# Barriers to the Utilisation of Mental Health Services in Zambia

A dissertation submitted in partial fulfilment
of the requirements for the degree of
Master of Public Health- *Health Policy and Management*

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## DECLARATION

I **MARGARATE NZALA MUNAKAMPE** declare that this research document being presented for the Degree of Masters of Public Health (Health Policy and Management) has not been previously submitted either wholly or in part for other Degree at this or any other University nor is it being currently submitted for any other Degree.

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Margarate Nzala Munakampe (Candidate)

**APPROVAL**

This dissertation of Margarate Nzala Munakampe is approved as fulfilling the requirement for the award of the Degree of Masters of Public Health (Health Policy and Management) by the University of Zambia.

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**TABLE OF CONTENTS**

**Chapter Six- Conclusion and Recommendations**



**Annexes**

## LIST OF TABLES

## LIST OF FIGURES

## ACRONYMS

**DSM** Diagnostic and Statistical Manual for Mental Disorders

**HCPs** Health Care Providers

**HIV** Human Immunodeficiency Virus

**MHaPP** Mental Health and Poverty Project

**MHUNZA** Mental Health Users Network of Zambia

**NCCM** National Collaborating Centre for Mental

**PHC** Primary Health Care

**SES** Socio-economic Status

**UNZABREC** University of Zambia Biomedical Research Ethics Committee

**UNZASoM** University of Zambia School of Medicine

**WHO** World Health Organisation

## EXECUTIVE SUMMARY

Globally, mental health is recognised as an important component of health. However, it is one of the most neglected areas in the health sector. Poor mental health has been linked to low socio-economic status. With many Zambians living in poverty, susceptibility to these conditions is high. While Lusaka has better mental health services than any other province, under-utilisation has been reported. The situation can only be much worse in other provinces and rural areas with limited access to services at primary level. The aim of this study was to explore the barriers to the utilisation of mental health services in Zambia at policy, facility and individual level.

A concurrent triangulation study was done in 2015; comprising a household survey of 270 participants from Chilenje Township in Lusaka and a qualitative case study of 12 participants including health workers, patients' family members and policy makers. The case study was conducted in 2 secondary health facilities, a tertiary mental health facility and the Ministry of Health. Data was collected using questionnaires and interview guides. Proportions and logistic regression were used to analyse survey data while thematic analysis was used to analyse qualitative data.

Inadequate financing to mental health services was observed as the main barrier to utilisation of services across the different levels investigated. Late detection of mental health conditions was attributed to little knowledge and low awareness about conditions, sometimes leading to relapse. Those knowledgeable about mental health conditions were over 3 times more likely to utilise services than those who were not (OR 3.1 95% CI, p=0.006). Knowledge could have led to utilisation or vice versa. Stigma from the community and health care providers and visits to traditional healers were also reported. There was a strong association between utilisation of services and stigma from health care personnel (OR 13.6 95% CI $p< 0.001$). A weak referral system was reported as well as lack of services at primary level. This was attributed to few health workers trained in managing mental health conditions despite undergoing basic training. The existing referral system and low levels of awareness in the community were also linked to overcrowding in secondary facilities.

Overall, mental health services are hindered by inadequate financing, stigma and low prioritisation at facility level. As such, there is lack of services at primary level creating a pattern of utilisation that begins at secondary level. There is need to improve financing for mental health as well as strengthen efforts to educate the community about mental health and mental health conditions. Also, the stipulated referral system needs to be reinforced so as to strengthen service provision at primary level. Most health care providers have basic knowledge that allows them to do so.

**Key words:** *mental health services, barriers, health service utilisation, utilization, Zambia, community stigma, health care provider stigma*

# CHAPTER ONE- BACKGROUND

## 1.0 Introduction

The World Health Organisation (WHO) (2005) describes mental health as a state "of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community". Mental health "consists of the ability to live happily, productively without being a nuisance; the capability of personal growth and development. It is the emotional resilience which enables us to enjoy life and survive pain, disappointment and sadness" (Cattan and Tilford, 2006:11) . One who has good mental health is tolerant of others, is a realist about life as well as his own abilities and they consider the needs of others (Simenda, 2013).

According to Kapata et al., (2010) mental illness refers to a situation where the mind is not well to the extent that the mental processes and behaviour of the affected person are not in synchronisation with what their society perceives as normal or acceptable. The diagnosis is done by a mental health practitioner using accepted diagnostic criteria. The common and current diagnostic tools globally are the Diagnostic and Statistical Manual for Mental Disorders V, (DSMV) and the International Classification of Disease, 10 (ICD 10) (APA, 2014, WHO, 1992). The ICD 10 classifies mental and behavioral disorders into 11 broad categories; Organic, including symptomatic, mental disorders mental and behavioural disorders due to psychoactive substance use, schizophrenia, schizotypal and delusional disorders, mood [affective] disorders, Neurotic, stress-related and somatoform disorders, behavioural syndromes associated with physiological disturbances and physical factors, disorders of adult personality and behaviour, mental retardation, disorders of psychological development, behavioural and emotional disorders with onset usually occurring in childhood and adolescence and other unspecified mental disorders (ICD 10).

The potential causes of ill mental health include poverty, poor family relationships such as unending wrangles, infections such as malaria, meningitis, syphilis and HIV; use and abuse and dependence on alcohol and other psychotropic substances (Kapata et. al., 2010, Anakwenze, 2013). Mental health should therefore, be the concern of everyone and not limited to individuals who suffer from mental disorders.

## 1.2 Prevalence

Globally, mental disorders are responsible for about 1 percent of deaths but account for about 14 percent of the burden of disease and is leading cause of disability (Jack-Ide, 2012). Projections for this disease burden are set to increase to about 15 percent by 2020 and depression will produce the second largest disease burden across all age groups (NAMI, 2014). The impact of mental illness on other diseases is underestimated (Burns, 2011) and can lead to death if not addressed, especially when co-morbid with other diseases such as heart disease (Kolappa et al., 2013, NAMI, 2014).
In Zambia, the prevalence of mental disorders is high at roughly 20 percent (Simenda, 2013) and about 3 percent for severe mental disorders and the rest for mild to moderate disorders (Mwape, 2010). Majority of the men **(**68 percent) have mental disorders owed to alcohol and substance abuse while others also have HIV/AIDS and this can be attributed to the vulnerability associated with mental illness (Simenda, 2013). Some of the common mental disorders reported in Zambia that require hospital care include major psychotic illnesses like schizophrenia, mania, affective (mood) disorders like bipolar disorder, alcohol and substance abuse related psychosis; temporary psychosis; and depression (Kapata et al., 2010).

There is a need for adequate mental health care delivery that meets the disease burden in the country. A health care delivery system is an organised system of services, equipment, personnel and facilities through which individuals, families or communities receive health services, including diagnosis, treatment and preventive measures and patient education for the purpose of promoting, maintaining and restoring health (Modeste, 2004).

In the Zambian health system, issues of mental health are guided by the Mental Health Policy of 2005 (Bird et al., 2010). According to Kapata et al., (2010) , the Mental Health Policy's vision is a society in which the government creates an environment advantageous to utilisation of mental health services. Early detection of mental illness requires more investment in awareness strategies and spending on mental health at all levels, especially the primary health care level (Abdelgadir, 2012, Johannessen et al., 2001).

There is a relationship between socio-economic status, SES and mental illness (Anakwenze and Zuberi, 2013), that is, poverty increases susceptibility (Mkhize, 2008, Tello et al., 2005), hence the creation of effective interventions that address mental health could also help reduce poverty and

social problems. The costs of poor mental health, both direct and indirect keep people in a cycle of poverty and mental disorder (Patel and Kleinman, 2003). Therefore, poverty can be a cause as well as an effect of mental health problems. In Zambia, poverty is over 60 percent prevalent (Chigunta and Mwanza, 2016), and this leaves the residents very susceptible to mental illnesses and disorders (Mwape, 2010). Mental health services are very important and it is therefore, important to look into them so that they can be improved (Bird et al., 2010). A significant portion of individuals with severe and persistent mental illnesses live in the rural areas (Bjorklund and Pippard, 1999). Mental disorders also leave many people without access to social determinants of health (Battams, 2010).

## 1.3 Barrier to Utilisation of Mental Health Services

Around the world, various barriers to the utilisation of mental health services have been found. The barriers have been summarized as supply side barriers, demand side barriers and structural barriers. They will be discussed at three levels; individual level, facility level and policy level.

### *1.3.1 Individual level Barriers*

Studies have shown that stigma from friends, family and society, as well as from the medical personnel is the greatest challenge at individual level (Stefl and Prosperi, 1985, Corrigan, 2004, Abdelgadir, 2012, Shim and Rust, 2013, Tsai et al., 2014). Owens et al. (2002) discovered that the United States of America lacked a policy that looked into the mental health of spouses and families of mental health care clients as they are also mentally affected by their relatives. Support structures are therefore, needed for both the users and their families (Wong et al., 2006).

Limited awareness about mental illness is a barrier to utilisation too as poor knowledge prevents early diagnosis of disorders (OAS, 2006, Saraceno et al., 2007, Kung, 2004). Studies in Sudan and the Niger Delta recognise the dependence on traditional healers in giving care to clients because some communities relate mental disorders to evil spirits. In Sudan, some patients are only admitted when they turn violent, or after the 'Sheikhs' or traditional healers fail to "treat" them (Woodward et al., 1992, Owens et al., 2002, Abdelgadir, 2012).

Anakwenze and Zuberi (2013), found that poverty affects mental health status. Social economic status can also be affected by the cost of mental illness (Saunders, 2007). For this reason it would be wise to engage in increasing mental health services and improving health facilities because

Zambia is over 60 percent poor (Abdelgadir, 2012, Jack-Ide and Uys, 2013). However, Bird et al. (2010) revealed that most developing countries have continued low priority and deficient information on mental health as it is overshadowed by other 'more pressing' programs such as Anti-Retroviral Treatment or malaria prevention (Raviola et al., 2011).

### *1.3.2 Policy level barriers*

In Zambia, the Mental Health Disorders Act is ancient and still under re-construction (Kapata et al., 2010). However, a mental health policy was developed in 2005 to address the needs of mental health service provision in the country (MoH, 2005). This policy has met the requirements of the WHO, but not the needs of the people as it was done without consultation from stakeholders such as users of the mental health care services (Mwanza et al., 2008).

A study by the MHaPP (2008) revealed that South Africa's Mental Health Care Act was passed in 2002. It showed a response to the human rights needs of the people and vital stakeholders were consulted in the development of this law. Services were moved from provincial to district level (Mkhize, 2008). It also promotes voluntary treatment as well as informed consent. However, Implementation of this law is however faced by challenges such as funding across all the districts and provinces consistently (MHaPP, 2008). Abdelgadir (2012), showed that Sudan faces legislation challenges too. Health insurance is one of the policies embarked on and increased coverage would improve patients' ability to get the treatment. However, health insurance does not cover all drug items and so the drugs are still not adequate. Due to poor funding at policy level, healthcare is expensive for the patients (Lea, 2014).

In Zambia, a policy brief was suggested to policy makers by Mwape (2010) involving integration of mental health services into primary health care. The first plan was incremental; starting with a pilot project of introducing services and then later expanding the project. The second plan was comprehensive; implementing services in all provinces at the same time. This would make the scaling up process of the services quick and effective enough. There is need to see how this has worked so far.

### *1.3.3 Facility level barriers*

A major area that prevents mental health care is the state of the facilities (Saraceno et al., 2007). Worldwide, 30 percent of countries do not have a budget for mental health at all (Chisholm et al.,

2007) and in Uganda, the national spending on mental health is not more than 1 percent of the total budget allocated for health (Abdelgadir, 2012). Most mental health facilities face drug shortages, few staff and overcrowding (Sherbourne et al., 2001 , Mwape, 2010, Kapata et al., 2010, Abdelgadir, 2012). Abdelgadir (2012), revealed that that the working staff in mental health facilities in Khartoum state lack recognition and financial support in order to improve their performance.

The Mental Health and Poverty Project survey (2008) reports that patients with mental disorders are sent to a tertiary level hospital without being screened. They refer cases to larger institutions when they could be handled them at the lower levels, causing a referral as well as overcrowding challenge at tertiary level. Most of the existing staff is not interested in mental illness cases (Yankauer, 1987), or could be interested in mental health but are underpaid (Mwape, 2010). According to Eaton et al. (2008), services are mostly provided by primary care physicians, rather than specialty mental health professionals. This can be attributed to the lack of mental health service personnel (Kauye, 2008).

In Zambia, there are psychiatric units within seven general hospitals across the country with Chainama Hills Hospital in Lusaka being the only third level mental health hospital in the country (Mwape et al., 2010). There are about 2667 patients per 100,000 people admitted to these psychiatric units (Mwape et al., 2010). These figures already show lack of capacity. There is also a problem with how data is captured at district level as the information is captured as psychosis and neurosis (Mwape, 2010); in accordance with the outdated DSM-II to DSM-III R (Kasschau, 1995). These have been replaced with more specific categories such as anxiety-based disorders, somatoform disorders, mood disorders, dissociative disorders and schizophrenia. This causes lack of reporting, under-reporting and misdiagnosis (Mwape, 2010).

However, Zambia now has three new psychiatrists, owed to the Master of Medicine in Psychiatry which was only introduced in 2010 at the University of Zambia. Prior to this, there were only three practicing psychiatrists in the country (Simenda, 2013). In light of this, there was need to find out the barriers to mental health policy implementation. The attack at the barriers at individual and facility levels are so that the burden of mental health problems can be reduced.

# CHAPTER TWO- THE MENTAL SERVICES STUDY

## 2.1 Statement of the Problem

Individuals with mental health disorders cannot easily be noticed and it often takes severe cases or aggressive behaviour for medical attention to be sought and usually by family members (Abdelgadir, 2012). Poor mental health can lead to or worsen other health conditions, or vice versa. Health care providers revealed that 40 percent of mental distress cases are due to HIV infection (Chipimo et al., 2011). According to the National Collaborating Centre for Mental Health (NCCMH) (2011), studies in the United Kingdom revealed an 80 percent increased risk in disease development and ultimately mortality when coronary heart disease and depressive disorders are both present. Therefore, mental illness, especially co-morbid with other diseases is very serious (Kolappa et al., 2013).

Globally, over 70 percent of individuals with mental disorders do not receive treatment from health care workers. Factors increasing the chances of avoiding treatment or delaying health care include lack of knowledge to identify features of mental illnesses, and ignorance about how to access treatment (Henderson et al., 2013). In Zambia, services are concentrated at the tertiary level and at primary health care level, they inadequate or lacking due to factors such as human resource constraints (Mwape, 2010). Only 15 percent of people at risk of developing mental disorders are covered and these mostly are students and prisoners among others (Banda, 2012). Even among the covered, a majority of them face significant challenges. For example, a study at an urban health center in Lusaka showed that over 80 percent of people face problems of poor accessibility and under-utilisation (Lungu (2015).

Mental health problems are highly likely to increase, considering the extent of poverty and unemployment, and many Zambians are at risk (Mwape, 2010). Programs that improve education, financial inclusion and improvement in mental health services could reduce the risk of mental disorders (Patel and Kleinman, 2003) but these programs are lacking too (Todaro and Smith, 2006, Lammermann, 2013). Therefore, there is need to explore the barriers to the utilisation of mental health care in Zambia so that sufficient response is given to mental health care needs of the country; so as to maximise the provision of already lacking services.

## 2.2 Justification

Poor mental health can affect how an individual thinks, feels and also their ability to communicate effectively with others (Simenda, 2013). Mental health is an area that is neglected (Raviola et al., 2011). It is not seen as a threat to human life or well-being and it does not have the same attention as other communicable and non-communicable diseases.

Therefore, this study highlighted the gaps in mental health care utilisation, as an important entry point to the implementation of the Mental Health Policy. However, of concern is the fact that Zambia still uses the Mental Health Act of 1951 (Mwape, 2010). Efforts to change this legislation are still in progress. The first DSM was published in 1952 while the fifth version was produced in 2013 (APA, 2014). Clearly, there is need for Zambia's legislation to be updated too. This study also shed some more light on policy and legislation issues with regard to mental health. The findings can be useful in addressing the barriers at individual and facility level too. There is limited information with regard to mental health, as such, this study has also added to knowledge in the area of mental health care in the country

## 2.3 Research Question

What are the barriers to the utilisation of mental health care services in Zambia?

## 2.4 Objectives

*General*

To explore the barriers to the utilisation of mental health care services in Zambia.

*Specific*

1. To identify the barriers which inhibit clients' access to mental health care- demand side barriers.
2. To find out the factors that affect health facilities's capacity to provide adequate mental health care services.
3. To document the challenges of implementing the Mental Health Policy.

## 2.5 Conceptual Framework

There are several factors that affect mental health care. These have been summarised into three categories; at the demand side (individual level), at the supply side (facility level) and at the structural side (policy level). At the individual level, many people who have mental illnesses face stigma, lack of knowledge about mental disorders, interference by traditional healers, financial constraints and poverty due to cost of care. There are also inadequate support structures.

At facility level, the hospitals or health units meant to handle mental health conditions are not only dilapidated but are too small to cater for all the clients. The human resources are also challenged as there are few trained psychiatrists. At policy level, there are inadequate budgetary allocations, perennial drug shortages and poor referrals.

The policy is inadequate to handle the mental health challenges in the country. The legislation is also being revised though it has taken quite some years to conclude. Insufficient focus by the government trickles down to even the individual level as interventions such as awareness about mental health are lacking in the community. The figure below shows the different barriers to utilisation in form of a diagram.

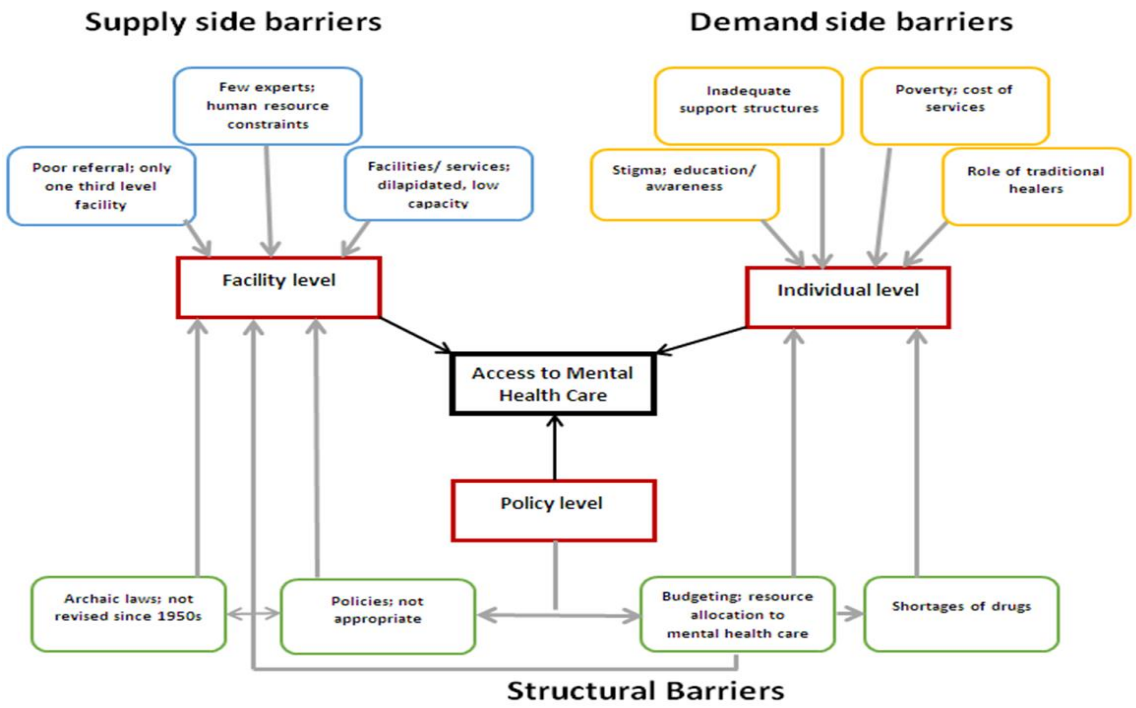


Figure 1: Conceptual framework presenting barriers to mental health care. It was designed based on information in literature on barriers to the utilisation of mental health services

# CHAPTER THREE- METHODOLOGY

## 3.1 Study Design

The research question was put at the centre and the best combination of methods was used to answer it (Creswell, 2009)., therefore, a Concurrent Triangulation study design was used. This was done by carrying out a cross-sectional survey and a qualitative case study at the same time. The survey addressed the barriers at individual level in the community which could not be captured by the qualitative case study. The qualitative case study addressed the barriers to utilisation that could be captured in a facility-based investigation. Each of these designs are now discussed in detail in the narration that follow

## 3.2 Qualitative Component- Case Study

### *3.2.1 Study setting, population and sampling*

The study was carried out at Chainama Hills Hospital in Lusaka, Ndola Central Hospital, Kabwe Central Hospital University Teaching Hospital-Clinic Six and Ministry of Health Headquarters in Lusaka. The study population included people with; experience with utilising mental health care and specialised information in the sector. No mental health users were sampled for ethical reasons, their family members were targeted instead. Since this was a facility based survey, all the eligible participants who were not be in the study sites during research were excluded.

The sample was purposively selected, comprising five (5) health workers, five (5) family members of care users; from each of the three institutions and two (2) key informants from Chainama Hills Hospital and from the Ministry of Health, Mental Health Unit. The health workers included nurses, clinical officers and doctors who treated and managed mental health conditions at the health facilities

### *3.2.2 Data collection, entry, management and analysis*

Primary data was collected from the respondents through the use of in-depth as well as key-informant interviews. The interviews were steered by an interview guide, and some recorded too. Field notes were also be taken. The data were collected over a period of about 2 months. At the health facilities, the health care providers were identified through the guidance of the officers in charge of the units. The key informants were identified through the facility's administration. This

was based on their experience in the mental health sector. The informed consent process was adhered to before each interview was done, so all participants took part in the interviews willingly and without coercion. The digitally recorded responses were transcribed verbatim and read. The field notes (some interviews were not recorded because participants did not consent to being recorded) were read too. The data were managed and analysed using NVIVO, version 10.

*Themes*

Thematic analysis was used as it was appropriate for analysing participants' responses and insights. The key themes were developed from a predetermined code structure, adopted from the literature review (see Figure 1: Conceptual Framework). These themes were used to create the structural themes, as well as some of the analytical themes. The data were then placed according to the themes, while also creating new emerging analytical themes. Even though the initial code list was predetermined, there was continued revision and addition of new codes due to the dynamic nature of the information that was collected. The coded data were then triangulated with the field notes and other less formal discussions and impressions.

### 3.3 The Household Survey

*3.3.1 Study setting, population, sampling and description of variables*

The study was undertaken in Chilenje Township. Chilenje was selected purposively. Chilenje is located in Lusaka and houses people with different SESs. It has a total population of 52,220 people, 24,367 men and 27,853 women; and a total of 10,330 households (CSO, 2010). All members of the household above the age of 18 years were included, those who refused to take part and those who are not residents of the households were excluded. Heads of the households or oldest household member were preferred if they were present at the time of the study. All the participants who were not feeling well will not take part in the study.

The sample size was determined by the formula below.

$$n = \frac{(z)^2\ p\ (1-p)}{\varepsilon^2}$$

where, n = sample size
z = standard normal deviate; 1.96 at 95 percent confidence
p = prevalence of mental disorders (20 percent, 0.2)
$\varepsilon$ = confidence error (0.05)

The sample is estimated at 246. Adjusting for non-response at 10 percent, the sample increases to 270 households. Households were selected using a systematic random sampling method. Chilenje

has 10,330 households (CSO Data). This total number of households in Chilenje was used as a sampling frame. Nine research assistants collected data from Chilenje town ship. With a sample of 270 participants, each of the research assistants had 30 questionnaires to administer. This allowed for good quality data to be collected as they did not have a very large workload. The first household was randomly sampled and subsequently every 38$^{th}$ household was picked (10, 330 households divided by 270 participants gave a sampling interval of 38). The list of households was used as there is no complete list of all the households in Chilenje town ship. Only one participant per household participated in the study. Houses with no response or without eligible candidates were excluded. All interviews were done privately as only the interviewer and the interviewee were present during the interview. The interviews were short so this allowed for the participant to be given privacy during the interview.

*Variables*

Measurement of Variables

| | Variable | Indicator | Type | Measurement |
|---|---|---|---|---|
| **Dependent** | Utilisation | Full<br>No utilisation | Binary | Accessed a service<br>Did not access |
| **Independent** | Knowledge | Name disease, cause & facility | Binary | Can name all three<br>Cannot name all three |
| | Stigma; | Stigma<br>No stigma | Binary | No fear of peoples' negative attitude.<br>Fails to access due to negative attitude. |
| | Traditional healers; | Yes<br>No | Binary | Visiting traditional. healer due to mental illness<br>No visit to traditional healer due to mental illness |
| | Support structures; | Type of support structure | Categorical | Church, Family, NGOs,<br>Other. |
| | Age | Years | Categorical | 18-34<br>35-40<br>40+ |
| | Gender | Male or female | Binary | Male<br>Female |
| | Education; | Non<br>Primary<br>Secondary<br>Tertiary | Categorical | Not educated<br>Semi educated (primary education)<br>Moderately educated (secondary education)<br>Very educated ( tertiary education) |

Table 1: Measurement of Variables

Definition of Variables

| Variable | Conceptual | Operational |
|---|---|---|
| **Utilisation** | Making use of something, turn into account or use efficiently (Fowler et al., 2011). | Access to any of these services; consultation, diagnosis, referral and treatment |
| **SES** | A person's status: relating to or concerning the interaction of social and economic factors (Fowler et al., 2011). | Income level used to determine affordability of mental health care. It will be determined by level of education and number of meals per day. |
| **Knowledge** | The sum of what is known about a particular subject (Fowler et al., 2011). | Knowledge of mental disorders; naming a disease, cause and treatment facility |
| **Stigma** | Denoting a person as having morally spoiled identity, having a social undesirability (Stafford and Scott, 1986). | Negative attitude towards people with mental disorders |
| **Traditional Healer** | One skilled in therapy derived from tradition (Dictionary, 1989) | Spiritual healers |
| **Support structures** | Complex institutions and organisations that provide a solace under afflictive circumstances (Dictionary, 1989) | Formal bodies that provide support to people with mental disorders |

Table 2: Definition of Variables

*3.3.2 Data collection, entry, management and analysis*

The study used a pre-tested semi-structured questionnaire to collect data. Interviews were conducted at household level. The interviewer saw to it that information was collected appropriately before completion of the interview. The researcher also went through all the interview scripts (questionnaires) before data entry. The data was checked for accuracy and consistency. It was then cleaned, coded and analysed using statistical software called STATA, version 13. Proportions were used to summarise the data. Logistic regression was used to test associations between the variables because utilisation is a binary outcome.

| Independent Variables | Dependent Variable | Analysis |
|---|---|---|
| **Categorical/ Binary** | **Binary** | |
| | Utilisation (Binary) | |
| Age (categorical) | | Proportion/ Logistic regression |
| Gender (binary) | | Proportion/ Logistic regression |
| Highest educational attainment (categorical) | | Proportion/ Logistic regression |
| Knowledge (binary) | | Proportion/ Logistic regression |
| Stigma-Community (binary) | | Proportion/ Logistic regression |
| Stigma-HCPs (binary) | | Proportion/ Logistic regression |
| Traditional healers (binary) | | Proportion/ Logistic regression |
| **All** | | **Logistic regression** |

Table 3: Data Analysis Plan

The respondents were asked a series of questions including whether they had ever utilised mental health services or not or if any household member utilised mental health services. They were also asked if they or a household member experienced stigma in the community, or by health care providers or if they visited a traditional healer due to mental health condition. Questions asking about an individual's experience or a household member's experience were combined to create new variables that represented the entire household. If a respondent said they experienced stigma for example, and also said a household member experienced stigma too, this was recorded once as data for the entire household.

The variable utilisation at individual level and utilisation at household level were combined to create a new variable representing utilisation at household level. The same was done for the stigma variables and traditional healer consultation variables. Knowledge (about mental health conditions) was also a variable of interest, but was asked once. It was assumed that knowledge of one household member held as knowledge for the entire household as it would have an impact on the outcome, utilisation.

### 3.4 Data Integration

After data from the quantitative and the qualitative components were collected, checked for accuracy and analysed separately, the results were then integrated at the discussion stage as a way to triangulate the findings from one component with the other.

### 3.5 Ethical Issues

Ethical approval was be sought from University of Zambia Biomedical Research Ethics Committee, UNZABREC. In conducting research some ethical issues expected could arise are; discomfort during interviews, psychological harm, stress, unwillingness to continue with the study, and refusal to be recorded even after agreeing to be interviewed.

In trying to address these issues, no patients of mental illness or disorders were interviewed during the study. Consent was sought from the participants and they were also given sufficient information for them to make the decision whether to participate in the research or not. They were not coerced or induced into taking part in the research and their personal information (which can identify the participants) was not revealed. The participants were not given any monetary reimbursement or incentives for taking part. All data were be kept confidential and were not given to anyone who is

not part of the research**.** This was done by limiting the access to the information to the Principle Investigator only.

Where a language barrier arose, the participants were encouraged to express themselves in the language of choice. The questionnaires and interview guides were not translated; however, all the research assistants were picked based on their ability to translate into the major local languages as they conduct the interviews. The questionnaires were pretested so as to make sure the content was not lost in translation. Where the participant refused to be recorded, their responses were written down instead. Participants who are not feeling well in the households did not take part in the study. The interviews were conducted in an environment which was secure and confidential enough for the participant. There was privacy at all times. This was not a problem as the interviews were not long. The privacy also enabled the interviewee to be free from stigma associated to mental illness. The study targeted all household members and not just those with mental health conditions. Finally, this study is beneficial in that it offers insights that can be used for the improvement of the utilisation of and access to mental health care in Zambia.

*Permissions*

Permission to carry out the research in the public health facilities was sought from the office of the Permanent Secretary, at the Ministry of Health. Permissions were sought at each of the provincial health offices in the 3 provinces; Lusaka, Kabwe and Ndola offices. Further, permission to conduct the study in the three institutions was sought from the offices of the medical superintendents, and subsequent heads of department.

# CHAPTER FOUR- RESULTS

## 4.1 Qualitative Case Study

### *4.1.1 Description of Participants.*

| Number | Location | Gender | Type | Facility |
|---|---|---|---|---|
| MH001 | Kabwe | Female | Family Member | Kabwe General Hospital |
| MH002 | Kabwe | Female | Family Member | Kabwe General Hospital |
| MH003 | Kabwe | Male | Nurse (Clinical Officer) | Kabwe General Hospital |
| MH004 | Lusaka | Female | Family Member | Chainama Hills Hospital |
| MH005 | Lusaka | Male | Policy Maker | Ministry of Health |
| MH006 | Ndola | Male | Nurse (Clinical Officer) | Ndola Central Hospital |
| MH007 | Ndola | Female | Nurse | Ndola Central Hospital |
| MH008 | Ndola | Male | Family Member | Ndola Central Hospital |
| MH009 | Lusaka | Female | Family Member | Chainama Hills Hospital |
| MH0010 | Lusaka | Male | Nurse (Doctor) | University Teaching Hospital |
| MH0011 | Lusaka | Male | Policy Maker | Chainama Hills Hospital |
| MH0012 | Lusaka | Female | Nurse | Chainama Hills Hospital |

Table 4: Description of Participants for Case Study (Facility Based Interviews)

### *4.1.2 Policy Level Barriers*

a) Outdated Laws

Information collected from respondents at policy level revealed various barriers to effective services relating to the treatment of people with mental health problems as well as implementing the mental health policy. They brought out the absence of a working legal framework to guide and reinforce mental health policies in Zambia. Therefore, mental health conditions were mismanaged by other people not qualified to do so such as the police. The existing procedures were drawn from the outdated law that was being enforced. The gap in legal backing in mental health practice in the country was attributed in part to the lack of will from government to repeal the old law. At the time of data collecting, the process was reported to have been under revision. There was hope that the new law would allow for policies to be responsive to current mental health practice rather than being based on 1949 experiences and thinking.

> *"The reading of the bill in parliament in order to enact the new laws that is the will of the government. So we expect that before, by the coming quarter next year (2016), we might have a new law in mental health that will bring in better innovation in mental health." No.11, Policy maker (Lusaka)*

b) Budget constraints and inadequate allocations

Financial constraints also emerged as a barrier to effective mental health practice as well as implementation of the mental health policy in Zambia. Respondents agreed that the reason why mental health services were lacking in Zambia was inadequate budgetary allocation. The budgetary constraints were the main reason why health activities such as Community Mental Health, and other outreach programs, where mental health personnel went into the community to give mental health education and other services. They could not be carried out because they were not budgeted for.

> *"We have in the past trained some Mental Health Assistants but these have been based here at the facility. But if the same people in the community were able to be trained and then share the knowledge with the rest of the community, I think that would be very useful…if there was an increase in the budget for mental health then there would be an improvement". No.01, Nurse (Kabwe)*

The plans (policies) were there but the finances were inadequate to achieve them. There was a need for more personnel to be trained at the different levels of health care so that awareness, education prevention and intervention programmes were reported as ways to reach the targeted clients in the community as these were the items/activities specified in the policies. Although in places such as Lusaka and Ndola Mental Health Assistants reach health programmes in communities, insufficient funding was reported to make it impossible to achieve the envisaged effectively. However, there was hope that interventions were likely to help mitigate these challenges.

> *"…definitely the funding isn't sufficient. It goes with what the WHO says, that it's below 1%, as many other African countries. The budgetary allocation isn't enough and it usually has a sealing. Last year it was about K300, 000. What can you do with that for national mental health service?"… "We have a program to do with mental health and HIV. We are now trying to convince people in child health, maternal health to see if we can do a program on child and maternal mental health, it would help improve the health status of maternal mental health. The solution is basically riding on other services". No. 5, Policy Maker (Lusaka)*

c) Drugs and Drug Shortages

Drugs administered in mental health care were reportedly very expensive. However, the drugs were reported to be usually available for clients, especially for the Lusaka based clients. While the ideal situation was explained, the medical personnel also pointed out that there were cases where they were forced to prescribe some drugs which the clients needed, but were not available at the hospital due to shortages. Sometimes the psychotropic drugs would be available but the medication to

counter the side effects were not always there. It was also stated that most of the clients came from poor communities, and this impacted negatively on patient care because they could not always manage to purchase the drugs. This has contributed to failure to handle the patients especially when they had violent outbursts.

> *"…some of the drugs are not available and so we have to tell the relatives to go and buy for them. There are about 5 types of Anti- psychotics but the anti-side effect drugs are not available. Even though we give the patients the prescriptions, the medicines are quite expensive". No. 7, Nurse (Ndola)*

Another barrier that was reported to be associated with drugs and drug shortages is the fact that some patients took medications unnecessarily and were misdiagnosed. This altered the pathway of treatment, and it was blamed on the fact that there was a serious lack of specialised mental health personnel in the country. In addition, some of the drugs could not be ordered at the facilities because they were not part of the PHC package kits. This was seen as a cause of so many referrals from lower level institutions. The policy stressed bringing these services as close to the people as possible but this was not possible because it had not been effected at the lower levels of service provision.

> *"So many times patients take medicines unnecessarily and many times they are wrongly diagnosed and the pathway of treatment is altered and changed from what it would have been if they had seen a professional". No. 10, Nurse (Lusaka)*

### *4.1.3 Facility Level Barriers*

a) Dilapidated Facilities

Infrastructure that was being used for mental health services was reported to be both dilapidated and inappropriate. The buildings were dilapidated in that they were set up many years ago but had not been reinforced. The Ndola unit was in a better state. The state in which these facilities were in had a bearing on how the family members also perceived the institutions where they brought their patients. Further, these facilities were seen as inappropriate because they lacked innovation that is meant for patients of mental health conditions.

> *"A patient who comes to seek treatment should feel like they are in a paradise. So if the institution is looking dirty, it is not therapeutic for them. The environment hinders progress. Some relatives deny services for their sick because of how the environment is looking". No. 3, Nurse (Kabwe)*

A low capacity at the facilities to meet the number of patients that were seen was also reported. Some nurses mentioned that there was need to separate the acute cases from the rehabilitation cases

as attending to all of them led to congestion in the facilities. The capacity of the units to see a lot of patients was thought to be limited. The bed spaces were simply not enough to meet the volume of patients who needed mental health services.

> *"And then there is also the thing of too much congestions sometimes. There are only 18 bed spaces in this ward but sometimes we can even have about 60 patients…" No. 6, Nurse (Ndola)*

b) Few experts or Human Resources

Generally, there was a shortage of manpower to meet the burden of mental health conditions in the country. This was attributed to a number of reasons. Most of the human resources who decided to take the mental health route usually got disinterested because they did not have a lot of opportunities to develop their career path. Thus, mental health services lost manpower because of lack of motivation and training opportunities. Some human resources went to these facilities as mental health experts but because of the nature of the referral system that had been established, they lacked opportunities to practice or see patients, they ended up diverting to other areas. One key informant had this to say;

> *"There is no motivation to work despite having knowledge and skill. There are no drugs so we can't treat the patient. There are no support staff like psychologists or social workers to come in. using the multi-disciplinary approach. There should be all these people so that a patient is treated holistically. Demotivation is too much, despite having the knowledge… within PHC there is also the secondary level where someone is already sick, there should be a lot of manpower, social worker, psychiatrist a psychologist, so that a patient can be treated holistically instead of just providing medication and allowing then to go". No.3, Nurse (Kabwe)*

The family members of patients acknowledged that the health care providers were trained well because they were able to attend to them when they went to these facilities. However, they were not sufficient to handle all their demands because they were too few. Training of Mental Health Assistants helped alleviate the problem of insufficient human resources at Chainama and Ndola central. Conversely, the continuity of this innovation suffered at the hands on insufficient budgetary allocation to mental health in the country. These were key in helping to prevent the occurrence or re-occurrence of mental health conditions in the community through sensitisation and awareness programmes

*"…this exercise (training of Mental Health Assistants) of course requires funds. And so if there was an increase in the budget for mental health then there would be an improvement". No. 6, Nurse (Ndola)*

c) Poor Referral System

Ideally, the structure was that the clinics or health centres were supported by the zonal health centres that were supported by the district hospitals which were in turn supported by the provincial hospitals. Where the cases were complicated, the service was then sought or the patients were referred to the specialist hospitals. However, this was reported to not to be the case when it came to mental health services because clients went directly to the provincial hospitals; to the mental health annexes or to Chainama Hills Hospital when the cases were more complicated. This was a serious breach of the system and thus led to overcrowding the specialist hospital. This referral was also reported to have a financial bearing on the patients and their families as transportation and living costs were solely theirs to bear. This compromised the quality of care in mental health services.

*"We receive very few referrals. People come straight to the hospital. Once they get detention orders they come here and "dump" their patients here…" No. 7, Nurse (Ndola)*

*4.1.4 Individual Level Barriers*

a) Education or Awareness (Knowledge about mental health conditions)

Knowledge about mental health conditions was reported as being the missing link in mental health care. All the family members acknowledged that prior to having a patient within their household, they had little or no knowledge about mental health conditions. Facing the condition was what made them more aware and knowledgeable. They also alluded to the fact that if they had known more about the conditions, it would have made the whole experience of taking care of their family members much easier.

The fact that the services were centralised however, is one reason why the family care givers sought medical attention directly from the provincial centres. The most knowledge that people had about these mental health conditions was where to go if they felt a family member fell sick. When a participant was asked if she knew about mental health conditions before the illness in the family, she has this to say;

*"No. I only knew after she was sick. I just used to look at people who are sick. I didn't have any thoughts regarding mental health problems. I just worried about feeding my family and seeing*

*to it that their needs were met. Because I am single. I didn't know anything about these diseases…" No. 1, Family Member (Kabwe)*

b) Poverty

Some nurses said mental health conditions were reported to affect the poor more than the well to do. The treatment of the patients was costly although most of the medication was provided at the health facilities. However, the cost of the illness was seen as a challenge for most of the family members of patients. The cost of illness refers to the extra costs that these family members incurred due to having a patient within the household. The fact that the services were at the provincial hospitals meant that family members had to travel from all areas of the province to access these services. Furthermore, they had to take care of their patients, while living in a shelter. Instead of working, they were held up at these annexes because they needed to care for the patients. The health care providers mentioned that patients who did not have support from family had challenges getting well. The costs were not only beyond financial means, but emotional as well.

*"…financially, it's been a challenge in that before he got sick we would both work, he had a job and I also sold some stuff, but right now, everything has stopped. Both of us are here. Now there is hunger in the home…Even the children suffer. I have one child at the moment and care became very difficult, so I just sent them to my relatives because I am at the hospital…the work has stopped because he is sick and I am here looking after him. It is very difficult…" No. 2, Family Member (Kabwe)*

c) Stigma

Stigma was captured at three levels. Self-stigma, stigma from family members and the community in which the patient lived and stigma from the health care providers. Self-stigma came about when the patient was aware that they are sick and they began to lose hope in the medication and care from family.

*"Also self-stigma from the clients themselves it becomes very difficult for someone to recover because of certain beliefs they come with from the community". No. 6, Nurse (Ndola)*

Another type of stigma came from the health care providers. This was not always present in the way they treated patients but from how many human resources ended up being mental health specialists there are at different levels of care, including Primary Health Care.

> *"The clinics do not attend to the patients because they feel lazy to take care of the patients. So whenever they see a mental condition, they just refer them here (facility)…the clinics refer them here because they take it for granted that here we have wards and bed spaces for treating these conditions, even though the conditions are not that bad".*

Both the family care givers and the health care providers themselves took pride in how the patients were treated. The family members of clients mentioned how the care was good, despite them being overwhelmed due to manpower shortages. The health care providers mentioned that their training was sufficient to not stigmatise patients but to treat them well. However, this treatment was at the provincial hospitals or Chainama. The lower level facilities did not even attend to the patients.

> *"The clinics do not attend to the patients because they feel lazy to take care of the patients. So whenever they see a mental condition, they just refer them here. Sometimes I send these back, because the clinics can handle some of the cases. Sometimes the patients are brought here in cuffs but they are not even violent. It just takes a little more understanding." No. 7, Nurse (Ndola)*

After making reference to self-stigma and health care provider stigma, there was also stigma from the community around the patient and the patient's family. The family of the patient was usually the first source of support for a household that had been stricken with mental illness. However, their patience also slowly ran out. Some patients were even left or "dumped" at the hospitals because of stigma. Even when the patient was discharged the family was not there to take them home. Some relatives even went as far as being irritated or angry with the health care providers for taking the patients back home to them.

> *"There is little support from family and so I am left alone to look after my husband. Support is there the nurses and the doctors because they treat him. Relatives have left us. They got tired early they were many at the beginning but they have fallen off one by one. Because this disease is difficult". No. 2, Family Member (Kabwe)*

The community was reported to also stigmatise patients with mental health conditions and this caused challenges with regard to adherence to medication and the well-being of the patient. Even when the family took care of the patient, they could not really protect them from the ridicule and judgment from their neighbours and friends. Finding out the community's stigma was also reported to lead to self-stigma as the patient was made aware of their condition.

> *"There is stigma in the community. Because they see you here at ward 12 and they even know that my husband is mad. Even when we are discharged when we reach the community. They are very mean, they call him "lishilu" her husband is a mad man. We may also try to hide from him, to hide the fact that he was here, like when he asks me what brought him here I say its high blood pressure. Because of fearing that the truth could cause a relapse. So people in the community are the ones that tell him what was wrong, that he had a mental illness. So he sometimes feels too embarrassed to even come back here for medication" No. 2, Family Member (Kabwe)*

Sometimes clients or families were stigmatised because mental illness was seen as a result of being involved in supernatural dealings that have backfired. The stigma was also noted to be propagated mainly by lack of knowledge about mental health conditions. Because the community members were not aware about the causes and how the conditions were treated as well as how patients should be cared for, they tended to have a negative attitude towards the patients. This judgment was founded in mostly myths and misconceptions about mental health conditions. Some misconceptions noted were that mental illness could be spread through bites from patients and that mental illness is sexually transmitted. Ultimately, this affected treatment of the mental health conditions because patients were not willing to continue treatment in the midst of stigma from the community. Community members were also seen to propagate relapse as they remind the patient that they had a mental health condition.

d) Traditional Healer and Support Structures (Church)

While the family members saw this as the first solution due to the "supernatural" nature of mental health conditions, the medical personnel complained that consultation of traditional healers usually interfered with the treatment pathway of a patient. Mental health conditions are chronic conditions; they always need to be watched and managed. Because of this, most families also ran out of patience when looking after their patients. This caused them to seek alternative treatments. These alternative treatment options affected the compliance to medication and care.

> *"A Zambian may be a Christian, but always has traditional healer at the back of the mind. When one thing doesn't work we go for the next alternative." No. 9, Family Member (Lusaka)*

Both the health care providers and the family care givers alluded to the fact that the traditional healers and other support structures such as the church are often consulted before, during and after the onset of mental health conditions. Most of the family members went to the traditional healers or

went for prayers first before going to the hospital. Some family care givers also reported that the church was a source of comfort because of the emotional strain that mental illness brought on them.

> *"Some people opt to see traditional healers instead of coming to the hospital. And only after they have failed do they come to the hospital. And by that time you find that the patient has even started to deteriorate. The brain becomes damaged so bad that even if you treat them, it can't even lead to the maximum level of functioning they were at before getting sick…" No. 3, Nurse (Kabwe)*

Health care providers said the family members usually decided to go to the hospital when the persons' health had really deteriorated and the other consultants failed to treat them. Mental health conditions usually end up being treated by traditional healers because it is associated with spiritual illness by many family care givers. However, the health care providers opted to encourage dual treatment or consultations. They did not focus so much on stopping the clients from seeing traditional and spiritual healers but rather that they needed to ensure that patients also went to the hospital for medical healing. So far, this helped to mitigate the delays or derailments that took place due to seeing the traditional or spiritual healers only.

> *"…over 80 per cent of the times we are able to convince them, they may continue seeing the traditional healers but they also take our medicines… The only conflict comes when the traditional healer says they cannot take our medications, and that's when the patients relapse…" No. 10, Nurse (Lusaka)*

*4.1.5 Other Barriers*

a) Management

The management of mental health services was also outlined as a barrier to the provision of mental health services in Zambia. Due to the existing legal framework, many patients of mental conditions were reported to be usually dragged to the institutions against their will with the help of the policemen through court orders, and ended up being rough and violent to the patients at times. Some patients were antagonistic towards receiving any medication due to such treatment.

> *"It is government policy for the police to come in, because the way he was he was scaring people so they cannot lock him up…until he stabilises and until the doctor says now he is okay… But even with a court order, the police should treat him well, because he isn't a criminal, it is an illness. You just talk to the person nicely" No. 4, Family Member (Lusaka)*

Many health care providers felt that even if they aired their views, nothing would change because

there had been very little significant change in the area of mental health. They felt as if their words would fall on deaf ears, despite saying where they felt change should start from. The main issue that these institutions faced was lack of money to carry out activities or to fully enable them to provide these services. Without much change in budgetary allocation, there was not much change that can be expected.

> *"I can blame this on management, because to do these, we need money and transport… I feel, there are no key people who can make decisions and implement them… If you have no voice, being heard is difficult, you just continue working the way you work. Your voice has no impact so you just do things within your circles of influence" No. 3, Nurse (Kabwe)*

On the policymaker's side however, it was reported that much had been done for mental health services despite the need for more work. Even when there were seemingly small changes taking place, such as community mental health and new psychiatrists, it was reported to be a result of much lobbying and negotiating at the policy level.

b) Lack of patient care and relapse

Lack of patient care and relapse were mentioned as other barriers to utilisation of mental health services. Some health care providers were of the view that if more care was given to the patients both at the facility and when they are discharged, they would have had less relapse cases. The health care providers mentioned that family members treated the hospital as a dumping ground for them to leave and forget about their family members. It was reported that sometimes the medication is too strong and they may not have sufficient food to help cope with the drugs. They also mentioned that when the patients were treated and went back to their homes, there was no awareness and they ended up getting involved in the activities that got them sick in the first place, especially for the substance abuse related conditions.

> *"…drug abuse in our community has now reached epidemic proportions in Zambia; alcohol, cannabis, cocaine, heroin, blue and other drugs, they are being widely used. And you see that these patients are the ones who occupy most beds at Chainama they come in they get a detox and they go out. And in a few months they are again back in the same lots in the same beds utilising services at the cost of others who will benefit more from utilising the same services. So it's a typical pattern that keeps happening. So all that can only stop by awareness" No. 10, Nurse (Lusaka)*

*Common disorders and common patients and gender related issues*

Some of the most common disorders were alcohol related illnesses, schizophrenia organic brain syndromes, brief psychotic disorder, alcohol and drug related mental disorders, substance-abuse induced psychosis and mania, epilepsy with psychiatric presentation, organic brain syndromes such as delirium, dementia and depression.

> *"Amongst males it is substance abuse, especially cannabis and alcohol abuse and opiates. This is the most prevalent…Amongst females, mood disorders are the most common, especially depression and then others could be anxiety disorders, phobias and last would be psychosis" No. 10, Nurse (Lusaka)*

All of the institutions mentioned that most men were institutionalised due to alcohol and drug-related mental disorders while most of the women suffered from depression. HIV-related mood disorders and HIV-related psychosis were also reported to be common in the female wards. While some reported that these came about due to secrecy about HIV status from partners, other owed these disorders to the gender inequality that women face.

> *"…females are more prone to being depressed because of several factors, could be the hormonal issues that the female does through…it can also be because of gender inequality which is highly prevalent in some parts of Zambia…" No. 10, Nurse (Lusaka)*

Also gender-related, another issue that was reported was the fact that when a man was sick, most of the activities came to a halt in the home because the wife devoted her time to looking after him. The work came to a standstill and there was no economic activity in the home. On the contrary when a woman was sick, she was sent to a sister or mother who looked after her. When the male was affected, there was more chance of the family ending up in poverty.

> *"Relatives have left us. They get tired early they were many at the beginning but they have fallen off one by one. Because this disease is difficult. When the husband goes mad, the one who suffers is the wife because now everything is on me." No. 2, Family Member (Kabwe)*

### *4.1.6 Suggestions for increasing awareness and improving utilisation of mental health services*

Community Mental Health was seen as a solution in helping to increase awareness about mental health conditions. This was a solution to increasing sensitisation as well as human resources for mental health called Mental Health Assistants. The Mental Health Assistants, after training, went to

the community to sensitise people and educate them about mental health and how it could be preserved. They increased the knowledge levels thereby equipping the community with information. This resulted in early diagnosis and prevention of mental health conditions because people were more aware of the mental health conditions, their risk factors, their causes and their symptoms. They could also be more prepared to take care of family members who were sick, reducing the numbers of relapse cases.

> *"Both the nurses and the community assistants would go in the field and sensitise people on the predisposing factors as well as the precipitating factors. It is also useful in educating the family members about the importance of supporting their patients. And to remind them that they are the key in making them get well as soon as possible. They are the key in preventing relapse" No. 3 Nurse (Kabwe)*

Another suggestion made to help to increase awareness was through media. It was mentioned that media sometimes propagated negativity associated with mental health disorders, in the music as well as films. However, other participants felt that media was a good way to increase awareness about mental health conditions. Campaigns would also be very useful in increasing awareness.

> *"There are so many radio stations now, the TV stations, newspapers… such things are good, that's why people lock up their family members with conditions in the homes, the disabled too and the HIV positive. AIDS is even better now because people have information. There should be funding for increasing awareness". No. 4, Family Member (Lusaka)*

One informant from the University Teaching Hospital mentioned that they had in the past worked with the clergy or chaplains in basic psychotherapy so they could be able to attend patients who were chronically ill or those who need any help. This could be adopted as a solution in trying to respond to the need for mental health services in the country; through training of other professionals such as the clergy and the police in basic psychotherapy.

> *"…we started training chaplains, we worked with the church organisations and these chaplains really go to hospitals and they sit with patients who are chronically ill or those who they think they need their help, so we trained them in applying these tool and forms our clinic as the resource center where they can be referred to. So where they found someone high on the scale, they would be referred to the clinic. So the next step would be to train them in doing a short psychotherapy so most cases they could handle there and there without referral". No 10, Nurse (Lusaka)*

Finally, the other suggestion or reinforcement is the integration of mental health services into primary health care. This was seen as a challenge at facility level because of the lack of human and financial resources. It was reported that most of the health care providers at primary level do did practice mental health care, and that became a challenge when they were faced with mental health conditions at primary health care level. The cases were consequently referred to the provincial hospitals.

This was viewed as a solution but that full integration could only take place if and when all the medications were accessible and all or most of the personnel were available at primary level. Increase in the number of trained personnel would be very beneficial

> **"***…that is the only way out; that is the pattern followed world over. Wherever mental health has improved or facilities have improved, care for the patients involved, they have gone ahead and integrated mental health into Primary Health Care…" No. 10, Nurse (Lusaka)*

In a realistic sense, the integration of mental health services could only be achieved if referral of less complicated cases that could be handled at the primary level facility was stopped. Training in mental health was already incorporated in most of the basic training of the health care providers at these facilities. But the practice part was lacking because of the pattern of utilisation that has emerged, where they refer all the mental health cases to the provincial annexes; thereby taking mental health services further away from the community

A need for more management of mental health conditions at the primary institutions was reported. This would increase the capacity of the facility to handle the cases. It would also increase the level of expertise and confidence of the health care providers at the primary facilities. Referral to the provincial hospitals was supposed to only take place when the condition was too complicated for them to manage.

### 4.2 Household Survey

A household survey was successfully conducted in Chilenje Township with a 100% response rate. Table 5 shows characteristics of the study participants.

| Characteristics of study participants related to utilisation of mental health services (n=270) | | | | | |
|---|---|---|---|---|---|
| **Characteristic** | | **% of total sample n (%)** | **% who utilised** | **Univariate Odds Ratio (95% CI)** | **Adjusted Odds Ratio (95% CI)** |
| **Age** | 18 – 29 | 138 (51) | 13.00 | 1 | 1 |
| | 30 – 40 | 77 (29) | 14.30 | 1.1 (0.4, 2.5) | 1.1 (0.4, 3.3) |
| | 41 + | 55 (20) | 21.80 | 1.9 (0.8. 4.1) | 1.1 (0.6, 5.2) |
| **Gender** | Female | 133 (49) | 14.20 | 1 | 1 |
| | Male | 137 (51) | 16.10 | 1.1 (0.6,2.2) | 1.8 (0.7, 4.5) |
| **Education** | Primary | 44 (16) | 18.20 | 1 | 1 |
| | Secondary | 84 (31) | 14.30 | 0.8 (0.3, 2.0) | 0.8 (0.0, 3.4) |
| | Tertiary | 142 (53) | 14.80 | 0.8 (0.3, 1.9) | 0.9 (0.2, 4.1) |
| **Income (K)** | < 1,000 | 80 (30) | 15.70 | 1 | 1 |
| | 1,000 - 3,000 | 47 (17) | 16.00 | 1.0 (0.4, 2.5) | 0.8 (0.2, 3.0) |
| | 3,000 - 5,000 | 43 (16) | 17.30 | 1.1 (0.5, 2.7) | 0.9 (0.2, 3.3) |
| | 5,000 - 10,000 | 52 (19) | 5.40 | 0.3 (0.08, 1.1) | 0.3 (0.07, 1.8) |
| | > 10,000 | 7 (2.6) | 41.70 | **3.8 (1.1, 13.6)** | 5.0 (0.8, 29.8) |
| **Knowledge** | Yes | 99 (37) | 24.20 | **2.9 (1.5, 5.7)** | **3.3 (1.4, 8.1)** |
| | No | 171 (63) | 9.90 | 1 | 1 |
| **Stigma (Community)** | Yes | 27 (10) | 55.60 | **10.4 (4.4, 24.7)** | 2.5 (0.6, 9.5) |
| | No | 243 (90) | 10.70 | 1 | 1 |
| **Stigma (HCPs)** | Yes | 25 (9.2) | 72 | **24.8 (9.4, 65.7)** | **14.4 (3.4, 60.7)** |
| | No | 245 (94) | 9.40 | 1 | 1 |
| **Traditional Healers** | Yes | 39 (14) | 41.00 | **5.7 (2.7,12.3)** | 2.6 (0.9, 7.5) |
| | No | 231 (86) | 10.80 | 1 | 1 |

Table 5: Characteristics of study participants in relation to utilisation of mental health services (statistically significant odds ratios are bold)

Overall, there was 15% utilisation of mental health services (49 out of 270). Table 5 shows that most of the participants were aged between 18 and 34 years old. Utilisation was slightly higher among men than women. Utilisation was also higher the more educated an individual was. About 37% of the people in the sample were knowledgeable about mental health conditions. Most of the

people, 44%, reported that they would turn to the church for support when faced with a mental health condition in the household (15% utilised), while those who said they would consult family members utilised mental health services more (22% utilised).

A bivariate analysis was carried out relating utilisation to age, gender, highest educational attainment, income level, knowledge, stigma from the community, stigma from the health care providers and if a traditional healer was consulted due to a mental health condition. (Table 5). Males were more likely to utilise mental health services than women and the odds of utilisation for the people aged 40 and above were higher compared to those aged between 18 and 34. However, these results were not statistically significant.

The results also suggested that the odds of utilisation of mental health services for those who were knowledgeable about mental health conditions are 2.9 times (95% CI: 1.5, 5.7 p 0.002) those of people who were not knowledgeable. There were also higher odds of utilisation for those who experienced both types of stigma. These associations were both significant. The analysis revealed significant relationships but regarding causality, stigma could have led to utilisation of services or utilisation led to stigma from the community or from HCPs.

Similarly, those who utilised the mental health services could have been knowledgeable due to utilisation or they could have utilised the services because they were knowledgeable about them. The participants who visited the traditional healer compared to those who did not had higher odds of utilisation too (95% CI: 2.7, 12.3 $p< 0.0001$).

A multivariate analysis of the all the variables was done (Figure 5). This revealed that the odds of utilisation of mental health conditions and services, for participants who were knowledgeable about mental health conditions are 3.3 times (95% CI: 2.7, 12.3) more likely to utilise mental health services compared to the participants who were not knowledgeable. Similarly, the odds of utilisation for people who experienced stigma and those who visited a traditional healer were still higher compared to those who did not. However, the odds of utilisation for those who experienced stigma from the community were not significant.

Further analysis was done to see which background characteristic were drivers to stigma and knowledge about mental health conditions. Table 6 and 7 below show these findings.

| **Bivariate and multivariate analysis of health care provider stigma** | | | |
|---|---|---|---|
| **Characteristic** | | **Bivariate Analysis OR (95% CI)** | **Adjusted OR (95% CI)** |
| **Age** | 18 – 29<br>30 – 40<br>41 + | 1<br>1.05 (0.39, 2.79)<br>1.28 (0.46, 3.62) | 1<br>0.89 (0.32, 2.43)<br>1.24 (0.43, 3.61) |
| **Education** | Primary<br>Secondary<br>Tertiary | 1<br>0.95 (0.33, 2.78)<br>0.37 (0.12, 1.16) | 1<br>0.85 ( 0.28, 2.56)<br>0.37 (0.12, 1.17) |
| **Sex** | Female<br>Male | 1<br>**0.34 (0.13, 0.85)** | 1<br>**0.36 (0.14, 0.90)** |

Table 6: Background characteristics and their relationship to Stigma from Healthcare providers

Both the bivariate and multivariate analysis showed that males were less likely to experience stigma from the health care providers compared to females (OR 0.36 95% CI 0.14, 0.9). These result revealed that women faced more stigma from healthcare providers than men

| **Bivariate and multivariate analysis of knowledge** | | | |
|---|---|---|---|
| **Characteristic** | | **Bivariate Analysis OR (95% CI)** | **Adjusted OR (95% CI)** |
| **Age** | 18 – 29<br>30 – 40<br>41 + | 1<br>1.05 (0.59, 1.87)<br>0.73 (0.38, 1.44) | 1<br>1.33 (0.71, 2.49)<br>0.72 (0.36, 1.48) |
| **Education** | Primary<br>Secondary<br>Tertiary | 1<br>0.74 (0.3, 1.82)<br>**3.7 (1.69, 8.05)** | 1<br>0.75 (0.30, 1.86)<br>**3.91 (1.76, 8.66)** |
| **Sex** | Female<br>Male | 1<br>1.19 (0.7, 1.9) | 1<br>1.07 (0.63, 1.83) |

Table 7: Background characteristics and their relationship to Knowledge

Regarding knowledge, both the bivariate analysis and the multivariate analysis also revealed that the participants who had attained tertiary education were over 3 times more likely to be knowledgeable about mental health conditions compared to the one with primary education (OR 3.9 95% CI 1.7, 8.7). This could mean knowledge about mental health conditions was driven by ones level of education.

# CHAPTER FIVE- DISCUSSION

## *5.1 Discussion*

Some of the barriers encountered at policy level in literature were indeed in tandem with the data sought in this study. These emerged as the main reasons why there were problems implementing the policies in the mental health sector. Budgetary allocation to mental health in the country was lacking and was the main reason why there were challenges in implementing the mental health policy. This had been a source of most of the challenges for the sector. This situation was not different from the other countries such as Ghana, Niger and Sudan, as they had a similar budgetary allocations of less than 1% (Chisholm et al., 2007, Abdelgadir, 2012, Lea, 2014).

The mental health policy was in existence, and part of its implementation was seen by efforts to integrate mental healthcare into the Primary Health Care package as was suggested by Mwape (2010). However, in reality, this had not been done as there were no mental health services at district level and lower. These services were only available at provincial and national level. As Kapata et al. (2010) reported, the Mental Health Act was under revision but was almost being concluded. The policy makers also reported that there was room to include mental health insurance, under the Social Health Insurance plan. This was the solution taken in Sudan to try and improve access to mental health care and medication (Abdelgadir, 2012).

At the facility level, the budget was also the main reason attributed to the inappropriate and dilapidated infrastructure of the mental health units. Most of the human resources who were trained to treat mental health conditions diverted to other fields and so the human resources were insufficient. This was similar to what Abdelgadir (2012) found in Sudan. In addition, the lack of mental health care at the district level going lower means that those human resources did not have the opportunities to practice their skills. This was why they diverted into other fields such as HIV care.

There were no specialised personnel at district levels or lower and even at the provincial hospitals, there were few or no psychiatrists available. This was similar to what Kauye (2008) found in Malawi. The concentration of services at the provincial and the national levels had led to over-crowding at the facilities as they were not meant to treat patients in those numbers. This was in line with what Mwape (2010) also found. Even temporary cases such as those caused by alcohol and

drug abuse, that could be handled at the primary care; level were referred to the provincial annexes and this causes overloading in the wards. This was the same as what was found by the (MHaPP, 2008) In South Africa, there were efforts to take these services from the provincial level to the district level too, in order to take the services closer to the people and these proved successful (Mkhize, 2008).

Stigma still remained a great barrier to the utilisation of mental health services. The family member at the facilities visited as well as the health care providers in the case study acknowledged how stigma was a challenge for the patient. Ridicule from the community and from health care providers caused problems in care for the patients. The family members interviewed in the case study suggested that they were treated well by the nurses and clinical officers at the facilities. However, this was not the same result in the survey as there was overwhelming evidence that most of the people who utilised mental health services experienced stigma from health care providers (OR 13, $P<0.001$, 95% CI). Stigma from the community was also higher among those who utilised the services compared to those who did not utilise though these findings were not statistically significant. These results were in line with the findings of Stefl and Prosperi (1985), Corrigan (2004), Abdelgadir (2012), Shim and Rust (2013) Jack-Ide and Uys (2013) and Tsai et al. (2014).

Men were less likely to experience health care provider stigma compared to females (OR 0.36, 95% CI 0.14, 0.90) and this finding was from the quantitative part of the study. However, the case study did not reveal any particular link between health care provider stigma and gender. A study in the United States of America revealed that men were more likely to experience stigma associated with mental health conditions. However, there was less stigma associated with conditions that were already known to be gender specific (Boysen and Logan, 2016).

Also at individual level, the inadequate budget and the limited implementation of the policy led to a pattern of utilisation where people have to travel long distances to the provincial mental health annexes to access mental health services. There were costs associated with such movements and these had a financial bearing on some of the families stricken with mental illness, despite services being offered for free. Budget shortages also led to some of the medication not being available at the facilities and so people had to purchase them for themselves to improve the care of the patients. These finding were in line with Jack-Ide and Uys (2013).

Lack of knowledge still held as a reason why early diagnosis is delayed as was found by (Kung, 2004, OAS, 2006, Saraceno et al., 2007). The survey revealed that people who are knowledgeable about mental health conditions were 3 times more likely to utilise mental health services (95% CI: 2.7, 12.3). The family care givers at the different facilities in the case study further showed that most of the people did not know much about mental health illness before being faced with these conditions. This suggests that knowledge levels among those who have utilised will be more.

Knowledge was also higher among those who had had attained a tertiary education compared to those with primary education (OR 3.91, 95% CI 1.76, 8.66) in the survey. There was an indication that knowledge and awareness about mental health conditions would be much lower in places where education status was low. A study by Patel and Kleinman (2003) revealed that there was an association between low levels of education and the risk of developing mental health conditions. Other studies indicated the need for health literacy in order to improve health status and reduce the burden of disease (Cho et al., 2008). In the case study however, the need for mental health assistants in the community to conduct mental health awareness was mentioned as necessary to increase knowledge and awareness and reduce relapse and improve mental health management.

Utilisation was also higher among those who had consulted a traditional healer due to mental illness compared to those who had not. This also suggested that traditional healers played an important role when one was suspected of having a mental health condition or when the modern medicine had failed. This was suggested by health care providers as well as family members at the facilities visited. The health care providers also admitted that many patients are only brought to them after the family had seen that the traditional healing was not improving the illness. This was in line with what Abdelgadir (2012) found in Sudan. The health care providers at the University Teaching Hospital encouraged families to seek both western and traditional healer's consultation to avoid any breaks in the pathways of treatment or to avoid late diagnosis.

Most of the people who were interviewed mentioned that they would go to the church for support in the face of a mental health condition. However, very few of these had utilised mental health services. The people who chose family for support utilised mental health services more than the others, suggesting that family was the most sought after support structure. This could have been due to lack of such support at national level, as in the case in the United States of America (Owens et

al., 2002), as well as due to stigma associated with mental illness (Stefl and Prosperi, 1985) (Corrigan, 2004).

The families of mentally ill patients mentioned that there were emotional as well as financial costs associated with management mental health conditions. They mentioned that taking care of their patients meant that their daily activities to earn a living were hampered. As such, poverty slowly entered their lives. This is in line with what (Saunders, 2007) found when he concluded that mental health conditions can affect socio-economic status.

*5.2 Strengths and limitations of the study*

The study collected both qualitative and quantitative data and was done in an effort to triangulate this information to yield more valid results. However, the qualitative component was carried out in selected locations hence transferability was limited as these locations may have been representative of limited social contexts in the country. Three provinces were selected in an attempt to increase transferability of findings. Since this information was acquired in government institutions, the private institutions may have had some insights that may not have been captured.

The quantitative part of the study was carried out in one township, Chilenje, which has people with similar characteristics and which was conveniently sampled. Hence, generalisability of the findings was limited. However, the right sampling and statistical analysis was done in order increase internal validity. More studies can be done in order to find out more information about the associations between utilisation of mental health services and stigma, traditional healer consultation and other factors or barriers.

In Kabwe, the nurses were the initial target group selected for the study because they have the most contact with the patients. However, their non-willingness to take part in this research led to including the Clinical Officers at Kabwe General Hospital into the study. This ended up being beneficial to the study as the interviews brought in more insights to the study. In Ndola, the family members were the ones not willing to take part in the study and so only one of the two family members of patients were included into the study. In Lusaka, the nurses were also not very willing to take part in the study so only one instead of two nurses were interviewed. These complications in the field reduced the sample size for the qualitative component. In response to these challenges, University Teaching Hospital- Clinic Six was therefore included into the study as a source of more information. Insights from this institution were also useful.

# CHAPTER SIX- CONCLUSION AND RECOMMENDATIONS

## *6.1 Conclusion*

The barriers to mental health service utilisation were mostly linked to inadequate budgetary allocation to the mental health sector. Consequently, many activities meant improve utilisation of mental health services are not undertaken. Stigma from the health care providers, community and from family members themselves has also hindered utilisation of services. Lack of prioritisation of mental health services in primary and some secondary health facilities, as well lack of or little knowledge about mental health conditions have fueled this stigma further.

Despite being a neglected area, good mental health is for everyone and therefore and these barriers must be addressed. In light of the exploration carried out, this study has generated information that could be useful in addressing the barriers at the three levels; policy, facility and individual. It is also useful in the implementation of the mental health policy as sources of these barriers have been exposed. Some recommendations can be suggested to this effect;

## *6.2 Recommendations*

### *Policy*

Some policy recommendations can be made in order to improve mental health services. Firstly, funding has been the greatest loophole in the provision of mental health services, therefore concentrating on linking mental health care with other conditions or programs such as maternal health or child health could be beneficial. This would increase funding to the sector, thereby increasing the awareness activities in the community as well as the number of health care providers of mental health.

Secondly, awareness about mental health conditions is quite low. This has contributed to relapse cases and to stigma too. Increasing awareness efforts and activities is a good way to tackle the barriers that arise due to low knowledge of mental health conditions.

Awareness messages and education specially targeted towards family members of care giver should also be carried out. This will help to improve patient care once the patient is discharged from hospital. Such a strategy would reduce the number of relapse cases.

These family members could also be used as stewards or agents of mental health who work voluntarily for other families in a similar situation. This has been rolled out in maternal health, where community members

*Practice*

In terms of practice, there is need to integrate mental health services into Primary Health Care. This is easier said than done, but can be introduced slowly in line with the existing capacity in the health facilities. Not all the cases that are transferred to the provincial centres too serious to be dealt with at primary level. Hence, integration at this level can be the beginning, and then slowly increase the capacity to handle more complicated cases. Despite under-going training in mental health, most health care providers do not provide the services at primary level. Practice (service provision at primary level) is one way to also increase capacity of the health care providers who study mental health as part of their training.

*Research*

This study created room for further inquiry on way to improve the face of mental health in the country. A small area of the country was included in the study so there are still more insights and opinions that need to be reconnoitered. While individual level barriers were explored in the survey, more research can be done into the barriers faced by individuals. Another way would be to engage students from institutions who require research to complete their studies to engage in participatory action research. This would help set a stage for change in the community, as well as enable them to complete their studies. This would hold for both policy and practice as research would be targeted at more useful community outcomes as opposed to other areas that are already funded by the health sector.

In order to facilitate and stimulate further research, the findings of this study will be published in a peer reviewed journal. A copy will also be made available in the UNZASoM Public Health Library, on the UNZA Repository, at the Ministry of Health and at all the institutions included into the study. These copies will also be available for the participants to read and see if their views were captured correctly.

# ANNEXES

## Annex 1: REFERENCES


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## Annex 2: Information Sheet

### Barriers to the Utilisation of Mental Health Services in Zambia

Hi. My name is Margarate Munakampe. I am a student at the University of Zambia, School of Medicine. I will read you a form that explains the research study you are being asked to join. This is a study to explore the barriers to the utilisation of mental health services in Zambia.

You have been asked to join this study because I believe you can give me information regarding utilisation of mental health care in form of an interview. I may call you for a subsequent interview if there is need, but this is very unlikely.

There are no physical risks involved in this study but you may feel uncomfortable answering some of the questions. You may refuse to answer any questions and stop the interview session at any time.

Your responses or participation in this study will not affect you in any way or even your access to any clinic facilities. However, this study will generate information regarding the barriers to utilisation of mental health care. The end point is policy change or even changes in policy implementation or improvement of services.

You can either choose to be in the study or not. If you choose to participate, you do not have to stay in the study until it ends and this will not affect you or any other privileges that you enjoy now.
In order to make sure your identity is kept secret, your name will not be revealed at any time of the study and after. Only the people who are involved in this study will have access to this information and there is no financial re-imbursement for participating in this study.

If you want to talk to anyone about this study, you can either contact me, the Principal Investigator, Margarate Nzala Munakampe at +260977941888, or you can call the Chairperson of the University of Zambia Biomedical Research Ethics Committee at +260211256067.

**Annex 3: Consent Form**

**Barriers to the Utilisation of Mental Health Services in Zambia**

**Consent Form**

By signing below, I _____, agree to take part in this study willingly. I understand the purpose of the study as well as the usefulness of the findings. I know my rights as a participant and I also know the risks and benefits of this research.

Participant's signature/ thumbprint: _____

Witness signature/ thumbprint: _____

Date: _____

*If you want to talk to anyone about this study, you can contact me, the Principal Investigator, Margarate Munakaampe at +260977941888, or you can call the Chairperson of the University of Zambia Biomedical Research Ethics Committee at +260211256067.

**Annex 4: Data Collection Tools**

**Interview Guide (Nurses)**

**Barriers to the Utilisation of Mental Health Services in Zambia**

Interview Guide: Nurses

Date: _____

Interviewee Study ID: _____

Interviewer name: _____

Location: _____

Age: Gender:

What do you think about mental health services in Lusaka/Ndola/Kabwe/Zambia?

What are the major challenges and obstacles in your opinion facing mental health care?

1. At the policy level

2. At the facility level.

3. At the individual level.

What factors do you think are contributing to the existing pattern of utilisation of mental health care?

What is the most common mental illness you diagnose?

How can we improve utilisation of mental health services?

What areas do you want to see improved in mental health?

What are the challenges facing service provision in your facility?

From where do you receive mental health patients?

What do you think of integrating mental health services into primary care?

What do you think of training lay persons to treat people with mental illness?

What hinders your progress in the provision of care? Traditional healers, church?

**Interview Guide (Family members)**

**Barriers to the Utilisation of Mental Health Services in Zambia**

Interview Guide: Family Members

Date: _____

Interviewee Study ID: _____

Interviewer name: _____

Facility: _____

Age: Gender: Occupation:

What do you think about mental health services in Lusaka/Ndola/Kabwe/Zambia?

What are the major challenges and obstacles in your opinion facing mental health care?

1. At the policy level

2. At the facility level.

3. At the individual level.

What factors do you think are contributing to the existing pattern of utilisation of mental health care?

Have you considered using alternative treatment? Traditional healers, church.

How has mental illness affected you financially as well as emotionally?

Do you feel there is sufficiently trained man power to handle service provision?

Do you feel stigmatised due to mental illness in your family? Health workers, community…

What did you know of mental illness before it started in your family?

What would you have done differently if you had known this information?

In your opinion, how can awareness about mental illness be increased?

**Interview Guide (Policy Makers)**

**Barriers to the Utilisation of Mental Health Services in Zambia**

Interview Guide: Policy Makers

Date: _____

Interviewee Study ID: _____

Interviewer name: _____

Facility: _____

Age: Gender: Occupation:

What do you think about mental health services in Lusaka/Ndola/Kabwe/ Zambia?

What are the major challenges and obstacles in your opinion facing mental health services?

1. At the policy level

2. At facility level

3. At individual level.

What factors do you think are contributing to the existing pattern of utilisation of mental health care?

How might we improve the utilisation of mental health care?

How can you improve the linkage between mental health services and the health system?

What policies do you think are working and what are not in mental health?

What challenges have arisen in implementing these policies?

Do you think that it is possible to integrate mental health services into primary care?

Do you think that the Ministry of Health will be open to this approach?

How can more funds be raised for mental health care?

What do you think of mental health insurance?

**Questionnaire**

**Barriers to the Utilisation of Mental Health Services in Zambia**

1. Introduce yourself
2. Establish rapport
3. Explain purpose of interview
4. Assure Confidentiality
5. Read Consent form and have it signed.

**Section A: Background information**

| | |
|---|---|
| Respondent's ID No. : | Interviewee's ID No. : |
| Starting time: | Ending time: |
| **1. Age**<br>18 – 29=1, 30 – 40=2, ≥ 40=3 | |
| **2. Gender**<br>Male= 1, Female= 2 | |
| **3. Highest school attained**<br>Non=1,Primary=2, Secondary=3, Tertiary=4 | |
| **4. Number of meals per day**<br>One meal=1, Two meals=2, Three meals=3 | |
| **5. Average monthly income**<br>Below K1,000=1, K1,000-3,000=2, K3,000-5,000=3, K5,000 –K10,000=4, K10,000 and above=5 | |
| **6. Occupation** | |
| **7. Denomination**<br>Catholic=0, Protestant=1, Muslim=2, Traditional=2, Any other=3 | |

*Tick where appropriate* [ ✓ ]

**Section B: Level of knowledge**

1. Do you know about mental health conditions?

   Yes [ ] No [ ]

2. If Yes, what is your understanding of the mental health conditions?

   ……

3. Can you name any mental health condition?

   Yes [ ] …….. No [ ]

4. Can you name a cause of mental health conditions?

   Yes [ ] …… No [ ]

5. Do you know where to get help for mental health conditions?

   Yes [ ] ……. No [ ]

6. Who do you think needs mental healthcare the most?

   Children [ ] Students [ ] Prisoners [ ] All persons [ ]

**Section C: Utilisation**

**1.** Have you ever accessed mental health care services?
Yes [ ] No [ ]

2. Has anyone in your household failed to access mental healthcare?

   Yes [ ] No [ ]

If yes why? ……

**Section D: Stigma**

3. Have you ever failed to access mental health care services because of other peoples' negative attitude?

   Yes [ ] No [ ]

4. Has anyone in your household failed to access mental health services due to negative attitudes from people?

   Yes [ ] No [ ]

5. Have you ever been given a negative attitude by health workers due to a mental health condition?

   Yes [ ] No [ ]

6. Has anyone in your household ever been given a negative attitude by a health worker due to a mental health condition?

   Yes [ ] No [ ]

**Section E: Traditional healers**

20. Have you ever visited a traditional healer instead of health facility due to mental health condition?

    Yes [ ] No [ ]

21. Has anyone in your household ever visited a traditional healer instead of facility due to a mental health condition?

    Yes [ ] No [ ]

**Section F: Support Structures**

22. Are there any places you can go to for support regarding to mental health conditions?

    Church [ ] Family [ ] NGOs [ ] Other [ ] …….. None [ ] ……..

**Section G: Other Barriers**

23. Have you experienced anything that has prevented you or anyone in your household from accessing mental health services?

    _____

**Thank you for your time and participation!**

## Annex 5: Study Timeline and Study Budget

Study Timeline Gantt Chart: June 2015- June 2016

| | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Submission to the REC** | | | | | | | | | | | | | |
| **Facility Permissions** | | | | | | | | | | | | | |
| **Data collection** | | | | | | | | | | | | | |
| **Data analysis** | | | | | | | | | | | | | |
| **Report writing** | | | | | | | | | | | | | |
| **Submission of 1st draft** | | | | | | | | | | | | | |
| **Submission of 2nd draft** | | | | | | | | | | | | | |
| **Final draft** | | | | | | | | | | | | | |

Study Budget

| Description | Per Day | Number | Days/Week | Duration | Cost (K) |
|---|---|---|---|---|---|
| | 50.00 | 10 | 5 | 3 weeks | 7,500.00 |
| Research Assistants | 50.00 | 2 | 5 | 2 weeks | 1,000.00 |
| Transport costs | 50.00 | 3 | 5 | 2 weeks | 1,500.00 |
| Ethical Approval | | | | 8 Weeks | 250.00 |
| **Item** | **Unit Pack** | **Quantity** | **Unit Cost** | | **Total Cost** |
| Voice recorder | Each | 1 | 500.00 | | 500.00 |
| Stationery | Assorted | 1 | 500.00 | | 500.00 |
| Other costs | Various, | 1 | 500.00 | | 500.00 |
| Printing, paper | assorted | 1 | 1,500.00 | | 1,500.00 |
| | | | | Miscellaneous expenses | 1,500.00 |
| | | | | Accommodation and Food | 5,000.00 |
| | | | | **Grand Total** | **19,750.00** |

## Annex 6: Code list (Qualitative Component)

| Code List | |
|---|---|
| **Name** | **Description** |
| **Policy Level Barriers** | All discussions about barriers that are not addressed or solved at policy level. They are also called structural barriers. |
| Archaic Laws | Any discussions about the legislation on mental health |
| Budget constraints and Inadequate allocations | Any discussions about budgetary constraints and inadequate funding |
| Drugs and Drug Shortages | Any discussions about the drugs and drug shortages in the mental health institutions |
| **Individual Level Barriers** | All discussions about barriers that individuals face in trying to access mental health services. The individuals are the clients trying to access these services, and so these are also known as demand side barriers. |
| Education or Awareness | Any discussions knowledge or lack of knowledge about mental health conditions |
| Patient care | Any discussions to do with the care of patients and the challenges associated with it. |
| Poverty | Any discussions that refer to poverty arising from the cost of illness, or how poverty can cause the mental health conditions. |
| *Cost of drugs* | Any discussions about the cost of drugs |
| *Cost of illness* | Any discussions about poverty arising due to the mental health conditions in the family |
| Stigma | Any discussions about stigma |
| *Community* | Any discussions about the stigma from the community including family members |
| *Health Providers* | Any discussions about stigma from the health workers and providers |
| *Self-Stigma* | Any discussions to do with stigma from the patient himself. |
| Support Structures | Any discussions about structures, institutions and organisations that support people with mental health conditions |
| Traditional Healer | Any discussions about consulting traditional healers or how they interfere or assist in dealing with mental health conditions |
| **Facility Level Barriers** | All discussions about barriers that are faced at facility level. They can also be called supply side barriers to the utilisation of mental health services. |
| Dilapidated Facilities | Any discussions about the state of the facility infrastructure |
| Few experts or Human Resources | Any discussions about the experts or the human resources in mental health services |
| Inappropriate Infrastructure | Any discussions about how the infrastructure is not suitable for the mental health patients |
| Low capacity for number of Patients | Any discussions about the capacity of the institutions to handle the number of patients |
| Poor Referral System | Any discussions about the referral system |
| **Other Barriers** | Any other barriers to mental health services mentioned by the participants |
| Common disorders and Common patients and Gender issues | All discussions about the pattern of utilisation and the most common mental health conditions mostly diagnosed. Can also involve who is treated the most. Also discussions about gender issues related to mental health |
| Management | Any discussions about the management of mental health services. This could bring out issues of prioritising too as well as integrating into PHC package |
| Relapse | Any discussions about relapse cases at the mental health facilities |
| Suggestions for improving mental health services | Any discussions about how to improve mental health services in the country or province |
| Suggestions for increasing Awareness | Any discussions about increasing awareness about mental health conditions |

## Annex 7: Permission Letters