EXPERIENCES OF COMMUNITY PSYCHIATRIC NURSES AND GUARDIANS OF DISCHARGED PSYCHIATRIC PATIENTS ON THE EFFECTIVENESS OF COMMUNITY MENTAL HEALTH SERVICES OF THE ZOMBA DISTRICT IN MALAWI.

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Supervisors statement

This is to certify that this study was conducted by Bertha Kachingwe

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DECLARATION

I declare that this study is the product of my own work and where I have used the ideas and words of others, I have referenced these correctly.

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DEDICATION

I dedicate this study to my three grand children; Patricia, Dorcas and Takondwa for their patience while I was away from home.

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ABSTRACT

Sturdy: Experiences of Community Psychiatric Nurses and Guardians of discharged psychiatric Patients on the Effectiveness of Community Mental Health Services of the Zomba District in Malawi.

Purpose: The purpose of the study was to explore and describe the experiences of community psychiatric nurses and guardians of discharged psychiatric patients with regard to failure of Community Mental Health Services of the Zomba District, and make recommendations to improve community mental health services. Although such services exist, their effectiveness is unknown, either from the nurses' point of view or from the consumers' point of view.

Method: A qualitative approach with phenomenological research design was used to answer the research question on the effectiveness of the services. This method was chosen because the researcher was committed to explore the lived in-depth experiences of the study participants. A purposive sampling method was used to select participants for the study, who were selected based on their knowledge of the phenomena. Data collection Instruments used were unstructured interviews, using face- to- face interaction. One broad, open-ended question was used to gather information from the participants. Data analysis was done using Atlas.ti software to help the researcher uncover complex phenomena hidden in the text.

Findings: Participants from both groups overwhelmingly reported that community mental health services were not effective. Four categories and eleven themes of barriers impacting on ineffective services emerged from the nurses. For example; *Inadequate service provision related to unavailability of resources (human, time and materials).* Themes hindering effective services emerged from the guardians for example; *Services not accessible related to inconsistent appointment dates, shortage of medications and poor economic status of participants.*

CHAPTER ONE

SCIENTIFIC FOUNDATION OF THE STUDY

1.1 Introduction

In this study, the researcher explored the experiences related to assumed ineffectiveness of the community mental health services of the Zomba District of Malawi, and made recommendations which might presumably contribute to the reduction of relapses and improve community mental health services of the District. The community mental health services are responsible for the comprehensive treatment and rehabilitation of the mentally ill people in the community at large. When community mental health services are effective, chances of relapses are very slim as there is continuity of quality care. Contrary to this statement, at the Zomba District in Malawi, there seem to be an increased rate of relapses and readmissions as well as a noticeable number of discharged patients roaming the streets unattended. This trend makes one wonder if the existing community mental health services are effective.

1.2 Back ground Information

Community mental health is the process of promoting the level of mental health among the people in the community and reducing the number of those suffering from mental disorders (Caplan, Anderson and Weber, 2004:42). The same authors state that the legitimate goal of a community mental health program is to increase the potential of a person to solve his/her problems in a reality- based way, within the framework of his/her traditions and culture. Kaplan and Sadock (2003:1374), refer to community mental health as a total system of care, and not a single service. To be effective, the services must be integrated and balanced, so that appropriate treatment modalities are available to fit patients' needs and organize a system of care.

Community mental health care should involve collaboration between a multi-disciplinary team and a multi-sector team. The multi-disciplinary team includes psychiatrists, clinical psychologists, psychiatric social workers, psychiatric nurses, occupational and recreational therapists. Multi-sector team members are all stakeholders involved in the care of psychiatric patients in their communities such as the police, judiciary, chiefs, teachers, and people from agriculture, political leaders, traditional healers, patients' guardians and non-governmental organizations (Thorncroft and Szmukler, 2001:29).

Kaplan and Sadock (2003:1374), state that each community health care centre must provide basic psychiatric services; emergency services for 24hrs, community consultation, day care services, and half-way houses for after care services and a broad range of out-patient services. Community mental health services include services for the aged and children, screening before hospitalization, follow-up care services for those who have been hospitalized, transitional housing, alcohol and drug abuse services, mental health promotion, prevention of mental illness and rehabilitation of patients who have been handicapped by the effects of mental disorders.

The community mental health services should be provided within a walking distance to a patient's residence and place of work to promote accessibility of care. Furthermore, with close proximity illness can be identified early, leading to early diagnosis, treatment and prevention of complications. This will make only brief hospitalization, when required (Caplan, Anderson and Weber, 2004:143).

Gaban, Michael and Richie (2004:401-408), state that sustained continuity of care improves quality of care by decreasing hospitalizations, decreasing emergency department use and improving receipt of preventative services. The same authors state that continuity of care is a cornerstone of primary care that has been promoted by recent trends in medical education and in the way health care delivery is organized.

Community mental health services in Malawi started in the early 1990's. The main aim of starting the program was to de-congest the Zomba Mental Hospital which was the only psychiatric hospital at that time, and patients were referred for treatment from the whole country. In Malawi, there are three regions namely; Northern Region, Central Region and Southern Region. At the moment, there are two (2) main Mental hospitals and one (1) psychiatric clinic. The Zomba Mental Hospital is a public hospital located in the Southern Region of Malawi. The second mental hospital is a private hospital, located in the Northern Region of Malawi. The psychiatric clinic which also belongs to the government is located in the Central Region of the country (WHO, 2005). Though such services exist, their effectiveness is not known, either from the nurses' point of view or from the consumers' point of view.

According to Malawi Health Information Systems (MHIS) statistics of 2009, the number of patients seen by the community psychiatric nurses per day is one hundred and thirty seven (137) per heavy clinic day, and sixty (60) per lighter clinic day. The community psychiatric nurses screen, diagnose, prescribe medications and manage psychiatric patients. They also follow-up on defaulters, do crisis interventions and mental health education. In schools they concentrate mainly on drug and alcohol abuse. The primary health centres are staffed by one (1) medical assistant one (1) or two (2) nurse midwives and two (2) health surveillance assistants These health personnel except for the health surveillance assistants, were oriented to psychiatric nursing during their training. They are the people who receive and refer psychiatric patients to a mental hospital when they have relapsed. They also supply medication on a day- to- day basis to those psychiatric patients who have missed the mobile clinic days and have run out of medication (WHO, 2005).

Malawi has a population of thirteen million (13,000,000) and the Zomba District has a population of 772,969. According to Zomba hospital records, the number of new admissions in 2008 was 1962, and in 2009 it was 1846. The total number of

discharges was 1676, while in 2009 it was 1618. The total number of relapses in 2008 and 2009 was 826 and 863 respectively. This means that although the Zomba District has community mental health services, the psychiatric patients are relapsing in large numbers. The researcher will conduct the study in the communities where participants live and receive the treatment through mobile clinics conducted in these areas.

1.3 Research Question

What are the experiences of the community psychiatric nurses and the guardians of the discharged psychiatric patients on the effectiveness of the community mental health services of the Zomba District?

1.4 Problem Statement

Although there are community mental health services in the communities of the Zomba District, the researcher has observed a lot of chronic discharged psychiatric patients who move aimlessly in the municipality of the Zomba District. Furthermore, there are an increased number of relapses and an increased rate of re-admissions at the hospital. , When one tries to go through the admissions' files of these patients at this hospital, one can see huge files full of re- admissions due to relapses. This trend raises the question as to what is happening to the community mental health services of the Zomba District. Moreover, frequent relapses are costly for the patient, guardians, the hospital and the country as a whole. Haya (2003 :40-45), found that it is costly to treat patients with relapses. The study showed that the cost of relapse in the treatment of schizophrenia during a six months period found that the cost for patients with relapses was high, and was associated with a high cost for in- patient services as well as out-patient services and medication. The author recommended that there is need for intensive out - patient services, such as partial hospitalization programs for patients with addictive disorders.

1.5 Definition of Key Concepts

Effectiveness: This term refers to producing the result that is wanted or producing a successful result (Uys and Middleton, 2004). In this study, the researcher is committed to find out whether the community mental health services of the Zomba District are effective or not. When community mental health services are done effectively, the rate of relapses decreases. As a result, psychiatric patients become more self- reliant and able to support themselves while still taking their medication. Also, when community mental health services are run properly, the psychiatric hospitals are decongested and therefore less of a workload for the hospital personnel.

Community Mental Health; This refers to the process involved in raising the level of mental health among the people in the community and reducing the number of those suffering from mental disorders (Kaplan and Sadock, 2003:1335). In this study, community mental health is the process involved in raising the level of mental health in the community. The same community mental health will be responsible for reducing the number of relapses and re-admissions in the community of the Zomba District.

Mental Health: The ability to think rationally and solve problems in a reality based way within the frame work of one's tradition and culture (Kaplan and Sadock, 2003:1334). When community mental health is effective, there is continuity of treatment and patients are likely not to relapse, be able to think rationally and solve their problems in a reality based way within the framework of their tradition and culture.

Experience: This refers to gaining knowledge or skill which comes from practice in an activity it includes sensing, interpreting and comprehending the world (Uys and Middleton, 2004:124). In this study, the researcher explored and described the experiences of the participants who were required to describe their

experiences of sensing, interpreting and comprehending the effectiveness of community mental health services of the Zomba District.

Psychiatric Nurse: A person who specializes in Psychiatric Nursing and looks after psychiatric patients (Kaplan and Sadock, 2003:1464). In this study, the researcher collected data from community psychiatric nurses who conduct mobile clinics in the communities of the Zomba District because they had the experience of the services.

1.6 Aim of the Study

The aim of this study is to explore and describe the experiences of the community psychiatric nurses and guardians of discharged psychiatric patients on the effectiveness of community mental health services of the Zomba District in Malawi.

1.7 Study Objectives

- To explore and describe the experiences of community psychiatric nurses on the effectiveness of community mental health services in the Zomba District.
- To explore and describe the experiences of guardians who accompany the patients to the mobile clinics during the months of November and December 2010, on the effectiveness of community mental health services of the Zomba District

1.8 Significance of the Study

This study will help the providers of community mental health services to think critically about the services that are offered to psychiatric patients in the community. When community mental health services are delivered effectively, the rate of relapse decreases, as a result psychiatric patients become more self-reliant and are able to support themselves, while they are still taking their medication. Also, when community mental health services are run properly, the

psychiatric hospitals are decongested and therefore there is less workload for the hospital personnel. Furthermore, the government will benefit from this study where gaps are identified, as it provides a clear picture as to what is going on and government will be able to fill in the gaps. When psychiatric patients are cared for in the community, the stigma is reduced, rather than admitting them in an institution.

1.9 Theoretical Framework

Lancaster and Stanhope (2006:456), define theory as a set of concepts and relational propositions that state specific links between the concepts. Theory provides a starting point to collect facts in a systematic way so that phenomena can be described, explained or predicted. Conceptual models and supporting theories identify the concepts that are essential for nursing and guide actions that nurses should implement in their practice.

Betty Neuman's system model (1972), which guides community -oriented nursing was adopted since the study was to be conducted in the community. This model was selected because of its unique feature of community- oriented nursing and its emphasis on assisting individuals, families, groups and communities to maintain their highest possible level of health. To accomplish this, the community is viewed from a holistic perspective as a motivator or disruptor of health. The goal is to asses, plan and evaluate ways to make the community a healthier place to live. The term "health" according to World Health Organization (WHO), is "a state of physical, social, and psychological well- being" and not merely an absence of disease. In the researcher's observations, the communities of the Zomba District are not healthy because of the presence of chronic psychiatric patients who walkabout aimlessly, and are at risk of being abused physically, emotionally and socially.

According Lancaster and Stanhope (2006:136), Neuman's system model can be used to describe and explain the behaviours of individuals, groups and communities and emphasizes how each isolated part affects the whole, and how the whole can affect its parts. Thus, communities which are made up of multiple systems and groups that interfere with and influence each other, can be analyzed, interpreted and understood from a system theory perspective. System models focus on organizing, interacting and the integrating of parts, and sub-parts and the interdependence of the parts on each other. According to this study, psychiatric patients are one of the groups that live in the community and are part of the systems, and if their mental health is not well looked after it can have adverse effects on the whole community. The aim of the study is to explore the views of the psychiatric nurses and those of the guardians of the patients, on how they experience the effectiveness of community mental health services of the Zomba District. If they are not effective, the researcher will make recommendations for the improvement of the services, which will reduce the rate of relapses and re-admissions and make the communities of Zomba a better place in which to live.

1.10 Research Methodology

A brief overview of research methodology applied in this study is provided in the current chapter, while a detailed application of the methodology follows in chapter three.

1.10.1 Research Approach

The researcher used phenomenological approach. Phenomenology is a science whose purpose is to describe a particular phenomenon of the appearance of things as lived experiences (Speziale and Carpenter, 2007:76). Phenomenology is based on the philosophy of Husseri who was a prominent leader of the phenomenological movement. He attempted to restore the 'reality' of humans in their 'life world' to capture the meaning of this, and revive philosophy (Speziale and Carpenter, 2007:81). These authors describe phenomena as the world of

experiences which cannot be explained by examining casual relations, but needs to be studied as the very things they are. Phenomena occur only when there is a person who experiences phenomena. Thus, the experiences must be described, not studied using statics (Burns and Grove, 2009. Speziale and Carpenter, 2007).

1.10.2 Research Design

Polgar and Thomas (2003:125), indicate that in qualitative research, the investigator seeks to understand the thoughts, feelings and experiences of individuals, focusing on face- to- face knowledge of participants. The same authors state that the qualitative method or interpretive field research, involves an investigation in their social setting. In this study, the researcher used the qualitative research method to explore and describe the lived experiences of participants, on the effectiveness of the community mental health services of the Zomba District. These experiences need to be investigated in face- to- face interactions and cannot be quantified using statistics.

1.10.3 Research Setting

This research was conducted in the Zomba District Community Health Centres. Community mental health services are under the umbrella of the District health officer, who is the overseer of all programs conducted in the communities around the Zomba District.

1.10.4 Population

Jupp and Sapsford (2006:132), define population as the total collection of elements actually available for sampling. The researcher selected community psychiatric nurses who conduct mobile clinics. The researcher also selected guardians of discharged patients (both males and females) who accompanied the patients two (2) to three times to the same clinic, and whose patients have been readmitted up to two (2) to four (4) times in a psychiatric hospital.

1.10.5 Sampling

Punch (2005:265), refers to sampling as the selection of research participants. It involves decisions about which people, setting, events, behaviour and social process to observe. Burns and Grove (2009:721), define sampling as selecting groups of people, events, behaviours or other elements with which to conduct a study. The aim is to select a sample which is rich in information.

1.10.6 Sampling Method

Purposive sampling method will be used to select participants for the study. Purposive sampling is a method of sampling which selects individuals for study participation based on their knowledge of the phenomena, for the purpose of sharing that knowledge (Speziale and Carpenter, 2007:94).The logic and power of purposeful sampling lies in selecting information rich participants for the study. In-depth information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of research. This sampling method will be suitable in the phenomenological inquiry because the researcher intends to gain insight and an in-depth understanding of how community psychiatric nurses and the guardians view the effectiveness of community health services of the Zomba District. The sample has the characteristics that the researcher has planned to understand and meets the criteria for inclusion in the study.

1.10.7 Sample Size

Two (2) groups of participants were selected for the study. Guardians of discharged psychiatric patients, who have been re-admitted for two (2) to four (4) times in a mental hospital, and community psychiatric nurses, were targeted. The number of these participants were determined by whether any new issues emerged from participants. That is when saturation is reached. This refers to the repetition of the same information from the participants..

1.10.8 Gaining Access to Participants

The researcher spent one week on the selection of a sample for the study. The community psychiatric nurses were selected by seeking permission from their

working place, the Zomba Mental Hospital. The guardians of discharged patients were selected through formal meetings with them and the community psychiatric nurses during mobile clinics. Ethical issues were addressed.

1.10.9 Instrumentation

The unstructured interview guide which was designed by the researcher was based on the objectives of the study, and validated by experts in the field of qualitative research method before data collection took place. The questions in the interview guides were as follows "What were your experiences on the effectiveness of community mental health services of Zomba District?," "What have you identified as being effective and not effective services", "what other what other mode of health services have you used".

1.10.10 Data Collection Methods

Unstructured interviews with an interview guide was used to collect data, and a tape recorder was used to record the interviews to ensure that all data is captured. Permission was obtained from the participants to record the interviews.

1.10.11 Pilot Study

A pilot study is a small preliminary investigation of the same general characters as the major study, which is designed to acquaint the researcher with problems that can be corrected in preparation for the larger research project (Drummond, 2003:156). The same author states that the aim of the pilot study is to identify potential problems in the data collection and to show that the study design is both appropriate and feasible. It gives some ideas of costs of the study, as well as experience in carrying out the project. The researcher conducted a pilot similar to the actual study, at a different health centre. The focus was on finding out if the interview guide to be used had problems and was not ambiguous, was valid and reliable. This process assisted in assessing whether the instruments tools were able to measure what they were supposed to measure and were accurate, before the actual data collection.

1.10.12 Data Analysis

Data analysis starts during interviews (Speziale and Carpenter, 2007:96). The purpose of data analysis is to preserve the uniqueness of each participant's lived experiences while permitting an understanding of the phenomena under investigation. They continue to state that there are three major analysis styles which are; template, editing and immersion/ crystallization style. Researchers whose research tradition is phenomenology, use procedures that fall within editing style (Polit and Beck, 2008:508). Researchers using editing style, act as interpreters who read through the data in search of meaningful segments and units. Once segments and units are identified, they develop category schemes and corresponding codes that can be used to sort and organize the data. Researchers then search for patterns and structures that connect categories. Since this study was phenomenological, the editing style of data analysis was used. As follows: Transcription of the interviews was done by the researcher, and then the data was read and re-read word for word, sentence by sentence, until the researcher was convinced that the data was interpreted correctly. This activity in phenomenological study is termed "dwelling" with the data (Burns and Grove, 2009:698). In this study, a search for themes or recurring regularities was done using Atlas.ti software. Using the software can make the analysis of qualitative data quicker and easier without the researcher losing touch with the data (Burns and Grove, 2009:519). The same authors state that, because of the ease of coding and recording, the researcher feels free to play with the data and experiment with alternative ways of coding. Researchers can also search for codes that tend to occur together and arrange them into categories or families

1.11 Trustworthiness and authenticity of the data

Carpenter and Speziale (2007:97), state that the issue of rigor in qualitative research is important to the practice of good science. The trustworthiness of the question put to study participants depends on the extent to which they tap the participant's experiences, apart from the participant's theoretical knowledge of the topic. Consistent use of the method and of bracketing of prior knowledge

helps to ensure pure description of data. To ensure trustworthiness of research analysis, each and every step of the research process was supervised by two supervisors, and the researcher presented the proposal at a seminar at the University of Fort Hare, Department of Nursing Science for quality control. An audit trail was used by engaging an independent auditor to draw conclusions about authenticity and trustworthiness of the data. Two examiners were appointed for quality control of the research report , after which the University of Fort Hare examination committee reviews the work.

1.12 Ethical Considerations

A project is ethical to the extent that its design and execution conforms to a set of standards or conventions guiding research (Polgar and Thomas, 2003:70-72). The researcher considered these three ethical principles of autonomy, beneficence and justice in order to protect participants of the study. The participants were not harmed as according to the ethical principle of beneficence. At the beginning of the interview each participant was given a participant information sheet concerning the study and written consent to participate in the study was obtained. Consent was also obtained for the audio and written recording of the interview.

Participants were ensured of anonymity. The researcher has an obligation to maintain confidentiality, in other words the data gathered during the study will not be divulged to other persons. The data was locked and stored in safe place and only accessible to the researcher.

1.13 Study Outlay

Chapter 1: Scientific Foundation of the Study

Chapter 1 portrays the introduction, background and motivation for the study. It also provides information on the research question, study objectives, theoretical framework, operational definitions, research methodology and study layout.

Chapter 2: Literature Review

In chapter 2 the literature review is presented.

Chapter 3: Research Methodology

Chapter three provides a description of the research methodology, as briefly outlined in chapter one.

Chapter 4: Data Analysis and Interpretation

In chapter 4 the results of the study are revealed, analyzed interpreted and discussed.

Chapter 5: Conclusions, Limitations and Recommendations

The results according to the study objectives are concluded and recommendations are made based on scientific evidence obtained in the study.

1.14 Conclusion

In chapter 2 the literature review provides a summary of issues related to effective and ineffective community mental health services.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Burns and Grove (2009), state that literature is conducted to generate an understanding of the phenomenon of the study. They further define literature review as an organized written work on what has been published by other scholars. In this study, the literature review was done to find out what other researchers have already done in similar studies of the effectiveness of community mental health services, so as to put this current study in context. A literature search was also done on the following; indicators of effective and ineffective community mental health services, and on what was happening in Malawi where the research was to be conducted. A literature search was also done on related methodologies and on the concept of community mental health services.

2.2 IN-DEPTH LITERATURE REVIEW

2.2.1 Community Mental Health Services

Thorncroft and Szmukler (2001:2), refer to community mental health services as services that treat and help people with mental disorders in proportion to the suffering or distress. Mental health services are rendered in collaboration with other agencies. Community mental health services are rendered in various communities to promote mental health, prevent mental illness and rehabilitate those suffering from the effects of mental disorders (Kaplan and Sadock, 2003:1374). The goal of prevention of mental disorders is to reduce or decrease the onset (incidence), duration (prevalence) and residual disability of mental disorders. Prevention of mental disorders is based on public health principles and is divided into primary, secondary and tertiary prevention. These levels of

prevention of mental disorders can only be achieved if there are enough human and material resources to carry out these activities.

2.2.2 Primary prevention of mental disorders

Primary prevention of mental disorders aims at promoting mental health in individuals who are mentally well and prevention of mental illness to 'at risk' groups in the community. The goal of primary prevention is reached by eliminating causative agents, reducing risk factors, enhancing host resistance and interfering with disease transmission (Thorncroft and Szmukler, 2001:492-493). The same authors argue that primary prevention, which aims at the reduction of the incidence of mental health problems, is an ideal but elusive goal. It is the most cost effective form of prevention at least for high incidence disorders, but it requires a good knowledge of the causal risk factors, especially those with large population- attributable risks. It also requires a good knowledge of the causal sequence in the onset of mental disorders, so that the most efficient intervention point can be selected. Such knowledge is still lacking for many mental disorders (Thorncroft and Szmukler, 2001:495). Primary prevention is achieved through mental health education programs to 'at risk' groups, such as adolescents, street children, ante-natal mothers, business people and orphans (Kaplan and Sadock, 2003:1378). It is very important that community mental health nurses should develop programs for community health education for these at risk groups to prevent occurrence of mental disorders, but these activities need enough time and human resources. In Malawi, it is routine to conduct community mental education before patients are screened and given treatment.

2.2.3 Secondary prevention of mental disorders

Thorncroft and Szmukler (2001:487) define secondary prevention of mental disorders as early identification and prompt treatment of an illness or disorder. The goal is reducing the prevalence of the conditions by shortening the duration. Although this level of prevention is very important, it has its own challenges because most psychiatric patients seek help from other sources before presenting themselves to the health worker when the symptoms have already

advanced. This happens either because of illness, behaviour prescribed by their culture or because of stigma and discrimination attached to mental illness. However, the communities need to be educated on early signs and symptoms of mental disorders and the importance of seeking treatment early.

2.2.4 Tertiary prevention of mental disorders

Thorncroft and Szmukler (2001:509), refer to tertiary prevention as minimization of the disabilities and impairment which are consequent upon illness or disorder. The goal of tertiary prevention is to reduce defects and disabilities caused by disorders. Both authors state that it enables those affected to reach the highest feasible level of functioning. This is reached through rehabilitation programs such as sheltered employments; follow up care of defaulters, skill acquisition through carpentry, tailoring and baking, provision of special schools and specially trained teachers for children with mental disability. The challenge at this level of prevention is that most rehabilitation services need funds which are not always available especially in low income countries, as a result patients roam the streets unattended. Malawi has only one(1) occupational therapist and no psychiatric social worker, which makes rehabilitation of psychiatric patients almost impossible (WHO, 2005).

2.2.5 Indicators of effective community mental health services

Thorncroft and Szmukler (2001:558), define effectiveness as the extent to which a specific intervention when used under ordinary clinical circumstances does what it is intended to do. A literature search on effective community mental health services related to the following: accessibility of community mental health services, continuity of mental health care, co-ordination, accountability, autonomy and self- determination of psychiatric patients, accountability and responsibility of both providers and consumers of services, collaboration and co-ordination amongst a multidisciplinary team and other stake holders, supervision of community mental health care, up to date government mental health policy and well developed services and structures (Thorncroft and Szmukler, 2001:160, Kaplan and Sadock, 2003:1334, Birkmann Sperdip and Smith 2006;155-157,

Pilkola, Sund Sillen and Wallpeck 2009:147-153). These are discussed further in this section.

2.2.5.1 Accessibility of mental health services

Thorncoft and Szmukler (2001:160), define accessibility as services which can be entered or reached. Community psychiatric patients should be able to reach and "get at" services where and when they are needed. Kaplan and Sadock (2003:1334), state that accessibility remains a complex concept, it is used in relation to geographical distances or to travel times from patients' homes to health centre sites, to delays in how long it takes for patients to be assessed, and selected barriers which reduce the uptake of services by all patients, such as stigma. If community mental health services are easily accessible to psychiatric patients, then chances of relapsing would be minimal. Some patients are unable to access services because of long distances and geographical features such as mountains and big rivers. Also, some relatives shun away from bringing their psychiatric patients for treatment because of stigma attached to mental illness. Health workers need to minimize delays when attending to patients, as they get frustrated and go away without treatment. In Malawi, accessibility to community mental health services seems to be a problem in terms of how long it takes for patients to be assessed, as the mobile clinics are always busy. There is, for example, one (1) psychiatric nurse attending to one hundred and thirty seven (137) clients at a busy clinic (MIHS: 2009).

2.2.5.2 Continuity of mental health care

When mental health services are accessible to psychiatric patients, there is continuity of care. Thorncroft and Szmukler (2001:159) describe continuity as an ongoing need by many patients for reliable sources of treatment and social support. There are two types of continuity namely: longitudinal continuity and cross-sectional continuity. Longitudinal continuity refers to the ability of services to offer uninterrupted services of contacts over a period of time. Cross-sectional continuity includes the continuity between different service providers. Gaban, Michael and Richie (2004: 401-408) state that sustained continuity of care

improves quality of care by decreasing hospitalization, decreasing emergency department use and improving receipt of preventative services. Continuity of care is a cornerstone of primary care that has been promoted by recent trends in medical education and in the way health care delivery is organized (Gaban et al, 2005:401-408).

2.2.5.3 Autonomy and self determination of psychiatric patients

Price (2007:334-336) describes autonomy as a 'personal' freedom of the doctrine of the self- determination of the will. Autonomy is a product of what a service does. It refers to the capability of the service to preserve and promote independence by positive experience and to reinforce strengths or healthy aspects of each patient, especially the most severely disabled, while controlling symptoms. Autonomy should be promoted by effective community health services and care. Self- determination allows the patients to seek help when needed (Price, 2007:334-336). Autonomy and self- determination of psychiatric patients minimize relapses as patients are empowered to seek help when needed without being told. Voluntary admissions of psychiatric patients are a sign of autonomy and self- determination.

2.2.5.4 Accountability and responsibility of health care providers and consumers of services

Effective Mental health care services come about if there is accountability and responsibility of both health care providers and consumers of the services. Thorncroft and Szmukler (2001:161), refer to accountability as an element of responsibility between staff and individual patients, a relationship that needs to be based upon confidentiality and trust. Each patient has a legitimate expectation that the nurse will offer treatment based upon a duty of care, and will do this according to the expected standards of professional practice such as confidentiality. If there is no accountability and responsibility on both sides, then the services cannot be effective and patients can lose trust in care givers and seek help elsewhere, on the other hand, if patients show lack of responsibility,

for example, not being compliant to treatment and appointment dates, then it becomes very difficult for the professionals to treat them.

2.2.5.5 Collaboration and co-ordination among the multi-disciplinary team members and other stake holders

Thorncroft and Szmukler (2001:558), define co-ordination as a service characteristic which is manifested by coherent treatment plans for individual patients. Each plan should have clear goals and include interventions which are needed and are effective, that is, the coordination of information and services within an episode of care. Longitudinal co-ordination is the inter-linkages between community healthcare staff and between agencies over a long period of treatment. Co-ordination between stakeholders and a multi-disciplinary team is very important for the well being of a psychiatric patient. Each one of these members has a role to play for the care of a psychiatric patient and the prevention of relapse. For example, in Malawi, the Police Department has a role of picking up psychiatric patients who are wandering aimlessly in the community and bring them back to the mental hospital. Similarly, social workers are supposed to look after the social welfare of a psychiatric patient such as finding a sheltered employment for a patient.

2.2.5.6 Supervised community mental health care

Psychiatric patients who are in the community need to be supervised on what and how to take medication and identify side effects (Gilbert, Plant & Nigel, 2008 : 85-92). The main supervisors are the caregivers themselves and patient's guardians. These guardians need to be empowered with knowledge on how to supervise their patients for continuity of care at home after discharge. Also, if guardians are encouraged to supervise their patients, they develop a sense of ownership and belonging (Thorncroft and Szmukler, 2001: 558). This literature is relevant to the researcher's study because the patients' guardians play a very important role in preventing psychiatric patients from relapsing. They should see the patient as their responsibility and not the responsibility of the nurses and doctors. In this study, it is assumed that the patients who are

relapsing in large numbers might lack good support systems to remind them about medication and appointment dates.

2.2.5.7 Up to date government mental health policy

Government policies concerning mental health care should be revised periodically to suit the current trends of care. Chee, Setoya and Yutalo (2006;110-118), found that the outcome of policy shift in Italy, where psychiatric patients were cared for in the community rather than the institutions as in-patients, showed that the numbers of new admissions were minimal at 26 per 100, 000 populations and psychiatric care had shifted from in -patient to community care. Community mental health care can lead to decongestion in patient mental hospitals, reduce stigma attached to mental illness, and assist patients to maintain their roles (Kaplan and Sadock, 2003:374). In order to achieve this there is a need to update mental health policies to suit current trends of care. The only challenge is that updating policies needs funds which are not easily accessible, especially in low income countries. In Malawi, the mental health policy was developed five years ago (WHO, 2005).

2.2.5.8 Well developed services with structures

Well developed community mental health services with structures from the national level down to the grass roots level is an indicator of effective mental health services. Services are organized and supervised effectively. Pilkola, Sund Sillen, and Wallpeck (2009:147-153), state that well developed community health services are associated with low suicide rates, rather than services oriented to patient treatment provision. If there are explicit structures for community mental health services, there is a chain of command and services are easily monitored to find out if objectives are being achieved or not.

2.3 Indicators of ineffective mental health services

Literature searched on the ineffective mental health services relate to the following: culture, stigma and discrimination, poor funding, lack of mental health policy, lack of evidence based studies to direct patient care, deterioration of

morale within the medical community, poverty, improper utilization of resources, unavailability of health workers in under-served communities and inequitable distribution of health workers (Scuglik, Aslar, Coin, Mark, and Logan, 2007:518-589,Genuis, 2008:31-34, Russel and Kenneth, 2010:303-307, Mari, Screenlives and Saxena 2007:83-88, Steiment and Braichet, 2010:43-45). These are discussed further in this section.

2.3.1 Culture contributing to ineffective mental health services

Scuglik, et, al. (2007:518-589), state that culture hinders effective community mental health care due to language barriers and misconceptions. They suggested that health workers should provide care which is culturally congruent in order to communicate effectively with patients and to diagnose and treat their disorders. Community Mental health nurses need to be familiar with the culture of the clients that they are dealing with in terms of communicating with the clients, otherwise they will not be able to counsel them concerning their disorders and the treatment they receive, regarding dosages, frequency, side effects and storage of drugs. Non-compliance to treatment instructions can contribute to the relapse of patients. In Malawi, mental illness is assumed to be caused by evil spirits or witchcraft. In this study the researcher will investigated whether cultural beliefs contribute to the ineffectiveness of community mental health services in the Zomba District.

2.3.2 Stigma and discrimination of psychiatric patients

The relocation of psychiatric patients from an institution to community-based facility was faced with public opposition. The community did not want mental health facilities to be established in their localities, a phenomena referred to as "NOT-IN-My-BACKYARD" (NIMBY) Syndrome (Cowan, 2005:329-366). This shows the attitude the public held towards people with mental health problems. Not in my backyard phenomena is a wide spread obstacle to people with mental illness.

Birkmann, Sperdip and Smith (2006:157-165), state that if mental health services are to be effective, healthcare workers need to fight stigma and

discrimination against psychiatric patients because fighting stigma and discrimination is fighting for mental health. If patients are stigmatized and discriminated against, they relapse because they lack support systems that can supervise their treatment. Furthermore, stigma contributes to isolation and loneliness, and as a result psychiatric patients relapse and develop chronicity. It is unknown whether stigmatization could be associated with ineffectiveness of community mental health services in Malawi.

2.3.3 Poor funding from the government

Poor funding from the government is an indicator of ineffective community mental health services. Poor funding creates challenges to the implementation of mental health care services in primary health care settings. There is need to motivate service providers through adequate funding and incentives so as to work harder and serve the patients better to prevent relapses (Jakob, Sharan Mirza, Garrindo- Cumbrera, Seedat, Screen-lives and Saxena (2007:83-88); Jacob, Sharan Mirza and Cromwell, 2010:110-118). In Malawi the country spends 2% of the total budget on mental health (WHO, 2005). In this regard it can be assumed that patients are wandering about aimlessly due to poor funding.

2.3.4 Lack of mental health policy in the country

The lack of a mental health Policy and legislation to direct mental health programs and services are of particular concern in Africa and South East Asia (Saxena, et.al 2007:178-189). As a result health workers lack direction as to how services should be organized due to the lack of strategic plans and monitoring tools to monitor whether goals are being achieved or not. The lack of health policy causes patients to relapse. In Malawi, the latest mental health legislation (Mental Treatment Act) chapter 34 subsection 02 was enacted in 1959 and was amended in 1968. In 2010 the act was reviewed and amended (WHO, 2005).

2.3.5 Lack of evidence- based studies to direct patients care

Russel and Kenneth (2010:303-307), state that another indicator of ineffective community mental health services is lack of published studies with evidence

demonstrating that existing technology practices provide little or no benefits. In such situations, community mental health services become stagnant and outdated thereby having adverse effects on the consumers of these services. Patients should receive care which is evidence-based to improve the quality of care. Quality care prevents patient from relapsing and ensures patient satisfaction with services.

2.3.6 Deteriorating morale within the medical community

Deterioration of morale within the medical community due to lack of motivation either through lack of incentives or lack of further training, is another indicator of ineffective community mental health services. The professionals no longer regard nursing or medicine as rewarding vocations. As a result, large numbers of discontented patients turn to assorted and unconventional therapies in search of help (Genuis, 2008:31-34). This causes them to relapse and become chronic. There is need to motivate health workers with incentives in order to serve patients better.

2.3.7 Poverty contributing to ineffective community mental health services

Poverty is an indicator of ineffective community mental health services. Saxena, Thorncroft, Knapp and White (2007:178-179) state that the poorest countries spend the lowest percentages of their overall health budgets on mental health. Most care is now institutional-based as the transition to community care would require additional funds that have not been available for mental health care. As a result there are substantial gaps and inconsistencies. Most of these countries allocate very scarce financial resources and have grossly inadequate human resources and infrastructure for mental health policy and legislation to direct mental health programs and services. Unfortunately, populations with high rates of socio-economic deprivation have the highest need for mental health care but the lowest access to it (Saxena, et al, 2007:178-189). When the country is poor it affects the smooth running of mental health programs. There is no continuity of care as there is likely to be a shortage of human, as well as material resources, such as medication and transportation for conducting mobile clinics. As a result

psychiatric patients are likely to seek treatment from other sources, and in the process they relapse and develop chronicity. In Malawi, the source of funding for mental health services are from tax payers and grants from donors.

2.3.8 Improper utilization of resources

Inefficiency in the use of available resources is a contributing factor to ineffective mental health services. Saxena et al, (2007:178-189), state that the inefficiencies include allocation and technical inefficiencies in financing mechanisms and interventions and overconcentration of resources in large institutions. Scarcity of available resources, inequality in their distribution and inefficiencies in their use pose the three main obstacles to better mental health in many African countries. The areas which are deprived of resources stop functioning and patients seek help from other avenues. As a result, they relapse and become chronic.

2.3.9 Unavailability of health workers in underserved communities

Indicators of ineffective services are related to unavailability of motivated health workers. Such a situation impacts negatively on the accessibility of healthcare services, more especially in the underserved areas (Steiment and Braichet, 2010:45-49). The unavailability of well trained and motivated health workers is more common in areas which are very remote with no proper social services, such as shops, markets and even proper schools for children. Most health workers decline to work in such places. As a result, psychiatric patients are neglected. There is need to motivate health workers with incentives, for example, adding a certain amount of money on top of their salary, for those working in underserved areas (Steiment and Braichet, 2010:47).

2.3.10 Inequitable distribution of health workers

The other indicator of ineffective mental health services is when there is an imbalance in the geographical distribution of health workers both in developed and developing countries. Approximately one half of the world's population live in rural areas, but these areas are served by only 38% of the total nursing workforce and less than 25% of the total are more prominent in developing countries because of low income (Steiment and Braichet, 2010:48). In the

areas which are deprived of health -workers, patients are likely to receive inadequate care.

2.4 Mental health profile in Malawi.

The Mental Health Atlas of the World Health Organization (WHO) of 2005, reports that in Malawi, Mental Health Policy was formulated in 2002. The components of the policy are as follows: advocacy, promotion of mental health, prevention of mental health problems and rehabilitation of patients with mental health disorders. The main goal of the Policy is the provision of comprehensive and accessible mental health services. This will be achieved through the inclusion of mental health in the National Health Plan and the integration of mental health into primary health care. The other component of the Policy is human resources development. The national mental health program was formulated in 1999. A national therapeutic drug policy was formulated in 1995.

The Mental Health Legislation (The Mental Treatment Act) chapter 34 subsection 02, was enacted in 1959 and was amended in 1968. The Act was reviewed in 2010.

With regard to mental health financing, a budget allocation for mental health activities is in place. The country spends 2% of the total health budget on mental health. The primary sources of mental health financing in descending order are tax- based and grants from donors. The country does not have social grants or disability benefits for patients with mental disorders. Mental disorders are not considered as a disability.

Mental health is part of the primary health- care system. Actual treatments of severe mental disorders are available at a primary level. The regular training of primary care professionals on mental health commenced in 2003. One thousand (1000) personnel have been trained. In medical undergraduate training, students are encouraged to consider how they may address mental health issues through the many and varied roles which doctors in resource- poor countries must fulfill. There are trainings of general health workers in mental health issues regarding early identification and treatment of mental disorders. There are community care

facilities for patients with mental disorders. Currently, the community psychiatric nurses provide community mental health services throughout the country. These centres are staffed by medical assistants, nurse- midwives and health surveillance assistance. The nurse- midwives and medical assistants have been oriented to psychiatric nursing during their training. Plans are underway to provide for monitoring and supervisory visits to all districts of Malawi.

2.5 Conclusion

According to the literature review, community mental health services are those services that promote mental health, prevent mental illness and rehabilitate those suffering from the effects of mental illness. Community mental health care services aim at prevention of mental disorders at three levels: Primary prevention, secondary prevention and tertiary prevention of mental disorders. The legitimate goal of community mental health services is to increase the potential of a person to solve his/her problems in a reality- based way within the framework of his/her tradition and culture. Contributing factors to effective and ineffective mental health services have been highlighted and these can act as guidelines when assessing communities to assess whether they are effective or not.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

In this chapter, the researcher describes the research methodology used to answer the research question, in order to get insight about the phenomena under study. The focus of the research methodology is on the research design, research setting, the study population, sample size, sampling method, the data collection methods, the pilot study, the data analysis, how rigor was applied, as well as ethical considerations.

3.2 Aim of the Study

The aim of the study is to explore and describe the experiences of community psychiatric nurses and guardians of discharged psychiatric patients regarding the effectiveness of community mental health services of the Zomba District.

3.3 Research Objectives

- To explore and describe the experiences of the community psychiatric nurses on the effectiveness of community mental health services of the Zomba District.
- To explore and describe the experiences of guardians who accompanied the patients to the mobile clinics during the months of November and December 2010, on the effectiveness of community mental health services of the Zomba District.

3.4 Research Question

What are the experiences of community psychiatric nurses and guardians of discharged psychiatric patients on the effectiveness of community mental health services of the Zomba District?

3.5 Research Methodology

3.5.1 Research Approach

In this study a phenomenological approach was used to capture and describe the lived experiences of study participants (Burns and Grove, 2009:54). The researcher attempted to understand the experiences within the context of the community psychiatric nurses and the guardians of discharged psychiatric patients.

3.5.2 The Research design

A qualitative research method was used to investigate how participants experience the effectiveness of community mental health services of the Zomba District. The qualitative method or design enabled the researcher to explore the depth, richness and complex inherent lived experiences of the participants as the investigation was done using unstructured interviews focusing on face- to- face interaction.

3.5.3. The Research Settings

This study was conducted in the community health centers of the Zomba District in Malawi. Mental health Services are under the umbrella of the District health officer who is the overseer of all programs conducted in the communities around the Zomba District. There are twenty-three (23) health centres which provide primary health care services. These community health care centres do not have designated mental health services. Psychiatric patients get their treatment from mobile clinics which come at specific intervals in these community health care centres. The community psychiatric nurses who conduct these mobile clinics

come from Zomba Mental Hospital, the only government psychiatric hospital in the country. The mobile clinics are conducted once every two (2) months in these health centres. The community health services in the Zomba District have two (2) supervisors, the District health officer, and the government psychiatrist who are based at the Zomba Mental Hospital.

3.5.4 Population for the Study

The researcher used the Zomba Mental Hospital's work schedule to select ten (10) of the community psychiatric nurses who conducted mobile clinics during the months of November and December 2010. The other population for the study was fifteen (15) guardians of discharged patients who had accompanied the psychiatric patients for two to three times at the same mobile clinic during the months of November and December 2010. The patients had a history of being admitted for two (2) to four (4) times in a psychiatric hospital.

3.5.5 Exclusion Criteria

The study had as its exclusion criteria, those who had no lived experiences concerning the effectiveness of community mental health services of the Zomba District namely; nurses who did not conduct mobile clinics, the guardians of discharged psychiatric patients with a history of less than two (2) readmission and of more than four (4), and those participants who could not express themselves in either English or any local languages.

3.5.6 Sampling Method

The researcher used purposive sampling method to select individuals for the study. This sampling method was suitable in this phenomenological inquiry because the researcher intended to gain insight and an in-depth understanding of how the community psychiatric nurses and the guardians of discharged patients viewed the effectiveness of community health services of the Zomba

District. The sample had the characteristics that the researcher had planned to understand and met the criteria for inclusion in the study.

3.5.7 Gaining Access to the Study Participants and Settings

The researcher spent one (1) week to select the sample for this study. The community psychiatric nurses were selected by seeking permission from their working place, namely, the Zomba Mental Hospital. The guardians of the psychiatric patients were recruited by the researcher and community psychiatric nurses through formal meetings before starting mobile clinics. Ethical considerations were observed. Gaining access to communities where the study was conducted was done by writing letters for permission to the district health officer of the Zomba District and the senior government psychiatrist of the Zomba Mental Hospital (appendix J, K and L)

3.5.8 The Sample Size

The sample size targeted for the study were community psychiatric nurses and guardians. An average clinic attendance on a busy clinic is one hundred and thirty seven (137) per day and the clinics are visited once every two months. Speziale and Carpenter (2007:460), state that in qualitative research data generation or collection continues until the researcher believes saturation has been achieved, that is, when no new themes or essences have emerged from the participants and the data are repeating. Data collection must continue until the researcher is assured saturation has been achieved. In this study, the researcher considered the purpose of the study as well as the depth of the information generated. Thus the researcher interviewed as many participants as possible until saturation took place. The saturation took place when the researcher had interviewed six (6) community psychiatric nurses and thirteen (13) guardians of discharged psychiatric patients.

3.5.9 Data Collection

Speziale and Carpenter (2007:94), state that there are a variety of strategies which can be used to collect research data in a qualitative study such as:

interviews, observations, narratives and focus groups. There can be other forms of data collection such as videos, memos, pictures, audios and visual recordings. In this study, the researcher used the following data collection tools or instruments namely; the researcher as an instrument and unstructured interviews.

3.5.9.1 The Researcher as an Instrument

The first data collection instrument was the researcher herself. The researcher as a person was totally involved in perceiving, reacting, interacting, reflecting, attaching meaning and recording as what should occur in a phenomenological study. The researcher addressed data collection issues related to the relationship between the researcher and participants. The researcher also recognized that personal characteristics, such as manners of speaking, gender, age and other personality traits may interfere with data collection (Speziale and Carpenter, 2007:110). The researcher made sure that she communicated clearly, audibly and was careful not to use other non- verbal messages that would disrupt data generation. The researcher conducted unstructured interviews with individuals in a face- to- face interaction.

3.5.9.2 Unstructured Interviews

The second data collection instrument in a phenomenological inquiry, is unstructured interviews, during which the researcher seeks to gather insight on how participants make sense of their experiences (Merrium, 2002:103). Interviews provide a way of generating empirical data about the social world by asking people to talk about their lives (Silverman, 2000 :104). In this respect, interviews are special forms of conversations and they provide more quality data for less money (Burns and Grove, 2009). Since interviewing is a skill, the researcher gave herself the opportunity to develop this skill before initiating the interviews. As a skilled interviewer, the researcher knew how to handle intrusive questions.

3.5.9.3 Data collection process

The researcher used open-ended questions in order to elicit a description of participants' perceptions regarding the effectiveness of community mental health services of the Zomba District. Open-ended questions apparently offer the opportunity for an authentic gaze into the soul of another (Denzin and Lincoln, 2002:72-75). The broad question that "kicked off" the interviews was; "What are your experiences on community mental health care services of Zomba District?" The other sub-questions on the interview guide were asked to probe for more information and to clarify issues that appeared vague. During the interview, the researcher as an instrument, probed for more information, writing notes of the contents of the interview, clarifying issues that sounded vague from the participants in order to capture the intended messages and observing both verbal and non-verbal messages. The researcher also used non-verbal messages to facilitate interactions such as nodding the head, or sounds that indicated interest. When some participants gave short answers, the researcher encouraged them to elaborate.

The researcher's emphasis was to allow or facilitate participants to talk freely about their lived experiences. Any question posed to them was there for clarification and to keep them on track. The researcher tried to "bracket" her presuppositions about the phenomena under study (Merium, 2002;125, Speziale and Carpenter, 2007 Burns and Grove, 2009, Polit and Beck, 2008). Questions to which the participants would answer 'yes' or 'no', were avoided because these would not offer much information during data analysis.

The length of the interview varied for each participant, because each interaction between the interviewer and the interviewee was unique. Each interview took (30) thirty to forty (40) minutes. Merrium (2002:130), argues that it is unlikely that any phenomena could be explored in less than half an hour. On the other hand, a two (2) hour interview would tire researchers and participants and would cast doubts on their ability to concentrate on the task at hand. A tape recorder was used throughout the interview process after seeking permission from the

participants. Interviews were recorded in order to prepare transcripts for later study (Polgar and Thomas, 2003:78). The environment for the interview was quiet to avoid the sensitive microphone from picking up even faint distorted voices, thereby increasing inability to make accurate transcriptions later during analysis (Burns and Grove, 2009).

The researcher also made sure that she had enough batteries to last for the entire interview to avoid embarrassment, and loss of a trusting relationship between the researcher and the participant. The researcher sought permission from participants before using the tape recorder to allay anxiety. The researcher continued to interview participants until saturation was reached. Thus, the interview ended when she heard the same statements or concepts over and over again.

3.5.10 Pilot Study

A small, preliminary investigation of the same general charcter as the major study was conducted (Drummond, 2003:156). The pilot study was designed to acquaint the researcher with problems that would be corrected in preparation for the large research project. It also tested the methods to be used in the larger, more rigorous study, which is sometimes referred to as the "parent study" (Polit and Beck, 2008:761). The aim of a pilot study is to identify potential problems in the data collection and to show that the study design was both appropriate and feasible (Drummond, 2003:156). The researcher conducted the pilot study before she conducted the actual study. The pilot study helped the researcher to practice interviews, gain artistic skills and refine the researcher's instruments, which was the researcher herself.

The pilot study was conducted at a different health centre from that of the actual study, to find out if the interview process and guide to be used had problems and were not ambiguous and unreliable. Thus finding out if the instruments were able to elicit the necessary responses from the participants before the actual data collection. The researcher conducted unstructured interviews with open –ended

questions with three (3) community psychiatric nurses and seven (5) guardians of discharged psychiatric patients. The researcher did not encounter many problems apart from disturbing cell phones form participants, and this was corrected by asking them to switch off the phones before starting the interviews. Data was analyzed and sent to the experts of qualitative research which were the supervisors and an expert in qualitative research in Malawi.

The researcher was recommended to proceed with the actual data collection for the main study by both supervisors and the expert of qualitative research from Malawi.

3.5.11 Ethical Considerations

The researcher considered these three ethical principles of autonomy, beneficence and justice in order to protect participants of the study. Polgar and Thomas,(2003:70-73) states that a project is ethical to the extent that its design and execution conforms to a set of standards or conventions. Ethical considerations for the study participants were done as follows:

3.5.11. 1 No Harm to Participants

Nursing research should never injure the people being studied, regardless of whether they volunteered for the study or not (Polit and Beck, 2008:170). The participants of this study had the right to self-determination and the freedom to participate or not to participate in the study. The ethical principle of beneficence required the researcher to do good and above all not to harm participants physically, psychologically, socially and economically. The researcher made sure that participants were not detained to conduct interviews for a period not more than one hour to prevent fatigue and unnecessary headaches. The researcher also avoided interviews that might cause sensitive issues to surface that may result in emotional trauma to the participants. To prevent harming the participants economically, the researcher held the interviews at the health centre in the communities where the participants lived, to prevent them traveling long distances. The researcher also developed one- to- one researcher participant

relationships to establish rapport and not to harm the participants socially, as well as to allay anxiety. The participants were told in advance not to answer questions with which feel uncomfortable. Participants who were included in the study were the ones who were in a position to comprehend what was happening.

3.5.11.2 Voluntary Participation

Voluntary consent was obtained after the prospective participants' had been given essential information about the study and had shown comprehension of the information. The researcher explained the purpose of the study to both groups of participants. They were also informed the benefits and risks of the study in clear language. Explanations to guardians of discharged psychiatric patients were done in a clear, local language, while to the community psychiatric nurses it was in English, the formal, official language of work in Malawi. Participants were also informed about the scope of the study and the type of questions that will potentially be asked. These participants were given sufficient information to help them decide whether they wanted to be research participants or not. Apart from explaining to the participants about the study, the researcher gave each participant a copy of the information sheet (see appendix G and H). The contents of the information sheet were: An introduction of who the researcher was, the purpose of the research, and the participants in the study, the duration of the interview and assurances of anonymity and confidentiality. A statement was made that participation was voluntary and any refusal to participate would not involve any penalty or loss of benefits to which the participants were entitled, such as not be given the medication. The information sheet also indicated that participants were free to withdraw at any stage of the interview.

After going through the information sheets, each participant was also given a written consent form to read and sign if they were in agreement with the contents of both the information sheet and the consent form. All the participants signed the consent forms which indicated that they were ready to participate in the study (See appendix D and E).The researcher requested permission to audio tape the interviews.

3.5.11.3 Confidentiality and anonymity

The researcher assured participants that confidentiality and anonymity would be upheld and that participants would be treated with respect and dignity. Newman (2000:99), states that in a confidential study, the researcher can identify a given person's responses but essentially promises not to disclose it publicly. Burns and Grove (2009), state that anonymity exists if the participant's identity cannot be linked, even by the researcher, with his or her individual responses. A breach of confidentiality can occur when a researcher, by accident or direct action, allows an unauthorized person to gain access to the raw study data. Confidentiality can also be breached in the reporting or publication of a study, when a participant's identity is accidentally revealed, thus, violating the participant's right to anonymity. Breach of confidentiality can harm participants psychologically and socially, as well as destroy the trust they had in a researcher, (Burns and Grove, 2009).

The researcher made sure that the names and addresses of participants did not appear anywhere because they were not necessary. The researcher was only interested to find out participants' views and experiences about the phenomena.

The interviews were carried out in quiet closed room away from people, for confidentiality and privacy. The researcher made sure that the information gathered from the interviews was not reported in a manner that identified the participants. The information (transcripts and the tapes) were only accessible to the researcher, the specialist of qualitative research and the supervisors. The transcripts were kept in a safe place and nobody accessed them and will be destroyed two years after publication of the research.

The researcher obtained permission to conduct the study from the University of Fort Hare's Ethical Committee, the Ministry of Health's Ethical Committee in Malawi, and the two institutions where the study was conducted (see appendix I ,J. K, and L).

This was done because research is an ethically significant activity and any research must be done in an ethically reflective manner to prevent violation of the rights of the participants, protect human life and privacy.

3.5.12 Authenticity and Trustworthiness of the data

Trustworthiness in qualitative research refers to validity and reliability (Denzin and Lincoln, 2000:84). Rigor in qualitative research is demonstrated through the researcher's attention to and confirmation of information discovered. The goal of rigor in qualitative research is to accurately represent study participants' experiences.

There are different terms to describe the process that contribute to rigour in qualitative research. Speziale and Carpenter (2007:48-52) and Lincoln and Guba (1985), had identified the following terms that describe operational techniques supporting the rigor of work; credibility, dependability, confirmability and transferability. For the purpose of this study, the criteria as described by Lincoln and Guba (1985) were applied.

3.5.12.1 Credibility

Credibility refers to whether the inquiry was conducted in such a manner so as to ensure that data gathered and emerging themes were accurately identified and described (Speziale and Carpenter, 2007).To achieve credibility of the data, the interviewer verified data collected, as well as the conclusions drawn from the information collected during interviews with participants to ensure that the interpretations made were correct. Speziale and Carpenter (2007), have called this activity "member checks". Polit and Beck (2008), state that member checking with participants can be carried out in an ongoing way as data are being collected (through deliberate probing), to ensure that interviewers have understood participants' meanings. The interviews were tape recorded to capture

the accurate responses of the participants. The transcribed data was checked with the audio tapes from time to time for accuracy.

3.5.12.2 Dependability

This is a criterion met once researchers have determined the credibility of findings. Polit and Beck (2008: 536-537), state that dependability refers to the stability (reliability) of data overtime and over conditions. The dependability question is - would the findings of an inquiry be repeated if it was replicated with the same participants in the same context? Credibility cannot be attained in the absence of dependability just as validity in quantitative research cannot be achieved in the absence of reliability. In this study, the transcribed data recorded during the interviews were verified by the participants themselves. The data was also verified for authenticity and accuracy and that it was the actual data as recorded during the interview. The analysis of the data was further verified by two (2) supervisors and an expert of qualitative research.

3.5.12.3 Confirmability

Confirmability of findings is to leave an audit trail which is a recording of activities over time that another individual can follow. This process can be compared to a fiscal audit (Speziale and Carpenter, 2007:97). The objective is to illustrate as clearly as possible the evidence and thought process that led to conclusions. The researcher left an audit trail by documenting clearly all the steps involved in the study. The initial coding of the data was done by the researcher and the two supervisors. It was later given to the experts of qualitative data analysis to review the categories and themes identified from coded data for validation.

3.5.12.4 Transferability

Transferability refers to the probability that the study has to others in similar situations. Transferability has also been labeled "fitingness"(Speziale and Carpenter,2007:98). It also refers essentially to the generalizability of the data, that is, the extent to which the findings can be transferred to or have applicability

of the data to other contexts. A qualitative study does not strive for generalizability.

3.5.13 Data Analysis

Data analysis was done by using steps as described by Speziale and Carpenter (2007:96), and from the website www.Atlas.ti.com (2008) as follows:

3.5.13.1 Transcription of data

The researcher transcribed the interviews to facilitate the process of data analysis. Most of the transcriptions were done on the same day of the interview. In cases where this was not possible, it was done within 24 hours of recording. In this manner, the researcher became familiar with the data as it was gathered.

3.5.13.2 Familiarization and immersion

The verbatim transcriptions or written responses were read and re-read word for word, sentence by sentence, until the researcher was convinced that the data was interpreted correctly. This activity in phenomenological study is termed as "dwelling" with the data (Burns and Grove, 2009). The transcriptions were compared with the audio-tapes for accuracy.

3.5.13.3 Coding of the data

Coding of the data was done using Atlas.ti software by examining each data line or sets of lines and naming the action and events found within the data. Computer assisted qualitative data analysis software (CAQDAS) helped to remove some of the work of cutting and pasting pages of narrative material. This program permitted the entire data file to be entered onto the computer (Polit and Beck, 2008}. Each portion of the interview was coded and then portions of the text corresponding to the specific codes were retrieved, printed and shown on the screen for analysis. The program provided tools that let the researcher locate, code and annotate findings in primary data material, to weigh and evaluate their importance and visualize complex relations between them (Polit and Beck, 2008).

Table 1 depicts a summary of the analysis stages as described on the website www.Atlas.ti.com (2008)

3.5.13.4 Summary of analysis stages

Table 1: Summary of analysis stages

Stages of Analysis	Analysis Process
1) Create a Hermeneutic Unit (an idea container)	Open a new Hermeneutic Unit to enclose data, codes memos and other structures under a single name.
2) Associate data files (Primary Documents) with your Hermeneutic unit	Select a file of the interviews from anywhere on the computer (desktop, flash disk, etc) and upload them in Hermeneutic Unit.
3) Coding of the data	Read and select text passages (or identify areas in a document) that are of further interest and assign code words.
4 Creation of Families/ Categories	Comparing data segments differently or equally, that is, putting similar codes in one family.
4) Formulation of networks	Linking of similar codes together and formulating a network
5) Interpretation and checking	Results integrated into a thorough description of phenomena.

3.6 Summary

Themes that emerged from guardians of discharged patients related to ineffective community mental health services were as follows: Services not accessible and the related sub-themes were: inconsistent appointment dates, shortage of medication, long distances and transport problems. Poor quality of services and its related sub-themes were: cultural incongruent services, poor supervision and lack of psycho-education. Themes that emerged from guardians of discharged patients regarding effective services were as follows: Services conducted near home village and its related sub-themes are: medications available and good supervision.

Themes that emerged from community psychiatric nurses related to ineffective community mental health services were as follows: Services not prioritized and its related sub-themes were; no representatives for mental health services, low morale and poor deployment of psychiatric nurses. Shortage of resources, and its related sub-themes were: material resources and human resources. Lack of quality care and its related sub-themes were: congested mobile clinics, lack of outreach programs and lack of dedicated transport. Stigma, and its related sub-themes were: services not well marketed, stigma by police and stigma by the community.

The theme that emerged from community psychiatric nurses related to effective services is as follows: services conducted near patient's home.

3.7 Conclusion

In chapter four (4), an analysis and discussion of research result is presented.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

4.1 Introduction

In chapter three the research methodology was explored and described in detail. The findings of the study are presented and discussed in this chapter. The data reflected the experiences of community psychiatric nurses and the guardians of discharged psychiatric patients on the effectiveness of community mental health services of the Zomba District of Malawi.

The data will be presented into three sections;

- Section A explains the demographic data of participants.
- Section B focuses on the themes that emerged from the Interviews with guardians of discharged patients.
- Section C focuses on the themes that emerged from the interviews with community psychiatric nurses who conducted mobile clinics.

Section A

4.2 Demographic data: guardians of discharged patients.

4.2.1 Age

The age of the participants ranged from 31 to 60 years and 15 to 30 years. Seven (7) of the participants were in the age group of 15 to 30 years old and six (6) participants were between 31 to 60 years of age.

4.2.2 Marital status

Nine (9) of the participants were married and four (4) participants were single.

4.2.3 Gender

There were thirteen (13) participants of whom seven (7) were males and six (6) were females. This signifies that both males and females were dedicated and willing to escort their patients to mobile psychiatric clinics to get treatment.

4.2.4 Frequency of attending clinics.

Eight (8) participants had escorted their patients to the mobile clinics three (3) to four (4) times. Three (3) participants escorted their patients more than four (4) times and two (2) participants escorted them two (2) times.

4.2.5 Relationship with patient

Five (5) of the participants escorted their sons- in-law, mothers in-law, husbands and wives. Five (5) participants escorted their sons; two (2) participants escorted their mothers while only one (1) participant escorted her daughter.

4.2.6 Number of admissions

The majority, that is twelve (12), guardians' patients were admitted to a psychiatric hospital three (3) to four (4) times. Only one (1) guardian's patient was admitted two (2) times.. This signifies that the frequency of relapses of patients is high in the Zomba District. According to the Zomba Mental Hospital records, the total number of relapses in 2008 and 2009 was 826 and 823 respectively.

4.3 Demographic data for community psychiatric nurses.

4.3.1 Age

All six (6) participants' ages ranged from 31 to 60 years old.

4.3.2 Marital status

One (1) participant was a widow, two (2) were single and three (3) were married.

4.3.3 Gender

All six (6) participants were females which signifies that nursing is still a female dominated profession in Malawi.

4.3.4 Frequency of conducting clinic

Four (4) participants had conducted the mobile clinics for more than four (4) times. Two (2) participants had conducted mobile clinics for three (3) to four (4) times. This signifies that all participants of this study were well experienced in conducting mobile clinics.

4.3.5 Duration of employment

Four (4) participants had been employed for eleven (11) to twenty (20) years and two (2) participants' duration of employment ranged from six (6) years to ten (10) years. This signifies that the participants were well experienced and information-rich.

4.4 The purpose of the study

The purpose of the study was to explore and describe experiences of community psychiatric nurses and guardians of discharged psychiatric patients on the effectiveness of community mental health services of Zomba District.

The themes that emerged from the participants have been classified under effective and ineffective services.

Section B

4.5 Themes that emerged from the interviews of guardians of discharged patients related to ineffective services.

Table 2: The two (2) cluster of themes that emerged from experiences of guardians of patients

Services not accessible	Poor quality of services
Inconsistent appointment dates	Cultural incongruent services
Shortage of medications	Poor supervision
Long distances	Lack of psycho-education

Services not accessible	Poor quality of services
Transport problems	

4.5.1 Services not accessible

Poor accessibility of services happened because of inconsistencies in appointment dates by the community psychiatric nurses, shortage of medication, travelling long distances from their communities to the mental hospital to access services and participants had transport problems. Table :3 depicts the subthemes relating to services not accessible.

Table 3: Services not accessible – sub-themes

Inconsistent appointment dates	Shortage of medications	Long distances	Transport problems

Community psychiatric nurses contributed to services not accessible due to **inconsistence in appointment dates.** Patients were given appointment dates by the nurses who conducted mobile psychiatric clinics but they did not turn up as promised to conduct the clinics as a result patients stayed without medication. Below are examples of statements related to inconsistence in appointment dates:

"Not really, sometimes he stays without medications, for example in January the clinic nurses did not come on the appointment dates to give us medication." (Interview number 2)

"Yes, sometimes they do not come because they are busy; as a result we follow them to the mental hospital to get medications because we want the patient to continue getting medications to prevent sickness from starting again". (Interview number 4)

Some participants reported that poor accessibility to services came about because the nurses did not give them enough medication to last to the next appointment dates due to a **shortage of medication**. As reported below;

"Yes, we are given medications for only one month and we are expected to take them till the next appointment, and yet the date is usually after 2 months. We are forced to go every month to collect medications for the other month". (Interview number 5)

"I have gone there several times, but I have been returned because they do not have medications". (Interview number 13)

Gaban, Richard and Smith (2005:120-123) state that sustained continuity of care improves quality of care by decreasing hospitalization, a decrease in emergency department use and improving receipt of preventive services. In rural America it was found that the absence of providers and services clearly correlated with decreased access to services and diminished treatment for patients (McCabe and Macnee, 2002:263-278).

Long distances contributed to poor accessibility to services. Some patients were not able to travel from their communities to the mental hospital to access medication when nurses were unable to conduct mobile clinics. An example of a statement related to long distances:

"It is about ten (10) kilometers". (Interview number 4)

Accessibility remains a complex concept. It is used in relation to geographical distances or to travel times from the patients homes to health centre sites and also to delays in how long it takes for patients to be assessed (Kaplan and Sadock, 2003:1382)

Problems with **transport money** contributed to poor accessibility to services especially when they were unable to access it due to non-functional clinics. Patients had no money to access medication at the mental hospital which was

very far from their communities Examples of statements related to transport problems:

"Transport problems, but sometimes I go there to collect medications. I went there once". (Interview number 7)

"The problem is that sometimes we are unable to have transport money to come here". (Interview number 12)

"No they do not give us. This time I have struggled to find transport money to come here, it's really a problem". (Interview number 13)

The country does not have social grants or disability benefits for patients with mental disorders. Mental disorders are not considered as a disability (WHO, 2005).

4.5.2 Poor quality of services

Poor quality of services were due to cultural incongruent services, lack of psycho-education concerning mental illness and poor supervision. Table 4: depicts sub-themes related to poor quality of services.

Table 4: Poor quality of services – sub-themes

Cultural incongruent services	Lack of psycho-education	Poor supervision

Cultural incongruent services contributed to poor quality of services because patients were taken to traditional healers instead of mobile clinics. This contributed to patients not taking medications as a result patients relapsed. The following are statements by participants on various cultural beliefs about mental illness:

"When she started to be sick, the patient was taken by her uncle to the traditional healer, I had no word to stop them because they are owners of the clan, and they

have all the power to control over their nieces and nephews' well being". (Interview number 3)

"I had taken him there because everyone at home was telling me that I should not depend on medications from the hospital; there is need to combine with traditional herbs" Interview number 5)

"I remember when I was at Nkhata Bay District, I went to a traditional healer following the culture of the Northern Region, they thought it was' Vimbuza' (Interview number 11).

A study by Tseng and Streltzer (2006:81-90) revealed that even though modern psychiatry has made significant progress in its scientific understanding of the nature of psychiatric disorders, many people still interpret mental illness as related to loss of soul, intrusion of illness objects, wrong doing of ancestors and deficiency of vitality. These are a few examples of folk interpretations of mental illness. Both authors state that an individual holding these beliefs might resist taking psychotropic medications. Such patients may want to perform religious rituals to regain his or her "lost soul," or may want to eat certain foods. For instance, in Arab societies and India, the mentally ill are respected and tolerated because of the historical notion that divine messages are sent through them. Language barriers and cultural misconception are cited in Scuglik, Aslar, Coin, Mark and Logan (2007:518-588), as factors related to incongruent psychiatric services to Somalis in the United States of America. Other barriers cited are their patriarchal family structure and working with interpreters, warring clan factions and patients' fear of being labeled "crazy". These authors suggested that health workers should provide care which is culturally congruent in order to communicate effectively with patients. Leinenger (2001:78) suggests that culturally congruent care is provided by accepting and complying with individual beliefs, planning, negotiating and restructuring care based on knowledge about the culture.

Lack of psycho-education emerged as a theme from guardians of the discharged psychiatric patients. This happened when nurses were not giving them information concerning the diagnosis of their patients' illness, supervision on medication and side effects. The quality of services were compromised because patients stopped taking medication because of the side effects of phenothiazines and lack of knowledge as to how long they were supposed to take these medications. The following are examples of statements on lack of psycho-education:

"We did not know what was wrong with the patient. We were not sure whether it was mental illness; some people were saying that he was bewitched". (Interview number 8)

The patient was refusing to take medications saying that he was tired of taking the medications. This made him to go back to mental hospital". (Interview number 1)

"It's me who keeps, but patient refuses medications, sometimes he throws them in a pit latrine saying that he is tired with medications". (Interview number 9).

Psycho-education is a specific method of working in partnership with consumers and families in a long- term treatment model to help them develop coping skills to deal more effectively with a serious mental illness (Thorncroft and Szmukler, 2001:51). Aho-mestonen, Miethinen, Raty and Timonen (2009:51-63), state that the main principle of psycho-education is that everyone has the right to receive information about the illness and treatment in order to take a more active role in relation to the illness, instead of being a passive recipient of care. Patients sometimes know little about their diagnosis despite long term illness. Family psycho-education is an evidence based practice that has been shown to reduce relapse rates and facilitate recovery of persons with mental illness (Dixon, Macfalene, Lufley, Cohen, Solomon, Soundheim and microwitz, 2001:903-910), studies have shown markedly higher reduction in relapses and re-hospitalization

rates among consumers whose families receive psycho-education, compared to those who receive standard individual services.

Poor supervision on medication by guardians of discharged patients contributed to the poor quality of services. Patients were not supervised by their guardians because of travelling to other places leaving the patients behind, disputes between the patient and caregivers and failing to remind the patient to take medication. Examples of statements on different reasons for poor supervision of their patients:

"Unfortunately, I was away for two months, and then my patient had no medications. He started cutting other peoples sugarcanes, he was beaten up and patient was taken to the mental hospital". (Interview number 5)

"You know in a family we sometimes quarrel and he decides to go back to his home village. Due to lack of supervision or because he leaves the medication behind, as a result he gets sick again". (Interview number 4)

One participant admitted that he failed his responsibility by not supervising his wife on medications when he reports;

"*as a husband, when I fail to remind her to take the medications*" (Interview number 11)

Accountability is an element of responsibility between staff and individual patients, a relationship that needs to be based upon confidentiality and trust (Thoncroft and Szmukler, 2001:170). Those psychiatric patients who are in the community need to be supervised on what and how to take medications and identify side effects (Gilbert et al, 2008:85-96). These authors continue to state that the main supervisors are the care givers themselves and patients' guardians. However, it should be borne in mind that supervising a psychiatric patient is not easy, it needs a lot of dedication. Fadden, Bebbington and Kuipers (2000:285-292) study, found out that the impact of the functional psychiatric illness on the patients family, revealed that the burden of caring for the patient at home is

considerable. They often affect caring relative's social and leisure activities and financial problems arise frequently. Relatives have difficulties in understanding and coming to terms with illness-related behavior and negative symptoms are often particular problem. Mojtubai, Fotchmann, Chang, Kotov, Craig and Bromet (2009:479-695), study on mental care needs of patients with schizophrenia, revealed that 40% of the respondents reported that they did not have received any mental health treatment for the preceding 6-12 months. These authors state that, Clinical Epidemiologists studies also found that many patients drop out of treatment after their first with services and receive little mental health care in subsequent years due to poor supervision. These authors continued to state that clinical studies of patients in routine treatment settings indicate that the treatment patterns of these patients often fall short of the benchmarks set by evidence-based practice guidelines. At least half of these patients continue to experience significant symptoms.

4.6 Themes that emerged from guardians of discharged patients related to effective services.

Table 5: Themes that emerged from guardians of discharged patients

Mobile clinics conducted near home village
Medication available
Good supervision

4.6.1 Mobile clinics conducted near the home village emerged as a theme from the participants. They were thankful because the clinics were conducted within their walking distances as a result they were able to access medications easily without walking long distances. Patients expressed happiness because their patients were able to do their household work because of their good supervision. Table 6 depicts sub-themes for mobile clinics conducted near the home village.

Table 6: Mobile clinics conducted near home village – sub-themes

Medication was available	Good supervision

Medication was available implied that guardians of discharged patients appreciated when there was availability of medications. They realized that when their patients were taking medication they were improving and not displaying abnormal behaviours. Examples of statements related to medications available:

I have seen that patient is improving with the treatment from the Mental Hospital because at first patient was undressing publicly "(interview *number 6)*.

"*Madam, things are getting better than it was previously, now we can differentiate. When we find that nurses from the Mental Hospital have not come to conduct the clinic, we become worried especially thinking that my patient will not have medication" (interview number 5)*

"I can see that the services are much better as compared to previous treatment when we gave him traditional medicine" (interview number 8)

Gaban, Michael and Richie (2004:120-123) state that sustained continuity of care improves quality of care by decreasing hospitalization, decreasing emergency department use and improving receipt of preventive services. continuity of care is a cornerstone of primary care that has been promoted by recent trends in nursing education and in the way health care delivery is organized.

Good supervision as a sub-theme emerged from the interviews of the guardians. They were happy with the services because their patients were able to help them with household work instead of depending on their guardians. An example of statement related to good supervision, is:

"*My mother is not walking many distances, is able to tie and untie the goats, she is able to interact with her friends, searching for water and bathing at the river" (interview number 10)*

The legitimate goal of a community mental health program is to increase the potential of a person to solve his/her problems in a reality-based way within the framework of his tradition and culture (Caplan, Anderson and Weber, 2004:42). To be effective, the services must be integrated and balanced, so that appropriate treatment modalities are available to fit patients' needs and organize a system of care (Kaplan and Sadock, 2003:1374). Community mental health services should be provided within a walking distance to a patient's residence and place of work to provide accessibility of care. Furthermore, with close proximity illness can be identified early, leading to early diagnosis, treatment and prevention of complications. This will make only brief hospitalization, when required.

Section C

4.7 Themes that emerged from the interviews of community psychiatric nurses related to ineffective services.

Table 7: The cluster of themes that emerged from community psychiatric nurses

Services not prioritized	Shortage of resources	Lack of quality care	Stigma
No representative for mental health services	Material resources	Congested mobile clinics	Services not well marketed
Low morale	Human resources	Lack of outreach programs	Stigma by the police
Poor deployment of psychiatric nurses		Lack of dedicated transport	Stigma by the community members

4.7.1 Services not prioritized

The interviews with community psychiatric nurses who conduct mobile clinics revealed that the government of Malawi, and the Ministry of Health in particular, did not prioritize mental health services. They cited unavailability of representatives (desk officers) at national and zonal levels to represent mental health services. As a result, nurses had low morale with their work and there was poor deployment of psychiatric nurses by the Government. Table 8 depicts the sub-themes relating to services not prioritized.

Table 8: Services not prioritized – sub-themes

No representative for mental health services	Low morale among nurses	Poor deployment of psychiatric nurses

No representative for mental health services emerged as one of the themes from the participants. Diseases such as Diarrhea, Malaria, Tuberculosis and HIV/AIDS have their own designated programs and representatives (desk officers) both at national and zonal levels. Mental health programs do not have representatives at these levels. Mental health services were not perceived by the government as a priority service. Example of statements related to no representatives for mental health services:

"Also our program is not known to the Government, it is not taken as a priority because in other hospitals we can find antibiotics; these can be out of stock for few days and they are in, while ours stay out of stock for so many days which shows our program is not taken as a priority". (Interview number 5)

"We don't have a representative, I have not heard any way that we have representatives. In other programs there are, but in mental health we do not have. Even in the zone offices, there is no representative for mental health issues". (interview number 6)

"Even the government they are not prioritizing psychiatric services as one of important services in the ministry". (Interview number 1).

Well developed community mental health services with representation at management level are associated with low suicide rates (Pilkola, Sund, Sillen and Wallpeck, 2009:147-153). Booyens (2006:56) states that an unbroken chain of authority and communication should extend from the highest to the lowest level. The same author continue state that most health organizations operate according to a hierarchical structure that resembles a pyramid. Power and authority increase at every level up to the top hierarchy. Psychiatry faces vast problems in implementing programs for the chronic mentally ill and to apply principles of differential therapeutics. These problems include the lack of funds for community services, and the continuing severe fragmentation of a psychiatric delivery 'non-system'. If the public mental health system is to survive, it must first be defined as comprising all settings, services and funding for the severely and

chronically mentally ill. It must shift the balance of resources and services from institutional to community- based. A range of financial and administrative mechanisms, such as various kinds of aggregate findings and division of responsibility among levels of government are available to accomplish that shift. The author continues to state that *"it is now abundantly clear that no longer is any single person in-charge of the psychiatric system or responsible for the entire patient population or any segment of it"* (Talbott, 2004:1136-1140).

Low morale as a theme emerged during the interviews. Since mental health services were not regarded as a priority service, participants were suffering the effects of the neglected services. There was lack of motivation for the participants because they were not sent for further training or given any other incentives such as being sent for a workshop. Example of statements related to low morale:

"Staff goes for training and remain at the same carder with no promotions, that also de – motivates staff to work in mental health service". (Interview number 1)

"All health personnel have no interest working at a psychiatric institution, why, because of a lot of things. They feel it's a risky job, no incentives". (Interview number 1)

Morale is a vague concept and the term itself is often used without being properly defined. It is usually associated with job satisfaction or lack of it. Both authors define morale as the mental and emotional attitudes of an individual to the function of tasks expected of him, as well as common purpose with respect to a group (Hall and Altiman, 2004 :94-97). Unmotivated employees are likely to be unproductive compared to motivated ones. Both authors explain that motivation is an important aspect of enhancing employee performance (Sullivan and Decker, 2005:78)

Poor deployment of psychiatric as a theme meant that many psychiatric nurses are trained every year and instead of deploying them to do psychiatric

nursing, they are sent to the government general hospitals while the mental hospital has a shortage of nurses and a large workload. Examples of statements related to poor deployment of psychiatric nurses:

"There are many who have been trained for mental health issues and are contributing to the problems, if government may put in place measures that those who have specialized in mental health issues whenever they qualify, they should do the work". (Interview number 6)

"Psychiatric nurses not properly deployed". (Interview number 1)

One participant reported on adverse effects of poor deployment of nurses as;

"That is just a waste of time and money and resources from the ministry. Things that the person learnt in class, they are supposed to practice them on the patient is not done and the patient Is not benefiting". (Interview number 1)

A study by Steiment and Braichet (2010:45-49), revealed that there is an imbalance in the geographical distribution of health- workers both in developed and developing countries. Approximately one half of the world population lives in rural areas, but these areas are served by only 38% of the total nursing work force and less than 25% of the total are even more prominent in developing countries because of low income.

4.7.2 Shortage of resources

A shortage of resources as a theme emerged from the participants. There was shortage of human as well as material resources such as medication and transport problems. Table 9 depicts clusters of sub-themes related to the shortage of resources.

Table 9: Shortage of resources – sub-themes

Shortage of human resources	Shortage of material resources

Shortage of human resources is a theme that emerged from the participants. This was evidenced by allocating one (1) community psychiatric nurse to conduct a clinic per health centre, they experienced work and overload pressure. Example of statements related to shortage of human resource:

"To see those patients is difficult because you expect one hundred and thirty seven (137) patients alone within a short period and for a psychiatric patient to come up with problems, they go round and round instead of hitting the nail on the head to explain the problems". (Interview number 1)

"And on top of that, when we see the patients, ten (10) or six (6) are new patients, so we have to look after old ones and those who are new and take time to treat them perhaps half the day". (Interview number 2)

"*Sometimes there are a lot of patients in each mobile clinic and there is only one nurse who goes there to look after them"* (Interview number 4)

"For example, if you go to Ngwelero Health Centre, you can see one hundred patients (100) and on top of that there are so many new patients and these patients they need thoroughly assessment which we cannot do because we are running short of time". (Interview number 5)

Usually, when one talks about shortages, it refers to either one of these two things, or to both supply or demand. In this case, it really seems to be an issue of supply (Ashton and Jarvis, 2011). Both authors continue to state that the shortage of human resources available for mental healthcare in most low income and middle income countries is likely to persist. Not only are resources for mental health care scarce, they are also in-equitably distributed between countries, between regions and within communities (Ashton and Jarvis 2011).

Scarcity of available resources, inequality in their distribution and inefficiency in their use poses the three main obstacles to better mental health in many African countries (Saxena et al, 2007:178-189). Both authors state that the areas that

are deprived of resources stop functioning and patients seek help from other avenues, as a result they relapse and become chronic.

Shortage of material resources, especially medication and transport for mobile clinics, and follow-up care were in short supply, as a result patients stayed without medications and were relapsing in large numbers. Examples of statements related to the shortage of resources:

"We are supposed to go there every month to see the patients but we have problems with transport". (Interview number 1)

"The other thing is that, there is no transport for the mobile clinic, so they miss drugs for that month which means that they also relapse". (Interview number 4)

These three participants shed more light on why there are problems with transport when they reported;

"They say that most of their cars are at garage and nowadays fuel problem". (Interview number 3)

This participant explained the effects of not going to mobile clinics because of transport problems;

"Some problems are because of us, we don't usually go there because of transport problem or due to bad roads during the rainy season, so we fail to go and give them services as a result they gather there at the clinic for the whole day, at the end they go back without medications". (Interview number 1)

"When we fail to go to their areas, those who have transport money can come here using their own transport, by bicycle or a vehicle coming here to collect drugs but others they cannot afford". (Interview number 5)

The shortage of medication as a theme meant that there was a short supply of medications, and this shortage caused participants to conduct irregular clinics

and not to adhere to patients' appointments. Other mobile clinics were completely closed and this caused inconveniences to some patients and others relapsed because of not having medication. The other contributing factor to the shortage of medication was that medication was out of stock in the Government central medical stores which supply medication to all government hospitals, as a result nurses were prescribing what was available and not what was appropriate for the patient. This caused patients to relapse, overcrowding in hospital wards, and inappropriate change of medication and inconvenience to patients and their guardians. Example of statements related to shortage of medication:

"Sometimes drugs, yes, we don't have enough like shortage of Chlopromazine and shortage of other drugs. As a result most of the patients that we visit are admitted again at the hospital". (Interview number 2)

"Medications, medications ohmm, nowadays there are problems because we are changing medications now and then, because let's say that the patient is on phenobarb at the particular time we are going there, we don't have that drug and instead of just leaving the patient without medication, we change from phenobarb to phenytoin". (Interview number 5)

The following participants reported the effects of shortage of medication on the patients' mental health;

"There are a lot of relapses because half of the year 2010 and this year there was shortage of drugs and we are having a lot of patients in the ward". (Interview number 3)

"Our program sometimes fails to go and see patients, as a result, they are relapsing and the hospital is congested because of more patients admitted". (Interview number 5)

"Like last month, we had shortage of first line medications like Chlopromazine which is mostly used and most of the patients like it. So whenever they are

prescribed on different medicine they definitely would relapse because they are given medication that they do not respond well". (Interview number 6)

"Last month they had been communicating that they don't have medications maybe it is the issue of money". (Interview number 6)

The problem with mental health care is the inability to segment and individualize the treatment so that the correct treatment is provided to each mentally ill person. Practice procedures and laws need to be changed so that each individual receives the services he or he needs, in the most optimal setting (Talbott, 2004: 1136-1140). The author continues to state that despite years of vowing to provide continuity of care, there is no such a thing in most communities. Instead patients wander around the landscape as if in a Russian super market passing the aisle of empty shelves. Balderman's (2010) article titled "Clinic closed", reported that in Elpaso Texas, a clinic that helped hundreds of psychiatric patients throughout the year was closed because of lack of funds. As a result a lot of programs were slashed because of a country budget crisis. A lot of patients without access to care went into psychiatric crisis and became a danger to themselves or others and that had a devastating impact to the community. Ashton and Jarvis (2010) state that unavailability of essential medicine also constraints mental health treatment. About a quarter of low income countries do not provide even basic anti-depressant medication in primary care settings. In many countries the supply does not extend to all regions of a country or is irregular, despite the fact that effective pharmacological treatment for many disorders depends on continuous access to medication for extended periods. Since medications are often not available in health care facilities, patients and their guardians may be forced to pay for them.

4.7.3 Lack of quality care

Lack of quality care as a theme meant that the participants were not able to provide quality care because the mobile clinics were congested with large numbers of patients and they did not have time to properly care for them. As a

result, psycho- education to patients and guardians were not given, There was lack of outreach programs such as follow up of defaulters and lack of dedicated transport because they used a vehicle from another institution. Table 10 depicts clusters of sub- themes related to the lack of quality care.

Table 10: Lack of quality care – sub-themes

Congested mobile clinics	Lack of dedicated transport	Lack of outreach programs

Congested mobile clinics as a theme meant that the mobile clinics were congested. The nurse/patient ratio was very high for example, one (1) psychiatric nurse against one hundred and thirty seven (137) patients per clinic day. As a result quality of care was compromised. Examples of statements related to congested mobile clinics:

"We need to assess the patients fully, we have to write the whole history and maybe subsequent patients have problems, we have to understand why they having those problems and counsel but sometimes we fail". (Interview number 5)

"Other patients come with guardians, you need to educate guardians on mental health services because you are alone you do short cuts want to finish the clients instead of giving proper care". (Interview number1)

"Sometimes it is difficult to collect data effectively because the nurse is under pressure". (Interview number 4)

"No we don't take history we just prescribe drugs we do not diagnose because of time". (Interview number 2)

One of the codes of ethics for nurses is that the nurse promotes, advocates for, and strives for the health, safety, and rights of the patients (Sullivan and Decker, 2005:22-25). Both authors state that nurses can be held reliable for acts and

omissions or commissions. Inadequate staff is not an excuse for negligent acts (Sullivan and Decker, 2005:24).

Lack of dedicated transport as a theme came about because when going to mobile clinics, participants used a vehicle from another institution and they were combining with other health professionals such as the Dental Technicians, Ophthalmic Nurses and Dermatology Technicians. These people managed to finish their clinics much earlier than the community psychiatric nurses because of congestion of patients. As a result, they were harassed as reported by this participant:

"While we are doing the assessment, one of the member of the team say can you hurry up, then we do ***bla bla bla*** *which is not good you are not helping the patient fully especially new patients".* (Interview number 5)

"Sometimes they choose a chairman who brings a pass book to the Zomba Mental hospital static clinic and they listed problems with the patient. We can relate to the paper that they have written. When distributing drugs to these people, we relate them to their health passport then prescribe the drugs". (Interview number 1)

Patients have a legitimate expectations that the nurse will offer treatment based upon duty of care and will do this according to expected standards of professional practice, such as confidentiality (Sullivan and Decker:24).

A lack of outreach programs as a theme meant that patients were not being followed up if they defaulted treatment to prevent them from relapsing because of a shortage of resources. Sometimes they only managed to trace those patients who lived near the hospital as they managed to go there on foot. Quality of care was compromised because the majority of clients were not reached and stayed without medication and relapsed. Examples of statements related to lack of outreach programs:

"To those who had not come to mobile clinics or those with some other problems connected with the environment they are staying, and needs follow-up, but you can't go because of shortage of staff". (Interview number 1)

"Sometimes we do, but sometimes because of the same problem, for those who are far we do not follow them". (Interview number 5)

A study by Kelly (2000:81-83), revealed that many persons with severe mental illness are caught in a vicious circle. They enter a psychiatric hospital for treatment, are discharged back to their community with no effective follow-up care, and end up homeless or back in the hospital.

4.7.4 Stigma

Stigma attached to mental illness emerged as a theme meant that community mental health services were not marketed and supported because psychiatric patients are discriminated and looked down upon, and services are not regarded as important and useful by the community members including the law enforcers such as the police. As a result patients defaulted treatment and relapsed. Table 11 depicts sub-themes for stigma.

Table 11: Stigma – sub-themes

Services not well marketed	Stigma by the community	Stigma by police

Stigma by the police as a theme meant that although it is stipulated in Malawi's Mental Treatment Act 32: 02 of 1959, that the "police" are supposed to pick up psychiatric patients who wander aimlessly in the community, regardless of whether they commit a crime or not, and take them for certification either by the Magistrate and obtain a "reception order" (R O) or by a general practitioner to obtain a temporary treatment order (T. T. O) to allow a patient to be admitted

at the mental hospital, it was not done. An example of a statement by the participants related to stigma by police:

"Most of the times they bring those who have committed a crime and people go to the police to complain, that are when they bring them here". (Interview number 3)

The patient who wanders about aimlessly in the community, is regarded to be a danger to himself as well as his community (Talbott, 2004 :1136-1140). In Kwa-Zulu Natal, the local South African Police (SAPS) are required by the Mental Health Act (MHCA) to transport psychiatric patients where necessary (Peterson, Bhana, Campbell, Mjadu, Lund, Klentijies, Housegood and Flisher, 2002). The SAPS participate in the annual district planning meetings, and although their personnel in the district had been oriented to (MHCA) requirements of the police, a fair amount of reluctance to deal with psychiatric patients was still reported. This seemed to steam from a belief that their care role was management of criminals and that psychiatric patients with challenging behavior should be managed by health personnel (Peterson et al, 2002)

Services not well marketed as a theme described that mental illness is not known, as a result it is not supported by Donors and other stakeholders because of the stigma from policy makers. Examples of statements related to services not well marketed;

"*On the other side, you know we fail publicity, people are not very much aware of mental health services*". (interview number 1)

"*Journalists, they don't have interest to know mental health issues pertaining to psychiatric services*". (interview number1)

Stigma by the community as a theme described that it was observed by the participants that a lot of patients had stopped taking medication because some community members were laughing at them during mobile- clinic visits. An example of a statement related to stigma by the community:

"*Some stopped taking the drugs because of stigma*" (interview number 2)

The stigma attached to mental illness is another obstacle in shifting the burden of care for mental illness (MacCabe and Macnee, 2002:263-278). Both authors state that, patients stop taking medication because of stigma. Residents of small rural communities who are seen going into identified mental treatment centres are highly stigmatized, increasing the likelihood that these patients would prefer to either present their concerns in the guise of a physical complaint, hoping for some assistance from the primary care providers or work with faith-based or natural community helper sources who are less clearly identified as mental health providers. The study by Perlick, Link, Miklowitz and Struening (2007:535-536) where they wanted to find out perceived stigma and depression among caregivers of patients with bipolar disorders, revealed that caregivers' perception of stigma may negatively affect mental health by reducing their copping effectiveness. Both authors state that the study showed that 43% to 90% of care givers of people with mental illness reported feeling stigmatized and that was associated with reports of depressive symptoms. The authors concluded by explaining that in addition to posing a barrier to the recovery of people with mental illness, stigma erodes the morale of the family members who care for them.

4.8 Themes that emerged from the interviews of community psychiatric nurses experiences on effective services.

Services conducted near patients homes as a theme described that services were somehow effective because patients received treatment near their homes despite the presence of scarce resources. Example of statements related to service conducted near home:

"*Somehow it is effective because most of the patients who are discharged from the hospital receive their treatment at the clinic near their homes" (interview number 4).*

"The flow of patients from their homes to the hospital has been reduced" (interview number 4)

Self- determination allows patients to seek help when needed (Price 2007:334-346).The author continue to state that autonomy and self-determination of psychiatric patients minimize relapses as patients are empowered to seek help when needed without being told. Voluntary admission of patients is a sign of autonomy and self-determination.

4.9 Application of Betty Neuman's Theory to the study

The researcher used the system's theory to guide the study. The theory provides a starting point to collect facts in a systematic way so that phenomena can be described, explained and predicted (Lancaster and Stanhope 2006:136). Similarly, the researcher followed a systematic way of finding out the phenomena using the research process. Neuman's conceptual model and theory identified the concepts that are essential for nursing and guides actions that nurses should implement in their practice. Similarly, the researcher selected the system model theory because of its unique feature of community- oriented nursing, as the study was done in the community in order to assist individuals and families of psychiatric patients, as well as groups and communities to maintain their highest level of mental health, by finding out through research the problem of having relapsed. Chronic psychiatric patients roam the streets of the Zomba District in Malawi, and yet there are community mental health services which are supposed to care for these patients and prevent them from relapsing.

Betty Neuman's system theory (1972) explains that individuals, families groups and communities are assisted by viewing the communities from a holistic perspective as a motivator or disruptor of health. Similarly, the researcher was committed to finding out the cause of the phenomena, of relapsed chronic psychiatric patients who are roaming the streets of the Zomba District. The presence of these patients in the community is a disruptor of health with a potential of being a danger to themselves and others. Furthermore, the

researcher found it important to select participants from the same community to describe their lived experiences of the community mental health services that treat these patients to find out whether they are effective or not. The researcher will make recommendations to the appropriate management levels to improve services for the patients' wellbeing and increase their potential to solve their problems in a reality- based way within the framework of their culture.

Neuman (1972) emphasizes that the goal of the system theory is to asses, plan and evaluate ways to make the community a healthier place to live. Similarly, the researcher followed this scientific approach when conducting this study. The researcher assessed and came up with the research problem and question and planned to find out ways that could be used to answer the research question through the appropriate research methodology. The researcher will evaluate the phenomena under study to find out if there is an improvement in the patients' well-being and the Zomba District community a healthier place to live.

4.10 Summary

In this chapter, themes that emerged from guardians of discharged patients concerning ineffective services were as follows: services not accessible due to inconsistent appointment dates, shortage of medication, long distances and transport problems. Poor quality services due to cultural beliefs and practices, poor supervision by guardians and lack of psycho- education. Themes that emerged from the guardians on effective services are as follows: mobile clinics conducted near home village, medication available and good supervision.

Themes that emerged from community psychiatric nurses on the ineffectiveness of services were as follows: services not prioritized due to lack of representatives for mental health services, leading to low morale of nurses and poor deployment of psychiatric nurses. Shortage of resources such as human resources and material resources, poor quality of care caused by congested mobile clinics, poor follow –up care. Stigma by police and community members and services not well marketed. Themes that emerged from community psychiatric nurses on effective

services are: services conducted near patients' homes thus, reducing readmissions of patients to the mental hospital.

4.11 Conclusion

In this chapter, the researcher analyzed data using ATLAS.ti Software and interpreted the data from both guardians of discharged psychiatric patients and community psychiatric nurses who conduct mobile clinics in the communities of the Zomba District of Malawi. During the analysis, the researcher interpreted what each theme signified and included direct quotations from the interviews of the participants.

Chapter five (5) provides a description of the conclusions, limitations and recommendations pertaining to this study.

CHAPTER FIVE

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 Introduction

In previous chapters, the researcher explained reasons for this study, and presented the applicable research methodology and data analysis for the purpose of this study. Results were also discussed in comparison to other literature and research studies. In this chapter, the researcher presents the conclusions on the findings, limitations and detailed recommendations on promoting effective community psychiatric services in the Zomba District of Malawi.

5.2 Conclusions

The objectives set for this study were the following:

- To explore and describe experiences of community psychiatric nurses on the effectiveness of community mental health services in the Zomba District.
- To explore and describe experiences of guardians who accompanied the patients to mobile clinics during the months of November and December 2010, on the effectiveness of community mental health services of the Zomba District.

5.2.1 Experiences of community psychiatric nurses on the effectiveness of community mental health services of the Zomba District

The experiences of some of the participants were that community mental health services of the Zomba District are not effective. They cited several factors which have contributed to its ineffectiveness. They also implied that several groups of people namely, the government of Malawi, through the Ministry of Health, the community psychiatric Nurses themselves, the guardians of discharged patients

and the patients themselves have contributed to the ineffectiveness of the services. However, there were also some participants who experienced the services as being effective.

This study has revealed that the Government of Malawi has contributed to the ineffectiveness of the services by not appointing representatives of community health services at the national, as well as at the zonal levels. Participants have argued that programs that look after physically ill individuals have representatives at these two (2) levels of management. These desk officers are able to co-ordinate and monitor the services. The implication for the community mental health services is that services were likely not to be monitored and coordinated. Furthermore, Malawi's Mental Health Policy and Legislation which direct Mental Health Programs are outdated (WHO, 2005). Mari, Screenlives and Saxena (2007:83-88), state that a lack of a mental health policy and legislation to direct mental health programs and services is of particular concern in Africa and South East Asia. As a result, health workers lack direction as to how services should be organized due to a lack of strategic plans and monitoring tools to find out if goals are being achieved. Patients receive care which is sub-standard and they relapse.

This study revealed that, Mental Health Services are not regarded as of priority services by the Government of Malawi. Participants reported that since services are not prioritized they felt the effects of a neglected service, such as poor deployment of psychiatric nurses, lack of motivation by not being given promotions or any other incentives for performing risky jobs. The implications are that nurses had low morale.

Fink (2010), states that leaders of health care organizations spend their time, resources and energy seeking out the best and the brightest employee the job market has to offer. However once these individuals are hired, management does not always know how to bring out the best in them. Instead, these individuals often remain misplaced and under-utilized, when in reality their

potential exceeds the level of placement. Unchallenging environments with little or no opportunities for professional growth and advancement often lead to employee low morale. Genius (2008:31-34) confirms by stating that employees with low morale no longer regard nursing and medicine as rewarding vocations. As a result, large numbers of discounted patients turn to assorted and unconventional therapies in search of help. Furthermore, lack of motivation leads to high staff turnover with major implications for patient care (Sullivan and Decker, 2005:46).

Participants reported that apart from shortage of staff to conduct mobile clinics, there was a shortage of material resources such as vehicles, fuel and medication. The implications for the services were that nurses failed to go to the mobile clinics. This resulted in failing to fulfill patients' appointment dates, and making the mobile clinics inconsistent. Furthermore, nurses were forced to prescribe the available medication to patients and not what was appropriate for the patients due to the shortage of medication.

Patients were also given half of the dosage that could not take them to the next appointment dates. These malpractices caused the patient to stay without medication and relapse in large numbers, and congested the hospital wards. Participants implied that the shortage of these resources were caused by poor funding from the government as essential medication was mostly out of stock at government Central medical stores.

This scenario seems inevitable for the government as it spends only 2% of the total budget on mental health activities (WHO, 2005). Poor funding creates challenges to the implementation of mental health care services in primary health care settings (Jacob, Sharan, Mirza, Garrido–cumbrera, Seedat, Mari Screenlives and Saxena, 2007:83-88). The situation of poor funding appears not unique only to Malawi. A study by Sharashidze Naneishvilli Silagadze, Begiashuvilli and Beria (2004:107-116), found that in 1998, Georgia allocated 0,6% of its Gross Domestic Product (GDP) to healthcare. The total expenditure

on healthcare that year by individuals and the State was estimated to be not more than US$20 per head (WHO, 2005).

The study by Saxena, Thorncroft, Knapp and White (2007:187-189), found that the poorest countries spent the lowest percentages of their overall health budgets on mental health. Most care is now institutional- based as the transition to community care would require additional funds that have not been available for mental health care. The same authors state that, as a result, there are substantial gaps and inconsistencies. Furthermore, these countries allocate few resources and have grossly inadequate manpower and infrastructure for mental health. Their study also revealed that populations with high rates of socio-economic deprivation have the highest need of mental health care, but lowest access to it (Saxena et al. 2007178-189).

This current study demonstrated that another contributing factor to ineffective services was the community psychiatric nurses themselves. Participants reported that they were unable to provide quality care to patients when conducting mobile clinics because the clinics were congested, (one hundred and thirty seven (137) patients per nurse per visit was sited). Thorncroft and Szmukler (2001:78-79), state that around the world the mental health workforce is coping with a large caseload, which works against implementing better methods of treatment and care.

The quality of care was compromised because participants were unable to give psycho-education, prescribing medication without taking a history, and prescribed medication without diagnosing. They also reported that they were performing shortcuts in care because they were working under pressure. The implication to the services is that patients were receiving sub-standard care and patients were relapsing. Buchanan and Aiken's (2010:3262-3268) study, showed that a shortage of nurses is not necessarily a shortage of individuals with nursing qualifications; it is a shortage of nurses not willing to work under the present conditions. Both authors state that the main cause of nursing shortages were

highlighted as inadequate workforce planning and allocation mechanisms, resource constraints, under supply of new staff, poor recruitment, retention and return policies, poor incentive structures and inappropriate support of employees.

The results of this study showed that community psychiatric nurses did not conduct outreach services to follow-up on patients who defaulted on treatment because of shortage of resources such as human and material resources like transport. Maritz (2010:61-68), states that follow-up care refers to the monitoring of the mental health status, the active and collaborative management of after-care plans (focusing on more than just dispensing medication), initiating action where needed, timely referral, continuous client education and identification of support resources. The same author's study, which was done in South Africa, found out that barriers which impact on quality follow-up care and follow through care were related to inadequate service provision associated with unavailability of resources (human, time and infrastructure), practice system support as well as the attitudes of the mental health care user and the family. Despite indications of pockets of excellence in South Africa's primary care setting, there seems to be a high level of unmet needs related to follow-up and follow-through services. The same author states that a lack of financial and human resources in the mental health services, as well as communities, impact on the ability of the communities to cope with transition from institutions to community- based mental healthcare. Lack of outreach services causes patients to relapse and be re –hospitalized and compromises the efficiency and promptness of health staff.

This study demonstrates that the guardians of discharged patients contribute to the ineffective services of the Zomba District. Participants reported that some patients were coming to the mobile clinics without guardians because their guardians were tired of looking after their patients. As a result, some patients were unable to communicate effectively and not able to give feedback concerning the effectiveness of their medication. Thorncroft and Szmukler (2006:49),stated that guardians are the people who know the pre-morbid state

and have shared the confusions, disruptions and emotional ravages of the illness. Both authors state that in most cases, a caring family continues to be the most stable resource for patients throughout a lifetime. However, guardians concerns of being tired seems understandable, as Thorncroft and Szmukler (2001:107-109), argue that, caregivers may have to contend with abusive or assaultive behaviours, socially offensive and embarrassing situations in public places, mood swings and unpredictability. Conflicts might arise about excessive smoking, poor hygiene, and damage of household property or sleep reversal patterns that may keep the household awake.

The implications are that the patients are feared and not supervised resulting in non-adherence to medication and relapse. Those patients who are fortunate enough are admitted at the hospital but the unfortunate ones end up homeless and roam the streets unattended.

It has been revealed in this study that patients were stigmatized by the law enforcers (the police) and the community members. These attitudes contributed to ineffective services because some patients stopped taking medication from the mobile clinics because of the stigma. community members automatically knew that the patients were mentally sick due to the fact that patients were seen getting medication from these mobile clinics.,. Furthermore, the police stopped picking up patients who were wandering about aimlessly in the streets and only picked up those who had committed a crime.

Carrigan's (2002:201-220), study revealed that people with serious illness are challenged doubly, on one hand they struggle with the symptoms and disabilities that result from the illness, on the other, they are challenged by the stereotypes and prejudices that result from misconceptions about mental illness. As a result of both, people with mental illness are robbed of the opportunities that define quality life, good jobs, safe housing, satisfactory health care and affiliation with diverse groups of people. Cowan's (2005:329-336) study found that relocation of psychiatric patients from an institution to a community- based facility was faced

with public opposition. The community did not want mental health facilities to be established in their localities, a phenomena referred to as "NOT- IN – MY-BACK YARD" NIMBY) syndrome. the same author states that this showed the attitude the public held towards people with mental health problems. Not in my back yard phenomena is a wide spread obstacle to people with mental illness.

Birkman, Sperdlp and Smith (2006:157-165), state that if mental health services are to be effective, healthcare workers need to fight stigma and discrimination against psychiatric patients because fighting stigma and discrimination, is fighting for mental health. If patients are stigmatized and discriminated against, they relapse because they lack support systems which can supervise their treatment. Furthermore, stigma contributes to isolation and loneliness, and as a result psychiatric patients relapse and become chronic.

Those participants who perceived that services were effective, cited that the patients were getting treatment near their homes. As a result, patients' movements to the mental hospital were reduced.

5.2.2 Experiences of guardians of discharged patients on the effectiveness of community mental health services of the Zomba District.

The result of this study demonstrated that some participants experienced the services of the Zomba District as being ineffective and others perceived them as effective. Those participants who experienced the services as not effective reported the following contributing factors: poor quality of services contributed by cultural beliefs and practices, poor supervision of patients by the guardians and lack of psycho- education.

The participants also reported that services were not accessible due to inconsistent appointment dates, shortage of medication, and long distances from their communities to the mental hospital to access treatment, as well as transport problems to cover the long distances.

Those participants who experienced the services as being effective reported that the mobile clinics were conducted near their homes, as a result they were able to access the treatment easily and their patients were improving and were able to do their household work.

Participants reported that services were not accessible because nurses were inconsistent in their appointment dates. Thus, they were not coming to conduct clinics on the appointment dates and patients were staying without medication as a result they were relapsing. Maritz (2010:61-68), states that the quality and continuity of mental health services are an important factor in terms of mental health care access. Accessibility encompasses a range of dimensions spanning from availability (for example: geographical distribution of mental health facilities, pharmaceutical products etc), transport and roads. Affordability (cost of treatment) and acceptability, referring to the social and cultural distances between the mental health care systems and their users. This mainly refers to the characteristics of health workers.

This study revealed that services were also not accessed when the patients stayed without medication due to a short supply of medication which could not last them to the next appointment dates. Sometimes when the prescribed medication finished they went to the Health centres in their communities to access medication, but unfortunately there was no medication at these Health Centres and patients relapsed. MacCabe and Macnee (2002:263-278), explain that individuals with mental illness have difficulties accessing treatment, paying for services they can find, and are most often treated by primary care providers who in general lack training time and resources to correct and effectively meet mental health needs.

Akawige (2010), reported that in Ghana with regard to a shortage of medication, only epileptic patients were able to access medication, however other patients with mental illnesses were not able to access medication because the psychiatric units in the hospitals that used to prescribe and dispense the drugs on a regular

basis did not have the medication to do so. The author states that it was crucial that they were regularly supplied with of medication because without medication they relapsed. He reported that at times when there was an acute shortage of drugs in the hospital, patients were given prescriptions to buy from private pharmacies, but they could not get them there and sometimes could not afford to buy them.

Participants reported that, when medication finished before the appointment dates, they were unable to access them at the mental hospital because of long distances from their homes to the hospital, and lack of transport money. As a result, they relapsed. Thorcroft and Szmukler (2001:159), describe continuity as an on-going need by many patients for reliable sources of treatment and social support. There are two (2) types of continuity namely; longitudinal and cross-sectional continuity. Longitudinal continuity refers to the ability to offer uninterrupted services of contracts over a period of time. Cross-sectional continuity includes the continuity between different service providers. Both authors state that continuity of care is important to ensure that persons have access to care at all levels and ideally, it is dealt with by the same team of services.

The study revealed that the services which were rendered in the Zomba District were of a poor quality, due to cultural beliefs and practices, poor supervision by guardians of discharged patients and a lack of psycho-education. Most participants reported that they were taking their patients to traditional healers instead of bringing them to the mobile clinics; some were giving their patients a combination of traditional herbs and medication from the hospital.

Participants reported taking their patients to traditional healers because they were following their tradition and culture as they believed that mental illness is caused by evil spirits and witchcraft. As a result, patients were not adhering to hospital medication and relapsed. Sharashidze et al, (2004:107-116) study conducted in Georgia found that mental illness in some communities is not

regarded as a clinical condition, but a sign of spirit possession or social punishment. The same authors state that medical professionals report that traditional healing practices have negative effects on psychiatric patients and frequently exacerbated psychiatric illness.

Thorncroft and Szmukler (2001:78), state that a meta-analysis of 24 studies, found that compliance in people with mental disorders ranged from 24 to 90%, the combined average being only 54% adherence. Both authors state that it was found that over the course of time, non-adherence rates climbed to 74% and in the absence of adherence, relapses' rates have been shown to reach over 74%.

This study revealed that the guardians of discharged patients were not given psycho-education. As a result, they lacked knowledge about mental illness such as causes of the illness, where to go and get appropriate treatment for their patients, signs and symptoms of relapse and side effects of medication. As a result, patients sort care from other avenues and some patients stopped medication because of side effects and because they were tired with medication and threw them in the pit latrines. Booyens (2006:112), states that learning begins at birth and ends at death. The same author explains that the need to learn originates in an individual's need to adjust to illness. Nasr and Kauser's (2009) study wanted to find out the impact of psycho-education on the burden of families with schizophrenic patients in Lahore, Pakistan. One group of family members received psycho-education and psychotropic drugs. The other group received psychotropic drugs only, without psycho-education. Both groups were assessed twice, prior and six (6) months after psycho-education intervention. Results showed that there was significant reduction in burden at post intervention assessment in the psycho-education group. Both authors concluded that family psycho-education can be an important intervention for patients with schizophrenia in Pakistan.

The researcher for this study found that guardians of discharged patients did not adequately supervise their patients. Participants admitted to not supervising their

patients and some left their patients for a period of two (2) months unsupervised. Some did not accompany their patients to access treatment. Others explicitly admitted to failing in their responsibilities by not reminding their spouses to take medication. As a result some patients stayed without medication and relapsed making the services ineffective.

Thorncroft and Szmukler (2001:558), explain that psychiatric patients who are in the community need to be supervised on what and how to take medication and identify side effects. The authors continue to explain that the main supervisors are the care-givers themselves and patients' relatives. The relatives need to be empowered with knowledge on how to supervise their patients for continuity of care at home and after discharge. Thorncroft and Szmukler (2001, 559) stated that families are a vital part of natural support to persons with mental illness, and it has been shown that those who live with families are better than others. The same authors explain that if patients take their prescribed medications and are closely monitored, the relapse rate falls to about 20% at 2 years after their initial episode.

Haya's (2003:40-45) study, where he wanted to assess the cost of relapse in the treatment of schizophrenia during a six (6) months period, revealed that patients' costs with prior-relapse were high. It was associated with high cost for in-patient services as well as outpatient services and medication. He recommended that there is need to intensify outpatient services, such as partial hospitalization programs for patients with addictive disorders. Maritz (2010:61-68), explained that relapse and re-hospitalization compromise the efficiency, quality and promptness of care by health- workers.

This study has revealed that some participants perceived the services as being effective. Participants reported that they were able to access services near their homes and that when their patients took medication; they improved and were able to do their household work. This development is very encouraging.

Thorncroft and Szmukler (2001:558), state that community psychiatry treatment aims to take place in locations which are accessible and acceptable to patients.

5.3 Findings

Community psychiatric nurses' experiences of the effectiveness of community mental health services of the Zomba District were overwhelmingly reported as not being effective. Barriers impacting on ineffective mental health care services can be divided into three main categories namely: inadequate service provision related to unavailability of resources (human, time and material). An inadequate practice system related to a lack of chain of command from national to grass-root level, leading to poor co-ordination and monitoring of activities. Poor quality of services related to lack of psycho-education, rehabilitation, and in-service education programs. Furthermore, it has been found that some of the themes from both groups seem to complement each other. Themes such as lack of quality care, services not accessible, poor supervision, shortage of resources especially medication and transport, were reported as contributing factors to ineffective services by both groups. The themes that emerged from the responses of those participants who experienced the services as effective were similar. This signifies the authenticity of responses concerning the situation under study from both groups of participants.

Guardians of discharged patients' experiences of the services were also overwhelmingly reported as being not effective. The barriers hindering the effectiveness of the services can be categorized as follows; services not accessible related to inconsistent appointment dates, shortage of medication and poor economic status of participants. Poor quality of services related to cultural beliefs and practices, poor supervision and lack of psycho-education.

5.4 Limitations

The limitations of this study are the time; the researcher managed to conduct the study in one District of Malawi. It would also be helpful if similar studies were

conducted in other Districts of Malawi as community mental health services are offered in almost every district in Malawi.

5.5 Recommendations for Nursing Practice.

5.5.1 Intensify follow-up care

The government of Malawi should increase funds for the effective follow-up of psychiatric patients who have defaulted on treatments to prevent relapse. Patients should not be caught up in a vicious cycle; entering a psychiatric hospital for treatment, and discharged back to their homes in the community without effective follow-up care, and ending up homeless or back to the hospital.

5.5.2 Enhance Patients independence and productivity through rehabilitation programs.

The government should design services to help persons with mental illness find fulfillment through real work, real home and real relationships to improve their independence and productivity in the community through rehabilitation programs.

5.5.3 Intensify community awareness campaigns

Community nurses should intensify community awareness campaigns through open days. These should not be done only on International Mental Health days. People with mental illness and their guardians should be taught to recognize signs of an impending relapse so that medication can be adjusted appropriately and health risk reduction measures are learnt.

5.5.4 Update both Mental Health Policy and Mental Treatment Act

Government should provide funds to update both documents which are outdated, to accommodate the current trends of practice and direct mental health activities so that patient care outcomes can be evaluated and monitored.

5.6 Recommendations for nursing education

5.6.1 Improve quality care through in-service education

Intensify in-service training for staff to obtain a minimum standard of core skills, including ability to identify mental disorders, assess and manage risks, basic knowledge of psychotropic medication and their side effects, and use of educational strategies with patients and guardians. They should also develop skills to improve patients' compliancy to medication to prevent relapses.

5.6.2 Utilize the sturdy results into nursing curriculum.

Nurse educators to include the results of this study as content into their mental health/ psychiatric nursing curriculum.

5.7 Recommendation for further research

Since the study was only limited to one district, further research of qualitative method should be done in the remaining districts of the southern region of Malawi where community mental health services are done the results to be compared with this study.

5.8 Summary

In this chapter, the researcher described the conclusions, limitations and recommendations based on the findings as defined, for the purpose of this study.

5.9 Conclusions

Since the findings of this study cannot be generalized to the other communities in other districts of Malawi, the researcher would like to appeal to the government of Malawi to release funds to conduct similar studies in the same district of Zomba using quantitative method.

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APPENDICES

Appendix A: INTERVIEW GUIDE FOR GUARDIANS OF DISCHARGED PATIENTS.

PART A

DEMOGRAPHIC DATA

Age----------

15-30yrs

31-60yrs

Marital Status----------

Single

Married

Others Specify

Gender----------

Female

Male

Frequency of attending clinic----------

2 Times

3-4 Times

More than 4 Times

Relationship to patient----------

Daughter

Son

Father

Mother

Others Specify

Number of admissions----------

2 Times

3- 4 Times

More than 4 Times

PART B

(1) What are your experiences on the effectiveness of community mental health services of Zomba District?----------

---

What have you identified as being effective or not effective services?---------

---

What other modes of health services have you used?----------

Appendix B : INTERVIEW GUIDE FOR COMMUNITY PSYCHIATRIC NURSES

PART A

DEMOGRAPHIC DATA

Age----------

15-30yrs

31-60yrs

Marital status----------

Single

Married

Others specify

Gender----------

Female

Male

Frequency of conducting clinic----------

2 Times

3- 4 Times

More than 4 Times

Duration of employment----------

1-5 yrs

6-10 yrs

11-20 yrs

More than 20 yrs

PART B

What are your experiences on the effectiveness of community mental health services of Zomba District?----------

---

What have identified as being effective and not effective services?----------

---

Considering the information you have just given what would you recommend to make services more effective----------
---

Appendix C: CHIKALATA CHOFUNSIRA MAFUNSO KWA OYANG'ANILA ODWALA MISALA

CHIGAWO CHOYAMBA

DZAKA……

15 -30yrs

31 – 60yrs

NDINU OKWATIWA----------

EYA

AYI

NDINU AKAZI KAPENA AMUNA……

AKAZI

AMUNA

NTHAWI YOBWERA KU CLINIC……

KAWIRI

KATATU KAPENA KANAYI

KUPITIRILA KANAYI

UBALE WANU NDI ODWALA……

MWANA WANGA WANKAZI

MWANA WANGA WA MAMUNA

BAMBO ANGA

AMAYI ANGA

ACHIBALE

NTHAWI YOGONA MCHIPATALA……

KAWILII

KATATU KAPENA KANAYI

KUPITILIRA KANAYI

CHIGAWO YACHIWIRI

(1) **Kodi chisamaliro chimene odwalawa amalandilachi mumachiona bwanji?**……………..

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Kodi kwa inuyo chimene mwachiona ngati chithandizo chabwino kapena choipa ndi chotani?--
----

Fotokozani za chithandizo chimene mwakhala mukugwilitsa ntchito? -------
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Appendix D: CONSENT FORM (CHICHEWA)

Ndikumuetsa kuti kulowanawo ndondomeko youfunsidwa mafunso ndi y osaumilizidwa. Ndikuti nditha kukana kulowanawo, nthawi iliyonse imene ndingafune opanda mulandu uli onse. Ndiye ndikutsilira umboni ofuna kulowa nawo mu ndondomeko yofunsidwa pa kafukufukuyu.

Ndikubvomelezanso kuti anditepe mau kufuna kuthandiza pa kafuku fukuyu. Ndikumvetsa kuti zones zojambula ndi kulembedwa zi dzatayidwa aka dzatha kafuku-fukuyu.

Dzina la ofunsidwa----------Date----------

Appendix E: CONSENT FORM (ENGLISH)

I understand that my participation is voluntary and that I may refuse to participate or withdraw my consent and stop taking part at any time without penalty. I hereby freely consent to take part in this research project. In addition to the above, I hereby agree to the audio recording of the interview for the purpose of data capturing. I understand that these records will be accessed by the researcher only and be destroyed after analysis is complete.

Signature of participant----------Date----------

Appendix F: LETTER FOR APPROVAL TO THE MINISTRY OF HEALTH MALAWI

University of Fort Hare
Nursing Science
P.O. Box 7426
50 Church Street
East London
RSA

1/8/2010

The Director of Nursing
Ministry of Health
P. O. Box 30077
Capital City
Lilongwe3

Dear Madam,

Seeking permission to conduct a research study

I would like to ask permission to conduct a research study in your Ministry. I am a master's student at the above university. The title of my study is: Experiences of Community Psychiatric Nurses and Guardians of discharged psychiatric patients on the effectiveness of community mental health services of Zomba District in Malawi. Attached is my research proposal

Your co-operation will be greatly appreciated.

Yours truly,
Bertha Maggie Kachingwe (Mrs)

Appendix G: CHIDZIWITSO KWA OLOWA KAFUKUFUKU.

1. **MUTU WA FAFUKUFUKU**

Maganizo a Namwino omwe a magwira ntchito zothandiza odwala misala mu midzi ndi abale a odwala misala amene anatulutsidwa mchipatala Pa nkhani ya mwene anaonera ntchito za chipatala zimene zimathandiza odwala misala m'midzi.

Mwini wa Kafukufuku : Mai Bertha Kachingwe. Cholinga cha Kafuku fuku, Kufuna kudziwa maganizo a namwino ogwira ntchito zothandiza odwala misala mu midzi ndi abale a odwala misala amene anatulutsidwa chipatala pa nkhani ya mmene amaonera ntchito za chipatala zimene zimathandiza odwala misala m'midzi.

Mukhale omasuka pa kulowa nawo mu gulu la Kafuku fukuyu. Musaope palibe chire chonse choopsya chimene chingakuchitituleni. Si inu omirizidwa kulowa mu guruli. Ndikhala nanu pa mphindi zochepa basi 20 – 30 minutes. Muli ndi ufulu kutukuka ngati mungaone kuti pali nkhani zosakukomerani. Ngati ndingafunse funso locititsa manyazi pali mwayi oti mukhoza kusayankha. Pakucheza pathu pakhala tape recorder yo ndithandiza pa kafuku fukuyu musaope chifukura pa mafunsowa palibe malo olemba maina anu. Zimene tikambe leno ndi za pakati pa inu ndi ine basi. Zotsatira za kafuku fuku palibe wina amene azione ndipo ndizisunga malo oti aliyense sangafikire. Zotsatilazi zidzatayidwa akatha kafuku fukuyu.

Pali funso?

Kafukufukuyu kuti ndichite ndinatenga chilolezo kwa anthu owona za ufulu wanu kumene ndi kuphunzira. Ngati mungakhale ndimafunso bwino lino mutha kundiyimbira pa hone number 0888363854 kapena 01524662 ku ntchito.

ZIKOMO

Appendix H: INFORMATION SHEET

TITLE: The experiences of community psychiatric Nurses and guardians of discharged psychiatric patients on effectiveness of Community Mental Health services of Zomba District of Malawi.

Investigator : Bertha Kachingwe: Student at the University of Fort Hare.

Aim of Study : This study aims at exploring and describing experiences of Community Psychiatric Nurses and guardians of discharged psychiatric Patients on effectiveness of Community Mental Health Services of Zomba District.

There should be no risk or discomfort as you will not be judged by your decision. Will spend 20 to 30 minutes of your time. You will be answering a few questions. I will be taking some notes during the interview. If I ask you a question which makes you feel sad or upset, we may stop and talk about it or you may choose not to answer such a question. Your name will not be on the tape recorder so that the data will not be linked with your name. All data will be stored in a secure place and no one expect the researcher will have access to the interview. These recordings will be destroyed after analyses are complete. Your identity will not be revealed when the study is published.

If you have a question about the study or about participating in the study feel free to ask me (Bertha Kachingwe) You may call me at 0888363854 (Cell phone) or 01524662 (work).

Your participation in this study is totally voluntary; you are under no obligation to participate. You have the right to with draw at anytime without any penalty. The study and its procedures have been approved by the appropriate people and the research ethics committee of the University of Fort Hare. I have discussed the above points with the participant understand the benefits and obligation involved in participating in this study.

Investigator----------Date----------

Appendix I: CLEARANCE FROM UNIVERSITY OF FORT HARE

OFFICE OF THE DEPUTY VICE-CHANCELLOR:
ACADEMIC AFFAIRS AND RESEARCH
Private Bag X1314, Alice 5700
Tel: 04060 22403
Fax: 0866282944
tsnyders@ufh.ac.za

University of Fort Hare
Together in Excellence

Application for clearance from the University of Fort Hare's Ethics Committee

Project Title:	**Perceptions of Community Psychiatric Nurses and of the Guardians of Discharged Psychiatric Patients on the Effectiveness of Community Mental Health Services in the Zomba District in Malawi**
Chief Researcher:	Bertha Kachingwe
Supervisor:	Dr N Tshotsho
Date of application:	10 August 2010

Having consulted the Dean of Research, I hereby grant permission to conduct the research.

Professor J R Midgley
Deputy Vice-Chancellor
Chairperson of the interim Ethics Committee

23 August 2010

Appendix J: PERMISSION FOR MASTER'S DEGREE RESEARCH PROJECT

Ref. No. ZMH/ //
Tel. No. 01- 524344/01-950 596
Telefax No. (265) 1 525 200

E-Mail: zmh@malawi.net

Please address all communications to:
The Director of Mental Health Services

MINI STRY OF HEALTH
ZOMBA MENTAL HOSPITAL
P.O BOX 38
ZOMBA
MALAWI

THE DIRECTOR OF MENTAL HEALTH SERVICES
25 NOV 2010

November 25, 2010

The Deputy Vice Chancellor,
(Chairperson of the Interim Ethics Committee
University of Fort Hare
Department of Nursing Science
P.O. Box 7426
East London 5201
REPUBLIC OF SOUTH AFRICA

Attention: Mrs. B. Kachingwe

Dear Sir/Madam,

RE: PERMISSION FOR MASTER'S DEGREE RESEARCH PROJECT

Reference is made to your application to conduct a Master's Degree Research Project at this institution (Zomba Mental Hospital).

I am pleased to inform you that permission has been granted for you to conduct the Research Project as requested. May I ask you to also seek permission from the District Health Officer for Zomba District as the Health centres you will be conducting the Research Project are in their catchment area.

Wishing you the best as you conduct the research.

Yours faithfully,

L.M. Lijoni
Chief Nursing Officer
FOR: DIRECTOR OF MENTAL HEALTH SERVICES

Appendix K: PERMISSION TO CARRY OUT RESEARCH FROM ZOMBA DISTRICT HEALTH OFFICE

Telephone: +265 01 524 588
Facsimile: +265 01 524 320

All Communications should be addressed to:
The District Health Officer

MINISTRY OF HEALTH AND POPULATION,
ZOMBA DISTRICT HEALTH OFFICE,
PRIVATE BAG 18,
ZOMBA, MALAWI

Ref. ZA/DHO/66

26th November 2010

TO WHOM IT MAY CONCERNED

Permission is granted to carry out the research on Perceptions of Community Psychiatric Nurses and guardians of discharged psychiatric patients.

However it should be emphasized that activities under study should be restricted to the ones stipulated in the research proposal document.

for DHO

THE DISTRICT MEDICAL OFFICER ZOMBA DHO 2010 -11- 26 PRIVATE BAG 18, ZOMBA

Medson Semba
DISTRICTS HEALTH OFFICER

Appendix L: PERMISSION FORM MINISTRY OF HEALTH AND POPULATION, MALAWI

Telephone: + 265 789 400
Facsimile: + 265 789 431

All Communications should be addressed to:

The Secretary for Health and Population

In reply please quote No. .....

MINISTRY OF HEALTH AND POPULATION
P.O. BOX 30377
LILONGWE 3
MALAWI

9th December, 2010

Bertha M. Kachingwe
University of Fort Hare

Dear Madam,

RE: PROTOCOL # 819: 'A STUDY OF THE PERCEPTIONS OF COMMUNITY PSYCHIATRIC NURSES AND OF GUARDIANS OF DISCHARGED PSYCHIATRIC PATIENTS ON THE EFFECTIVENESS OF COMMUNITY PSYCHIATRIC MENTAL HEALTH SERVICES IN ZOMBA DISTRICT, MALAWI'

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review. Please be advised that the NHSRC has reviewed and **approved** your application to conduct the above titled study.

- **APPROVAL NUMBER : 819**
- The above details should be used on all correspondences, consent forms and documents as appropriate.
- **APPROVAL DATE : 30/09/2010**
- **EXPIRATION DATE**
  This approval expires on 29/09/2011. After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the NHSRC Secretariat should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the NHSRC within 10 working days using standard forms obtainable from the NHSRC Secretariat.
- **MODIFICATIONS:** Prior NHSRC approval using forms obtainable from the NHSRC Secretariat is required before implementing any changes in the protocol (including changes in the consent documents). You may not use any other consent documents besides those approved by the NHSRC.
- **TERMINATION OF STUDY:** On termination of a study, a report has to be submitted to the NHSRC using standard forms obtainable from the NHSRC Secretariat.
- **QUESTIONS:** Please contact the NHSRC on telephone number *+265 1 789 400/321*or by email on doccentre@malawi.net.
- **OTHER:** Please be reminded to send in copies of your final research results for our records (Health Research Database).

Kind regards from the NHSRC Secretariat.

SECRETARY FOR HEALTH
2010 -12- 9
P.O. BOX 30377, CAPITAL LILONGWE 3

.....
For: CHAIRPERSON, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE

Promoting Ethical Conduct of Research