EXPLORATION OF INDIGENOUS KNOWLEDGE AND PRACTICES OF THE RELATIVES OF MENTAL HEALTH CARE USERS REGARDING MANAGEMENT OF MENTAL DISORDERS IN MALAWI.

By

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DECLARATION

I, Yasinta Kavalo hereby declare that this dissertation is a product of my own work and that where I have incorporated words or ideas of others, these have to the best of my knowledge been referenced properly. This dissertation is the first of its kind in my scholarly work and it has never been submitted to any other University.

SIGNED :..... DATE. .....

DEDICATION

This study is dedicated to my lovely sons Terry, Chimwemwe, Limbani and Gift for being understanding and for giving me the moral and spiritual support that I needed most during the period of this study.

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I would like to thank God Almighty for opening up the way for me, You had it all planned. Thank you Lord for the wisdom, guidance and the power to sail through, You made it possible for me.

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ABSTRACT

Topic: Exploration of indigenous knowledge and practices of the relatives of mental health care users regarding the management of mental disorders.

This study was conducted to explore the management of mental disorders amongst the indigenous people of the Dedza District in Malawi. The government of Malawi declared public mental health services to be free of charge, as a strategy to reduce the burden of disease to the country. Yet despite the free health care services, the indigenous people of Malawi did not take advantage of these free mental health care services, as they regarded them to be culturally incongruent. Instead they used traditional healing systems for mental disorders and consulted the Western health systems only when the traditional systems had failed, the mental health condition had become worse and the mental health care user had become unmanageable. This study was then conducted to explore what the Malawians regarded as culturally sensitive public mental health services.

Method: A qualitative phenomenological research approach was adopted to explore the views of the relatives of mental health care users about culturally sensitive public mental health care services. A purposeful sampling method was used to select information rich participants amongst the relatives of mental health care users of indigenous Malawian origin. An unstructured interview guide was used to gather data through face to face interviews. Saturation of data was reached after interviewing fifteen (15) relatives.

The verbatim transcribed data from the participants were content analyzed to identify the themes, categories and subcategories. Themes that emerged were: community beliefs; perceived causes, delayed decision making and health system factors.

Findings: The community beliefs about the management of mental disorders were on traditional and religious health systems. The traditional healers were consulted in cases where mental illness was believed to be caused by witchcraft and spiritual healers were consulted where mental illness was believed to be caused by ancestral wrath. Even such consultations were delayed as the decisions on the type of healer to be used to manage the mental health care user, had to come from the extended family members. These processes took place during the acute phase of the mental illness and thus explain the delays in consulting with the Western mental health care systems. Such delays had a potential to contribute to the chronicity and the related complications of the illness. The Western health care services were only consulted when the indigenous healing systems were unsuccessful. Yet even the western healing systems were not the best option due to the negative and disrespectful attitudes of health care professionals, the impersonal nature of services, the use of foreign language and delays in service delivery. The recommendations were that the results of this study should be used as guidelines to develop strategies for culturally congruent mental health care services to the indigenous Malawians as the development of the strategies was beyond the scope of this study. The focus of the guidelines to ensure the development of evidence-based nursing practices in rendering culturally congruent mental health services to the indigenous Malawians. Firstly, there should be an integration of both the Western and the traditional healing systems to ensure a holistic patient centered approach to the care of the indigenous people of Malawi; secondly to use the nursing process phases, starting with the assessment, the formulation of the nursing diagnosis, the expected outcomes, the development and implementation of the nursing interventions and the discharge

plans to incorporate the belief systems of the indigenous Malawians as identified in this study.

CHAPTER 1: ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

This study was conducted to explore the management of mental disorders amongst the indigenous people of the Dedza District in Malawi. The government of Malawi declared public mental health services to be free of charge, as a strategy to reduce the burden of disease to the country (Government of Malawi, 2011-2016:28). The expectation therefore was that once the symptoms of illness are identified, the mental health care user would be taken to the clinic or hospital for treatment and medication. Despite the free health care services, the indigenous people of Malawi did not take advantage of these free mental health care services, instead they used traditional healers as their first point of consultation for any illnesses and mental disorders.

A number of studies have shown that relatives of mental health care users resort to seeking care from traditional healers and other than conventional mental health workers. A study conducted in South Africa found that 45% of the black patients that attended a community mental health clinic had consulted a traditional healer for their problem and 26% were simultaneously seeking treatment from traditional healers and psychiatrists(Ministry of Health South Africa and WHO 2007).

Similarly, in Malawi a study conducted by Crumlish et al (2007)on insight, psychopathology and global functioning in schizophrenia revealed that traditional beliefs were widely held as indicated by the proportion of patients who initially sought treatment from traditional healers. Whereas, Campbell-Hall, Petersen, Bhana, Mjadu Hosegood, Flisher & HaPP (2010) argue that traditional practitioners provide

culturally appropriate care which is linked to indigenous explanatory models of illness held by many South Africans.

The indigenous people of Malawi consulted the Western health systems only when the traditional systems had failed, the mental health condition had become worse and the mental health care user had become unmanageable(Dedza Social Economic Profile, 2007-2010:23); (Malawi Human Rights Commission (MHRC), 2012:7-8).In Bandawe, (2010:22) it is reported that mental health care users that are believed to be associated with cultural beliefs are treated by herbalists as opposed to those treated at the health facility. A similar situation was reported in Crumlish, Samalani, Sefasi Kinsella, Ocallagan and Chilale, (2007:262-263);Blue, Charles & Fleming, (2009:64-67), wherein it is stated that Malawians attribute sickness, various types of mental disorders and death to witchcraft and as such their first point of entry to health care services are traditional healers and herbalists, a practice which results in delays to consult Western mental health care services.

The possible explanation for the delay to consult western health systems, was the cultural incongruity of the western health systems as they did not take into consideration the cultural beliefs and practices of the indigenous Malawians. The situation seemed to be compounded by the health care workers' lack of knowledge of related indigenous mental health care concepts, terminology and practices as their training and government policies were based on the Western systems of health care. Such practices and belief system negatively impacted on the timely treatment, care and rehabilitation of the people with mental disorders and often lead to chronicity. There seemed to be a need to identify the best approach to render mental health care services that are responsive to the needs of the indigenous people of Malawi as shown in the literature elsewhere. For example, inTeuton, Dowrick and Bental(2007),

it is stated that in most African countries, healing systems for mental health problems are pluralistic and include indigenous, religious and health care systems and practices. Similarly Liddel, Barret and Bydawell (2005) reported that indigenous views of illness exhibit coherent structure in which causation, prevention and treatment relate to one another in functional ways. Whereas, Ypinazar Margolis, Haswell-Elkins and Tsey et al (2007:467-478) in a study on Australians' Understanding Regarding Mental Health and Disorders, reported that the importance of understanding indigenous descriptions and perceptions of mental health issues is crucial to enable two way understanding between indigenous peoples constructs of wellness and Western biomedical labels and treatment pathways for mental disorders and mental health problems. Similarly, in Malawi healing practices on mental health care users are of two fold depending on the perception of the community.

The background information as presented assisted with the conceptualization of the area of study which is indigenous knowledge and practices of indigenous people elsewhere and thus directed the need for this study amongst the indigenous people of Malawi.

This study was then conducted amongst the indigenous Malawians to explore the views of the relatives of the mental health care users in the Dedza District, on the management of mental disorders as an attempt to render culturally sensitive public mental health services that are evidence-based.

1.2 STATEMENT OF THE PROBLEM

The study stems from the observation that even though the mental health care services are free and are provided at all levels of health care, relatives of mental

health care users delay consulting these services, instead they first consulted with traditional healers. They only consulted the Western health care services when their mental health care users were already in a chronic stage. Such a situation seemed to be blamed to the cultural incongruity of services rendered as the indigenous knowledge and practices of the people of Malawian origin were excluded within the Western health care system. The mental health services were not culture specific and even the mental health care policies did not make reference to culture specific terms, concepts and practices. The lack of cultural specific approaches to mental health care service delivery to the mental health care users and their relatives, will be the focus of this study.

1.3 RESEARCH QUESTIONS

This study aimed at responding to the following questions;

i. What are the views of the relatives of mental health care users with regard to the use of indigenous knowledge and practices in the management of mental health disorders in the Dedza District of Malawi?
ii. What do indigenous people of Malawi consider as culturally congruent mental health care services?

1.4 OBJECTIVES OF THE STUDY

Burns and Groove (2009:778) define objectives of the study as clear, concise, declarative statements that are expressed to direct a study and are focused on identification and description of variables or determination of the relationships among variables or both.

The objectives of this study were;

i. To explore the views of relatives of mental health care users about indigenous knowledge and practices in relation to the management of mental health disorders.

ii. To recommend suggestions for rendering culturally congruent mental health care services to the indigenous mental health care users.

1.5 PURPOSE OF THE STUDY

The purpose of a study is a concise, clear statement of the specific goal or aim of the study that is generated from the problem (Burns and Groove, 2009:779).The purpose of this study was to suggest guidelines for developing culturally sensitive mental health care services for the indigenous Malawians in the Dedza District.

1.6 SIGNIFICANCE OF THE STUDY

Significance of the study is part of the research problem that indicates the importance of the problem to nursing and to the health of individuals, families and communities (Burns and Groove, 2009:722).This study was to contribute towards the development of mental health care services that were sensitive to the culture specific needs of the indigenous communities of Malawi and thus contribute towards holistic quality mental health care services.

1.7 DEFINITION OF TERMS

The following terms are defined in this study as based on the Western health care systems, namely:

Mental health

According to World Health Organization (2000) mental health is a state of well-being in which an individual realizes his/her own abilities to cope with the normal stresses of life, work productively and be able to make a contribution to his or her community.

Mental health is the foundation for effective individual well-being and the effective functioning of a community.

The WHO definition of mental health was adopted in this study as it related to culturally acceptable abilities to cope with normal stresses of life, working productively and the ability to make contributions to indigenous communities.

Mental disorders or illness

Means a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorized to make such a diagnosis (Mental Health Care Act (Act No.17of 2002:6). This study has adopted this same definition.

Health care

Through-out the study health care shall mean the prevention, treatment and management of illness and the preservation of mental and physical well-being through the services offered by the health care professionals.

Indigenous knowledge

Indigenous knowledge (IK) is the local knowledge that is unique to a given culture or society, it is the basis for local-level decision–making in agriculture, health care, food preparation, education, natural resource management and other activities in rural areas (Warren 1991). For the purpose of this study indigenous knowledge refers to the knowledge the traditional Malawian relatives of mental health care users have in relation to mental disorders.

Culture

Culture refers to the learned, shared and transmitted values, beliefs, norms and patterns of behaviour characteristic of a particular social group that guides their thinking, decisions and actions in patterned ways (Leininger, 2002). In this study culture shall reflect the beliefs, and patterns of behaviour of Malawians with regard to mental health care seeking behaviour.

Mental health care user

Mental health care user means a person who is receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a person (Mental Health Act (Act No.17 of 2002:5).

Relative of a mental health care user

A relative of a mental health care user is someone who is related to the mental health care user by kinship and renders care and support to the mental health user.

1.8 RESEARCH DESIGN AND METHOD

Burns and Groove (2009:553), refer to research design as a set of advanced decisions that make up the master plan specifying the methods and procedures for collecting and analyzing the needed information. While Polit and Beck (2004:731) define a research method as a technique used to structure a study, to gather and analyze information in a systematic way.

A qualitative phenomenological research approach was adopted in this study as it was more appropriate for the exploration of the indigenous knowledge and practices of the people of Malawi on managing the mental disorders in their own context of the

Dedza District. Qualitative research is a systematic, subjective approach used to describe life experiences of participants and give them significance (Burns and Groove 2009:717).This study was qualitative in nature as it sought to study and seek in depth understanding and allowed for the development of meanings and interpretations of indigenous knowledge and practice systems on the management of mental illness based on the experiences of the relatives of the mental health care users in the Dedza District of Malawi.

1.8.1 TARGET POPULATION

Target population is defined as the entire population in which the researcher is interested and to which she would like to generalize the results of a study (Burns and Groove,2009:724). The population for this study was relatives of mental health care users who wereof Malawian origin and were accompanying the mental health care users for follow up care in the clinics during the months of March and April 2014. The population was selected because they were indigenous relatives of mental health care users and were a rich source of knowledge in relation to knowledge and cultural practices related to management of mental disorders. Additionally, these relatives of mental health care users were more reliable informants since they had experience in caring for a mental health care user within the context of their culture.

1.8.2 STUDY SITE

The study was conducted in the Dedza District amongst relatives of discharged mental health care users. The relatives were found in the mobile mental health care clinics where they had accompanied the mental health care users for follow up care. There is one (1) static mental health clinic and thirty (30) mobile mental health clinics in Dedza. On average these clinics register 84 mental health care users per month (Dedza HMIS, 2007).

1.8.3 SAMPLING

Sampling is the selection of research participants from an entire population, and involves decisions about which people, settings, events and behaviours and social processes to observe (Burns and Groove, 2009:720).

In this study the researcher used a purposive sampling technique to select the research sample. Qualitative researchers use purposive sampling to select information rich cases or those cases that can teach them a great deal about the central focus or purpose of the study (Burns and Groove, 2009:355).This technique was chosen because among others factors, it dealt with participants with specific experiences. For this study, the relatives of mental health care users had experience in caring for a mental health care user and belonged to the indigenous Malawian culture. Furthermore, the in-depth interview that was used to collect data helped the participants to elicit their views, practices and indigenous knowledge that they had in relation to mental disorders.

1.8.4 SAMPLE SIZE

This is the number of subjects or participants recruited and consenting to take part in a study (Burns and Groove, 2009:721). The study aimed at selecting at least twenty (20) participants, but the actual number was determined by the saturation of data hence 15 participants were interviewed. Participants in qualitative research are selected based on their first-hand experience with culture, social interaction or phenomenon of interest. In this study, the participants were the relatives of mental health care users since they had experience in caring for them.

1.8.5 DATA COLLECTION AND DATA COLLECTING INSTRUMENT

Burns and Groove (2009:695), defines data collection as the gathering and measuring of information on variables of interest in an established systematic fashion that enables one to answer research questions, test hypotheses and evaluate outcomes. In depth-interviews were conducted using an unstructured interview guide as a method of choice for data collection. This approach enabled the participants to provide their subjective knowledge on the phenomenon. During this process the interviewer asked open-ended questions followed by probing for further and indepth understanding of the phenomenon (Brink andRensburg, 2012:150-152).

The questions which were captured in the unstructured interview guide were based on the following:

- How did you manage your relative when he/she became mentally ill?
- You have brought your relative who is mentally ill here at the clinic, what are your views about the services rendered here at the clinic?

Further questions were based on further probing and clarification from the responses of the participants. And data collection stopped when the information obtained from the participants was repetitive, thus saturation of data was reached.

1.8.6 DATA ANALYSIS

Data analysis is the processing of data into information for decision making (Burns and Groove 2009:695). In qualitative research data analysis differs from that of quantitative research since the data is non numerical, it is usually in the form of words, video tapes, audio tapes and photograph (Brink& van Rensburg, 2012:192). Usually large amounts of data are collected in a form of text which makes analysis time consuming. However, data analysis in this study was done simultaneously with

data collection. Interviews were transcribed and compared with the recorded interviews. Thereafter, data was analyzed manually. In addition sorting and formatting of data into themes took place simultaneously with data collection. This provided an opportunity to capture explanations and patterns that could have been missed if data analysis was to take place later after data collection.

1.8.7 TRUSTWORTHINESS

Trustworthiness indicates the rigour with which a study has been undertaken in relation to its credibility, transferability, dependability and confirmability(Taylor 2014:308).To ensure trustworthiness of research analysis, each and every step of the research process was monitored by two supervisors, and the researcher presented the proposal at a research seminar at the University of Fort Hare, Department of Nursing Science for quality control. Credibility, dependability, transferability and confirmability were the criterion used to achieve trustworthiness in this study.

1.8.8 ETHICAL CONSIDERATION

Ethical considerations are defined as norms that distinguish between acceptable and unacceptable behaviour (Burns and Groove 2009:699).The researcher sought ethical clearance from the Higher Degrees Committee of the University Of Fort Hare before commencing the study. Approvals were also sought from the District Commissioner (DC) of Dedza and the District Health Officer (DHO). The purpose and process of the study was explained to all prospective study participants and they were assured of confidentiality and anonymity as their names were not required and were not going to appear anywhere in the study. The researcher informed the participants about the study and provided them with necessary details and asked them if they were willing to participate in the research process. Thereafter a written

consent was obtained from possible participants who were willing to participate. All participants were assured of their right to participate or decline or indeed withdraw from the study at any time should they feel uncomfortable. They were also assured that no harm would happen to them. The right to fair selection was assured by selecting the study participants based on the research problem. The researchers' choice was not motivated by any benefits the participants received. The researcher also treated participants fairly by observing and honouringthe duration of times agreed upon for the interview.

N.B: Further elaboration on research methodology is in chapter 2.

1.9 Chapter overview

Chapter 1 presented the background to the study, the problem statement, research questions,objectives,and the significance of the study. An outline of the chapters is also provided in chapter one.

Chapter 2presented the applied research methodology, sampling, data collection methods and data analysis, specifically focusing on ensuring trustworthiness and credibility of the study, was used in this study. Themes that emerged were identified. The chapter further highlighted ethical considerations of the research.

Chapter 3 presented the findings and interpretation of the results on the indigenous knowledge and practices of relatives of mental health care users.The findings were discussed and supported with literature as it is the case with qualitative research studies.

Chapter 4: The results according to the objectives of the study were concluded and recommendations were made and the limitations of the study were presented.

1.10 CONCLUSION

This chapter presented an orientation to the study reflecting the need for this kind of study as shown by available literature on similar studies elsewhere, specifically focusing on the need for such a study within the mental health care services in the Dedza District of Malawi. Specifically, it outlined the research problem, the significance of the study, definition of concepts, research questions as well as the objectives guiding the study.

CHAPTER 2: RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

This chapter discusses the research design and methodology adopted for this study. In so doing, it provides details of the particular methods employed, including the sampling and data collection methods as well as the data analysis techniques. Justification for the chosen technique was offered. In addition, the chapter discusses trustworthiness issues, piloting and ethical issues taken into consideration during the course of this research. A qualitative phenomenological research method was used to explore the indigenous knowledge and practices of the relatives of the mental health care users in relation to management of mental disorders.

2.2 RESEARCH METHOD

The study aimed at exploring the indigenous knowledge and practices of relatives of mental health care users regarding management of mental disorders. This research approach was better suited for this study as it sought to understand the phenomenon of indigenous knowledge and practices of relatives of mental health care users in the management of mental disorders in Dedza through their daily experiences.

2.5.1 JUSTIFICATION FOR CHOICE OF THE STUDY APPROACH

A qualitative approach is a systematic, subjective approach used to describe life experiences and give them meaning (Burns and Groove, 2009:717). This approach allowed the researcher to identify issues from the perspective of indigenous Malawians who were relatives of mental health care users and to understand the meanings and interpretations that they gave to behaviour, events or objects. For

example, in this study, participants were expected to express their experiences and practices with regard to cultural terminology about management of mental disorders and mental health related practices (Hennick, Hutter and Bailey, 2011:9).

Thus, in this study qualitative research was used to explain the relatives' beliefs, behaviour as little was known about the phenomenon of indigenous knowledge and practices of the Malawians with regard to mental illness. The objective was to gain a detailed understanding of underlying reasons, beliefs or motivations with regard to the experiences of the relatives of the mental health care users(Hennick et al, 2011:109-131). In addition this approach addressed the challenges the relatives of mental health care users faced given the use of western approaches and methods within mental health care services. In line with the aims and objectives of this study the researcher adopted the phenomenological descriptive qualitative design. According to Brink (2012:128)the purpose of a descriptive design is to describe a certain phenomena in a particular community. Phenomenology is defined as a research approach that explores individuals' lived experiences (Immy, 2005: 294).Phenomenological inquiry brings to language perceptions of human experience with all types of phenomena (Speziale & Carpenter, 2007:75).

The researcher gathered detailed concrete relatives' descriptions on indigenous management of mental disorders as they lived and experienced it. This was presented in the form of the verbatim transcripts. The researcher adopted the attitude of phenomenological reduction in order to intuit, or to indicate the presence or appearance of indigenous practices that were then open to evaluation, that is mainly the intelligibility of what was given in the experiences of the relatives. The researcher sought the most invariant meanings for the context of indigenous knowledge and practices.

2.5.2 THE RESEARCH SETTINGS

The study was conducted in the researcher's home country, Malawi specifically in Dedza District. This was based on ease of access to participants and language of communication with people from rural areas. The district has one referral hospital situated at the centre of the town with a catchment population of 28,803. There are 33 health centres in the rural areas distributed in all the eight Traditional Authorities. The common diseases are malaria and diarrheal, HIV/AIDS prevalence rate is estimated at 10% compared to 16.4 of the national rate. Medical conditions are estimated at 54000 annually and out of these 3480 (6.4%) are mental health care users (Dedza Social Economic Profile, 2007-2010:63-64; Dedza HMIS, 2012).

The study was conducted in two Traditional Authorities namely Kamenyagwaza and Kaphuka. The facilities involved were Dedza district hospital, Bembeke clinic and Chongoniclinic. There is one (1) static mental health clinic and thirty-two (32) mobile clinics in Dedza. On average these clinics register 84 mental health care users per month (Dedza HMIS, 2012).

2.5.3 POPULATION

Babbie and Mouton (2011:190)refers to a study population as the aggregation of elements from which the sample is actually selected. The population comprised of relatives of mental health care users who had accompanied the mental health care users to the mental health care clinics for follow-up care during the months of March and April, 2014.

2.5.4 SAMPLING

The researcher used purposive sampling technique to select the research sample. Informative participants that were deemed knowledgeable and experienced in caring

for mental health care users in the Dedza District of Malawi were identified and selected. Relatives of mental health care users who had accompanied their relatives who were mental health care users to the clinic, were selected to get information on indigenous knowledge and practices regarding management of mental disorders. This technique was chosen because among others factors, it dealt with respondents with specific experiences. Furthermore, purposive sampling also referred to as judgmental sampling as it involves the hand-picking of individuals by the researcher based on the knowledge of the population and the purpose of the study (Babbie 2011:166).The researcher visited the clinics and with the assistance of the professional nurse on duty, identified the relatives who had accompanied mental health care users to the clinic. These relatives were selected as they had experience in caring for a mental health care user and were knowledgeable about the cultural practices, knowledge and behaviours regarding mental illness and thus were information rich.

2.5.5. THE SAMPLE SIZE

Burns and Groove (2009:721)define a sample as the number of subjects or participants recruited and consenting to take part in a study. The researcher aimed at selecting a minimum sample size of 20 participants for the study which involved relatives of mental health care users who were found in mental health care clinics. However, the actual size of the sample was determined by saturation of data hence 15 participants were interviewed. In qualitative research data collection continues until saturation has been achieved, this is when no new themes are emerging from the participants and data is repeating itself (Speziale and Carpenter 2007:460).

2.5.6 RESEARCH INSTRUMENTS

The research instruments that were used were as follows, namely, the researcher herself was the primary instrument for data collection; the unstructured interview guide for in-depth interviews; the field notes and the audio recorder. The researcher as the primary instrument for data collection was actively involved in interacting with the study participants and recording the interviews. In addition the researcher made sure that she communicated clearly, audibly and was careful not to use non-verbal messages that could disrupt data generation.

The unstructured interview guidewas used to seek and to gather insight on how participants made sense of their experiences (Brink 2012).

2.5.7 DATA COLLECTION

Before data collection started, the researcher obtained a Research Ethics Clearance certificate from the University of Fort Hare to proceed with data collection. A letter requesting permission to use the health facilities in Dedza District was presented to the District Health Officer (DHO) who assigned the District Mental Health Coordinator to assist in identifying the mental health care clinics. The Mental Health Coordinator is a district level manager who oversees the operations of mental health care services. The data collecting schedule was drafted in line with the District Health Officer's monthly visit schedule for the month.

The data collecting tools were translated into the local language Chichewa considering that most Malawians are illiterate (Government of Malawi, 2011-2016:16). During the actual data collection, informed consent was sought from the participants and the researcher was actively involved in interviewing the participants

and writing field notes. The researcher sought permission from the participants to use a voice recorder in order to capture everything said during the interview.

Creswell (2014:191) states that in qualitative study, there are four main categories of data sourcing which are observations, documents, interviews and audio visual materials. In most cases, researchers use more than two types of data sources to give validity to their sourced data. However, in this study interviews were the main source of data. The study employed the use of in-depth interviews as its main method for collecting data with the aim of gaining deeper insights into the indigenous practices regarding management of mental disorders. In-depth interviews were used to seek individual, personal experiences from the relatives about specifically the indigenous practices(Hennink et al 2011:109-131).

Advantages of in-depth interviews:

The researcher chose to use in-depth interviews based on its advantages as outlined by (Brink, 2012:153)that firstly, the participants do not need to know how to read or write. Secondy, it yields a high response rate and there is a high control of the interview situation. Thirdly, the interviewer is able to record the context of the interview and the non-verbal gestures of the respondents. Fourthly, the interviewer is able to locate and secure co-operation of the respondents. Fifthly, the interviewer motivates and guides the interviewees through the questionnaire and can probe and finally, the researcher is able to maintain rapport with the respondents (Brink, 2012:153). Furthermore, in this study in-depth interviews helped to elicit more information from relatives of mental health care users. Relatives in this study were observed to be giving brief answers initially, therefore the probing helped to get more details from them. During the interview process the questions were paraphrased for

the understanding of the participants. Considering these advantages and the low literacy levels in most rural communities in Malawi, the researcher opted for a face-to-face interview**.**

Challenges of in-depth interviews:

Although this study used in-depth interviews as its main data collection method, the researcher was conscious of the following shortfalls of in-depth interviews, which could have negatively affected the process and trustworthiness, firstly, the use of interviews require some expertise and knowledge with the subject matter and communication skills. Secondly, the interviews are time consuming and the arrangements for interviews may be difficult to make. Thirdly, participants may be anxious because answers are being recorded and could also be influenced by interviewer characteristics and finally interviewer may misinterpret non-verbal behaviour of participants (Brink, 2012:153).In response to such challenges, the researcher took the following precautions, firstly, the researcher was a specialist in communication skills as she is a professional psychiatric nurse and is a Malawian familiar with the spoken language of the participants. This was further addressed through the use of the language of the local people during data collection. On time spent on each interview, the researcher took time off from formal employment so as to apply herself fully to the interviewing process and on average each interview lasted for about 30 to 45 minutes. The researcher further allayed the anxieties of the participants on the use of the tape recorder. She explained that the tape recorder was used mainly to ensure that their utterances were captured accurately and further obtained permission from them for the use of the tape recorder. The questions which were captured in the unstructured interview guide were based on the following:

- How do Malawians refer to the symptoms that prompted you to seek mental health care services?
- What are the traditional methods used in Malawi to treat and manage mental illnesses?
- Based on your experiences of both the western and the traditional treatment methods, what are your views with regard to both of these methods?

Saturation was reached after successfully interviewing fifteen (15) relatives.

2.6 PILOT STUDY

A pilot study is a trial run to test questionnaires, or test the use of methods for a study (Taylor 2014:306). The researcher conducted a pilot study to determine whether the unstructured interview guide could assist in obtaining the intended data. For the purpose of the pilot study, two relatives of mental health care users were selected in a different area from the study site. Apart from convenience, this was done to observe if data from the interview guide could confirm or disconfirm the findings from the in-depth interviews. After the pilot study, necessary corrections and amendments were made in relation to the terminology of the local people.

2.7 TRUSTWORTHINESS

In this study, certain procedures were followed to achieve trustworthiness of the study.Credibility, dependability, confirmability and transferability are the criterions that wereused to ensure trustworthiness of data (Polit and Beck, 2008:492).

2.7.1 CREDIBILITY

Credibility which involves truthfulness of data and its interpretation was achieved through prolonged engagement with the transcriptions. This assisted the researcher to collect enough data until saturation was reached (Polit and Beck, 2008:497) and

(Brink 2012:192). In addition, the researcher used peer debriefing as she used the supervisor to check and debate with her about the research processes. Member checking is also vital in ensuring credibility of the study. The researcher checked with the participants to determine if the data was interpreted in a manner congruent to their experiences or whether it needed to be corrected. Participants agreed, with the emerging themes and main points in the discussion. All interviews were recorded on a reliable digital recorder. This was complemented by hand-written notes taken by the researcher. In addition a letter to the co-coder and an example of a transcript are kept in the appendix section for ease ofreference.

2.7.2 DEPENDABILITY

According to Babbie(2011), an inquiry must provide its audience with evidence that if it were repeated with the same or similar subjects, its findings would be similar. In other words, dependability is referred to as the stability of the data overtime and over conditions.

Dependability relied on an independent audit of the research method by an expert in qualitative data analysis who followed the processes and procedures used and determined whether they were acceptable. Furthermore, the analysis of data was verified by the supervisor and the co-coder.

2.7.3 CONFIRMABILITY

Confirmability is the degree to which the findings are the product of the focus of the inquiry and not of the biases of the researcher. In addition, confirmability guarantees that the findings, recommendations and conclusions of the study findings are supported by the data and further determine whether the study collected data it intended to collect(Brink 2012:125). To achieve confirmability the researcher made

sure that she documented clearly all the steps involved in the study, for example the initial coding was done by the researcher and later it was given to an expert of qualitative data analysis to review the categories and themes identified from the coded data for validation.

2.7.4 TRANSFERABILITY

Transferability refers to the extent to which the findings can be applied in other contexts or with other respondents. In addition, it also refers to the generalization of the data, that is the extent to which the findings can be transferred to or have applicability of the data to other contexts. However, a qualitative study does not strive for generalizability(Babbie and Mouton 2011:277). The research method used in this research responded to the principles of transferability and audit trail as the researcher had detailed all the processes followed in conducting the study up to the results stage, the discussion of the results, the recommendations made and the presentation of the limitations.

2.8. DATA ANALYSIS

Data analysis is understood as one of the critical processes in research that is used to reduce, organize and give meaning to the sheer massive volumes of information (Burns and Groove, 2011:535).The analysis in qualitative research differs from that in quantitative research because of techniques and approaches used. In qualitative studies sorting and formatting of data into themes or stories may take place simultaneously with data collection, which may not be possible with quantitative research (Burns and Groove, 2011:93-97). In this study, the approach was adopted and preliminary analysis was done even at the time of data collection.

Hand documentation of the interviews was done and a voice recorder was used in order to capture everything said during the interview. The transcripts which were correctly labeled were kept safe under lock and key for purposes of security. Notes taken were reviewed and checked for correctness and completeness on the day of collection while the transcription of audio information was done after 24 hours.

The researcher transcribed verbatim all tape recorded interviews. Transcriptions were done within 24 hours on completion of the interviews. Transcripts were read ad re-read word for word sentence by sentence in search of recurring statements or regularities until the researcher was convinced that the data was correctly interpreted. Through the interpretative approach the researcher reached an understanding of the relative's experiences while safeguarding the uniqueness of each participant. The researcher attempted to enter the attitude of the phenomenological reduction in order to become as faithfully present to the intrinsic intelligibility of the meaning in the transcripts. In the process of understanding, the researcher tried to be present not to words themselves, but to the meanings given through the words in such a manner as to achieve descriptive adequacy.

The description of the steps that were followed was as follows: Firstly, through the process of transcription and familiarization to obtain a sense of each transcript as a whole experience. Each complete transcript was read as many times as necessary in order to understand it as a whole experience. This was done by immersing oneself in the world of the description by disciplining oneself to become open to such world views. Such discipline required the suspension of one's preconceptions as much as possible. This constituted the kind of phenomenological reduction that brackets theory from outside of the phenomenon as explanatory concepts. The researcher nonetheless maintained an understanding that the descriptions did not just reveal a

world-in-general, but an experience of a specific phenomenon in its context, which in this study was the participants' involvement in managing mental disorders from an indigenous perspective. As the researcher listened to descriptions and was dwelling with the data, common themes or essences began to emerge. This process involved complete immersion in the generated data to fully engage in the analytic process. The researcher had to dwell with the data for as long as was necessary to ensure a pure and accurate description (Speziale & Carpenter, 2007:86). The sense of the whole then provided an intuitive reference within which the specific details could become intelligible.

Secondly, the researcher performed content analysis to adopt an in-depth understanding of the meaning of the content. During this process, the researcher then applied the principle of discrimination of meaning of units. This phase involved refining the contextual understanding achieved in the previous step by focusing on discrete changes of meaning within the larger context of each individual transcript. Each transcript was re-read noticing and marking each time a change of meaning which occurred with reference to the phenomenon studied, This was a way of ensuring that the researcher accounted for all relevant nuances and details in her further analysis, and that she spent some time considering all meanings when moving to a greater degree of a broader meaning later. At this stage the meaning units in the transcripts were marked or numbered for further consideration.

This phase involved formulation of the transformed meaning, that is, inducing themes and categories by grouping significant statements and phrases into columns of themes, categories and sub-categories, a process known as coding. During this process the participants' everyday expressions and language were then transformed into expressions of meaning for the phenomenon of study (indigenous practices and

knowledge systems in managing mental disorders) that carried more general and transferable insights. The researcher then read each meaning with the following questions in mind, namely, ‘within the total context of this transcript, what did this change of meaning tell me about the experiences of the phenomenon in a more general way? How could I express this specific quality in such a way that it does justice to the concrete situation, yet indicates the more general meanings? Here the researcher went beyond the language used by the participants to formulate the sense and meaning of the particular expression for what it could tell further about the phenomenon under study, that is, formulation of meanings from significant phrases and statements.

The next phase involved formulation of essential general structures that is clustering by grouping related meanings of statements and phrases, in the form of categories and subcategories into themes. This process involved the synthesis of transformed meaning units into a consistent statement of the invariant themes that ran through the different experiences and concrete occasions. The aim was to establish what was typical of the phenomenon and to express such typicality in an insightful and integrated manner. The researcher used own intuition of the whole sense of the different accounts of the experiences as well as the transformed insights contained in the discrete meaning units to articulate, formulate and synthesize the typical themes that arose from the life-world descriptions. In a sense the whole experience was put in language in a communicative way in order to achieve descriptive adequacy, that is, in a way that accounted for the specific meaning units. During this process the researcher had to go back and forth between the emerging formulation of the general structure of the phenomenon-as-a-whole and the individual experiences (parts) to see how the formulations better make sense of the parts, and

to see whether the emerging formulation needed to be refined in some way in order to better account for some parts. The communicative concern was to find ways of expressing the general structure in a narrative form that facilitates understanding in readers. The researcher undertook this communicative task in a narrative and accessible form to express how she achieved own digested understanding of the essential structure of the phenomenon to arrive at the themes, as new knowledge derived from the participants about the indigenous knowledge and practices. According to Speziale & Carpenter (2007:86) this process is referred to as the describing operation wherein the essence is to communicate and bring to written and verbal description distinct, critical elements of the phenomenon. These processes in the practical sense occurred simultaneously. The summary of the approach and stages of data analysis followed are outlined in the table 2.1 below:

Table 2.1: Summary of stages of data analysis

STAGE	PROCESS ANALYSIS
Transcription and Familiarization	Transcriptions and descriptions read by the researcher
Content Analysis (a process of immersion)	In depth understanding of content by researcher
Inducing themes and categories	Grouping significant statements and phrases into columns of themes categories and sub-categories
Coding	Formulation of meanings from significant phrases and statements
Clustering	Group related meanings of statements and phrases, to reduced number of themes, categories and sub-categories
Preliminary data analysis and recording	Draw up analysis and meaning from data and record

Themes that emerged from the data collected were:Community beliefs; delayed decision making; perceived causes; health system factors.

2.9 ETHICAL CONSIDERATIONS

In any study, ethical considerations are vital because they ensure the safety of both interviewees and researchers, ensure good quality research and promote professionalism. Some of the ethical themes that were carefully applied to ensure

protection of participants included informed consent, minimizing harm and ensuring protection and confidentiality.

Informed consent:

Prior to conducting the study permission was obtained from the District Commissioner and the District Health Officer of Dedza in order to use the district as the study area. Refer to appendix B and C. Before starting interviews oral consent as indicated in appendix 3 was obtained from the participants as some of them were illiterate. Participants were also made aware of the consequences of their participation as well as the objectives of the study. This was done in local language so as to enable the participants to understand the process better. The researcher made it clear to the participants that the data was to be used strictly for academic purposes, and all participants participated voluntarily and were assured of confidentiality (Babbie, 2011:522-523). There after a written consent was obtained from possible participants who were willing to participate.

Minimizing harm:

The researcher was careful to avoid inflicting stress on respondents considering that nursing research should never injure the people being studied, regardless of whether they volunteered for the study or not (Polit et al,2008:170). Care, for example, was taken in choosing a venue in which respondents would feel comfortable without any disturbances and also proper explanation on the use of a recorder was done to allay anxiety.

It was most likely that participants could perceive the research as threatening but the researcher avoided mental harm in terms of shame or embarrassing the participants

or causing physical harm. Therefore, the researcher treated all respondents with respect and with the dignity they deserved (Hennick, et al 2011:67).

Anonymity and confidentiality:

Another ethical issue relates to confidentiality. The participants remained anonymous as no names were used in the data collection instruments, and strict confidentiality of the proceedings was upheld. This was achieved by removing any information that could identify the participants from the recorded interviews and transcribed data (Hennick et al, 2011:71). This was done in order to induce the participants to give honest answers. Furthermore, the interview transcripts and tape recorder was kept safe by the researcher. Disposal of these materials was to be done two years after completion of the research.

2.10 CONCLUSION

This chapter presented the research methodology employed in conducting this study, with special focus on processes followed in collecting and analyzing data so as to elicit an in-depth understanding of the indigenous knowledge and practices regarding management of mental disorders in Dedza district. Relatives of mental health care users constituted the entire population of the study and were sampled through the use of a purposeful sampling technique. In terms of data collection, the chapter highlighted the use of in-depth interviews. Data analysis processes were discussed in detail as well as the ethical considerations.

CHAPTER 3: DISCUSSION OF RESULTS AND INTERPRETATION

3.1 INTRODUCTION

In chapter two the researcher explored and described in detail the methodology adopted in this study. In this chapter, the findings of the study were presented.This chapter aimed at presenting the views of relatives of mental health care users regarding the use of indigenous knowledge and practices in the management of mental disorders in the Dedza district. The findings were derived from data collected through in-depth interviews with the relatives of mental health care users. The results were presented in the form of themes derived from the research data in response to the research questions. The research questions were:

- How do Malawians refer to the symptoms that prompted you to seek mental health care services?
- What are the traditional methods used by Malawians to treat and manage mental illnesses?
- Based on your experiences of both the western and the traditional health system methods, what are your views with regard to both methods?

3.2 DEMOGRAPHIC DATA

The results on demographic details of the participants were presented in Table 3.1 as a summary of the characteristics of the relatives of the mental health users interviewed in this study. The demographic data were presented mainly for ease of reference and subsequent discussion. A total of fifteen participants were interviewed. All participants were drawn from selected clinics in Dedza district. The clinics included static and mobile ones. The participants came from Traditional Authority Kamenyagwaza, Kachere and Kasumbu and were found in mental health care

follow-up clinics of Dedza, Bembeke and Chongoni. Six participants were interviewed at Dedza clinic, five and Bembeke and four at Chongoni. Seven were male participants and eight were female participants.

Table 3.1: Summary of the characteristics of the relatives of the mental health users interviewed in this study.

Participant Code	Age	Sex	Type of relation	Location of stay	Name of Clinic
O1	26	F	Husband	Urban	Dedza
02	34	F	Daughter	Rural	Dedza
03	49	F	Son	Urban	Dedza
04	37	M	Son	Urban	Dedza
05	42	M	Brother	Rural	Dedza
06	53	M	Wife	Rural	Dedza
07	36	M	Wife	Rural	Bembeke
08	+50	F	Son	Rural	Bembeke
09	50	F	Wife	Rural	Bembeke
010	25	F	Sister	Rural	Bembeke
011	+50	F	Son	Rural	Bembeke
012	36	F	Son	Rural	Chongoni

Participant Code	Age	Sex	Type of relation	Location of stay	Name of Clinic
013	33	F	Mother's friend	Rural	Chongoni
014	48	M	Son	Rural	Chongoni
015	51	F	Daughter	Rural	Chongoni

3.3 Themes that emerged

The following themes emerged from data analysis:

- Community beliefs
- Delayed decision making
- Perceived causes
- Health system factors

The themes were classified into categories as shown in Table: 3.2:

Table 3.2: Themes and categories on indigenous knowledge and practices of the people of Malawi regarding management of mental disorders.

NO.	MAIN THEMES	CATEGORIES
1	Community beliefs	• Beliefs in traditional healers • Religious beliefs • Multiple care seeking.

2	Delayed decision making	• Consultations before seeking care • In ability to make own decision.
3	Perceived causes	• Witchcraft. • Evil spirits • Alcohol/substance abuse • Other causes
4	Health system factors	• Quality of western mental health care services. • Poor health worker attitude. • Long waiting time • Lack of psycho-education

3.3.1 Discussion and presentation of themes

This discussion was on the themes and categories and was supported by direct quotations from the participants as well as from literature.

3.3.1.1. Theme: Community beliefs

The cultural beliefs that the relatives of mental health users held were related to traditional healers, religious beliefs and multiple care seeking behaviours.

Table 3.3: Categories for community beliefs

beliefs in traditional healers	Religious beliefs	Multiple care seeking behaviour

Beliefs in traditional healers

Relatives of mental health care users preferred taking their mental health care users to traditional healers as their first option. Western health care clinics were only consulted only when there was no improvement from the traditional healers' treatment. Such an approach contributed to delays in treating mental illness during the acute phase and led to the illness progressing to chronicity. .

> *"When my relative got ill, and we saw that it was mental illness we went to a traditional healer, we were admitted for a month but there was no improvement. After some time other people advised us to try a government hospital and we did. "*

> *"We did not sleep that night, things were bad so someone told me that at Chigwa (one of the places in Dedza), and there is a traditional healer who is good in treating mental disorders so I rushed there. But aaa nothing changed, that is why I am here now."*

In a study by Patel (2011:2), it was revealed that in Uganda, people with mental illness continued to visit traditional sector despite the increase of awareness in biomedical treatment.In addition, another study in South Africa found that 45% of the black patients that attended a community mental health clinic had consulted a healer for their problem and 26% were simultaneously seeking treatment from traditional healers and psychiatrists (Ministry of Health South Africa and World Health Organization, 2007).

Although beliefs in traditional healers were observed, participants expressed doubt in the efficacy of traditional medicine. The participants pointed out that at traditional

healers they were given a variety of medicines but their mental health care users showed little or no improvement at all.

> *"As for me I have taken my son to traditional healers and indeed they were giving us different types of medicines but the illness was progressing, he continued beating people, throwing away food aaaa it was not nice at all. I thought that it was just expensive so we decided to try the hospital. Look at him now, he is calm though at times he talks to himself but he is much better."*

Seeking help from traditional healers as the first option was reported to apply to other illnesses as well, though very much pronounced with mental illness. These findings are in line with findings in studies conducted in South Africa.Burns, Jhazbhay, and Emsley, (2011)in a study on causal attributions, pathway to care and clinical features of first-episode psychosis revealed that in South Africa many people subscribe to traditional belief systems and consult traditional healers for mental illnesses.

Yet another study conducted in South Africaon Collaboration between Traditional Practitioners and Primary Health Care Staff, revealed that the majority of the black South African population in South Africa utilized both traditional and public Sector Western systems of healing for mental disorders (Campbell et al, 2010:611).

In Nsereko (2011), the belief in traditional healing was noted to be so strong, that even when traditional healers realized that they could not be of help and send patients to health facilities, the patients did not go but instead tried other traditional healers only accepting the health facility as an option much later in the illness process.

However, the situation in India is more complicated because many people adopt a pluralist approach to health care and are willing to access a range of services, some of which may not be congruent with their conceptualization of the health problem, for example they can seek biomedical solutions for problems perceived to have social or even supernatural problems (Charles, Manoranjitham and Jacob 2007:325-332).

Religious beliefs

The cultural belief systems of relatives were related to religious beliefs wherein the relatives saw prayers as the only method of healing and as such were forbiddenby their churches from accessing other mental health care serviceslike clinics and even terminated treatment on their own with the hope that prayers would bring about permanent recovery.

> *"We are strong believers and we like praying so at first I didn't know that my wife had a problem. I just thought that maybe she was hearing real voices, that something will happen at our place so we were just praying, praying. We went to different churches. When we went to Soul Winners Church she improved but then she relapsed after giving birth to this child and it was worse this time so she was taken to Zomba mental hospital. After discharge we started visiting this mental health care clinic because that is what we were advised to do on discharge.*

> *"I believe that my son will get better one day with assistance from God. I know that this is the will of God and he is going to be fine one day".*

Even though some churches do not allow members to go to the health facility some members go there secretly.

“My son has been sick for a long time and we have been attending prayers at my church with little improvement. We are not allowed to seek medical treatment but then we had no peace at home so I decided to take him to a health facility and he is now calm”.

In Nsereko (2011:10) it is reported that it is becoming a common practice for many frustrated people to run to churches for consolation and prayers or in the pretext of getting saved, when they are overwhelmed by problems in life. Preference for healing prayers was observed in East Africa wherein Teuton et al (2007) statedthat in East Africa, spiritual forces guide the health seeking behaviors such that mental disorders are often attributed to the influence of Satan and interventions include prayer, deliverance and counseling. Whereas Patel (2007) made reference to a similar view stating that that spiritual models of illness causation are common in Africa such that they represent an indigenous model to explain the distressing symptoms of non- psychotic mental illness.

Furthermore, studies have revealed that African Americans believe that mental disorders improve on their own without treatment and prefer to seek guidance for psychological concerns from the clergy, non-health professionals and family or friends than from the professional mental health resources (Knapp et al, 2006).

Multiple care seeking

The findings reveal that community beliefs in relations to those of relatives, led them to multiple care-seeking behaviours as it was common for the relatives of mental health care users to go to the health facility first and then to the traditional healer

especially when the illness persisted after taking traditional medicine. It emerged from the data that some participants combined both traditional and Western medicine as they indicated that it works either way, like one could start seeing a traditional healer first then visit a mental health care clinic or vice versa. However, the participants admitted failing to identify the effective type of care between the two systems since treatment was offered at the same time.

> *"In 1987 we came to hospital but by then the illness was just starting, she responded and we were discharged. Although she responded we took her to a traditional healer where she was treated. She relapsed after some years and this time we took her to a traditional healer and she responded. This time we went straight to hospital."*

> *"When my son got ill I decided to go to mental health care clinic but my relatives went to a traditional healer so he was taking both treatments - it is not easy but it worked."*

Abdulraheem and Parakoyi(2009:679) reported that health care-seeking behaviour in rural communities in developing countries is pluralistic based on the perception and labeling of illnesses such that relatives delay treatment as they move from one provider to another and this consequently led to progression of illness to chronicity.

3.3.1.2: Theme: Delayed decision making

Delayed decision makingwas characterized by consultations which had to be undertaken before seeking care for the user as well as inability to make own decisions about the care of the user. The relatives had to consult with extended family members before seeking care for the mental health care users. They were also unable to independently take decision as any decisions taken have to be agreed upon by the whole family. Any action or behavior contrary to this belief system would have been interpreted as a violation of cultural norms.

Table 3.4: Categories for Delayed decision making

Consultations before seeking care	Inability to make own decisions

Consultations before seeking care for the mental health care user:

Consultations before seeking mental health careas a feature of indigenous practices as decisions to take the mental health care users for treatment were predominantly made by the immediate family members like father and mother. Yet there were instances where the extended family members had to be consulted and had to have a say as what steps to be taken in managing the mental health care user. The data revealed that the decision making process involved a chain of people within the extended family and local leadership system.

“We came late because her uncle stays in Salima District so we were waiting for him to tell us what to do”.

lnability to make own decisions

Inability to make own decisions by relatives of mental health care users was related to indigenous practices as the data revealed that participants explained that they took the mental health care users for assistance to places recommended by the relatives. The interpretation of this practice was that the relativeswere unable or not allowed to make their own decisions following thecondition of the users.

> *"When my son got sick I took him to hospital but other people at home advised me to take him to a traditional healer which I did, but after sometime there was no improvement so Iwent back to hospital."*

Consultations done and decisions taken before taking a mental health care user to hospital may originate from cultural assumptions about causes of mental disorders (Gupta 2010:13). Although this may be viewed as an exercise of authority over the family, it is also a way of getting advice from elders on what could be the cause of the mental illness.

3.3.1.3: Theme: Perceived causes of mental disorders

Culturally perceived causes of mental disorders were related to witchcraft, evil spirits, alcohol and substance abuse and other causes.

Table 3.5: Categories for the theme: Perceived cause of mental disorders

Witchcraft	Evil spirits	Alcohol/substance abuse	Other causes

Witchcraft

Relatives believed that traditionally mental disorders were associated with witchcraft.

*“My son got married to a lady in another village but suddenly they brought him back to me while sick. Since then they have never come back to see him, on top of that they took over my land while I was busy looking after him. I know*why, *my son was doing well in his tomato garden and they thought that I would become rich. Aaa! Something was done to my son. He was bewitched.”*

“For me I see that eee, though I don’t believe but the relationship with her relatives is not good, just imagine that they never come to our house to visit us. She was bewitched. What can one say there, there is something indeed.”

Literature shows that the choice of where to seek help depends on what is believed to be the causal factor of illness.A study by Ali and Jaham (2012) revealed that there was a wide spread belief in supernatural causation of mental illness in care givers of persons with mental disorders and it influenced pathway to psychiatric care.Similarly, in Africa witchcraft and possession of evil spirits are believed to be amongst the many causes of mental disorders as revealed by several studies. In Uganda, it was revealed that mental illness is perceived to be due to witchcraft, curses and evil or ancestral spirits. Help is therefore, mostly sought from traditional healers first and with western form of care systems used as a last resort (Nsereko, et. al.,2011). Furthermore,in Zambia, the Zambian mental health profile (1998 -2002)revealed that cultural beliefs about mental disorders are attributed to spirit possession or social punishment and witchcraft, which can only be treated through traditional means and not conventional medicine.

Evil spirits

Although data revealed that traditionally the cause of mental illness was attributed to witchcraft, evil spirits were also identified as a cause.

“Our father passed away so we were thinking that it was the evil spirits from him that made my son sick, then we went to his grave to make a tombstone so that the evil spirits should come out of him.”

In Uganda mental disorders are associated with witchcraft, curses and evil or ancestral spirits (Nsereko et al.2011). Similar findings in a study conducted in Malawi, (Crumlish et al.(2007:263) reported that auditory hallucinations were interpreted as voices of deceased ancestors and traditional healers were consulted.

Drug and alcohol abuse

The results revealed that culturallymental disorder in some mental health care users was as a result of either alcohol or drug abuse. However, data also revealed that in some instances there were doubts about drug abuseas drugs were usually used in privacy.

“I don’t know the cause of this mental disorder for my son because in our family there is no history of mental illness but being a school boy it can be that he was smoking dagga(Indian hemp used as a narcotic). He must have smoked, you know these school boys”.

“Hmm, it is difficult to know the cause of this problem because my son was a good man. He was a business man and was doing well but he started drinking a lot, maybe this can be the cause of his illness”.

The monitoring exercise by Malawi Human Rights suggests that in Malawi alcohol and substance abuse is ranked as the leading causative factor of mental disorders for males and depression for female mental health care users.

Other causes

Although people hold different views on causesof mental disorders, results revealed that there was also uncertainty as to what could have caused the relatives' mental disorder from a traditional perspective.

> *"For me I don't know what caused this illness, at home we just think that he is sick, it is one of the illnesses, that is all- nothing else".*

3.3.1.4 Theme: Health system factors

Health system factors from a traditional sense were related to culturally incongruent services, health worker attitude, lack of psycho-education and long waiting time as depicted in Table 3.6.

Table 3.6: Categories for theme: Health system factors

Culturally incongruent services	**Health worker attitude**	**Long waiting hours**	**Lack of psycho-education**

Culturally incongruent services:

Relatives regarded services as culturally incongruent as they were based on a foreign culture and as such sought help from other sources which had a Malawian traditional approach instead of the Western mental health care clinics.

> *"When my son got sick, we took him to a traditional healer in Mozambique because we were advised that this traditional healer is performing wonders on mental disorders, and there is a good waiting place".*

"… mental health care is different at traditional healers, at a traditional healer you are given several types of medicines as well as tattoos".

However, results revealed a degree of mixed feelings or contradictory experiences as data revealed an indication of satisfaction with the western methods.

"I don't have problems at this mental health care clinic. I met the nurse who is in the other room when I first came here and to say the truth the services are good."

"Sometimes it is good to say the truth. For me I have been visiting this clinic for some time now but I have not had any problems though at one time the drugs were not enough. That nurse but (I don't know her name) is very nice and kind. You know the first time we were admitted at the district, my son was very aggressive, others were not happy with his behaviour but she was giving him injections until my son was calm again. She kept on reassuring me that with time my son will be calm."

Health worker attitude

Health worker attitudewhich were depicted as negative from a traditional perspective, contributed to mental health care users being taken to traditional healers. The study revealed that participants were not free to discuss their experiences regarding heath workers' attitude. However, the findings show that health workers were depicted as unfriendly and disrespectful.

"As for me I have never been insulted but most people complain about this behaviour, I don't know why. Sometimes health workers say patients are

demanding, sometimes the time patients come they are not prepared to assist."

"I was insulted but I don't know why, she just started shouting at me. I just thought that I was just unlucky or it was my misfortunes from home. It is not good."

Furthermore, the study revealed that the reception at traditional healers was good as compared to that at mental health care facilities. Examples of statements on preference between western and traditional approaches were as follows

"At the hospital the treatment is good and it is better than at the traditional healer because the patient is examined. However, at the traditional healer the reception is good. That is one way of attracting people; it is business so they try hard not to disappoint customers."

On health worker attitude within the western health care systems, studies seem to associate this with the stigma attached to mental illness as many people who would benefit from mental health services chose not to pursue them or fail to fully participate once they have begun. One of the reasons for this disconnect is stigma, namely to avoid the label of mental illness and the harm it brings. Furthermore stigma diminishes self-esteem and robs people of social opportunities (Watson,Corrigan, Larson and Sells 2007).

According to the World Health Organization (2005), stigma about mental disorders and discrimination against patients and families prevent people from seeking mental health care. Similarly a study in India on community beliefs about causes and risks for mental disorders, reported that the vast majority of care for people with mental

illness was provided by the family and the reasons include substantial concerns about stigma and discrimination, as a result many people remained untreated (Kermode, Bowen, Arole, Joag and Jorm 2007).Furthermore, literature has shown that in African American culture admitting that one has a mental illness is sometimes viewed as a personal weakness, and such the perceived stigma deterred African Americans from discussing their mental health with family members and from approaching professionals concerning services (Alvidrez, Snowden, and Kaiser, 2008).

Similarly, the Zambian mental health country profile (1998-2002), indicated that people who are mentally ill in Zambia are stigmatized, feared, scorned, humiliated and condemned. Community support is low largely because most mentally ill are considered as invalids who have little to contribute. Furthermore, the family members of those affected with mental disorders often also stigmatize this condition as a result they take their relatives with mental illness to a traditional healer first.

Interestingly, even health workers who are viewed to have a better understanding of mental illness stigmatize the condition. A study in Nigeria by Chikaodiri (2009:19) conducted to determine health worker's opinions about caring for psychiatric patients in a general hospital,revealed that stigma was abound among health workers in most cultures. Similarly in Malawi, a study conducted to assess attitudes towards mental illness in Malawi concluded that stigma exists across the globe, including Africa where culturally appropriate interventions will need to be developed.

Studies and available literature in this subsection show that negative attitudes more especially as associated with stigma against mental disorders, is a common practice

globally. Such practices negatively impact the consultationwith western mental health care methods.

Long waiting time

Although the results revealed a degree of satisfaction with the care at the mental health care clinics, there were some areas which needed improvement like waiting time as people waited for long periods for services especially at the mobile clinics Where at times the mobile team visits two or more facilities in a day so by the time they reach the final health facility the mental health care users were tired.

> *"I started off early in the morning to escort my daughter to the clinic. We have been sitting there waiting for this mobile vehicle. Iii we have no choice but to wait because if she misses the drugs, she relapses. We are tired and hungry."*

Lack of psycho-education

Lack of psycho-education emerged as a sub-theme of health system factors asrelatives were not given information as regards the diagnosis of their relative's illness,the cause of the illness and the treatment that they got from the western mental health care clinics.

> *"Aaa!I was not told the name of the drug but they are very small white tabletsto be taken twice a day and then I was given big white ones to take at night. Initially he was taking the big tablets twice a day, in the morning and at night."*

> *"I was not told the name of the illness but I think they call it mental illness because when I was on the queue with my son who is sick, the ward attendant (the one who puts on the green uniform) said all those who have*

come with mental illness should go to that room. But the nurse inside did not tell me anything. She just asked my son some questions and then she told me that it is important that I should be coming with him for follow up care every month".

However, data revealed some inconsistencies on the issue of psycho-education as there was an indication that participants had been told by the nurse the type of illness, its causes and the type of treatment the mental health care user was given.

"When I first came here we were told everything only that my son was aggressive so they gave him an injection to sleep and he slept."

On healthcare healing systems, the prevailing attitude of health workers towards mental health care users who consult services for mental and emotional problems, is an important enabling factor in the process of consulting mental health services.A similar view is addressed in Andersen's model of health service use, wherein it stated that several factors must be in place to motivate patients' use of health services. Such factors include availability of professional mental health workers and their attitudes towards patients, the quality of health care services and availability of drugs and other equipment.In Kauye, Chiwandira, Wright, Common, Phiri, and Mafuta(2006)it is reported that in Malawi, the commonest reasons which discouraged mental health users from seeking treatment from a health facility, were related to service delivery rather than home or community constraints. Other reasons included inadequate drugs at the health facility, financial costs, lack of professional mental health workers especially at primary level, poor quality of care and lack of local data on mental health care.

However, evidence suggests that mental health care systems in many countries are seriously under-developed, yet mental health problems not only have huge consequences for quality of life, but particularly in low andmiddle in-come countries, they also contribute to economic burden and reinforce poverty (Knap, Funk, Curran, Prince, Grigg and Mc David 2006:157-170).

Similarly, a study by Hellium and Swartz (2010) in South Africa on factors influencing access to health services among Xhosa speaking people with psychosocial disabilities in Madwaleni, reported that availability of mental health care services was limited in this community, and where services were available, there was limited use and access to them. In addition, mental health care users needed to be assured of the presence of skilled mental health professionals at the facilities in order for them to consult them during the acute phase of illness. With regard to western health care systems, a monitoring exercise on mental health services by Human Rights commission revealed that the Malawian public health system is grossly compromised by not having adequate health workers, and the shortage of health care professionals is even acute in mental health services (MHRC, 2012).

However, Kauye (2011) urges that inappropriate deployment contributes to shortage of professional mental health workers, whereas the country has been training psychiatric nurses for over twenty years, but most of them are absorbed into general nursing duties and only a few carry out mental health related activities.

Furthermore, in 2009 the World Health Organization identified Malawi as one of the countries in Sub- Saharan Africa with limited resources for people with mental illnesses and where there is great need for scaling-up services for people with mental health problems.

On the nature of service delivery, accounts by many participants in a study conducted in Uganda to examine the views of the people on mental health seeking behaviour revealed that the way in which care is delivered is a major influencing factor in help seeking behavior (Nsereko et al,2011). The widespread choice of traditional healing as a mode of treatment was seen to be influenced by the way in which traditional healers deal with clients. Most people feel that traditional healers have good counseling skills, they give good care and have enough time for the patient. This is in contrast with the conventional psychiatric practitioners who are believed to be brief and not conclusive (Nsereko et al 2011).

The issue of culturally congruent care is important in motivating people to use health services. Despite this fact, evidence-based descriptions of culturally competent psychiatric nursing care are scarce. However, in a study conducted to explore whether African American clients with mental illness think that psychiatric nursing care is effective in meeting their cultural needs and if psychiatric nurses think that they provide culturally competent psychiatric nursing care, it was indicated that clients had problems identifying and describing their cultural needs. Interestingly, the nurses who believed that their care met the cultural needs of their patients would not express what they did to make sure that the client's cultural needs were met. It was therefore, concluded that both the nurses and patients lacked information about culture and how it affected psychiatric nursing care (Wilson, 2010).

In addition, research around the world is validating the theory of cultural care as an important means to provide culturally congruent care to families, clients and groups of diverse cultures (Whaley, Arthur, Davis and King, 2007).A study in Ghana by Read, Adiibokah and Nyana, (2009) on local suffering and the global discourse of mental health and human rights concluded that maltreatment of the mentally ill in

many low-income countries is common in psychiatric hospitals. Chaining and beating of the mentally ill was found to be common in homes and western treatment centers that were studied, an indication of culturally incompetent services.

Findings from a study in America suggest that Afro-Americans view mental health providers with mistrust, stemming from experiences they have had with culturally incompetent therapists (Alvidrez, Snowden, &Patel, 2010).

Similarly, in Malawi the monitoring exercise of the mental health services found that the conduct of staff especially nurses was generally hostile at the Zomba mental hospital. The nurses were not willing to assist and did not take patients' concerns seriously and this made it difficult for the mental health care users and their relatives to express discontent (MHRC, 2012).

Furthermore, Shankar, Saravanan and Jacob (2006:222-223)state that the ExploratoryModels of Common Mental Disorders Among Traditional Healers and Their Patients in Rural South India suggest that an understanding of local patient perspective of common mental disorders allows modern medicine to provide culturally congruent care.

However, in Malawi, the cost of services did not seem to influence the health seeking behaviours of Malawian as the services are free. The only explanation for preference of traditional systems of care seem to be the culturally incongruity of services. The results of this study was based on the views of relatives of users who were of Malawian culture, seem to indicate that there is need to create awareness and to develop strategies to address the needs of the indigenous Malawians within the hospitals and the clinics instead of treating them as second class citizens in their own turf.

3.4 Alignment of this study processes on indigenous knowledge systems with Leiningers' Transcultural Nursing Theory:

The study processes on determining the indigenous knowledge and practices systems of relatives of mental health care users in Malawi with regard to the management of mental disorders seem to bear resemblance to the principles of Leininger's transcultural nursing theory. This theory refers to a set of interrelated cross-cultural nursing concepts and hypotheses which take into account individual and group caring behaviours, values and beliefs based upon cultural needs to provide effective and satisfying nursing care to people. According to Leininger's theory if health practices fail to recognize the culture specific aspects related to individual's needs, there will be signs of less effective nursing care practices with potentially unfavorable consequences to those served. In essence, the transcultural nursing theory is based upon the belief that transcultural nursing care practices should be derived from a careful study of a cultural group's diverse beliefs, values and caring behaviors so that health and nursing care will be able to identify and implement care which is not only culturally specific, but which will also include universal care practices. Leininger's theory is also based on the premise that cultures can determine most of the care the cultural groups desire or need from professional care-givers, and that the local culture's view, knowledge, and experiences are important determinants for planning and implementing nursing care (Leininger, 1978: 33-34). The relevance of Leininger's theory to this studyis now discussed. Firstly study has been conducted amongst the indigenous Malawian relatives of mental health care users to determine what they perceive as culturally congruent services in relation to their beliefs systems, values and practices.As in Leininger's Theory, this study has discoveredthe diverse and universal culturally care

based factors that influence the Malawians' mental health and illness practices. The results of this study have revealed that Malawians have their own indigenous knowledge and practices systems which influence their mental health care seeking behaviours. The results on the indigenous mental health care practices and belief systems determine most of the care the Malawians desire or need from professional care-givers and have a potential to serve as important determinants for planning and implementing nursing care (Leininger, 1978: 33-34).Suchindigenous knowledge and practices systems could serve as important determinants for developing a conceptual framework for culturally congruent mental health care policies, programs and services and to direct the nursing care rendered to the indigenous Malawians. The study seem to indicate the Western health care systems as currently practiced are culturally incongruent and as such, as espoused in Leininger theory, Malawians people choose not to consult with modern medical treatment and procedures except only when the traditional treatment methods have failed.

The need for clinicians to become more sensitive to cultural differences and gain an understanding of transcultural concepts has been repeatedly stressed by Leininger (1988) and this view has been captured in this study in relation to the professional health worker attitudes and long waiting hours in the clinics which seemed to further impact negatively on the mental health care services rendered to the relatives and the mental health care users.

In this study recommendations have been made with reference to the incorporation of Malawians indigenous knowledge and practices on mental health systems into the general mainstream health care services of the country to promote culturally sensitive services.Due to the recurrent concerns regarding the challenges encountered in the care for culturally diverse patients, transcultural care has become

an important aspect of health care. The goal of the medical system is to provide optimal and holistic care for all patients and as such cultural congruity seems to be an important ingredient for quality patient care.

3.5 SUMMARY

This chapter has presented the findings of the study. Firstly, the demographic details of the respondents have been high lightened. Secondly, themes that emerged from the in depths interviews have also been presented, interpreted and discussed. The relevance of Leininger's Transcultural Nursing Theory has been discussed as a theoretical foundation for the results of this study. Chapter 4 presents the conclusions, limitations and recommendations pertaining to the study.

CHAPTER FOUR:CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

In this chapter, the conclusions, limitations, summary and the recommendations of the study, are presented.However it is necessary to remind the reader of what has been discussed in the previous chapters in the process of discovering new insights and knowledge.

Chapter one presented an overview of the study covering the background to the topic under study, made reference to the free health/mental health care services in Malawi as a strategy to reduce the burden of disease. The research problem highlighted that even though mental health care services were free of charge, the use of western health care systems in the services, was a deterrent to the indigenous Malawians.There was an apparent absence or non-existence of information on the traditional mental health care knowledge and practices of the indigenous Malawians within the services. Indigenous Malawians delayed consulting the western health care services instead theirfirst option to consult was traditional healers.The gap in indigenous knowledge and practice system within the mental health care services motivated the researcher to conduct this study.The significance of the study was to contribute towards the development of mental health care services that were sensitive to the culture specific needs of the indigenous communities of Malawi and thus contribute towards wholistic quality mental health care services.

Chapter two presented the qualitative phenomenological research methodology employed in conducting this study until the emergence of the themes. The focus was on processes followed in collecting and analyzing data so as to elicit an in-depth

understanding of the indigenous knowledge and practices regarding management of mental disorders in the Dedza district of Malawi. Relatives of mental health care users constituted the entire population of the study and were sampled through the use of a purposeful sampling technique. Data was collected through in-depth interviews using an unstructured interview guide . Ethical issues were observed such that the rights of the participants were upheld. Data analysis processes were conducted to ensure the trustworthiness of the study in relation to credibility, confirmability, and to provide an audit trail of the study.

Chapter three presented the findings of the study in the form of the demographic details of the participants to give credibility and authenticity of the source of data and more so that the recorded interviews were transcribed verbatim for data analysis. The summary of stages used in data analysis were as follows, namely: transcription of data, familiarization with data; content analysis (which involved a process of immersion); Inducing themes and categoriesand subcategories by coding and clustering, a process which involved grouping of related meanings of statements and phrases to reduce the number of themes, categories and subcategories. Verbatim quotations from the data were used in the discussion of themes to substantiate the results. The results were further discussed in relation to available literature on similar studies.

The relevance of Leininger's Transcultural Nursing Theory was discussed to be supportive of the results of this study.The following section presents the concluding remarks on this study.

4.2 CONCLUSIONS

Theconclusions serves as an account of the achievement the objectives set for this study. Reference is also made to the implications of the results of the study to the broader mental health services in the Dedza District of Malawi.

The objectives of this study were as follows, firstly, to explore the views of the relatives of mental health care users with regard to indigenous knowledge and practices in the management of mental health disorders in Malawi. Secondly, to recommend suggestions for culturally congruent mental health care services to the indigenous mental health care users of Malawi. The following discussion focuses on the identified indigenous knowledge and practices of Malawians as well as the suggestions on how such information could be integrated with the Western health care systems to promote culturally congruent mental healthcare services.

The indigenous mental health care knowledge and practices of Malawians in managing mental health care problems are entrenched in their community beliefs, in the delayed decision making processes, in the perceived causes of mental disorders as well as their encounters with the Western health care systems.

4.2.1 The community belief systems

The Malawians have entrenched community belief systems which reflect a great reliance and confidence in traditional healers, religious beliefs and multiple care seeking practices.

Apart from traditional beliefs in management of mental disorders, the study revealed that some participants believed in healing prayers for mental disorders. This finding is supported by a study conducted in Kenya by Teuton (2007), wherein it is stated

that in East Africa the religious health systems diagnosis are undertaken under the guidance of spiritual forces and mental disorders are attributed to the influence of Satan and interventions include prayer, deliverance and counseling. Although the participants believed in healing prayers, the study observed that an element of mixing Western type of treatment with prayers was present. The implications are that the mental health care users delayed in receiving appropriate care which can lead into chronicity as they did not receive any medication during the period of prayers, in fact in some instances medication was forbidden.

Of importance is that health care professionals when rendering services to the mental health care users should respect these community belief systems as they determine the uniqueness of the Malawian people.Information onthe community belief systems can be identified from the user's history during the assessment phase of the nursing process and could be of value in determining the duration and chronicity of the illness. The process of consulting atraditional healer during the acute phase of illness could be an indication of the duration of the illness as well as the treatment regimen that has been prescribed by the traditional healer.

Of importance for mental health care professionals is that the study revealed that despite the reported community belief systems about mental illness, mental health care users end up being referred to the Western health systems for the relief of symptoms. In fact the very presence of the relatives of mental health care users at the research sites was an indication that there was reliance on the western health systems when all else had failed with traditional systems. There seem to be a need to stop the late consultation as it has a negative impact not only to the mental health care user, but also to the health care systems as a whole. Firstly the user has to be

admitted in hospital for the control of the distressing symptoms of mental illness. The nurses and other health care professionals are overworked because of the increase in admissions and readmissions. The economy of the country is also affected as the admissions of mental health care users for lengthy periods of time impacts negatively on the human as well as financial resources of the country. The family members of the users are also negatively affected as they are responsible for taking the ill relative to the traditional healers and have to ensure thathe/she adheres to the treatment protocols of the traditional healers. The relatives are continuously under pressure as they carry the burden of looking after someone whose behavior, thought processes and emotional expressions are bizarre. The pressure and strain of looking after a mentally ill individual whose condition is not improving instead is getting worse, forced the relatives to ignore the cultural beliefs and practices and consult the western health care systems in the form of a hospital or a clinic for a positive relief of the symptoms.

The assessment process also helps to determine what Malawians perceive to be the cause of a mental disorder and the related treatment approaches.

4.2.2 Perceived causes of mental disorders

The study revealed that the decision on the type of health service to be consulted for the mental illness is determined by what is believed to be the cause of the illness. Malawians attributed the cause of mental disorders to both biomedical and cultural causes. Mental disorders that were attributed to biomedical causes were taken to health facilities while those attributed to supernatural causes like bewitchment and acts of evil spirits were taken to traditional healers. In instances where the mental disorder was attributed to both biomedical and supernatural causes, the multiple

care-seeking behaviour and switching between health care providers were adopted. From the indigenous people's view point, there seem to be merit in both health care systems, hence the need to integrate both systems.

Supporting this finding is a study conducted in urban Malawi to assess the relationship between insight, psychopathology and functioning in schizophrenia wherein it is reported that the traditional explanation of mental illness in the area where the study was conducted, was bewitchment and traditional healers were frequently consulted (Crumlish et al 2007:262).

In addition, evidence suggests that there is a marked discrepancy in explanatory models of mental illness between Africa and other parts of the world. In a study by Read, Haslam and Davies (2006) on prejudice and schizophrenia, it is reported that the general public internationally preferred psychosocial and biogenetic explanation for mental illness. The authors also report that in Africa taking a mental health care user to a traditional healer explains the cultural perception while those with biogenetic and psychosocial explanation consult health facilities.

This study also revealed that mental illness was blamed to evil spirits as well besides witchcraft. In a case of evils spirits the treatment of choice as prescribed by the traditional healers was about conducting rituals and ceremonies as a means of obeying to the demands of the spirits. Such rituals or ceremonies were arranged either as sacrifices, like slaughtering of a beast, while others could be performed by erecting tombstones for the ancestors. Such performances take place during the acute phase of the mental illness, a situation which further contributes in delays in seeking appropriate care and thus contributing to the chronicity of the illness.

Of importance to note for the health care professionals, is that during these ritual ceremonies, even the mental health care user who are already on psychotropic

medication are usually forbidden from taking any prescribed psychotropic medication.Stopping medication without the doctor's orders, results in non compliance and thus relapse of the mental health care user with all the related negative implications.

The professionals need to educate the people of Malawi about the scientifically proven predisposition to mental illness and as well as the psycho-education in relation to signs and symptoms. Education to highlight that the clinical features of mental illness are related to the disorganized behavior, disorganized thinking and disorganized emotions, often characterized by hallucinations, delusions, depression, hyperactivity and disorientation to self, time, and environment.

The Zambian mental health profile (1998-2000) makes reference to the statement that both communities and professionals in Sub-Saharan Africa believe that mental disorders are associated with cultural and social beliefs and as such use similar treatment approaches.

Furthermore, the study found that in Malawi the relatives made reference to alcohol and drug abuse as another cause of mental disorders.This belief system about alcohol and substance abuse as a cause of some mental disorder has been scientifically proven in the Western health care system. The implications for health care professionals are that they need to focus on primary prevention of alcohol and substance abuse. In instances where the mental health care user is suffering from the effects of alcohol and substance abuse, mental health professionals should use the proven and tested methods of managing such problems. The methods should include the management of withdrawal symptoms, use of medication like dissulfaram, psychotherapies, cognitive behavioural therapies, family therapy, the

involvement of the multi-disciplinary team and referral to relevant NGOs in the community for rehabilitation and support to families of the affected individuals.

Similarly, Crabb et al. (2012:541) in a study on attitudes towards mental illness in Malawi, reported that most participants attributed mental disorder to alcohol and illicit drug abuse, brain disease and spirit possession.

4.2.3 Delayed decision making

The study revealed that in Malawi when a member of the family is suffering from a mental disorder, the extended family members are consulted for a decision on the management of the illness. The study found that even though the tradition is dying away due to changes in family structures and urbanization, the practice is still common in Malawi. The consultation process, which is usually a prolonged process, further contributes to a delay in taking the mental health care user for immediate intervention in the Western health care settings. From the researcher's experiences, such a practice could be dangerous, depending on the nature of the mental illness. For example, the mental health user could pose a danger to himself or herself and/or others during the acute phase of psychosis.

In practice the information about the identification of the decision makers could help with the identification of the meaningful others and support systems to the mental health care user and relatives. Such family members could be targeted for inclusion in the multi-disciplinary mental health team sessions, in the pre-discharge planning and psycho-education with special focus on the benefits of prompt consultations and the complications of delayed consultation during the acute phase of the illness.

Communities therefore need to be made aware of the complications related to delays in treating the acute symptoms of illness. Awareness could be created

through health education talks in public gatherings and through campaigns. The traditional healing systems and structures used by indigenous people, could be targeted for such education and campaigns.

4.2.4 Health systems

The findings revealed that in Malawi the relatives of mental health care users who had an experience on consulting with the Western health care services were negative about the Western methods. Malawians viewed Western health care systems to be of poor quality as the health care professionals had negative attitudes, were disrespectful, used language and terms that were foreign,were incompetent, had poor ineffective communication skills and had poor interpersonal relationships towards the relatives and health care users.The relatives made reference to being insulted and shouted at during the period of seeking mental health care services. Such behaviors werea culture shock to the mental health care users and their relatives.

The relatives were also dissatisfied with the long waiting time at the mobile clinics due to the shortage of staff andvehicles. The mobile clinic team arrived late at the clinic site as they had to conduct clinics at two or more clinic sides in a day.

The relatives made reference to lack of psycho-education as they were never informed about the condition of the mental health care user neither were they informed about the cause of the mental disorder and the type of treatment their mental health care users were receiving whereas the traditional healers do provide an explanation and link the cause of the illness, for example, to witchcraft, evil spirits and ancestral wrath. The Malawians preferred and seem related better with the traditional systems which were more user friendly, accommodating, use indigenous

languages and do spendsome time talking and engaging with the mental health care users and the relatives.

In support of these findings the Malawi Human Rights Commission stated that quality of services is compromised by limited resources like shortage of drug, limited financial resources, and shortage of professional mental health workers especially at primary level (MHRC, 2012:8).

These findings seem to be consistent with the findings in a study conducted in Uganda to examine the views of the people on mental health seeking behaviour which indicated that the widespread choice of traditional healing as a mode of treatment was seen to be influenced by the way traditional healers deal with clients. Most people felt that traditional healers have good counseling skills and have enough time for the patient. This is in contrast with the conventional psychiatric practitioners who are believed to be brief and not conclusive. This could explain the lack of psycho-education as revealed in this study.

The implications for mental health care professionals is that when interacting with indigenous Malawians, they need to use the indigenous spoken languages. The mental health workers need to be trained in adopting positive interpersonal skills, need to be trained to adopt emotional intelligence when interacting with the mental health care users and their relatives as is the case with the traditional healing practices. Relatives and mental health care user should be attended to promptly thus reducing the long waiting time for the mobile clinic services. Mental health care professionals need to be exposed to continuing in-service training to uphold the rights of mental health care users.The introduction of the suggestions as thus presented has a potential to increase the positive treatment outcomes.

The community belief systems on treatment approaches of the traditional healers are an important factor to consider for cultural congruity of mental health care services. The professionals need to not argue the ineffectiveness of traditional medicines, but need to educate the mental health care users and their relatives about the benefits of psychotropic medications as they help to relieve the distressing symptoms of mental illness on the mental health care users. Such education should include the possibility of drug interactions when Western medication is taken simultaneously with traditional medicines. The issue of relapse need to be included in education as it is possible in cases of non-compliance with medication. The non-compliance is an important factor to consider more especially in situation where some religious belief systems promote the predominant reliance on prayers with the exclusion of medication.

The discussion in this chapter has presented the perspective of what is regarded as the indigenous knowledge and practices of the relatives of mental health care users in Malawi with regard to the management and care giving mental health practices, with the view of promoting culturally congruent services. The discussion also addressed how best the indigenous knowledge and practices as identified could be integrated into the Western health care services to promote culturally congruent services.

4.3 IMPLICATIONS OF THE STUDY RESULTS

The implications of the study results are presented in relation to practice, education and research.

4.3.1 Recommendations for nursing practice

The research findings are suggestive of introducing culturally congruent services to address the mental health care needs of the indigenous people of the Dedza District

in Malawi and of the revision of the revision of the approaches used to deliver mental health care services. There seem to be an implied need to integrate western and indigenous health care systems, an area suggestive of further research to test this assumption.

4.3.1.1 Conduct sensitization campaigns

Mental health/psychiatric nurses should conduct sensitization campaigns in the communities about the availability and benefits of mental health care services. Communities should be sensitized on importance of taking mental health care users to mental health care clinics early to prevent chronicity and promote compliance with treatment regimens. The indigenous health systems whichare often consulted by relatives with regard to mental illness, to be targeted in such campaigns and education.

4.3.1.2 Rehabilitation programmes

Ministry of Health to establish and intensify substance abuse prevention and rehabilitation programs for mental health care users and their relatives who are associated with alcohol and substance abuse.There is a need for authorities in Malawi to introduce alcohol and substance prevention programmes and services to school going children, youth and out of school youth, with special focus oneducating them about the dangers of alcohol and illicit drugs and where to access services when the need arises.

4.3.1.3 Intensify outreach visits

Dedza District Health Office to consider revising strategies for outreach programs and increase the resource allocation for mental health services, with special focus on increasing the staff establishment, transport with more and frequent mobile clinics.

This could warrant that the increase of mobile clinics and the increase in the staff establishment for a dedicated specific cadre of community psychiatric nurses.

4.4 Recommendations for education

4.4.1 Intensify in-service education for staff

Include mental health/ psychiatric nursing topics on in-service training schedule for staff to learn about the indigenous knowledge and practices to enable them to render culturally oriented services. During history taking, nurses to determine the action taken related to consultation of traditional healers or spiritual healers as well as prescribed medication, where applicable. Such information will assist to determine the duration of the illness and to take into consideration the drug interactions that could occur as a result of use of concurrent use of traditional and western medication.

4.4.2 Colleges should include the study results in the nursing curriculum

The nursing colleges should consider including the results of this study as content into their mental/psychiatric nursing curriculum as a component of transcultural nursing education.

4.5 Recommendations for Research

Based on the findings of this study, there seem to be a need to replicate the research more extensively in order to explore broadly the indigenous knowledge and practices of Malawianpeople in other regions with regard to the management of mental disorders. Research could also focus on piloting the implementation of the recommended strategies in the various settings of mental health care nursing.

4.6 LIMITATIONS OF THE STUDY

The study was restricted to the geographical location of Dedza, only in three health facilities to be precise and the results therefore do not capture the essence of the indigenous health/healing system of the people of Malawi in other districts.

A further limitation relates to the use of language. The interviews were conducted in Chichewa and the collected data was transcribed and presented in English. The loss of somemeaning during the process of translation and interpretation is unfortunate, but often inevitable.

4.7 SUMMARY

Recommendations made were based on the suggestions to use the results of the study for rendering culturally sensitive mental health services to indigenous Malawians within the mental health care hospitals and clinics.

This chapter has presented the results of the study in relation to the set objectives of the study. The implications of the results for practice, education and research, have also been presented. The limitations and summary of the thesis has been presented.

4.8 CONCLUSION

The findings on the views of indigenous knowledge and practices of relatives of mental health care users who are Malawians, gave a perspective in relation to the community belief systems, the delayed decision making systems, the perceived causes of mental illness and the health systems' approaches.

The findings of the study seemed to indicate the need for an integrated approach when delivering mental health care services as both systems had positive and negative aspects. More so,that some relatives preferred taking their mental health

care users to traditional healers first rather than going to mental health care clinics. Whereas other relatives consultedboth health systems at the same time.

Further the findings seemed to point to a situation for a negotiated compromise for the benefit of the indigenous users and their relatives. From the experiences of the researcher such a compromise could be considered by involving the traditional healers within the multi-disciplinary mental health care team; by inviting the relatives and the traditional healers to be involved in the discharge planning for each mental health care user as well as the implementation of the discharge plan in the community. Such suggestions could be a negotiated compromise for the benefit of the user.

Health care professionals may need to be trained and familiarized with the indigenous knowledge and cultural practices when working in areas of diverse cultures. The predominant spoken and working language should preferably be geographically determined instead of imposing foreign cultures on to the indigenous people, without of course ignoring the benefits of acculturation.

The recommendations were that the results of this study should be used as guidelines to develop strategies for culturally congruent mental health care services to the indigenous Malawians as the development of the strategies was beyond the scope of this study. The focus of the guidelines to ensure the development of evidence-based nursing practices in rendering culturally congruent mental health services to the indigenous Malawians. Firstly, there should be an integration of both of the Western and the traditional healing systems to ensure a wholistic patient centered approach to the care of the indigenous people of Malawi; secondly to use the nursing process phases, starting with the assessment including history taking,

the formulation of the nursing diagnosis, the expected outcomes, the development and implementation of the nursing interventions and the discharge plans to incorporate the belief systems of the indigenous Malawians as identified in this study.

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APPENDIX A: APPROVAL LETTER FROM THE UNIVERSITY OF FORT HARE

University of Fort Hare
Together in Excellence

ETHICAL CLEARANCE CERTIFICATE

Certificate Reference Number:	TSH031SKAV01
Project title:	**Exploration of indigenous knowledge and practices of the Malawian people regarding mental disorders in Dedza District**
Nature of Project:	Masters
Principal Researcher:	Yasinta Kavalo
Supervisor:	Dr N Tshotsho
Co-supervisor:	

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instrument(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above.

Please note that the UREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the document
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research

The Principal Researcher must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

Special conditions: Research that includes children as per the official regulations of the act must take the following into account:

Note: The UREC is aware of the provisions of s71 of the National Health Act 61 of 2003 and that matters pertaining to obtaining the Minister's consent are under discussion and remain unresolved. Nonetheless, as was decided at a meeting between the National Health Research Ethics Committee and stakeholders on 6 June 2013, university ethics committees may continue to grant ethical clearance for research involving children without the Minister's consent, provided that the prescripts of the previous rules have been met. This certificate is granted in terms of this agreement.

The UREC retains the right to

- Withdraw or amend this Ethical Clearance Certificate if
  - Any unethical principal or practices are revealed or suspected
  - Relevant information has been withheld or misrepresented
  - Regulatory changes of whatsoever nature so require
  - The conditions contained in the Certificate have not been adhered to
- Request access to any information or data at any time during the course or after completion of the project.
- In addition to the need to comply with the highest level of ethical conduct principle investigators must report back annually as an evaluation and monitoring mechanism on the progress being made by the research. Such a report must be sent to the Dean of Research's office

The Ethics Committee wished you well in your research.

Yours sincerely

Professor Gideon de Wet
Dean of Research

17 March 2014

APPENDIX B: REQUEST FOR PERMISSION TO USE HEALTH FACILITIES IN DEDZA DISTRICT

University of Fort Hare,

Department of Nursing,

East London,

502.

20th February, 2014

The District Health Officer,

Dedza District Hospital,

P.O. Box 136,

Dedza,

Malawi

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am Yasinta Kavalo, a Master's degree student at the University of Fort Hare in the Republic of South Africa. One of the requirements for this qualification is to conduct a study in the related field. The title of the research study that I propose to do is "Exploration of indigenous knowledge and practices of the Malawian people regarding management of mental disorders in Dedza district".

The main purpose of the study is explore the indigenous knowledge and practices related to mental disorders so as to promote culture sensitive services in government hospitals in Dedza district as a strategy to increase utilization of mental health care services. The study will contribute towards the development of mental care programs and services that are culturally congruent to the indigenous communities of the

Malawian people. I therefore, apply for your consideration to grant me permission to conduct this study. Regards

Yasinta Kavalo (Mrs.)

APPENDIX C: REQUEST FOR PERMISSION TO CONDUCT A STUDY IN DEDZA DISTRICT

APPENDIX C: REQUEST FOR PERMISSION TO CONDUCT A STUDY IN DEDZA DISTRICT

University of Fort Hare,

Department of Nursing,

East London,

502

20th February, 2014

The District Commissioner,

Dedza District Assembly,

Dedza,

Malawi

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am Yasinta Kavalo, a Master's degree student at the University of Fort Hare in the Republic of South Africa. One of the requirements for this qualification is to conduct a study in the related field. The title of the research study that I propose to do is "Exploration of indigenous knowledge and practices of the Malawian people regarding management of mental disorders in Dedza district".

The main purpose of the study is explore the indigenous knowledge and practices related to mental disorders so as to promote culture sensitive services in government hospitals in Dedza district as a strategy to increase utilization of mental health care services. The study will contribute towards the development of mental care programs and services that are culturally congruent to the indigenous communities of the Malawian people.

I therefore, apply for your consideration to grant me permission to conduct this study.

Regards

Yasinta Kavalo (Mrs)

DISTRICT COMMISSIONER
DEDZA DISTRICT ASSEMBLY
2014 -03- 12
63
P.O. Box 140, DEDZA.

Permission has been granted

Director of Administration
12-3-2014

APPENDIX D: REQUEST FOR A CO-CODER

University of Fort Hare

Department Of Nursing

East London

502

17th April, 2014.

Mrs. Sophie Chirwa

University Of Malawi

College of Medicines

P/BAG 3600

Blantyre 3

Dear Madam

REQUEST FOR A CO-CODER FOR MY STUDY

I write to request you to be my co-coder in my study. I am studying at the above University for a Master's Degree in Psychiatric Nursing. My research title is Exploration of indigenous knowledge and practices regarding management of mental disorders. The study is qualitative in nature hence my request that you be my co-coder.

Your assistance will be greatly appreciated.

Regards

Yasinta Kavalo

APPENDIX E: CONSENT

(English version)

My name is Yasinta Kavalo a student at University of Fort Hare in the Republic of South Africa. I am conducting a research to explore the indigenous knowledge and practices of the Malawian people regarding management of mental disorders as part of my Masters course. I would like to get some information that will help in improving the management of mental health care users in health facilities. My interest is on the relatives of mental health care users who have experience managing them. The questions that I will ask you relate to the topic under study and everything you tell me will not be shared with anyone.

Do you have any questions about the study before we begin? Are you willing to participate?

RESPONDENT AGREES TO BE INTERVIEWED……CONTINUE

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED……..END

APPENDIX F: CONSENT-KALATA YOVOMEREZA KUTENGA NAWO MBALI PAKAFUKUFUKU

Chichewa version

Inendine Yasinta Kavalo, panopandikupangamaphuro pa sukuluya University ya Fort Hare mu dziko la South Africa. Mbaliimodziyamaphunziroangaimafunikakutimunthuupangekafukufuku, ndiyeinendikupangakafukufukuwokhudzanandimomweanthukumudziamaganizirako masozomweamachitaposamaliramunthuwodwalamatenda a misala.Zimenendingapeze pa kafukufukuameneyundikufunazidzathandizirekutichithandizochomwechimaperekedwakuchipatalachikhalechokomeraanthu a ku Malawi molinganandichikhalidwechawo.Chidwi change chiri pa anthuomweakusamaliraodwalamisalachifukwaathakundiuzamomweiwowoamamusamaliraodwalayu.Mafusoomwendikufensenindiokhudzamutuwakafukufukuyibasikomasozomweinumundiuzepanosindiuzamunthuwinaaliyense.

Mulindimafuso?

Kodi mwavomerakupanganawokafukufukuyu?

Ngatimunthuwavomera.....pitirizani

Ngati sanavomere.....osapitiriza

APPENDIX G: INTERVIEW GUIDE-UNSTRUCTURED QUESTIONNAIRE (English version)

CLINIC NAME.....

QUESTIONNAIRE NUMBER.....

DATE OF INTERVIEW.....

“Indigenous knowledge and practices of the Malawian people regarding management of mental disorders in Dedza district”

1. Based on your traditional culture as a Malawian, what did you do when your relative became ill?
2. What was the name or names of the illness that affected your relative?

The following questions guided the probes

1. Whom did you consult when the patient got ill?

1 What was the cause of the illness?
2 What treatment was given to your relative?
3 When you took your mentally ill relative to hospital, what was the name of the illness given by the nurses and doctors?
4 What did the nurses and doctors say about the cause of the illness?
5 What treatment was given to relative?
6 Having been exposed to both traditional and western approach of treatment, what is your preference between these two and what are your reasons?

APPENDIX H: INTERVIEW GUIDE- UNSTRUCTURED QUESTIONNAIRE
(Chichewa version)

CLINIC NAME.....

QUESTIONNAIRE NUMBER.....

DATE OF INTERVIEW.....

“Indigenous knowledge and practices of the Malawian people regarding management of mental disorders in Dedza district”

1. Kutengera pa chikhalidwechathu cha chi Malawi, munapangapochiyanim’balewanuatadwala?
2. Matendaameneanadwalam’balewanumunkawatchulakutichiyani?
3. Atadwalamunafusachithandizokwandani?
4. Chinayambitsamatendaamenewandichiyani?
5. M’balewanuanalandiramankhwalaanji?
6. Mutapitanayekuchipatala ma dokotalandianamwinoamatiakudwalachiyani?
7. Ma nurse ndimadokotalaamatimatendaamenewadzina lake ndichiyani?
8. Anamupatsamakhwalaanji?
9. Inumwapitakokwaasing’angakomasokuchipatala, pakati pa chisamaliro cha kwaasing’angandikuchipatala, inumungakondechitindipochifukwachiyani?

Appendix I: interview schedule

April 16, 2014	Bembeke clinic
April 16, 2014	Chongoni clinic
April 24, 2014	Dedza clinic

Participant's Code: 05 –Rural
What is your name? XXXXXXX

Sex: male

How old are you? 42

Where do you live? Kamenyagwaza

What is your religion? Roman Catholic

Q. Based on your traditional culture as a Malawian, what did you do when your relative became ill?

Participant: When my relative got ill, the time he became ill, before we came to hospital, when we saw that it was mental illness, we thought that maybe it was from evil people so we went to a traditional healer. Then after going here and there, there was no assistance so people told us not to waste time but to try the hospital, it can be that something is wrong with his brain, the health workers can see what to do. So indeed we went to hospital and we were admitted here for two months then we were discharged. After some time we cameagain for another two months and we were discharged but there was little improvement. Then we were thinking that eee should we go to Lilongwe but we did not have a referal letter. Some people were saying even if you go to Lilongwe or Zomba mental hospital the treatment is the same. There are a lot of people who are facing problems so better go to Dedza clinic which we did. At first when we came to get medication there was a problem because he was not taking the medication, so he was relapsing, relapsing, relapsing-pause-indeed madam.

Q. So at the traditional healer what treatment did you get**?**

Participant: At the traditional healer they were just giving us medicines, sometimes to drink, some he was being bathed because they were saying that maybe it is evil spirits. Our father passed away so we were thinking that it is from evil spirits of our father, so we went to the grave yard to make a tombstone so that the evil spirit should come out of him but there was no help. That is how we tried yaaa

Q.Aaaa so when you came to this hospital, what was the name of the illness that the nurses gave it? Did they explain?

Participant: They said that this person his head is not functioning well yaa but to explain further no, because sometimes when it was time to get drugs eee was just chasing people in the ward yaa, doing this and that, just like a person who has smoked dagga yaaa, a person who has smoked dagga his head does not function well you just see that nothing is going well, yaa indeed.

Q. So what drugs were you given?

Participant: Aaa the drugs were tablets only, tablets, tablets eee

Q. Having been exposed to both traditional and Western approach of treatment, what is your preference between these two and what are your reasons?

Participant: As for me I like the hospital, the Government hospital because that is where there is proper assistance because at the traditional healers mostly they just cheat, that is what I know, they just still from us at traditional healers.

Q. Thank you for taking part in this study

Participant: Thank you

END OF INTERVIEW