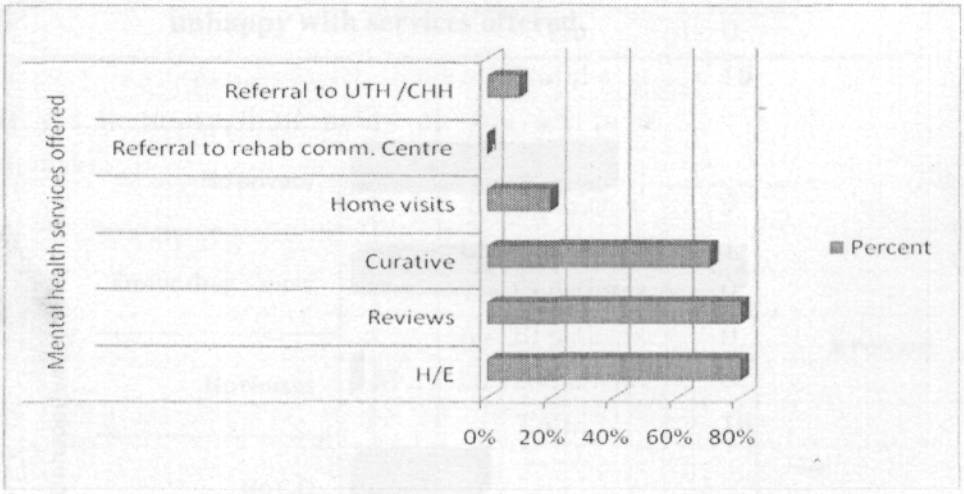
UTILIZATION OF MENTAL HEALTH SERVICES (N=10)

Table 4.7: **Frequency distribution on Respondents, Utilization on mental health services.**

	Frequency	Percentage
Seen mentally ill patients this year		
Yes	10	100
No	0	0
Total	**10**	**100**
If yes to above, how many do you see in a month?		
0 – 5 patients	9	90
6 – 10 patients	1	10
11 – 15 patients	0	0
16 – 20 patients	0	0
More than 20 patients	0	0
Total	**10**	**100**

The table above shows that the majority, 10(100%) had seen the mentally ill patients this year and 9(90%) had seen 0-5 patients in a month.

Figure 4.15: **Frequency distribution Respondents' Mental Health Services offered**



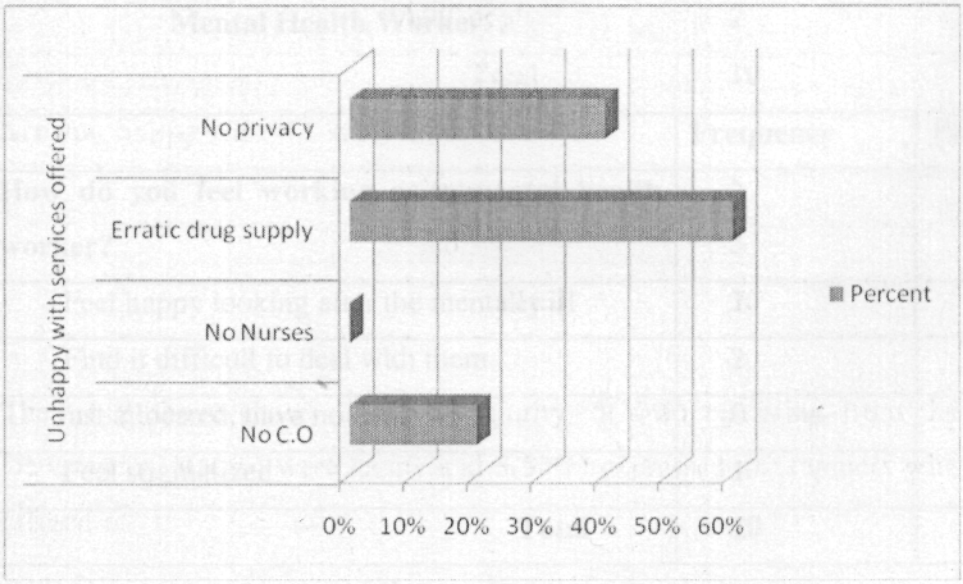
The figure above shows that the majority, 8(80%) offered health education and reviewed patients.

Table 4.8: **Frequency distribution on Respondents' Working Department and Feeling on mental health services offered.**

Department operating from if not seeing psychiatric patients	**Frequency**	**Percentage**
MCH	1	10
OPD	5	50
TB corner	2	20
ART dep't	2	20
Total	**10**	**100**
Are you happy with the services offered?		
Yes	5	50
No	5	50
Total	**10**	**100**

The table above shows that the majority, 5(50%) operating from the Out-Patient Department, 5(50%) were happy and 5(50%) expressed unhappiness with the services offered.

Figure 4.16: **Frequency distribution on respondents' expression on why they are unhappy with services offered.**



The figure above shows that the majority, 3(60%) complained of having erratic drug supplies while none complained on shortage of nurses.

Table 4.9: **Frequency distribution on Drug Availability in Health Centres**

	Frequency	**Percentage**
Available psychotic drugs		
Largactil	6	60
Phenobarbitone	2	20
Carbamazepine	6	60
Haloperidol	0	0
Artane	1	10
Amitriptiline	2	20
None	2	20

The table above shows that the majority, 6(60%) had Largactil (Chlorpromazine) and Carbamazepine (Tegretol) in the Health Centres while none (0%) had Haloperidol.

ATTITUDE OF HEALTH WORKERS (N=10)

Table 4.10: **Frequency distribution on Respondents' Feeling on working as a Mental Health Worker.**

	Frequency	**Percentage**
How do you feel working as a mental health worker?		
Feel happy looking after the mentally ill	7	70
Find it difficult to deal with them	2	20
Just allocated, have no choice	0	0
Feel stigmatized	1	10
Total	**10**	**100**

How do none psychiatric workers treat you?	Frequency	Percentage
Stigmatised	0	0
Don't treat me any differently	10	100
Isolate me	0	0
Do not involve me in their programmes	0	0
Total	**10**	**100**
Do none Psychiatric Health Workers get involved in mental health delivery?		
Yes	6	60
No	4	40
Total	**10**	**100**
If yes to above, what activities are they involved in?		
Home visit	1	16.66
Health education	4	66.66
Curative services	4	66.66
Reviews	4	66.66
None of above	0	0

The above table shows that the majority, 7(70%) feel happy looking after the mentally ill, 10(100%) don't feel treated any differently by non- psychiatric workers, 6(60%) of non- psychiatric workers get involved in offering mental health services and 4(66.6%) offer curative services, give health education and reviewed patients.

Table 4.11: **Frequency distribution on General Nurses' Failure to handle the mentally ill.**

If no to Q14, give reasons to your answer	Frequency	Percentage
Shortage of staff	1	25
No knowledge to handle cases	2	50
Stigmatize psychiatric workers	1	25
No response	1	25

Recommendations made to improve mental health services in health centres	Frequency	Percentage
Have mental health services in each health centre	8	80
Train more psychiatric workers	6	60
Sensitize the community about mental health	8	80
Refresher courses	4	40

The table above shows that the majority, 2(50%) of non- psychiatric workers have no knowledge of how to handle cases and 8(80%) recommended for community sensitization and provision of mental health services in all health centres.

CROSS TABULATIONS ON PATIENT FINDINGS

Table 4.12: **Sex in relation to Sensitization and Knowledge of mental health services**

Sensitization and knowledge of mental health services	SEX		TOTAL
	MALE	FEMALE	
Good	0	0	0
Average	23(79%) (23/29*100)	18(86%) (18/21*100)	41(82%) (41/50*100)
Poor	6(21%) (6/29*100)	3(14%) (3/21*100)	9(18%) (9/50*100)
TOTAL	29(100%) (29/29*100)	21(100%) (21/21*100)	50(100%) (50/50*100)

For the 29 male respondents, 23(79%) had average knowledge and sensitization while from the 21 female respondents, 18 (86%) had average knowledge and sensitization. From the 29 male respondents, 6(21%) and from the 21 female respondents 3 (14%) had poor knowledge and poor sensitization. None of all respondents had good knowledge and sensitization.

Table 4.13: **Age in relation to Sensitization and Knowledge of mental health services**

Sensitization and knowledge of mental health services	AGE					TOTAL
	15-24	25-34	35-44	45-54	Above 55	
Good	0	0	0	0	0	0
Average	6(67%) (6/9*100)	10(83%) (10/12*100)	14(87%) (14/16*100)	9(100%) (9/9*100)	3(75%) (3/4*100)	42(84%) (42/50*100)
Poor	3(33%) (3/9*100)	2(17%) (2/12*100)	2(13%) (2/16*100)	0	1(25%) (1/4*100)	8(16%) (8/50*100)
TOTAL	9(100%) (9/9*100)	12(100%) (12/12*100)	16(100%) (16/16*100)	9(100%) (9/9*100)	4(100%) (4/4*100)	50(100%) (50/50*100)

For the 9 respondents who had 45-54 years, 9(100%); out of 12 respondents who had 25-34 years, 10(83%); from the 16 respondents who had 35-44 years, 14(87%); from the 9 respondents who had 15-24 years, 6(67%); from the 4 respondents who had above 55 years, 3(75%) all had average knowledge and sensitization. From the 9 respondents who had 15 – 24 years, 3(33%); from the 12respondents who had 25-34%), 2(17%); from the 16 respondents who had 35 – 44years, 2(13%); from the 4 respondents who had above 55 years, 1(25%) had poor knowledge and sensitization. None of all ages had very good knowledge and sensitization.

Table 4.14: **Marital Status in relation to Sensitization and Knowledge of mental health services**

Sensitization and knowledge of mental health services	MARITAL STATUS					TOTAL
	Single	Married	Divorced	Widowed	Separated	
Good	0	0	0	0	0	0
Average	17(71%) (17/24*100)	9(100%) (9/9*100)	9(100%) (9/9*100)	4(80%) (4/5*100)	3(100%) (3/3*100)	42(84%) (42/50*100)
Poor	7(29%) (7/24*100)	0	0	1(20%) (1/5*100)	0	8(16%) (8/50*100)
TOTAL	24(100%) (24/24*100)	9(100%) (9/9*100)	9(100%) (9/9*100)	5(100%) (5/5*100)	3(100%) (3/3*100)	50(100%) (50/50*100)

From the 9 respondents who were married, 9(100%); from the 24 respondents who were single, 17(71%); from the 9 respondents who were divorced, 9(100%); from the 5 respondents who were widowed, 4(80%); from the 3 respondents who were separated, 3(100%) all had knowledge and sensitization. From the 24 respondents who were single, 7(29%) and from the 5 respondents who were widowed, 1(20%) had poor

knowledge and sensitization. None in all categories had very good knowledge and sensitization to mental health services.

Table 4.15: **Education in relation to Sensitization and Knowledge of mental health services**

Sensitization and knowledge of mental health services	**EDUCATION**					**TOTAL**
	Primary	**Secondary**	**College**	**University**	**None**	
Good	0	0	0	0	0	0
Average	11(79%) (11/14*100)	15(88%) (15/17*100)	6(86%) (6/7*100)	3(100%) (3/3*100)	6(67%) (6/9*100)	41(82%) (41/50*100)
Poor	3(21%) (3/14*100)	2(12%) (2/17*100)	1(14%) (1/7*100)	0	3(33%) (3/9*100)	9(18%) (9/50*100)
TOTAL	14(100%) (14/14*100)	17(100%) (17/17*100)	7(100%) (7/7*100)	3(100%) (3/3*100)	9(100%) (9/9*100)	50(100%) (50/50*100)

From the 14 respondents who had primary education, 11(79%); from the 17 respondents who had secondary education, 15(88%); from 7 who had college education, 6(86%); from the 3 who had university education, 3(100%) and from 9 who had no education, 6(67%) had average sensitization and knowledge about mental health services. From 14 respondents who had primary education, 3(21%); from the 17 respondents who had secondary education, 2(12%); from the 7 who had college education, 1(14%); from the 9 respondents who had no education, 3(33%) had poor sensitization and knowledge about mental health services. None of all categories had very good sensitization and knowledge about mental health services.

Table 4.16: **Employment in relation to Sensitization and Knowledge of mental health services**

Sensitization and knowledge of mental health services	EMPLOYMENT			TOTAL
	Formal	Informal	Unemployed	
Good	0	0	0	0
Average	6(86%) (6/7*100)	13(100%)(13/13*100)	22(73%) (22/30*100)	41(82%) (41/50*1(
Poor	1(14%) (1/7*100)	0	8(27%) (8/30*100)	9(18%) (9/50*100)
TOTAL	7(100%) (7/7*100)	13(100%)(13/13*100)	30(100%) (30/30*100)	50(100%) (50/50*100)

From the 13 respondents who had informal employment, 13(100%); from the 7 respondents who had formal employment, 6(86%) and from the 30 respondents who

were unemployed, 22(73%) had average knowledge and sensitization. From the 7 respondents who had formal employment, 1(14%) and from the 30 respondents who had no employment, 8(27%) had poor knowledge and sensitization. None of all respondents had very good knowledge and sensitization.

Table 4.17: **Sex in relation to Accessibility and Utilization of mental health services**

Accessibility and utilization of mental health services	**SEX**		**TOTAL**
	Male	**Female**	
Very accessible and utilized always	0	0	0
Moderately accessible and utilized sometimes	4(14%) (4/29*100)	2(10%) (2/21*100)	6(12%) (6/50*100)
Poorly accessible and under-utilised	25(86%) (25/29*100)	19(90%) (19/21*100)	44(88%) (44/50*100)
TOTAL	29(100%) (29/29*100)	21(100%) (21/21*100)	50(100%) (50/50*100)

From 29 male respondents, 4(14%) and from the 21 female respondents, 2(10%) had moderate accessibility and sometimes utilized the mental health services. From 29 male respondents, 25(86%) and from the 21 female respondents, 19(90%) had poor accessibility and underutilization of mental health services. None had very good accessibility or utilized mental health services always.

Table 4.18: **Education in relation to Accessibility and Utilization of mental health services**

Accessibility and utilization of mental health services	**EDUCATION**					**TOTAL**
	Primary	**Secondary**	**College**	**University**	**None**	
Very accessible and utilized always	0	0	0	0	0	0
Moderately acc. and utilized sometimes	1(7%) (1/14*100)	1(6%) (1/17*100)	1(14%) (1/7*100)	3(100%) (3/3*100)	0	6(12%) (6/50*10
Poorly acc. and under-utilised	13(93%) (13/14*100)	16(94%) (16/17*100)	6(86%) (6/7*100)	0	9(100%) (9/9*100)	44(88%) (44/50*100)
TOTAL	14(100%) (14/14*100)	17(100%) (17/17*100)	7(100%) (7/7*100)	3(100%) (3/3*100)	9(100%) (9/9*100)	50(100%) (50/50*100)

From the 14 respondents who had primary education, 1(7%); from the 17 respondents who had secondary education, 1(6%); from the 7 who had college education, 1(14%); from the 3 who had university education, 3(100%) and from the 9 who had no education, none had moderate accessibility and sometimes utilized mental health services. From the 14 respondents who had primary education, 13(93%); from the 17 who had secondary education, 16(94%); from the 7 who had college education, 6(86%) and from the 9 who had no education, 9(100%) had poor accessibility and underutilization of mental health services. None of all respondents had very good accessibility or utilized mental health services.

Table 4.19: **Employment in relation to Accessibility and Utilization of mental health services**

Accessibility and utilization of mental health services	**EMPLOYMENT**			**TOTAL**
	Formal	**Informal**	**Unemployed**	
Very accessible and utilized always	0	0	0	0
Moderately acc. and utilized sometimes	2(29%) (2/7*100)	0	3(10%) (3/30*100)	5(10%) (5/50*100)
Poorly acc. and under-utilised	5(71%) (5/7*100)	13(100%) (13/13*100)	27(90%) (27/30*100)	45(90%) (45/50*100)
TOTAL	7(100%) (7/7*100)	13(100%) (13/13*100)	30(100%) (30/30*100)	50(100%) (50/50*100)

From the 7 respondents who had formal employment, 2(29%); none of the 13 respondents with formal employment and from the 30 respondents who were unemployed, 3(10%) had moderate accessibility and sometimes utilized mental health services. From the 7 respondents who had formal employment, 5(71%); from the 13 who had informal employment, 13(100%) and from the 30 respondents who had no employment, 27(90%) had poor accessibility and underutilization of mental health services. None had very good accessibility or always utilized mental health services.

Table 4.20 : **Sex in relation to Stigmatization**

Stigmatization	SEX		TOTAL
	Male	Female	
Very high	0	0	0
Moderately high	11(38%) (11/29*100)	12(57%) (12/21*100)	23(46%) (23/50*100)
Low	18(62%) (18/29*100)	9(43%) (9/21*100)	27(54%) (27/50*100)
TOTAL	29(100%) (29/29*100)	21(100%) (21/21*100)	50(100%) (50/50*100)

From the 29 male respondents, 11(38%) and from the 21 female respondents, 12(57%) were moderately high stigmatized. From the 29 male respondents, 18(62%) and from the 21 female respondents, 9(43%) were lowly stigmatized. None of all the respondents were very highly stigmatized.

Table 4.21: **Marital status in relation to Stigmatization**

Stigmatizatin	MARITAL STATUS					TOTAL
	Single	Married	Divorced	Widowed	Separated	
Very high	0	0	0	0	0	0
Moderately high	13(54%) (13/24*100)	4(45%) (4/9*100)	4(45%) (4/9*100)	3(60%) (3/5*100)	3(100%) (3/3*100)	27(54%) (27/50*100)
Low	11(46%) (11/24*100)	5(55%) (5/9*100)	5(55%) (5/9*100)	2(40%) (2/5*100)	0	23(46%) (23/50*100)
TOTAL	24(100%) (24/24*100)	9(100%) (9/9*100)	9(100%) (9/9*100)	5(100%) (5/5*100)	3(100%) (3/3*100)	50(100%) (50/50*100)

From the 24 single respondents, 13(54%); from the 9 married respondents, 4(45%); from the 9 divorced respondents, 4(45%); from the 5 widowed respondents, 3(60%) and from the 3 separated respondents, 3(100%) had moderate high stigmatization. From the 24 single respondents, 11(46%); from the 9 married respondents, 5(55%); from the 9 divorced respondents, 5(55%) and from the 5 widowed respondents, 2(40%) had low stigmatization. None of all the respondents had very high stigmatization.

Table 4.22: **Education in relation to Stigmatization**

Stigmatization	EDUCATION					TOTAL
	Primary	Secondary	College	University	None	
Very high	0	0	0	0	0	0
Moderately high	7(50%) (7/14*100)	6(35%) (6/17*100)	2(29%) (2/7*100)	2(67%) (2/3*100)	2(22%) (2/9*100)	19(38%) (19/50*100)
Low	7(50%) (7/14*100)	11(65%) (11/17*100)	5(71%) (5/7*100)	1(33%) (1/3*100)	7(78%) (7/9*100)	31(62%) (31/50*100)
TOTAL	14(100%) (14/14*100)	17(100%) (17/17*100)	7(100%) (7/7*100)	3(100%) (3/3*100)	9(100%) (9/9*100)	50(100%) (50/50*100)

From the 14 respondents who had primary education, 7(50%); from the 17 respondents who had secondary education, 6(35%); from the 7 who had college education, 2(29%); from the 3 who had university education, 2(67%); from the 9 who had no education, 2(22%) had moderate high stigmatization. From the 14 respondents who had primary education, 7(50%); from the 17 who had secondary education, 11(65%); from the 7 who had college education, 5(71%); from the 3 who had university education, 1(33%) and those who had no education, 7(78%) had low stigmatization. None of all respondents had very high stigmatization.

Table 4.23: **Employment in relation to Stigmatization**

Stigmatization	**EMPLOYMENT**			**TOTAL**
	Formal	**Informal**	**Unemployed**	
Very high	0	0	0	0
Moderately high	3(43%) (3/7*100)	5(38%) (5/13*100)	13(43%) (13/30*100)	21(42%) (21/50*100
Low	4(57%) (4/7*100)	8(62%) (8/13*100)	17(57%) (17/30*100)	29(58%) (29/29*100
TOTAL	7(100%) (7/7*100)	13(100%) (13/13*100)	30(100%) (30/30*100)	50(100%) (50/50*1(

From the 30 respondents who were unemployed, 13(43%); from the 13 who had informal employment, 5(38%) and from the 7 with formal employment, 3(43%) had moderate high stigmatization. From the 30 respondents who were unemployed, 17(57%); from the 13 who had informal employment, 8(62%) and from the 7 who had formal employment, 4(57%) had low stigmatization. None of all the respondents had very high stigmatization.

Table 4.24: **Sex in relation to Traditional Beliefs and Perception of mental illness**

Traditional belief and perception on mental illness	**SEX**		**TOTAL**
	Male	**Female**	
Not willing with good perception	21(72%) (21/29*100)	18(85%) (18/21*100)	39(78%) (39/50*100)
May be willing with fair perception	8(28%) (8/29*100)	3(14%) (3/21*100)	11(22%) (11/50*100)
Willing with poor perception	0	0	0
TOTAL	29(100%) (29/29*100)	21(100%) (21/21*100)	50(100%) (50/50*100)

From the 29 male respondents, 8(28%) and from the 21 female respondents, 3(14%) may be willing to follow traditional beliefs with fair perception on mental illness. From

the 29 male respondents, 21(72%) and from the 21 female respondents, 18(85%) were not willing to follow traditional beliefs with good perception on mental illness. None of all the respondents were willing with poor perception.

Table 4.25: **Age in relation to Traditional Beliefs and Perception of mental illness**

Traditional beliefs and perception on mental illness	**AGE**					**TOTAL**
	15-24	**25-34**	**35-44**	**45-54**	**Above 55**	
Not willing with good perception	7(78%) (7/9*100)	10(83%) (10/12*100)	14(87%) (14/16*100)	6(67%) (6/9*100)	2(50%) (2/4*100)	39(78%) (39/50*100)
May be willing with fair perception	2(22%) (2/9*100)	2(17%) (2/12*100)	2(13%) (2/16*100)	3(33%) (3/9*100)	2(50%) (2/4*100)	11(22%) (11/50*100)
Willing with poor perception	0	0	0	0	0	0
TOTAL	9(100%) (9/9*100)	12(100%) (12/12*100)	16(100%) (16/16*100)	9(100%) (9/9*100)	4(100%) (4/4*100)	50(100%) (50/50*100)

From the 9 respondents who had 15-24 years, 2(22%); from the 12 who had 25-34 years, 2(17%); from the 16 who had 35-44 years, 2(13%); from the 9 who had 45-54 years, 3(33%) and from the 4 respondents who had 55 and above years, 2(50%) may be willing to follow traditional beliefs with fair perception on mental illness. From the 9 respondents who had 15- 24 years, 7(78%); from the 12 who were 25-34 years, 10(83%); from the 16 who had 35-44 years, 14(87%); from the 9 who were 45-54 years, 6(67%) and from 4 who were 55 years and above, 2(50%) were not willing to follow traditional beliefs with good perception on mental illness. None of all the respondents were willing with poor perception.

Table 4.26: **Marital status in relation to Traditional Beliefs and Perception of mental illness**

Traditional beliefs and perception on mental illness	**MARITAL STATUS**					**TOTAL**
	Single	**Married**	**Divorced**	**Widowed**	**Separated**	
Not willing with good perception	19(79%) (19/24*100)	6(67%) (6/9*100)	8(89%) (8/9*100)	3(60%) (3/5*100)	3(100%) (3/3*100)	39(78%) (39/50*100)
May be willing with fair	5(21%) (5/24*100)	3(33%) (3/9*100)	1(11%) (1/9*100)	2(40%) (2/5*100)	0	11(22%) (11/50*100)

perception						
Willing with poor perception	0	0	0	0	0	0
TOTAL	24(100%) (24/24*100)	9(100%) (9/9*100)	9(100%) (9/9*100)	5(100%) (5/5*100)	3(100%) (3/3*100)	50(100%) (50/50*100)

From the 24 single respondents, 5(21%); from the 9 married respondents, 3(33%); from the 9 divorced respondents, 1(11%); from the 5 widowed, 2(40%) may be willing to follow traditional beliefs with fair perception on mental illness. From the 24 single respondents, 19(79%); from the 9 married respondents, 6(67%); from the 9 divorced respondents, 8(89%); from the 5 widowed respondents, 3(60%) and from the 3 separated respondents, 3(100%) were not willing to follow traditional beliefs with good perception on mental illness. None were willing to follow with poor perception.

Table 4.27: **Education in relation to Traditional Beliefs on mental illness**

Traditional beliefs and perception of mental illness	**EDUCATION**					**TOTAL**
	Primary	**Secondary**	**College**	**University**	**None**	
Not willing with good perception	12(86%) (12/14*100)	14(82%) (14/17*100)	6(86%) (6/7*100)	1(33%) (1/3*100)	8(89%) (8/9*100)	41(82%) (41/50*100)
May be willing with fair perception	2(14%) (2/14*100)	3(18%) (3/17*100)	1(14%) (1/7*100)	2(67%) (2/3*100)	1(11%) (1/9*100)	9(18%) (9/50*100)
Willing with poor perception	0	0	0	0	0	0
TOTAL	14(100%) (14/14*100)	17(100%) (17/17*100)	7(100%) (7/7*100)	3(100%) (3/3*100)	9(100%) (9/9*100)	50(100%) (50/50*100)

From the 14 respondents who had primary education, 12(86%); from the 17 respondents who had secondary education, 14(82%); from the 7 respondents with college education, 6(86%); from the 3 with university education, 1(33%) and from 9 with no education, 8(89%) were not willing to follow traditional beliefs and had good perception on mental illness. From the 14 respondents who had primary education, 2(14%); from the 17 with secondary education, 3(18%); from the 7 with college education, 1(14%); from the 3 with university education, 2(67%) and from the 9 with no education, 1(11%) may be willing to follow traditional beliefs with fair perception on mental illness. None of all the respondents were willing to follow traditional beliefs with poor perception on mental illness.

Table 4.28: **Employment in relation to Traditional Beliefs on mental illness**

Traditional beliefs and perception of mental illness	EMPLOYMENT			TOTAL
	Formal	Informal	Unemployed	
Not willing with good perception	6(86%) (6/7*100)	11(85%) (11/13*100)	24(80%) (24/30*100)	41(82%) (41/50*100)
May be willing with fair perception	1(14%) (1/7*100)	2(15%) (2/13*100)	6(20%) (6/30*100)	9(18%) (9/50*100)
Willing with poor perception	0	0	0	0
TOTAL	7(100%) (7/7*100)	13(100%) (13/13*100)	30(100%) (30/30*100)	50(100%) (50/50*100)

From the 30 respondents who were unemployed, 24(80%); from the 13 who had informal employment, 11(85%) and from the 7 with formal employment, 6(86%) were not willing to follow traditional beliefs and had good perception on mental illness. From the 30 who were unemployed, 6(20%); from the 13 who had informal employment, 2(15%) and from 7 with formal employment, 1(14%) may be willing to follow traditional beliefs and had fair perception on mental illness. None was willing and had poor perception.

CROSS TABULATION ON DATA ANALYSIS OF HEALTH PERSONNEL

Table 4.29: **Age in relation to Utilization of health services by Health Workers.**

Utilization of health services.	AGE				TOTAL
	20-30	31-40	41-50	Above 51	
Very good	0	0	0	0	0
Good	0	1(50%) (1/2*100)	4(80%) (4/5*100)	2(67%) (2/3*100)	7(70%) (7/10*100)
Poor	0	1(50%) (1/2*100)	1(20%) (1/5*100)	1(33%) (1/2*100)	3(30%) (3/10*100)
TOTAL	0	2(50%) (2/2*100)	5(100%) (5/5*100)	3(100%) (3/3*100)	10(100%) (10/10*100

From the 5 respondents who were 41-50 years, 4 (80%) had good utilization of mental health services, from the 3 respondents who were about 50 years 2 (67%), from the 2 respondents who were 31-40 years 1 (50%) also had good utilization of the services. For the respondents who poorly utilized the mental health services, out of 2, 1(50%) were respondents who had 31-40 years, from 4, 1(20%) had 41-50 years and out of 3, 1(33%) were above 50years. None of all respondents had very good utilization of mental health services.

Table 4.30: **Rank in relation to Utilization of mental health services by Health Workers.**

Utilization of health services.	RANK						TOTAL
	EPN and EN	RMN	CMHN	COP	COG	DR	
Very good	0	0	0	0	0	0	0
Good	7(78%) (7/9*100)	0	0	1(100%) (1/1*100)	0	0	8(80%) (8/10*100)
Poor	2(22%) (2/9*100)	0	0	0	0	0	2(20%) (2/10*100)
TOTAL	9(100%) (9/9*100)	0	0	1(100%) (1/1*100)	0	0	10(100%) (10/10*100)

From the 9 respondents who were EPNs, 7 (78%) and from 1 respondent who was a C.O.P, 1 (100%) had good utilization of mental health services. From the 9 respondents who were EPNs, 2 (22%) had poor utilization of mental health services while none from all respondents had very good utilization of mental health services.

Table 4.31: **Period of service in relation to Utilization of mental health services by Health Workers.**

Utilization of health services.	PERIOD OF SERVICE				TOTAL
	Less than 1 year	1-5 years	6-10 years	Over 10 yrs	
Very good	0	0	0	0	0
Good	0	3(100%) (3/3*100)	1(50%) (1/2*100)	3(75%) (3/4*100)	7(70%) (7/10*100)
Poor	1(100%) (1/1*100)	0	1(50%) (1/2*100)	1(25%) (1/4*100)	3(30%) (3/7*100)
TOTAL	1(100%) (1/1*100)	3(100%) (3/3*100)	2(100%) (2/2*100)	4(100%) (4/4*100)	10(100%) (10/10*100)

From the 3 respondents who served for 1-5 years, 3 (100%), from the 2 respondents who served for 6-10 years 1 (50%) and from 4 respondents who were above 10 years in service 3 (75%) all had good utilization of mental health services. For the respondents who had poor utilization of mental health services, from 1, 1 (100%) served less than 1 year; out of 2, 1 (50%) had served for 6-10 years and from 4, 1(25%) served for more than 10 years. None of all respondents had very good utilization of the services.

Table 4.32: **Age in relation to Attitude of Health Workers.**

Attitude of health workers	AGE				TOTAL
	20-30	31-40	41-50	Above 50 yrs	
Good	0	0	0	0	0
Average	0	2(100%) (2/2*100)	4(80%) (4/5*100)	2(67%) (2/3*100)	8(80%) (8/10*100)
Poor	0	0	1(20%) (1/5*100)	1(33%) (1/3*100)	2(20%) (2/10*100)
TOTAL	0	2(100%) (2/2*100)	5(100%) (5/5*100)	3(100%) (3/3*100)	10(100%) (10/10*1(

From the 2 respondents who had 31-40 years, 2 (100%); from the 5 respondents who had 41-50 years, 4(80%) and out of 3 respondents who are above 50 years, 2(67%) all had average attitude to mental health services and patients. For the respondents who had poor attitude, from 5 respondents, 1(20%) had 41 – 50 years; and from 3 respondents, 1(33%) had above 50 years. None of all respondents had good attitude.

Table 4.33: **Rank in relation to Attitude of Health Workers**

Attitude of health workers	RANK						TOTAL
	EPN and EN	RMN	CHMN	COP	COG	DR	
Good	0	0	0	0	0	0	0
Average	7(78%) (7/9*100)	0	0	1(100%) (1/1*100)	0	0	8(80%) (8/10*100)
Poor	2(22%) (2/9*100)	0	0	0	0	0	2(20%) (2/10*100)
TOTAL	9(100%) (9/9*100)	0	0	1(100%) (1/1*100)	0	0	10(100%) (10/10*100)

From the 9 respondents who were EPNs, 7 (78%); out of 1 respondent, a COP, 1 (100%) had average attitude. From the 9 respondents who were EPNs, 2(22%) had poor attitude while none of all respondents had good attitude.

Table 4.34: **Period of service in relation to Attitude of Health Workers**

Attitude of health workers	PERIOD IN SERVICE				TOTAL
	Less than 1year	1-5 yrs	6-10 yrs	Above 10 yrs	
Good	0	0	0	0	0
Average	0	3(100%) (3/3*100)	2(100%) (2/2*100)	3(75%) (3/4*100)	8(80%) (8/10*100)
Poor	1(100%) (1/1*100)	0	0	1(25%) (1/4*100)	2(20%) (2/10*100)
TOTAL	1(100%) (1/1*100)	3(100%) (3/3*100)	2(100%) (2/2*100)	4(100%) (4/4*100)	10(100%) (10/10*100)

From all respondents, none had good attitude. From the 3 respondents who have served for 1- 5 years, 3(100%); from 2 respondents who had served for 6-10 years, 2(100%); and from 4 respondents who had served above 10 years, all had average attitude. From the 4 respondents who had served above 50 years, 1(25%) had poor attitude.

CONCLUSION

Data analysis is the systematic organization and synthesis of research data, and testing of the research hypothesis. Data was collected from 50 subjects / respondents who attended Out-Patient Department at Chainama Hills Hospital in Lusaka and also from 10 health personnel from 6 Health Centres within Lusaka urban. The respondents ranged from 15 to 65 years old of whom the majority, 16(32%) had 35-44 years. About 30(60%) were not educated while the majority 17(34%) had secondary education. Most of the respondents had knowledge on mental health services though the majority was unable to access and utilize them from the Health Centres. Data also reviewed that more than half of the respondents were not stigmatized by the community and health workers. The majority of health workers utilized mental health services though they only see a few patients of 1-5 per month. The majority of respondents was not willing to follow traditional beliefs and had good perception on mental illness. However the data collected reviewed that the majority complained of not having psychotropic drugs available at the Health Centres for the patients to utilize the mental health services.

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS AND IMPLICATIONS FOR THE HEALTH CARE SYSTEM

5.1 INTRODUCTION

The Study was conducted with the aim of determining Factors Contributing to Under-utilization of Mental Health Services in Health Centres within Lusaka Urban. The data pertaining to the study was collected from 50 patients / study units from Out Patient Department at Chainama Hills College Hospital and 10 health personnel from 6 different clinics / Health Centre within Lusaka. Data was then analyzed manually using a calculator and interpreted. The findings of the study are discussed below.

5.2 SOCIAL DEMOGRAPHIC DATA

The demographic data showed that the majority of respondents where males with 58% while females were 42%. This could be associated to stress experienced by men. Literature reveals that stress is common in men because of work overload, too much responsibility and they work longer hours and harder to overcome the pressure - this results in physical and mental exhaustion (MHAZ, 2009).

The study also showed that the majority of respondents were within the range of 35 to 44 years. From all the respondents, 18% were in the range of 15 to 24 years, 24% of the respondents were within 25 to 34 years, 32% ranged from 35 to 44 years, 18% ranged from 45 to 54 years while those above 55 years were 8%. The majority of respondents being within the range of 35 to 44years could be attributed to the fact that this is the most literate and are able to read about mental health and mental illness hence go to the hospital for treatment (Table 4.2). Substance abuse could also contribute to this age group because they are a vulnerable group. According to Ministry of Health (2005), the problem of substance abuse in the country is on the increase. A case review among

psychiatric establishments in Zambia showed that 10% of admissions for acute psychotic states are alcohol and drug misuse related, were more males are reported to abuse alcohol and drugs than females. The males and females who were admitted for alcohol abuse are within the sexually active age group (Ministry of Health, 2005).
The study also revealed that 48% of the respondents were single, 18% were married, 18% were divorced, 10% were widowed and 6% were separated. The study show that the majority of respondents are not married. This is attributed to the fact that in Zambian society the users (patients) are regarded as not to lead productive lives within their communities and should be locked away in institutions (MHAZ, 2009).

The results also found that 28% of the respondents attained primary education, 34% had secondary education, 14% went to college, 6% attained university education and 18% had never been to school. Results show that the majority of the respondents had low education. The low education level of most respondents is assumed to be as a result of the Zambian society thinking that the mentally ill persons can never lead a normal life. They are therefore feared, scorned at, humiliated and condemned by the society and this is most times also transferred to the afflicted family members. On the other hand, the mentally ill may be neglected by their own families (MHAZ, 2009).

The study also reviewed that 60% of respondents were unemployed, 26% were in informal employment and 14% were in formal employment. The low employment level may be attributed to low educational levels as it is shown in the study. According to other studies / reports, it was revealed that the society think that the mental health users or consumers should not be employed or can only work low level jobs but aren't suited for really important or responsible positions (MHAZ,2009). It also could be attributed to lack of skills for good jobs due to low education levels.

The study finding showed that the majority, 90% were Enrolled Psychiatric Nurses and 10% were Clinical Officer Psychiatry (COP). There were no Registered Mental Nurses (RMN), Community Mental Health Nurses (CMHN), Doctors, etc. This may have a negative impact on the follow-up care of the mentally ill patients in that these

categories of health workers are more inclined to activities at the Health Centres, such as screening and administering treatment. The Health Centres are so busy that even the mental health workers are too involved in general activities, thereby leaving a gap in the care of the mentally ill patients. Most of the respondents, 50% are working at Out Patient Department, 20% from the T.B. corner, 20% from the ART department and 10% at MCH department. None is operating at a psychiatric unit at the Health Centre. This goes to show therefore, that there is need for more Community Psychiatric Nurses to coordinate psychiatric activities and lobby for mental health services from other stakeholders at Health Centres.

5.3 DISCUSSION OF VARIABLES

5.3.1 SENSITIZATION AND KNOWLEDGE ON MENTAL HEALTH SERVICES BY THE MENTALLY ILL.

The survey revealed that the majority of respondents from the patients showed that they had average knowledge and sensitization on mental health services. About 18% of respondents had poor knowledge and sensitization on mental health services while 82% of respondents indicated that they knew that the community and Health Centres were supposed to offer follow-up services in mental health so as to take services as close to the families as possible. The average knowledge and sensitization may be attributed to the education and communication done by the psychiatric workers at Chainama were they avail information to the mentally ill on mental health services and illness. According to the Chainama Action Plan of 2009 – 2011, one of the roles of psychiatric workers at OPD is to give Information Education Communication (IEC) to clients.

From the findings, it appears that education, age and marital status do not affect the level of knowledge and sensitization about mental health services and awareness in the community. The results showed that 94% of respondents indicated that Community Mental Health Services (CMHS) is sensitizing people on mental health in the community and 88% indicated that these are services offered to improve on individual's mental health status in the community. None of the respondents indicated

not knowing what CMHS are. From the same study, 82% of respondents indicated that they learnt about the CMHS through health workers at Chainama, 46% through friends, 14% through radio and television, 12% through reading books, 24% through Mental Health Users Network of Zambia Association (MHUNZA) and Mental Health Association of Zambia (MHAZ) while none (0%) from the Community Health Workers.

The findings also reviewed that the majority (98%) refused having the CMHS while 2% agreed to having the services in their community. According to analysis of findings, this could be attributed to lack of funds and shortage of health and community workers to organize mental health activities in the communities.

5.3.2 ACCESSBILITY AND UTILIZATION OF MENTAL HEALTH SERVICES

The study reviewed that the majority of psychiatric worker respondents, 100% had seen psychiatric patients the past one year. Though they had seen these patients, about 1 – 5 patients are seen per month compared to 240 patients seen at Chainama per month as follow-ups (Ministry of Health, 2008). Even if they see these patients, the health workers cited the shortage of psychotropic drugs and lack of privacy when seeing psychiatric patients in the Health Centres. The respondents indicated that they had about 60% of Largactil, 20% had Phenobarbitone, none (0%) had Haloperidol, 10% had Artane, 20% had Amitriptline and 20% had no drugs at the time when data was being collected. They also complained of inexistence of psychiatric units at Health Centres and yet Lusaka Urban District Health Management Team (LUDHMT) states that all Health Centres are supposed to offer mental health services. This is shown by the study results were psychiatric health workers in the Health Centres are deployed to General Departments such as OPD and TB corner.

On the other hand, the patient respondents gave a different view. The study reviewed that the majority, 88% had poor accessibility and utilization of mental health services at

health centres. Out of the 50 respondents 92% go to Chainama for reviews / follow-ups, 4% go to UTH but had come to Chainama due to shortage of drugs and another 4% go to Health Centres but had also come to Chainama due to shortage of drugs at the Health Centres.

The study also reviewed that most of the respondents come from the residential areas with Health Centres nearby but they prefer to go to Chainama for reviews because usually there were no drugs at the Health Centres as stated by 81% of respondents. This response agrees with the one by the health workers which indicated that there was a shortage of psychotropic drugs in the Health Centres. According to literature, Ministry of Health (2005) stated that "there is little access to basic psychotropic drugs at all levels, especially at Health Centres and First Referral Levels. The reason being that psychotropic drugs are categorized as specialized, they cannot therefore be prescribed by lower level staff. Therefore, psychotropic drugs are not readily available at most hospitals and Health Centres in Zambia" (MOH, 2005). From the analysis it is evident most patients preferred Chainama because of the availability of the drugs. This means that patients have to travel long distances in search of medication. This is not easy especially where they have to travel by bus and considering that most of the respondents, 60% are unemployed.

Among the respondents who attend reviews at the Health Centre and UTH, the majority, 100% stated that they are treated nicely, kindly and with respect by the psychiatric workers while 25% stated that they are ignored. The majority, 75% mentioned that they are attended to within 30 minutes and 1(one) hour by the health workers. From the analysis it is evident that the patients are treated well at the Health Centres.

According to WHO (2001), it was reported that community based care was cheaper and improves patients quality of life. The researcher agrees with the report because if services were available at the health centre it would be cheaper for the patients to follow –up at the Health Centres and would not have to travel long distances and spend

money on transport. It is also cheaper in that with health facilities within reach, the patient would easily follow-up and reduce on relapses and eventual unnecessary readmissions which are costly to Chainama and the patients. Therefore, where the hospital is far away the patient should be referred to the nearest clinic for follow-ups.

5.3.3 STIGMATIZATION

The findings from the study revealed that the majority, 58% of the respondents experienced moderately high stigma in the community. Most of the respondents 62% indicated that they were neglected by mostly their families who feel they cannot cope with them, 71% labeled them as mad persons, 80% treated with respect while 4% were laughed at. According to Ministry of Health 2005, this can be attributed to the fact that throughout the Zambian society, lack of knowledge about mental illness, traditional and cultural myths on mental illness continue to stigmatize the mentally ill. These misconceptions include the myths that a person who has had a mental illness can never lead a normal life and they are more dangerous. MHAZ, 2009 also adds that the Zambian society is bombarded with images of people who are homicidal madmen or homeless people talking to themselves. It is also seen that the media are responsible for many of the misconceptions which persist about people with mental illness. News papers, in particular, often stress a history of mental illness in the background of people who commit crimes of violence. The television news programmes frequently sensationalise crimes where persons with mental illness are involved. Comedians make fun of people with mental illness, using their mental disability as a source of humor. The media, therefore, does not show the better side of the mental users and problems they go through.

The results also showed that 90% of respondents indicated that their neighbours or community are aware they have a mental problem while 10% indicated their neighbours did not know. From those whose neighbours did not know, 60% feared to be stigmatized while 40% had moved to a new residential area. The results also reviewed that the majority, 100% of respondents wished they could be respected,

supported psychologically and spiritually and also to be addressed by name while the minority 4% asked for assistance with money, and other materials.

5.3.4 TRADITIONAL BELIEFS AND PERCEPTION ON MENTAL ILLNESS

The findings from the study showed that 78% of respondents were not willing to follow traditional beliefs and had good perception on mental illness while 22% may be willing to follow traditional beliefs and had fair perception on mental illness. The study reviewed that the majority, 98% of patient respondents understood the cause of mental illness to be that of inheritance, 96% witchcraft, 86% as due to a curse while 4% indicated sleeping with an uncleansed widow or widower. The mixture of understanding of the causes can be attributed to the culture and tradition the Zambian is brought up in and also the information given by the health providers.

The study also reviewed that the majority, 64% of respondents have never been to the traditional healers while 36% had been to the traditional healers. According to the Ministry of Health 2005, about 70 – 80% of people with mental health problems consulted the traditional health practitioners before seeking help from conventional health practitioners. From the analysis of the findings, the results gave a different view. The high level of respondents not consulting traditional health practitioners could be attributed to the IEC given to patients and relatives about conditions and also by reading about mental illness. These people are able to share the information with the community and advise them to come to Chainama especially when there is a new case. Therefore, there is need for utilization of Health Centres for follow-up care as many more patients are consulting the conventional health practitioners.

The study reviewed that those who saw the traditional healers 33% were told that they were bewitched by relatives, 22% were bewitched by other people, 17% had dead spirits after them and were also possessed with evil spirits which attack them when annoyed while 5% were told that they had slept with the uncleansed widow or widower (table 4.6). The majority of respondents denied improving after treatment and ended up

at Chainama. In terms of the use of traditional medicines in mental illnesses, the majority of respondents, 62% indicated that it was not good and does not work while 6% indicated that it is as good as modern medicines. This can be attributed to the experiences the patients may have gone through and also the information given by the health practitioners. There is therefore need for the health care providers to intensify IEC to patients, the relatives and the community on mental illness / health as the patient is in the ward to improve care of the patients in the community.

5.3.5 ATTITUDE BY HEALTH WORKERS

The study revealed, on the other hand, that the majority of 80% respondents experienced good attitude from the non-psychiatric health workers in Health Centres. 100% of respondents were not treated any differently and none were stigmatized. This could be attributed to the fact that the mental health workers are operating from different non-psychiatric department, hence, they mingle with others.

The study also revealed that the majority, 70% of the respondents are happy looking after the mentally ill patients, 20% find it difficult to deal with them and 10% feel stigmatized working as mental health workers. The respondents with difficulties could be attributed to the fact that only a few patients are seen in a month, hence not practicing much. They are also concentrating on the general work due to inexistence of the psychiatric units. From the study analysis, table 4.8 shows that 50% of respondents are working from OPD, 20% from T.B. corner, 20% from ART department and 10% at MCH department when they are not attending to the psychiatric patients.

The study also revealed that 60% of non-psychiatric health workers get involved in mental health service delivery while 40% do not. About 67% offer curative services, conduct reviews and give IEC together with the psychiatric health workers while 16% conduct home visits. From the 40% who did not get involved, 50% did not have knowledge how to handle cases. This could be attributed to the shallow knowledge acquired during training as general student nurses.

5.4 IMPLICATIONS TO THE HEALTH CARE SYSTEM

The results and finding of the study reflect the primary aim of the study which was to identify Factors Contributing to Underutilization of Mental Health Services in Health Centres within Lusaka Urban. The implications are related to the problem under study, its objectives and hypothesis. The study revealed that 82% had average sensitization and knowledge of mental health services. This includes those with post secondary, secondary, primary and those without any education. This implies that the respondents had average knowledge regarding mental health and disorders.

The study findings show that 88% of the study respondents had poor accessibility and utilization of the mental health services at the Health Centres.

The findings which focused on stigmatization noted that 58% of the study respondents experienced moderately high stigma in the community. Age, marital status and education did not affect the stigmatization experienced by the respondents.

Another study finding focused on the attitude by non-psychiatric health workers towards the psychiatric workers at the Health Centres. This noted that 80% of the study respondents experienced good attitude from the non-psychiatric health workers.

The other interesting aspect of the study findings showed that 78% of the respondents were not willing to follow traditional beliefs and had good perception on mental illness. In summary, despite being stigmatized and having poor accessibility and utilization of mental health services, the respondents had average knowledge and sensitization on mental health services and they were not willing to follow traditional beliefs. They also had good perception of mental disorders.

These findings now have implications on the different aspects of nursing care under education, administration, practice and research.

5.4.1 **PRACTICE**

The Findings of the study showed that 80% of staff respondents had good practice in conjunction with good attitude and utilization of health services at Health Centres. On the other hand, 88% of the patient respondents had poor accessibility and utilization of mental health services due to shortage of drugs. Therefore, the health care systems need to identify best practices for the mentally ill patients to access mental health services. This can be done by the government supplying psychotropic drugs to the Health Centres and putting qualified psychiatric workers who can prescribe the drugs. It is the government's health vision to integrate mental health services into primary health care and cover a full range of services so as to ensure continuity of care and a balance mix of community and in-patient services (MOH, 2005).

The study revealed that among the respondents' practice towards the use of drugs, the commonly used drugs were not stocked at the Health Centres. 81% of respondents indicated that they go to Chainama for reviews or follow-ups due to shortage of drugs at the Health Centres.

5.4.2 **ADMINISTRATION**

The study revealed that the majority of both the patients and staff respondents cited the shortage of drugs at the Health Centres as the major problem. The implication is that many mentally ill patients do not access treatment or go for follow-ups at their nearest local clinics. This implies that the administrators at district level and at policy making level in the health care system should consider improving the levels in the health care system at the community and health centre level by supplying drugs and provide specialised psychiatric health workers. This would improve accessibility to the services as patients would go to the Health Centres as close to their homes as well as reducing on financial constraints on transport to Chainama Hills College Hospital.

There is also need to beef up the Health Centres with specialized psychiatric health care providers such as the Clinical Officer Psychiatrists and Registered Mental Nurses so as

to improve psychiatric services in all clinics in Lusaka Urban and even the country as a whole. This will improve accessibility to psychiatric facilities because the vision of the Ministry of Health of "taking health facilities as close to the family as possible" will be fulfilled.

5.4.3 EDUCATION

The findings of the study showed that 82% of respondents learnt about mental illness through health providers with Chainama as the most cited source. This implies that the educators in the health care system should provide training to the students which will equip them with adequate knowledge and be able to give IEC to the patients, relatives and community.

The study has also revealed that the level of education is low. Most of the respondents have neither been to school or have ended up with primary education. The implication to this is that the health care system should package the IEC materials in a simplified form for easy understanding

The study has also revealed that most of the respondents experienced moderately high stigma. There is need therefore that the community is sensitized about mental disorders to increase awareness and reduce stigmatization. Probably the health care system should consider improving the level of health care at community level so as to educate the community on mental disorders. It is by understanding the conditions that the community will reduce the stigmatization and help out the mentally ill.

5.4.4 RESEARCH

The findings of this study has shown that there are various factors such as shortage of drugs, stigmatization, shortage of Clinical Officer Psychiatry and Registered Mental Nurses who can prescribe the psychotropic drugs, and also inexistence of psychiatric units. The effect of these factors should further be investigated through research. This

implies that the LUDHMT should come up with creative ideas and advocate in this area.

Improved mental health depends on adequate research into the causes of mental health problems and disorders, and the different modes of service delivery (MOH, 2005). Therefore, there should be some funds to increase research and evaluation studies in the mental health area for the development of strategies in mental health delivery.

5.5 RECOMMENDATIONS

1. Lusaka Urban District Health Management Team (LUDHMT) need to be supplying adequate psychotropic drugs to Health Centres in order to improve mental health services at Primary Health Care (PHC) Level.

2. There is need for proper representation of mental health at all levels of health care levels especially at the LUDHMT and National levels to advocate for mental health services at PHC.

3. The Ministry of Health to clearly define the Mental Health Policy on intergration of mental health services into PHC so as to take the services as close to the families as possible.

4. LUDHMT in conjunction with Ministry of Health should be able to send existing mental health workers for refresher courses and be able to prescribe the drugs. They should also plan to employ more psychiatric workers to beef up the shortage in the Health Centres.

5. More Community Mental Health Workers to be trained to improve community care of the mentally ill patients.

6. Chainama Hills Hospital to work in collaboration with the Health Centres to improve mental health at primary level.

7. Further research in mental health should be encouraged so as to help develop new strategies in mental health delivery system.

5.6 DISSEMINATION OF FINDINGS

Dissemination of findings will be done through written report. The researcher will make five (5) copies of the report. The copies of the research will be distributed to the University of Zambia Department of Nursing Sciences, Ministry of Health, LUDHMT, Chainama Hospital and one copy will be kept by the researcher.

5.7 LIMITATION OF THE STUDY

The Study sample was too small due to limited financial resources and time available for the study. Funding was inadequate and could not allow the researcher to conduct a large scale study. As a result of this, generalization of the findings should be made with caution in relation to the general population.

5.8 CONCLUSION

The study aimed at determining factors that contribute to under-utilization of mental health services in Health Centres within Lusaka urban. The researcher undertook this study because of the concern about high rates (92%) of patient follow-ups at Chainama while leaving the Health Centres which are close to their families or homes.

The study findings revealed that there were several factors that contribute to under-utilization of mental health services in Health Centres. These include; shortage of psychotropic drugs, shortage of COPs and RMNs, stigmatization and lack of psychiatric units in Health Centres. These factors were cited by both patients and Psychiatric Health Workers. The findings of the study failed to reject the first and second hypotheses which stated that:

a) -"Inadequate psychotropic drugs influence underutilization of mental health services in Health Centers" as it is indicated by the majority, 81% of respondents.

b) -"Community stigma towards the mentally ill influence underutilization of mental health services at Health Centers" as indicated by the majority, 58% of respondents who experienced moderately high stigma.

On the other hand, the third hypothesis was rejected which stated that, "Inadequate knowledge on availability of mental health services in Health Centres influence underutilization of these services" because the majority, 82% of respondents indicated that they knew that the community and Health Centres were supposed to offer follow-up care services in mental health.

The study also revealed that the majority, 82% of respondents had average knowledge and sensitization on mental health services and also 78% were not willing to follow traditional beliefs but to consult conventional health practitioners. This is good because it poses a challenge to the Policy Makers and administrators at LUDHMT to integrate mental health into primary health care to meet the government's vision of taking health services as close to the family as possible and improve the welfare of the mentally ill patients.

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APPENDIX 1

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF NURSING SCIENCES

A STRUCTURED INTERVIEW QUESTIONNAIRE FOR DATA COLLECTION ON FACTORS CONTRIBUTING TO UNDERUTILISATION OF MENTAL HEALTH SERVICES IN HEALTH CENTRES WITHIN LUSAKA URBAN.

QUESTIONNAIRE NO.....

DATE OF INTERVIEW.....

INSTRUCTIONS TO THE INTERVIEWER

i. Introduce yourself to the respondent

ii. Explain the purpose of the study

iii. Explain the assurance of strict confidentiality. No names or address of respondents will be asked or written.

iv. Ensure respondents are free when answering questions through out the interview.

v. Circle the correct answer or state your responses in the space provided.

vi. Thank each respondent at the end of each interview.

SECTION A

BACKGROUND INFORMATION (DEMOGRAPHIC DATA) **OFFICIAL USE ONLY**

1. Sex of respondent
   a) Female
   b) Male

2. How old are you?
   a) 15 – 24 years
   b) 25 – 34 years
   c) 35 – 44 years
   d) 45 – 54 years
   e) Above 55years.

3. Your marital status.
   a) Single
   b) Married
   c) Divorced
   d) Widowed
   e) Separated

4. What is your educational status?
   a) Primary
   b) Secondary
   c) College
   d) University
   e) None of the above

5. What is your religion?

OFFICIAL USE ONLY

a) United Church of Zambia

b) Roman Catholic Church

c) Baptist Church

d) Seventh Day Adventist

e) Others (specify).....

6. What is your tribe?

a) Luvale

b) Bemba

c) Nyanja

d) Tonga

e) Lozi

f) Others (specify).....

7. Where do you live?

a) Misisi

b) Chawama

c) Matero

d) Mtendere

e) Chelstone

f) Others (specify).....

8. What type of employment are you involved in?

a) Formal

b) Informal

c) Unemployed

SECTION B

SENSITISATION AND KNOWLEDGE OF HEALTH SERVICES

OFFICIAL USE ONLY

9. What do you know about community mental health services?

   (Tick all that is appropriate).

   a) Services offered to improve an individual's mental health status in the community.

   b) When patients are supported by families, churches and friends.

   c) Linking patients to skills training centres in the community

   d) Sensitizing people on mental illness.

   e) Don't know

10. How did you learn about community mental health services?

    a) Through friends

    b) Through health workers

    c) Through community health workers

    d) Through radio and television

    e) Others (specify)

11. Do you have mental health services in your community?

    a) Yes

    b) No

12. If answer to question 11 is yes, what services are there?

    (Tick all the appropriate)

    a) Drug dispensary

    b) Skills training

c) Home visits **OFFICIAL USE**

d) Community sensitization on mental illness

e) Others, (specify) .....

.....

13. Do you utilize these services?

a) Yes

b) No

14. If no, please explain?

.....

.....

.....

15. What recommendations would you make to the government and other stakeholders about improving the community services

a) Community sensitization to be done by health workers

b) Community sensitization to be done by community health workers

c) Community sensitization to be done through radio and television.

d) Others (specify).....

.....

SECTION C

ACCESSBILITY AND UTILISATION OF HEALTH SERVICES

16. Does your nearest health centre offer psychiatric out-patient follow-up services?

a) Yes

b) No

17. If answer to question 15 is yes, how often are these services offered? **OFFICIAL USE**

a) Once per week

b) Twice per week

c) Three times per week

d) All the days of the week.

18. How are you treated by health workers at the Health Centre?

a) Nicely

b) Ignored

c) Kindly

d) Respectfully

e) Others, (specify).....

.....

19. How long does it take before you are attended to by health workers?

a) Less than 30 minutes

b) Between 30 minutes to 1 hour

c) Between 1hour and 1hour 30minutes.

d) Between 1hour 30minutes and 2 hours

e) More than 2hours.

20. Are you happy with the health services offered by the Government clinic?

a) Yes

b) No

21. If no, please explain? **OFFICIAL USE**

.....

.....

.....

22. What recommendations would your make for the Government to make mental health services available at the Health Centres.

.....

.....

.....

SECTION D

STIGMATISATION

23. How long have you had the mental illness?

a) 1 – 5 years

b) 6 – 10 years

c) 11 – 15 years

d) 16 – 20 years

e) Others (specify)

24. Do your neighbours know you have a mental problem?

a) Yes

b) No

25. If no, please explain?

.....

.....

.....

26. If yes to question 24, how do they treat you **OFFICIAL USE**

(Tick all that is applicable)

a) Insulted

b) With respect

c) Labeled as a mad person

d) Laughed at

e) Neglected

f) Others (specify)

27. How would you like the community to treat you?

a) With respect

b) Support me psychologically and spiritually

c) Address me by name

d) Others,(specify).....

.....

SECTION E

TRADITIONAL BELIEFS ON MENTAL ILLNESS.

28. What do your understand are the causes of mental illness?

a) Witchcraft

b) Curse

c) Inherited

d) I don't know

e) Others (specify).....

29. Have you ever been to a traditional healer?

a) Yes

b) No

30. If yes, please explain? **OFFICIAL USE**

.....

.....

.....

31. What services were you given?

(Tick all the appropriate)

a) Given medicines to use when bathing

b) Was admitted

c) Was given medicines to drink

d) Prayed for

e) All the above

f) Others, (specify).....

.....

32. What is your comment on the use of traditional medicine?

.....

.....

.....

.....

THANK YOU FOR TAKING PART IN THE STUDY!

APPENDIX 2

QUESTIONNAIRE (TO BE ANSWERED BY THE HEALTH WORKERS)

UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF NURSING SCIENCES

DATE OF INTERVIEW.....

QUESTIONNAIRE NO.....

NAME OF HEALTH CENTRE.....

INSTRUCTIONS

1. Do not write your name on the questionnaire
2. Answer all the questions
3. Please circle the appropriate answer and comment in the spaces provided.
4. The information given will be treated as confidential.

SECTION A: GENERAL INFORMATION **OFFICIAL USE**

1. How old are you?
   a) 20 – 30 years
   b) 31 – 40 years
   c) 41 – 50 years
   d) Over 51 years

2. What is your rank?
   a) Enrolled psychiatric nurse
   b) Registered mental health nurse
   c) Community mental health nurse
   d) Clinical officer psychiatry
   e) Clinical officer general
   f) Doctor

3. How long have you been working at this health centre?
   a) Less than one year
   b) 1 – 5 years
   c) 5 – 10 years
   d) Over 10 years

SECTION B:
UTILISATION OF HEALTH SERVICES

4. Have you ever looked after the mentally ill patients this year?
   a) Yes
   b) No

5. If yes to question 4, how many patients do you see in a week? **OFFICIAL USE**

   a) Less than 5 patients
   b) 6 – 10 patients
   c) 11 – 15 patients
   d) 16 – 20 patients
   e) More than 20 patients

6. What health services do you offer to these patients?
   (Tick all that is appropriate)

   a) Health education
   b) Reviews
   c) Curative services
   d) Home visits
   e) Referral to rehabilitation community centres
   f) Others specify.....

7. If answer to question 4 is no, please explain?

   .....
   .....
   .....

8. Which Department are you operating from if you do not see the Psychiatric patients?

   .....

9. Are you happy with the services offered to the patients?

   a) Yes
   b) No

10. If no, please explain? **OFFICIAL USE**

.....

.....

.....

11. What psychotropic drugs do you have available?

.....

.....

.....

SECTION C: ATTITUDE OF HEALTH WORKERS

12. How do you feel working as a mental health worker?
    a) Feel happy looking after the mentally ill patients
    b) Find it difficult to deal with them
    c) Just allocated have no choice
    d) Others, (specify).....

    .....

13. How do health workers who haven't done psychiatric training treat you as mental health worker?
    a) Stigmatised
    b) Don't treat me any differently
    c) Isolate me
    d) Do not involve me in their programmes
    e) Others (specify).....

    .....

14. Do the health workers who do not have psychiatric training get involved in mental health service delivery? **OFFICIAL USE**

a) Yes

b) No

15. If answer to question 13 is yes, what activities are they involved in? (Tick all those applicable)

a) Home visits

b) Health education

c) Curative services

d) Reviews

e) None

f) Others specify.....

16. If no, give reasons to your answer.....

.....

.....

.....

.....

17. What recommendations would you make to improve the mental health services in the health centres?

a) Have mental health services in each health centre

b) Train psychiatric nurses and clinical officers

c) Sensitize the community about mental health.

d) Others, (specify).....

.....

THANK YOU FOR TAKING PART IN THE STUDY!

APPENDIX 3

WORK PLAN

TASK TO BE PERFORMED	RESPONSIBLE PERSON	DATES	TIME REQUIRED
Literature Review	Researcher and Supervisor	Continuous	Continuous
Compiling Research Proposal	Researcher	1st June 2009 to 28th August 2009	13 weeks
Clearance	Researcher	1st September 2009 to 18th September 2009	3 weeks
Pilot study	Researcher	5th October 2009 to 7th October 2009	3 days
Data collection	Researcher	12th October 2009 to 6th November 2009	4 weeks
Data analysis	Researcher	9th November 2009 to 4th December 2009	4 weeks
Report writing	Researcher	7th December 2009 to 29th January 2009	8 weeks
Draft report	Researcher	1st February 2009 to 12th February 2009	2 weeks
Finalization of report	Researcher	15th February 2009 to 19th March 2009	5 weeks
Monitoring and evaluation	Researcher and Supervisor	Continuous	Continuous
Dissemination of results	Researcher	22nd March 2009 to ..... April 2009	..... Weeks

APPENDIX 4

RESEARCH BUDGET

BUDGET CATEGORY	UNIT	UNIT COST "K"	QUANTITY	TOTAL "K"
1. STATIONARY				
Duplication paper	Ream	35,000	5	175,000
Pens	Each	1,000	5	7,500
Pencils	Each	500	5	2,500
Note books	Each	2,000	4	8,000
Tip-ex	Box	12,000	2	24,000
Staples	Box	5,000	1	5,000
Stapler	Each	25,000	1	25,000
Scientific calculator	Each	90,000	1	90,000
Folders	Each	5,000	2	10,000
Pencil sharpeners	Each	5,000	2	10,000
Sub-total				357,000
2. SECRETARIAL SERVICES				
Diskettes	Each	10,000	5	50,000
Questionnaire typing	Pages	3,000	10	30,000
Questionnaire				

photocopying	Pages	250	500	125,000
Research report typing	Pages	3,000	100	300,000
Research report photocopying	Pages	300	500	150,000
Typing and binding proposal	Each	450,000	1	450,000
Binding report	Each	130,000	5	650,000
Sub-total				1,755,000
3. PERSONNEL				
Researcher's lunch	Days	50,000	30	1,500,000
Researcher's transport	Days	50,000	30	1,500,000
Sub-total				3,000,000
Others				
Refreshments	Each	20,000	50	1,000,000
Research bag	Each	150,000	1	150,000
Allowances	Each	20,000	20	400,000
Sub-total				1,550,000
Total				6,662,000
Contigency 10%				666,200
Grand total				7,328,200

APPENDIX 5:

BUDGET JUSTIFICATION

1. STATIONARY

The researcher will require stationary for typing the research proposal, writing the final research report as well as typing and printing the report. The notebooks will be needed for record keeping during data collection and analysis. The staples and stapler are needed to put questionnaires together and to maintain their proper arrangement. The researcher will also require a scientific calculator for data analysis.

2. SECRETARIAL SERVICES

The Researcher will need funds to cater for the photocopying and typing services. The diskettes will be required for data storage. Money will also be required for binding the research proposal and report. The researcher bag will be needed for carrying the interview schedules.

3. PERSONNEL

The researcher will need transport money to go to other institutions in search of information and the field test. There will also be need for lunch allowance during data collection period.

4. CONTINGENCY

This is the 10% of the total amount of the budget. It is required to cater for any unseen expenses during the research.

5. DISSEMINATION WORK SHOP

The dissemination workshop will be required to communicate the research.

THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE

DEPARTMENT OF NURSING SCIENCES

Telephone: 252453
Telegrams: **UNZA**, Lusaka
UNALUZA 44370
Fax: +260-1-250753

P.O Box 50110
Lusaka

Date: ..1.....

Dear Sir/Madam,

The bearer _____ is a forth year student at the Department of Nursing Science, School of Medicine, University of Zambia. She/he is pursing a Bachelor of Science in Nursing Degree. She/he is expected to carry out a Research study in partial fulfillment of the requirements of the programme. Her/his research topic is _____

I am requesting your good Office to avail her/him with the information she/he needs for her/his project. For any further clarifications you could contact the undersigned.

Your continued support is highly appreciated.
Thank you.

Dr. Prudencia Mweemba
COURSE CO-ORDINATOR

All Correspondence should be addressed to the
Permanent Secretary
Telephone: +260 211 253040 5
Fax : +260 211 253344

In reply please quote

No

REPUBLIC OF ZAMBIA

MINISTRY OF HEALTH

NDEKE HOUSE
P.O. BOX 30205
LUSAKA

20TH August 2009

The Executive Director
Chainama Hills College Hospital
P.O. Box 30043
LUSAKA

Dear Sir,

REF: AUTRORITY TO CONDUCT RESEARCH; **Ms LUNGU MARY**

The above caption refers.

Ms Lungu is a student at the University of Zambia, School of Medicine in the Department of Nursing Services. She has been referred to the Mental Health Unit for assistance regarding her school project that involves "carrying out a research in Mental Health". We feel that this activity can be best done at your institution.

She will be looking at *factors contributing to underutilization of mental health services in health centers within Lusaka urban.*

Please find attached herewith a copy of the letter from the Course Coordinator.

Your Kind support will be highly appreciated.

Yours faithfully

PASCAL KWAPA
Principal Mental Health Officer

Cc The Director; Public Health and Research
The Chief Mental Health Officer

P.O. Box 50827
Lusaka
Tel: +260 - 211- 235554
Fax: +260 - 211- 236429

In reply please quote
No.....

Republic oF Zambia

MINISTRY OF HEALTH
LUSAKA DISTRICT HEALTH MANAGEMENT TEAM

Date:8th September, 2009

The In-Charge
..... Health Centre
BOX 50827
LUSAKA.

Dear Madam,

RESEARCH: MS MARY LUNGU

Be informed that permission has been granted to the above named student to be attached to your Health Centre for research in Mental Health.

However, this must be done with minimal disruption to the day to day activities at the health centre.

Your usual cooperation will be appreciated.

Yours faithfully,

DR. M. KABASO
CLINICAL CARE EXPERT
FOR/DISTRICT DIRECTOR OF HEALTH

The University of Zambia

School of Medicine

Department of Nursing Sciences

P.O. BOX 50110

LUSAKA

The Executive Director

University Teaching Hospital

P.O. Box

LUSAKA

UFS Head of department

Department of Nursing Sciences

Dear Sir / Madaam,

RE: Request for permission to carry out a pilot study

I am a fourth year old student at the University of Zambia pursuing a Bachelor of Science in Nursing. In partial fulfillment of the programme, I'm required to carry out a research project. The title of my research project is "A study to determine factors contributing to underutilization of mental health services in health centres within Lusaka urban.

The purpose of this letter is to kindly request your office to allow me carry out a pilot study from your institution at clinic 6 –psychiatric clinic.

I'll be very grateful if my request will be considered and your earliest response to this letter will also be highly appreciated.

Yours faithfully,

Mary Lungu

The University of Zambia

School of Medicine

Department of Nursing Sciences

P.O. BOX 50110

LUSAKA

The Executive Director

Chainama Hills Hospital

P.O. Box 30043

LUSAKA

UFS Head of department

Department of Nursing Sciences

Dear Sir / Madaam,

RE: Request for permission to carry out a research study

I am a fourth year old student at the University of Zambia pursuing a Bachelor of Science in Nursing. In partial fulfillment of the programme, I'm required to carry out a research project. The title of my research project is "A study to determine factors contributing to underutilization of mental health services in health centres within Lusaka urban.

The purpose of this letter is to kindly request your office to allow me collect data from your institution.

I'll be very grateful if my request will be considered and your earliest response to this letter will also be highly appreciated.

Yours faithfully,

Mary Lungu