

UNIVERSITY OF NATAL

DURBAN

MENTAL HEALTH CARE PROVIDED BY
NURSES IN THE PRIMARY HEALTH
CARE CLINICS IN SWAZILAND.

BY

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PREFACE

*I certify that the thesis is the original work of
MAKHOSAZANA ZANELE HLATSHWAYO.*

*All other informational that is used as sources of information has been
indicated and acknowledged in the reference list.*

SIGNED: *M. Z. Hlatshwayo*
M. Z. HLATSHWAYO.

DEDICATION

THE STUDY IS DEDICATED TO MY TWO LOVELY BOYS:

NKOSINATHI AND PHIWAYINKOSI

*WHOSE LIVES MAY HAVE BEEN DIFFERENT HAD I NOT
UNDERTAKEN THE DEGREE AT SUCH A DELICATE TIME OF THEIR LIVES.*

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The guidance and patience given to me by Professor Nomthandazo Gwele is invaluable. She did not only help me go through the study but, helped me to learn that education is not only books but involves 'ubuntu' thank-you very much Thandie - may the Lord bless you.

I wish to thank all the staff of the School of Nursing for all the encouraging words they offered to me when the going was tough. Without those words I would not have worked as hastily as I did to complete the Project.

My greatest gratitude is extended to all the nurses who participated in the study. The nurses at Mankaine, Nhlangano, Hlathikhulu and Ndzevane. The cooperation that I received was so incredible. Thank-you very much. Without your input the study would not have been a success. May the Lord enrich you with his love so that you may in turn extend it to the people you care for in the various places of work. Thanks.

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TO ALL OF YOU THANK-YOU VERY MUCH.

ABSTRACT

The study was designed to examine and describe mental health care provided by the nurses in the primary health care settings of Swaziland. The study sought to answer one main questions namely:

- what was the nature of mental health care provided by nurses in the primary health care clinics?

A sample of 31 primary health care clinic nurses was used to generate data for the study. The sample consisted of registered nurses with only one having a mental health qualification. The study used both qualitative and quantitative methods for data collection. Data analysis involved simple frequency and percentage counts using SPSS manual as well as descriptive narratives using NVIVO computer analysis methods..

Findings revealed that mental health care in the primary health care clinics was mainly traditional involving immunizations, family planning and antenatal services. Limited mental health care was provided by the only mental health nurse involved in the study. Nurses stated that the care they provided was in line with their job descriptions.

The study concluded that the mental health care provided at the primary health care clinics was based on the traditional approach that did not encompass mental health care. Recommendations made were related to the promotion of the integration of mental health care into the services provided in the primary health care settings with nurses being prepared for the role.

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CHAPTER I : INTRODUCTION

1.1 INTRODUCTION:

The beliefs associated with mental health care have been undergoing a transformation for the past two decades following the inception and adoption of primary health care (PHC) worldwide. The driving force behind the primary health care concept is the World Health organization (WHO). The PHC strategy to health was officially accepted by WHO member states as an appropriate model to health care internationally in 1978. A number of the WHO member countries responded to the recommendation by developing strategies and plans for successful establishment and implementation of the PHC concept (Ebrahim & Ranken, 1988). Swaziland is one of the 166 WHO member countries who adopted and planned for the implementation of the PHC strategy (WHO, 1978).

Swaziland is situated in the Southern part of Africa. The Republic of South Africa surrounds the country, except at the eastern boarder, which adjourns Mozambique. The area of the country is 17 364.4 square kilometers and is divided into four regions. According to the National Development Strategy (NDS) the population of Swaziland was estimated at above 950 000 in 1979 and is envisaged to rise by 3.2% yearly (NDS, 1997). The literature reveals that in most countries, at least 40% of the population is suffering from some form of mental or neurologic disorder (WHO, 1999), this means that about 40% of the Swazi people need mental health care in varying ways. It is also assumed that the incidence of mental illness in the country is likely to increase even more with the high rate of HIV/AIDS and its related psychological effects.

The country's health care system has been decentralized to each of the four regions. This is in keeping with the PHC philosophy of health. Each region has at least one general hospital. Three of the general hospitals have a psychiatric unit attached to it. In addition there are four (4) community mental health centers distributed unevenly within the country. There is one national psychiatric hospital situated in Manzini, the center of the country (The Ministry of Health, 1999). The health centers attached to the different hospitals admit a limited number of patients with acute mental disorders or those requiring supervision, other cases are referred to the main psychiatric hospital. All the mental health centers in addition to providing curative care also provide outpatient community services, which involve review and giving of psychotherapy, counseling services, health education to the general public and social welfare services. The psychiatric hospital in Manzini admits more or less 300 patients per year, carries out all the activities done in the health centers and in addition runs outreach services throughout the country (The Ministry of Health, 1999). Annex 1 is a map of Swaziland showing the distribution of the mental health facilities.

Mental health care has undergone a lot of dynamics in the past years in the country like the rest of the world. The changes are related in part to the changes in society and challenges that mental health has been going through. Mental health care has shifted from a point of custodial care, to institutionalization, deinstitutionalizations, community mental health and now the contemporary PHC model.

Deinstitutionalization was initiated with the aim of involving the society in caring for the mentally ill. It was later seen as a problem in that a lot of mentally ill people were returned prematurely to their communities with no provision for supportive care and therapeutic services,

this necessitated a shift to community mental health care. Community mental health care emphasized on comprehensive community based mental health care (Haber, Leach, Schiddy & Sidelean, 1982). The literature on related studies is consistent in the aspect of community mental health care. The studies reveal that community mental health care is the relevant approach for the care of the mentally ill (Abiodun, 1990; Reed, 1987; Uys & Middleton, 1997; WHO, 1999). Much as the community mental health approach has shown a lot of success in improving mental health care delivery, it has been observed that it requires a lot of infrastructure and resources that could not be afforded by a lot of developing countries. The PHC model of care is practical in that it does not only apply to developed countries, but also to the developing third world countries. Its emphasis is on the prevention of the occurrence of disease at various levels with full responsibility taken by the people through community participation (Fry & Hasler, 1986).

The Alma-Ata declaration in 1978, defined the essential elements of health care. In defining these elements the declaration stressed that PHC should be the main strategy used to deal with health problems in the community. The declaration also respects that health problems vary and therefore the way of solving those problems also will vary from one country to another and one community to another (WHO, 1978).

Swaziland is one of the WHO member countries that adopted and implemented the PHC philosophy by setting up strategies and plans that address it within the country's health care system (NDS, 1997). PHC is practical, scientifically sound and socially acceptable for the country as well as other developing countries (WHO, 1996). However there is limited documentation of the strategies set for mental health care to achieve the objectives of PHC in Swaziland. According to the NDS (1997) the country is in the process of reviewing various

program activities and develop policies, strategies and target areas to promote PHC. This may include mental health care. WHO has drawn new strategies for mental health improvement. The cornerstone for the strategy is “formulation and strengthening of national mental health policies, development and implementation of programs in all the member states in the African region” (WHO,1999, p.4). It is hoped that through the strategy, mental disorders will be reduced, mental health care be equitable, accessible, be cost effective and the people will adopt healthy life styles resulting in the improvement in the quality of life (WHO, 1999).

Since 1983, Swaziland has affirmed her position “to improve the health status of the Swazi people by providing preventive, promotive and rehabilitative health care services which are relevant and accessible to all people” (Health Policy, 1983). The country’s policy statement by the Rt Honorable Prime Minister Dr B. S. Dlamini in March 1999, reaffirms the objective of providing health services that are appropriate and accessible to all.

1.2 BACKGROUND OF THE PROBLEM:

One of the major problems faced by mental health professionals in Swaziland, particularly mental health nurses is the understanding of the nature of mental health care provided at the primary health care levels. The WHO (1978) recommendations view PHC as an effective framework to provide comprehensive health care including promotive, preventive, curative and rehabilitative care with the participation of the communities. Mental health is also seen as an integral part of this comprehensive health care. Since the inception of the PHC philosophy and principles by WHO in 1978, Swaziland has transformed the national health care delivery system to embody the elements of PHC (NDS, 1999; WHO, 1978).

While the adoption and implementation of the above strategies have the potential to

improve the provision of mental health care, evidence suggests the need to explore the nature of such care at the primary levels. From the literature review and existing studies it appears that:

There is limited documentation on mental health care provided at PHC level in the country. The preliminary literature review done by the researcher revealed a lack of scientific information around the topic. This is also supported by WHO (1999) regional reports on mental health services which indicates that in most African countries of the WHO Afro Region; documentation related to mental health problems and care is very limited.

Nurses constitute about 80% of the main health care providers in the country (NDS,1997). However, the number of nurses with mental health qualification is very limited as compared to the general nurses. The existing register for nurses of the country showed that out of 1438 registered nurses; 61 are qualified psychiatric nurses (Swaziland Nursing Council, 1995). This means that mental health care is mainly provided by nurses with limited knowledge and skills in mental health care. Therefore, it seems relevant to explore the mental health care provided by those nurses at the primary health care settings.

There is a high rate of mental health or psychosocial problems among clients visiting PHC settings presenting with physical complaints. However, those conditions are frequently missed during diagnoses and therefore inappropriately managed. Although such evidence is not documented in Swaziland, studies done elsewhere have demonstrated that 20-30% of common mental disorders are prevalent amongst the general population and about 40% among all clients attending the general out patient. The

implication is that nurses working within those settings should be able to provide comprehensive care including mental health (Abiodun, 1990; WHO, 1999)

The demand for mental health care at PHC settings has increased as a result of the high incidence of wars, natural disasters, poverty and many forms of violence that are observed in the region and the additional burden of HIV/AIDS (WHO,1999). Nurses are expected to provide a range of care including counseling, psychosocial support, crisis intervention, individual and family therapy and community-based care. It is therefore, relevant for the clinical mental health nurse specialist to explore mental health care provided by nurses of Swaziland at that level of health care delivery system.

It was against the above problems that the researcher undertook to examine mental health care provided by nurses at selected PHC clinics in Swaziland

1.3 AIMS AND OBJECTIVES OF THE STUDY:

The aim of the study was to examine and describe mental health care provided by nurses in selected primary health care clinics in Swaziland.

The objectives of the study were to describe mental health care provided by nurses as :

Practitioners

Educators and

Co-ordinators in selected primary health care clinics.

1.4 RESEARCH QUESTION:

The study was set to answer one main question:

What is the nature of mental health care (promotive, preventive and rehabilitative) that is provided by nurses as practitioners, educators and co-ordinators in selected primary health care clinics?

1.5 SIGNIFICANCE OF THE STUDY:

The findings of the study will help to understand the extent to which mental health care is provided by nurses in their roles as practitioners, educators and coordinators in the primary health care clinics of the country. The results might be used to assist nurses working in those settings to formulate appropriate mental health care programs that will meet the needs of mental health clients at that level . The findings might be used also as a referral document for nurses, researchers and policy makers interested in mental health care provided by nurses at the PHC levels. Furthermore the results will contribute in the development of curricula and training programs for general nurses that are effective in equipping the nurses with the relevant knowledge and skills to enable them to provide efficient mental health care to the community .

CHAPTER II : LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.1 Literature Review:

2.1.1 INTRODUCTION:

Primary health care (PHC) is a model of care that has been viewed as a solution to the problems related to health in developing countries. Its recommendation was based on the fact that developing countries have numerous health problems with limited resources to deal with them (WHO,1978). However, PHC has been seen as a health care system that is not only appropriate to developing countries but for the developed countries as well. The model is comprehensive in that it addresses all health issues including the absence and presence of disease. This makes it applicable to mental health as well. When applied to mental health it is frequently seen as a continuum of community mental health care (Howard, 1996). As a result, the current goals of primary health care have been adopted for community mental health care as well. Countries such as the United Kingdom have been implementing community mental health care since the early seventies (Katz,1979). Numerous studies (Crosby, 1987; Field, 1993; Sheppard, 1991 White, 1993;) have thus been conducted in the United Kingdom to evaluate the effectiveness of the care. This chapter examined existing studies and views of issues on community mental health care, primary health care, community participation and deinstitutionalization. The concept of mental health nursing and care rendered was the focus in the review of literature as it relates to the study at hand.

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2.1.2 COMMUNITY MENTAL HEALTH CARE:

Community mental health care is the care given in the community to promote mental health, provide comprehensive treatment and rehabilitative programs whilst being accessible to all. It offers a variety of services including emergency mental health care, crisis intervention, partial hospitalization, day treatment programs, case management, home treatment programs, rehabilitation, consultation and support by a professional multi-disciplinary team using innovative treatment approaches (Kaplan, Saddock & Grebb, 1991; Shives, 1990; Wilson & Kneisl, 1996).

Among the related studies conducted on community mental health care, Pallock (1989) studied the effectiveness of community psychiatric nursing services offered in Britain in two communities. From this study it was evident that nurses played a major role in the implementation and success of community mental health services. The study showed that nurses made the system work by consistently improvising for resources needed. Also revealed by the study was that nurses are not trained for community psychiatric care, but were socialized by other nurses working to work the way they do. The study clearly showed that community psychiatric services had limited resources, however nurses always did their best to make a success out of community mental health services that would otherwise fail.

The shift from hospital based care to a community based service has resulted in a change in the relationship between the consumers and service providers. Patt (1990) concluded from a study that relatives of mentally ill clients at community level tend to increase contact with service providers when such a service is offered. She contends that it is difficult to measure the effectiveness of community care, however the levels of functioning within the family change and this has an ultimate positive effect on the mental status of the client.

Field (1993) carried out an analytic study on the views of patients on the service they receive from community psychiatric nurses (CPNs') in the United Kingdom.. Three major components of the community service were evaluated, namely; structure, process and outcome. The results revealed that most patients were pleased with the services rendered by the CPNs', however, the small fraction that showed some dissatisfaction stated that they were not happy with CPNs' coming in at any time without making appointments and coming with students for home visits. From this analysis Field revealed that there is little that is known about community mental health services and the CPNs' did not allow an understanding of the patient's view.

White (1993) also carried out a study in the United Kingdom, to evaluate the organization, education and practice of CPNs'. White notes in the study that the community service roles were not clearly implemented and linked to the National Health Service (primary health care). This is also true for education. White concludes that there seemed to be a need to review community psychiatric services in order to achieve the potential advantages of primary health care for mental health services in the U.K.

In another study of the goals and objectives of CPNs', Pallock (1990) concluded that the goals of community psychiatric nursing practice are not explicit nor mutually negotiated by the CPNs. This results in community mental health nursing practice being fragmented such that it is either patient, job focused or family centered in nature. Pallock concluded that although nurses feel they achieve the goals of community psychiatric nursing, there is a need to clearly define the roles of nurses and patients in order to improve community mental health nursing.

Crosby (1987), in her study of community care of the chronically mentally ill noted that community care for the mentally ill is important because it is considered safe for the patient and it

alleviates resistance and fear for the general community. She further notes that it has limited success, but still remains the best therapeutic modality of care for the chronically ill mental patients. There is however, a vivid need for structure and support in designing any intervention program to facilitate its implementation and adaptation. Furthermore Crosby noted that nurses are the key professionals to ensure community mental health program development because such a program focuses on care not cure and nursing also has its focus on caring.

Sheppard (1991) looked into mental health work in the community for the practice of social work and community psychiatric nursing. Although he was interested in finding out if social workers and community psychiatric nurses could draw together their work, the study also revealed a lot on community mental health practice. The work of community mental health professionals involved assessment of individuals, planning, linking clients to formal and informal care systems and service provision. According to Sheppard's study, community practice for mental health is very effective in curbing mental illness, however, the study also revealed that social workers are better equipped for case management than community psychiatric nurses. From the study, it seems that there is a relationship between actual practice and acquisition of knowledge, this could be associated with the differences in the approach by the nurses and social workers.

A pilot study carried out in Sheffield City in England by Munton (1990) was aimed at evaluating the useful and non-helpful interventions by the CPN. From this study it transpired that clients value interpersonal relationships and that the community psychiatric services afforded them that opportunity.

Another study conducted by Reed (1987) looked into community nursing for mental disorders. She gathered that community nursing in mental disorders remains small but a rapidly growing community resource. Reed recommends clarification of the roles to be performed by clinical, educational, organizational aspects and the evaluation of outcomes for the various services and practitioners involved in community mental health care.

Drew (1991) looked into various ways of combating social isolation of chronic mental illness. Group therapy, psychodrama, primary nursing and rehabilitative case management were among the therapies she studied. All the therapies were effective in promoting acceptability of the mentally ill. However, Drew observed that case management was more effective in the community than within the hospital environment. She further notes that a shift from hospital to community case management implies that the role of the nurse will expand, therefore there is need to prevent burnout in community mental health nurses by preparing them to meet the challenges of the expanded role. This can be achieved by educating the nurses on their expectations and roles.

A study carried out by Smith, Meyer and Delaney (1998) on homeless alcoholics, proved that the community reinforcement approach led to decreased alcohol consumption. In this study the target group was homeless people with a primary diagnosis of alcohol dependence. These were assessed for the effect of an adapted community reinforcement approach in which participants were provided with grant houses, a job and an opportunity for community involvement, such as participating in community planning meetings. The study results were also in line with other studies (DeLaGanza, 1998 Hunter, 1974;) on community management in that it revealed that community care is the best and most effective approach.

A descriptive survey by Bugge (1998) was done to determine the perceived skills an

community skill requirements of mental health staff in Britain. The study was incited by the shift from hospital to community mental health care. As a result of the shift there was a perceived need for training of mental health staff, however there is no clear document that spells out the content for teaching. The study indicated that mental health professionals perceived themselves as having a wealth of skills (Bugge, 1998 p.226), however the professionals differed in the way they perceived the necessary skills for community mental health care. From the study therefore, there is evidence of need to give mental health staff new skills to help them adapt to the current changes related to community based care, this will enable them to provide effective mental health care.

Nurses are a powerful tool in the success of therapeutic community treatment of mental illness. To be effective nurses in the community have to put less emphasis on physical treatment, patients discipline, cleanliness of patients, formal professional approach to patient care but should focus on providing a service to both the patient and family in all possible and practical means, carry out home visits, link the client to the hospital and facilitate patient independence (Hunter, 1974). Hunter provides a historical description of community psychiatric nursing in Britain. The study revealed that community nursing is an old concept that has been expanding rapidly in the past decades. Hunter further associates the expansion to changes that have been taking place within health and social services. It is evident throughout the historical trends outlined by Hunter, that nurses are the main actors in the provision of community mental health care and that community mental health care is dynamic in response to health and social needs of every country.

Much as community mental health care has all the advantages, a study by Mackenzie, Holroyd and Lui (1998) revealed that community care places more challenges and responsibilities on the families of clients resulting in a lot of stress and burden on the family members. The study

was done in Hong Kong with an aim of identifying current practices of community nurses in assessing stroke patients and their carers. The results of the study maybe linked to community mental health practice in that the researchers adopted a carer assessment scale as a guide for assessing the family and patient within the community. The scale is recommended for use in community practice to evaluate care provided by family carers as well as evaluate specific needs of individual clients after discharge. Since families play a major role in community health services, Mackenzie, Holroyd and Lui conclude that the use of a scale to evaluate care in community settings would facilitate the recognition of essential activities by the nurses in community services. The researchers further alluded to the fact that community nursing involves educating and supporting family carers and very little hands on care by nurses.

The nursing care offered at community level is beneficial for both clients and nurses. In addition the community is a valued learning environment for nursing students. DeLaGanza (1998), established from her study that community nurses practice with greater autonomy. According to the study community settings provide a conducive learning environment for nursing students to practice client and family teaching related to medication, disease processes, coping strategies and cultural orientations present within the community. It is evident from the study that stigmatization of the marginalized vulnerable populations was common in the community. The study echoes other studies that have stressed that the community is the best environment for clients.

In a conference paper Kgosidintsi (1996) presented a study on the role of the community health nurse in Botswana, the problems and needs they have as they take care of patients suffering from schizophrenia in the community. The study affirms what other studies have found, mainly that the diversity of the nurses role and the fact that the country's policy has a major influence on

the activities carried out by each nurse and the resources available for care. Problems presented in Botswana are similar to those of other countries in that they include lack of transport, personnel and etc. It seems the policies of the country have a great impact on the practice of the nurse, this could be related to the fact that policy makers also determine the availability of resources and through setting a standard, they compel themselves to make sure that people adhere to it. To promote mental health therefore it would seem necessary for the government to support the activities of community mental health care.

Whilst advocating for the development of a theoretical framework for psychiatric rehabilitation, Uys (1991) noted that nurses are the cornerstone for most of the community mental health services in South Africa. She recommended that the rehabilitative approach to community treatment for psychiatric clients needs to be adopted in order to make treatment of the mentally ill more therapeutic. From the study by Uys, it seems apparent that community based health care has many potentials for improving mental health care. According to Uys, the rehabilitation model she postulated was a tool that could be utilized to explore the potentials that community mental health possesses as a treatment approach to mental illness, especially on discharge back to the community.

2.1.3 DEINSTITUTIONALIZATION:

Large numbers of mentally ill patients are discharged from psychiatric hospitals into the community to receive psychiatric outpatient care. This is the process of deinstitutionalization. It does not offer comprehensive services but rather treatment and rehabilitative services in the institutions available in the community such as half way houses, after care clinics, board and care facilities and public rehousing units. Where such facilities are lacking, clients remained in the

community with whatever care they could access if any at all. This frequently led to the revolving door syndrome (Kaplan, Saddock & Grebb, 1991).

The shift to community care for the mentally ill has raised various issues noted by many associations of nurses in Africa. Amongst the issues raised is the lack of respect for the mentally ill as reflected by poor implementation of deinstitutionalization, ill definition of mental health problems versus psychiatric problems and the method of education offered for mental health nurses. Butterworth (1995), identified these as challenges for mental health care and recommended future strategies to overcome these and to integrate the strategies in PHC with an aim to improve mental health within the aspects of preventive and promotive health.

2.1.4 COMMUNITY PARTICIPATION:

The involvement of the community in decision making about the mental health care needs and programs in the community is termed community participation. The concept of community participation makes those that are served to have ownership over the services thus facilitating spontaneous and full utilization of the services.

The perception of mental illness is influenced by the cultural beliefs of each community or country. This is a revelation by Stockman (1994) in a study of mental health care in Central Africa and China. In both countries several cultural factors were associated with mental illness. Treatment was done by the family, failure of which outside treatment was sought. The patient was accepted back on recovery. It is clear that various communities have different ways of dealing with mental illness, however it is not clear if such models of treatment are effective enough for mental health problems, Stockman observes in the study.

Citizen participation in community mental health programs was studied by Miller (1979).

She/He notes that mental health care is an evolving and dynamic framework.. The period in which the study was conducted is an evidence that the community mental health approach has been in existence for the past two decades, implying that citizens have been participating in their own health care for many years. At this time, the definitions for citizen participation were closely related to the current definitions of community participation. The advantages of citizen participation according to Stockman is that it:

- increases the flexibility, responsiveness and accountability of service providers and service delivery;
- increase the possibility that potential consumers and the public at large will become better informed regarding the availability, nature and appropriateness of services.

The study concluded that professionals have a negative attitude towards citizenship participation and such attitudes need to be changed for the strategy of community participation to be a success.

Another study by Chan, Fing and Leung (2000), published recently, was done to compare the outcomes of case management service with that of conventional community service for chronic schizophrenic clients living in Hong Kong. It was revealed that clients in case management improve faster than clients managed as groups in the community. This means that the level of functioning and mental status improve greatly when patients are involved in their own care within the community versus where the community psychiatric nurse plans and implements the care without involving the family and client.

This recent study conforms with other studies that community health care is invaluable to mentally ill patients, furthermore, such care should focus on the patient as an individual with needs and perceptions of his/her values, needs and solutions, that is, participatory mental health

care.

Community support was guaranteed by Thatcher (1989) to promote health and self care for elderly people. Through community support older adults were able to maintain or improve their health care, care for themselves and continue living at home for as long as they wished. According to Thatcher, programs included in community support are exercise, nutrition, stress reduction ,physical and mental health. Nurses have an essential role in the identification of issues that impact on the development of community based programs for the health promotion of the elderly clients. Nurses also are responsible to ensure optimal utilization of community health services, allocation of health care resources and availability of nursing services. Thatcher, concludes that community care requires further development and cost attainment through carrying out extensive research to identify relevant activities and it also requires joint interdisciplinary team work and active involvement of the clients as well as the health team.

2.1.5 PRIMARY HEALTH CARE:

Primary health care is the full range of basic services that include promotive, preventive, curative and rehabilitative care. Services within this category of care are essential as well as adapted to the needs and resources available in each setting. Health is defined as "a state of complete physical, mental and social well being and not merely the absence of disease and infirmity" (WHO, 1978). It is comprehensive care provided to the clients utilizing resources available in the community and with the community's full participation. By including the mental health component in the definition of health, there is an implied existence of primary mental health care (Pillay & Subedar, 1992).

Since the inception of community care in the United Kingdom, mental health care has

been provided by practice nurses in the primary care settings. Gray et al (1999) sought to quantify practice nurses involved in the provision of mental health interventions in the primary care settings. The study revealed that practice nurses play a significant role in the assessment, treatment of mental health problems and screening for depression. Seventy percent (70%) of the practice nurses who participated in Gray et al's study had not received any mental health training. The results of the study revealed that practice nurses would be more effective in the care they give to the mentally ill if training could be offered. The study is consistent with the WHO strategies for mental health care in PHC settings, that advocate for orientation and training of PHC nurses to enable them to carry out the role of mental health care providers.

Grazzin (1999) looked into the feasibility and implications of implementing the national policy within the lower Orange district. The national policy has been towards the integration of mental health services into the PHC system. The study found that services at the lower orange district were accessible, patient friendly, are curative in nature, organized vertically from Kimberly and experiencing a lot of problems related to non availability of drugs, transport and reliance upon a psychiatrist who is responsible for the whole population of Northern Cape.

The study revealed that, even though there are many problems faced by the mental health services, the nurses' primary mental health care staff strongly supports the integration of psychiatric services into PHC clinic services. Concerns raised however, were the capacity to manage the extra workload without compromising the health care, the lack of knowledge, skills and confidence to undertake care of the psychiatric patients in this regard.

In another study it was evident that community psychiatric nursing is becoming highly oriented to PHC. These are the results of a study by Brooker and White (1990) in which the current

role of community psychiatric nurses was sought. The study further reflected that nurses educated in institutions of higher education operate within an area of primary prevention. From the study Brooker and White concludes that community psychiatric nurses perceive their role as closely allied to PHC and that this may be a problem for those patients with long term conditions.

An editorial commentary note by Owiti (1996) about the plight of mental health care in Kenya, echoes the history of mental health and its implication to mental health care. In Kenya, the mentally ill were poorly cared for until mental health policies were drawn which advocated and impinged for mental health support. Today Kenya is well developed and rooted in community mental health as advocated by PHC. Owiti strongly believed that a national health policy, that is oreinted to law enforcement has staged mental health and the health services of Kenya where they are today, that is PHC grounded.

Frequently the incidence of mental health is rated very low in most of the African countries. Sebit (1996) conducted a study in Nairobi and discovered that the prevalence rate of mental illness was more than 60% as compared to previous rating of 30%. The study also revealed that most cases presenting with mental illness were having socioeconomic problems as well. Sebit concludes that the study results can be used to develop mental health policies that will be effective in caring for the mentally ill clients. The recommendations by Sebit are in line with the principles of PHC.

In another study conducted in Kenyatta national hospital. Kigamwa (1991), found that the prevalence for mental illness was 22% and the referral rate was 9% among medical in-patients. The study proves that a number of mentally ill patients are admitted into medical wards, however a few are referred because some do not need referral and some because the psychiatric disability is

not diagnosed. The study also revealed that some patients go undetected and that the prevalence of mentally ill patients in the hospital medical wards, out patient and community was relatively high. The study is evidence that integration of mental health care into the primary health care clinics is more realistic because even clients with anxiety problems that are often overlooked and treated for the physical symptoms, as a result being mismanaged will be catered for.

WHO instigated the promotion of mental health care through the Alma-Ata declaration in 1978. In 1996 a White paper was issued pointing out that mental health programs were still poorly developed globally. It was also noted in the same paper that the incidence of mental illness was also high throughout the world and was contributing to a loss in the country's economical growth. Various recommendations were made in this white paper and these included:

- affording appropriate resources for mental health care.
- development of policies geared towards improving mental health.

The latest recommendations by WHO for mental health improvement are highlighted in the Report of the regional strategy for health (1999). The strategies lay an emphasis on the fact that mental health care should be a priority challenge for all countries in the African region.

Mechanic (1984) observed that mental health services are fragmented and mental health care is not continuous. He advocates for the integration of physical and mental health care services because both problems are interrelated. An example that is highlighted is somatic illness that later develops into a mental health problem. Mechanic looked into various ways of integrating the services, however he still views integration as a challenge to medical and mental health services. Mechanic recommends that considerable costs would be reduced by including mental health care programs into the existing community mental health centers, clinics and psychosocial programs.

Such a move would reduce hospital use and provide a wide range of services to clients within their geographic locality while staying within the budget.

The services provided at the community may be further improved by mental health providers becoming specialized in the field of mental health care. The discussion by Mechanic is consistent with recommendations by WHO (1999) outlined in the Global Action for the implementation of Mental health care. In this paper WHO advocates for the integration of mental health care into the primary health care clinics.

Another study by Abiodun (1990) alluded to the observation by Mechanic that mental health services are " grossly inadequate in most of the third world countries" (Abiodun, 1990; Mechanic, 1984; WHO,1999). Further more, Abiodun observes that mental health facilities are few, most of those that are existing are overcrowded, understaffed, custodial in nature and in most instances provide chemical therapy and electroconvulsive therapy. The improvement of mental health services is deemed as one of the most needed ventures in most developing countries. Integration of the services into general health services is one of the recommended steps that would provide for better coverage of the population. Among the strategies for integration Abiodun recommended the following:

- establishment of primary care programs that will incorporate mental health care services.
- development of effective, cost effective set of interventions within the community.
- adoption of WHO objectives for extending mental health care to guide the establishment of community oriented mental health services.
- training of PHC workers.
- regular evaluation of the services for evidenced based planning.

- commitment of the various national governments by providing sufficient funding for the PHC program.

Abiodun, clearly showed that mental health care services are currently inaccessible and not effective for the African clients. He is emphatic to the concept that PHC is the appropriate strategy for improving this predicament.

Primary health care settings provide an entry point for most of the health care issues. Psychological care has to be rendered in these settings as well as physical care to ensure wholistic appropriate care. A study carried out by Reeler (1992) revealed that clients seem to by pass primary health care facilities and go directly to hospital services for mental health care. Several other routes were revealed in the study as being taken by mentally ill clients before going to the psychiatric services. These included traditional care, community nurse, general practitioner, police and the hospital doctor. According to Reeler, the pathways taken by clients before specialist care contributes to the development of more severe symptoms presented in the psychiatric services. Reeler, also observes that by passing primary care settings means that some clients with a physical illness presenting with psychological symptoms, may receive inappropriate management.

The study affirms findings by other similar studies that PHC settings are important in the improvement of mental health care because such a strategy will make it possible for symptoms of mental illness to be arrested in time before they reach an uncontrollable stage and through this concept clients would be managed wholistically. In addition PHC clinics would offer comprehensive care if they are utilized for mental health problems as well. Since most of the PHC clinics are in the communities, community health services will also be made more accessible to the mentally ill clients.

A study by Petersen (1999) alludes the move to orientale primary health care nurses towards the provision of a comprehensive approach to case management. This follows the contemporary move towards provision of comprehensive community based mental health care that is integrated into the PHC system. Inception of such a service calls for training of primary health care personnel. The study revealed that even with training, PHC nurses do not fully implement what they have learned. Mediating factors to these observations were related to the nurses personality, living in the same community as the people being serviced and lack of culturally based care. It is important that all health personnel be oriented to the approach so that the approach can receive the support it deserves. It is also necessary to explore the effects of the past structure and organization of health, the numbers of patients seen, lack of privacy in mobile clinics during implementation of the process.

2.1.6 SUMMARY:

The literature on related studies is consistent in the aspect of community mental health care, in that, from all the studies reviewed there is an apparent revelation that community mental health care is the best approach for the care of the mentally ill. Furthermore, community mental health care is effective when the client is fully involved in the planning and implementation of his/her own care. It is also evident that community mental health care has been implemented in many countries including African countries, however most of the evaluation was done in the United States of America and the United Kingdom. There is therefore a dire need to carry out an evaluation of this approach in countries where the primary health care concept has been implemented for a distinctive period now, in Africa, especially Swaziland.

2.2 Conceptual Framework

The study was guided by the illness prevention model of care. The illness prevention model outlines three levels of prevention as fundamental in the provision of community mental health care. The literature (Howard, 1996; Uys & Middleton, 1997; WHO, 1994) describes the prevention model as a model that is in line with the objectives of PHC and therefore is relevant in the practice of mental health care within the national health system. The levels of prevention are delineated as primary, secondary and tertiary levels of prevention. Each of the above levels of prevention is linked to specific functions of the nurse which are also consistent with the objectives of PHC. It is suggested that the concepts of primary, secondary and tertiary levels of prevention are vital in nursing practice in that they enable the nurse to provide promotive, preventive, curative and rehabilitative mental health care to individuals, families, groups and the community.

Howard (1996) integrates the roles and functions of the nurse into the three levels of prevention, and describes this as follows:

- **Primary Prevention:** which refers to the reduction of mental health risks through mental health care provision. It involves the identification of conditions that have the potential of inducing stress and mental illness. The author supports that most of the functions of the educator role are aimed at primary prevention. Primary prevention aims at decreasing the incidence of psychiatric morbidity in the community. (Howard, 1997; Uys & Middleton, 1997).
- **Secondary Prevention:** refers to activities aimed at reducing the prevalence or pathological nature of a psychiatric condition through early diagnosis and effective

treatment. Most functions of the practitioner role as well as co-ordination role fall into secondary prevention.

- **Tertiary Prevention:** refers to restoration and enhancement of functioning through rehabilitation programs. Many of the practitioner and co-ordinator role activities fit into tertiary prevention..

Stanhope and Lancaster (1999) supports that nurses within the community are the key people who enable the achievement of the objectives of PHC. They support that as enablers, nurses play a role of co-ordinator, educator and practitioner in the provision of primary, secondary and tertiary care to individuals, families, groups and the communities at large. The three roles and functions are described by Howard in Stanhope & Lancaster as follows:

- **Practitioner:** As practitioner, the nurse helps clients to maintain or regain coping abilities that promote optimal functioning. In this role the nurse is required to have the necessary skills to help her/him make correct nursing diagnoses and management of mental health problems. It includes case management, counseling and psychotherapeutic nursing interventions for various individuals and groups in a variety of settings within the community.
- **Educator:** In the educator role the teaching and learning principles are utilized to enhance the understanding of the clients about the various dimensions of mental illness and mental health. It is the basic strategy for the promotion and maintenance of community mental health as well as enhancement of community participation to help achieve the objectives of the community.
- **Co-ordinator:** As co-ordinator, nurses promote the health and the well being of clients

through encouraging independence and self-care in the least restrictive environment. The nurse co-ordinator is able to evaluate the effectiveness of care through this role. It involves crisis intervention, home visits, case finding, referral and follow up care of clients for the purpose of determining available community resources for supporting the client. Co-ordination also involves working with other sectors within the community, families, community leaders and relevant support groups to promote prevent and rehabilitate clients receiving mental health care.

The role of practitioner, educator and co-ordinator are seen as a continuum and frequently overlapping. Therefore, these roles and functions will be explored within the framework of mental health prevention. The literature supports that mental health prevention is fundamental to comprehensive mental health care and to community mental health practice. Uys and Middleton (1997) agreed that comprehensive mental health care from the perspective of the illness process, includes primary (before the illness), secondary (during the illness) and tertiary prevention (after the illness).

¹In Summary the conceptual framework will be applied in the study as presented in the diagram, below:

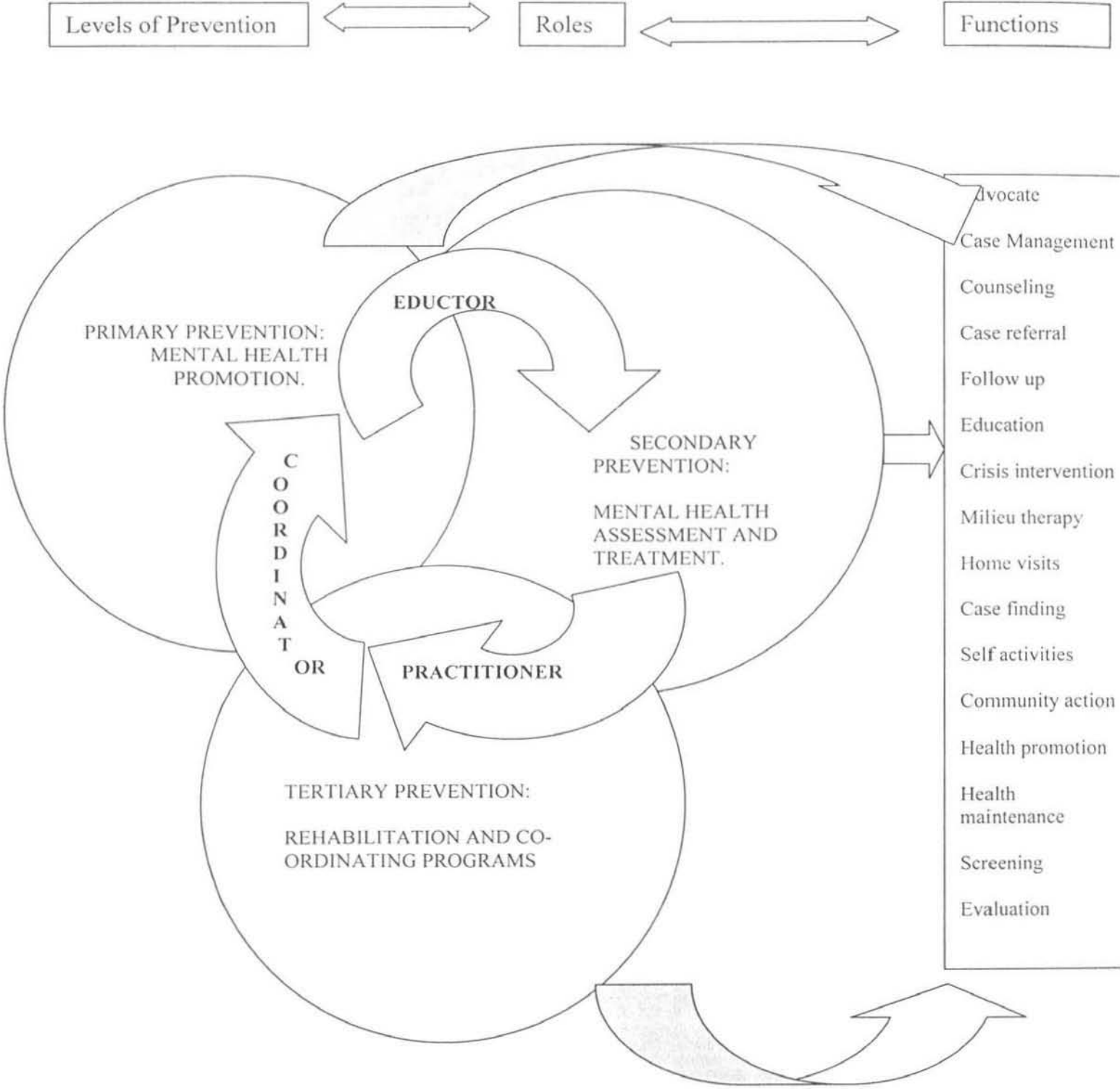


Figure 1: mental health care provision conceptual framework.

CHAPTER III: RESEARCH METHODOLOGY

Introduction:

The chapter is divided into four domains namely; research setting, sample and sampling techniques, research instruments, ethical considerations and data collection and data analysis methods.

3.1 RESEARCH SETTING AND DESIGN:

3.1.1 *Research setting:*

The study was conducted in four primary health clinics in Swaziland. According to the documentation on the distribution of mental health services, the PHC clinics in the study were those that had a community based mental health nurse (see annex 1). In addition the clinics were staffed by registered nurses with or without a specialization in midwifery, community health nursing, psychiatric nursing and other qualifications in nursing. The clinics were Mankaine , Nhlangano, Hlathikhulu and Ndzevane PHC clinics.

3.1.2 *Research Design:*

A descriptive survey design was used to examine mental health care provided by nurses in the PHC clinics. It was a descriptive study because it attempted to identify mental health care provided by nurses in their roles as practitioner, educator and co-ordinator without manipulation of the data generated. Burns and Grove (1987) support that descriptive study designs are used to generate data as described by the respondents. A survey was conducted to generate data that was descriptive. A survey is a non experimental technique that uses questionnaires and /or interviews to generate data. The data gathered by survey addresses the

variables being explored by the study. The survey was seen as an appropriate data gathering technique for the study as is for descriptive studies (Burns & Grove, 1987).

The study examined how nurses at the PHC clinics provided mental health care (preventive, promotive and rehabilitative) in their role as practitioners, educators and coordinators. The literature supports that exploratory study designs assist the researcher to generate rich data about the phenomena under study (Burns & Grove, 1987; Morse, 1993; Wilson & Kneisl, 1985).

3.2 SAMPLE AND SAMPLING TECHNIQUE:

A total number of 31 nurses working at the four community mental health clinics, namely Mankaine, Nhlangano, Ndzevane and Nhlangano were included in the study. At least eight nurses were allocated in each health clinic however one was on holiday, giving a total of thirty one (31) registered nurses. All 31 registered nurses were included in the initial data collection. Thereafter, purposive sampling was obtained for in depth interviews. A purposive sample is the selection of participants as judged by the researcher to have the necessary knowledge and experience to contribute meaningful data to the study. It was assumed that the qualified mental health nurses and those that provide direct primary health care; were aware of their expected roles and were involved in the daily implementation of these roles. These nurses included nurses in charge of the clinic and the only mental health nurse that was directly involved in the care of mentally ill clients and made a total number of 10 nurses.

3.3 RESEARCH INSTRUMENTS:

3.3.1 Instruments Used:

Initial data was collected using a structured 3 point likert scale questionnaire with responses ranging from always, sometimes and never. The questionnaire sought to answer the

question of the nature of mental health care that is provided by the nurses in their role as practitioners, educators and co-ordinators. The questionnaire design was based on the conceptual framework and consisted of three closed ended questions with subsections designed to elicit information about the activities that nurses carry out to fulfil the role of practitioner, educator and co-ordinator. Annex 2 is the questionnaire form.

The second step of the data collection utilized an unstructured interview guide developed to explore how the nurses carry the role of practitioner, educator and co-ordinator. Unstructured interview is a method of obtaining information by asking open ended questions that are not preset in an attempt to understand complex behavior from a certain cadre of society. It is flexible because like the descriptive study it allows the interviewer to question all the areas that raise a concern whilst giving an allowance for the informant to raise concerns as well (Denzin & Lincoln, 1994). As a result an unstructured interview was conducted to fulfill the descriptive design of the study. Bless and Higson-Smith (1995), supports the use of unstructured interviews for descriptive research as it helps "to clarify concepts and problems". Unstructured interviews also enable the discovery of new areas of the subject under study through in-depth probing and seeking of explanations. This allowed each individual nurse to describe his/her individual experience thus unveiling factors involved in the provision of mental health care. The interview schedule consisted of open ended questions, beginning with broad and general then specific. Below is the basic guideline that was followed in the interview guide. Annex 3, is the interview guide.

Interview schedule:

Outline/ broad categories:

- introduction of self

- Demographics: age, qualification, experience, length of community service.
- Community related nursing care:
- role of the nurse in community mental health care including PHC role.

Throw away questions:

These were done to develop trust and rapport: for example

- "tell me about yourself but do not tell me your name "

Essential questions:

A broad question to elicit the core data was asked first, then followed by the questions outlined in the interview guide, these included:

- what is your role as a community mental health nurse?"

Extra questions:

These were done to test reliability of the first responses to the first questions for example;

- " how do you carry out the roles?"

Throw away questions:

These were done at the end because they were very personal and sensitive as a result may **have** disrupted

the interview if they would have been done early: for example:

- "When did you complete your nursing?"

Probing questions:

To gather more explanations, these were open ended and were fitted in as need arise, to motivate respondents to give more information, for example

- "tell me more about... "

Wording of questions and affective communication:

- open ended questioning were utilized to elicit detailed responses and double barrel questions were avoided..
- simple language was used, native or siswati or a mixture as preferred by the interviewees.
- affective questions used at the end. e.g age, qualifications etc.

3.3.2 Validity And Reliability of Instrument:

The instrument was checked by the supervisor for consistency and applicability to the study questions. Reliability and validity was ensured by administering the tool to one group twice to find out if it yields the same results. Reliability is a measure used to determine the consistency, accuracy and precision of the instrument. An instrument that is reliable will produce consistent results or data on repeated use (Wilson,1985). Validity is the measure used to determine whether a method measures what it is set out to measure (Burnard & Morrison, 1990).

In the study reliability and validity of the instrument was established by administering the questionnaire twice to a group of 10 nurses in one of the clinics selected for the study. There was consistency in the responses in that there was no significant differences in the crosstabs carried out for each question, the results for the ANOVA one way test was 0.05 meaning that there was no significant difference. The results show consistency and enabled the researcher to assume that the instrument was valid and reliable.

3.4 ETHICAL CONSIDERATIONS :

A written request and research proposal was submitted to the Ministry of Health in Swaziland . Letters seeking for permission to undertake the study in the participating health clinics was submitted to the matrons in charge (annex 4). The Ministry of health gave written permission and the various clinic matrons also granted permission verbally.

Verbal permission was obtained from the nursing staff working in the clinics who participated in the data collection. Nursing staff were instructed not to write their names on the research instruments. All information was treated with confidentiality.

3.4 DATA COLLECTION AND DATA ANALYSIS METHODS:

3.4.1 *Data Collection Methods:*

Collection of data was done during the winter break in the month of July. A questionnaire was used to generate data for the quantitative data. Questionnaires are instruments that facilitate the collection of numerical or quantifiable data. Interviews were conducted on ten (10) registered nurses purposefully selected for the study. The unstructured interview was used to generate qualitative data. Interviews and questionnaires both involve direct questioning of subjects. Unstructured interviews are relevant data collection methods for qualitative research whilst questionnaires are appropriate for quantitative descriptive data (Cormack, 1991). He/she stated that data collected by means of interview and questionnaires may pertain to personal information (what the subjects do and did in the past), level of information on a particular topic and opinions, attitudes and values. The methods used to collect data in the study are appropriate as descriptive data was necessary to explain the means and type of activities nurses carried out in their role as educators, practitioners and coordinators.

On obtaining permission, the matrons of the PHC clinics informed the nurses about the research study; a brief meeting with the nurses participating in the data collection was held for the purpose of explaining how the questionnaire was to be completed, the purpose and the implications of the study. Concerns raised were addressed and each nurse was allowed time to fill the questionnaires in the privacy of their offices.

The completed questionnaires were collected as soon as they were completed and then

given a coded for each clinic. The interviews were conducted after the clinic routine was completed usually at about 2pm, with one or two nurses as they fitted with the purposive sampling technique. Interviews took place in a private office to prevent any disruptions and lasted between 20 and 1½ hours depending on the information that the nurse had on the subject.

3.4.2 Data Analysis:

Collection of data and the first step of analysis involving transcribing of tapes was done simultaneously. This was done through transcribing interviews and the field notes at the end of each interview so as to formulate themes and categories of data. The interviews were then typed and rechecked against the tapes to confirm the information typed out. The interviews were exposed to NVIVO computer analysis for segmentation, coding and clustering. Categories emerging from the data were then matched against the three categories within the conceptual framework, to determine description that match the role of practitioner, educator and coordinator. This is called straight description. (Crabtree, 1994; Wilson, 1985.)

The questionnaire was coded and analyzed using the statistical packages for the social sciences (SPSS) manual. Responses from always and sometimes were recorded as roles that were performed by the nurses.

Measures obtained included frequencies and percentages to describe the activities performed by the nurses in the PHC clinics.

CHAPTER IV: PRESENTATION OF RESULTS AND DISCUSSION OF FINDINGS

INTRODUCTION:

The results are presented in three points; sample description, mental health care provided (primary prevention, secondary prevention and tertiary prevention) and description of the mental health care provided within the three levels of prevention.

4.1 SAMPLE DESCRIPTION:

A total number of 31 registered nurses working in the four clinics selected for the study completed the questionnaire designed for the study. Ten other nurses were purposively selected for in-depth interview. Table 1 shows the sample description.

4.1.1 GENDER AND YEARS OF EXPERIENCE:

Table 1 also shows that about 83.3% of the population was females with more than 3 years experience of working in a primary health care clinic. Diagram 2 is a representation of the description of the gender for the population.

4.1.2 PROFESSIONAL QUALIFICATIONS AND POSITION HELD:

The population had a variety of professional qualifications, however only one (3.2%) was qualified in mental health nursing. This is shown in table 1 and figure 2.

4.1.3 DISTRIBUTION OF SAMPLE:

Figure 4 shows the size and distribution of the sample in the four areas used for data collection. The sample included nurses serving Mankaine, Ndzevane, Nhlangano and Hlathikhulu. The sample covered the areas of the country assumed to have a community mental health nurse.

25.4% of the population comprised of nurses from Mankaine, 38.7% from Hlathikhulu, 19.7% was from Nhlangano and 16.4% from Ndzevane.

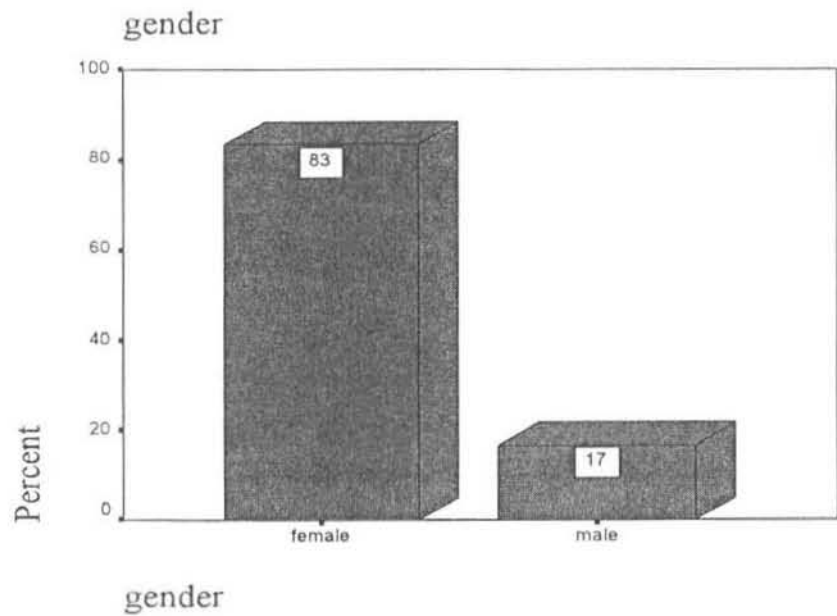


figure 2: gender description of the population

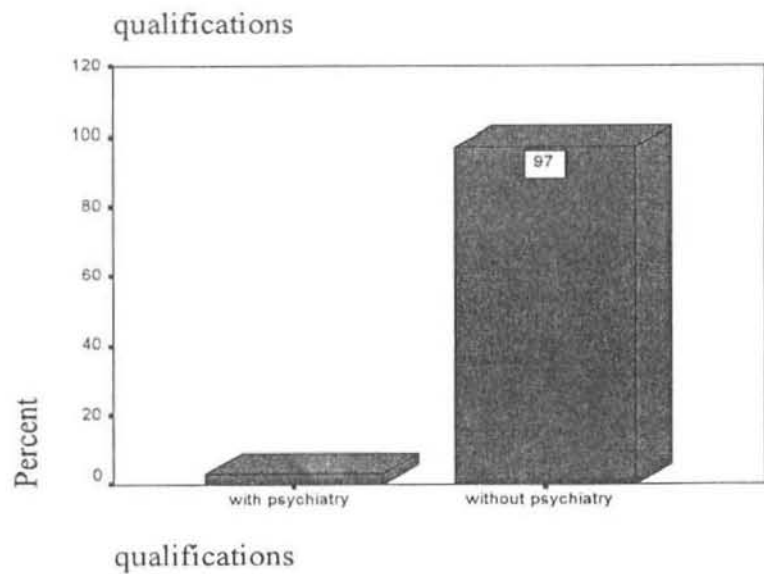


Figure 3: qualification description of the population

TABLE 1. CHARACTERISTICS OF THE SAMPLE

CHARACTERISTICS	NUMBER OF NURSES (N=31)		
	FEMALE	MALE	TOTAL %
Experience in months as a nurse:			
0-12 months	3	0	3.9
12-36 months	7	1	23.4
37-72 months	6	2	23.3
73-144 months	8	2	33.7
144-above	2	0	9.0
Experience in months in a PHC clinic:			
0-12 months	5	1	25.8
12-36 months	8	2	32.3
37-72 months	8	2	22.6
73-144 months	3	0	9.4
144-above-	2	0	9.6
Qualifications:			
with mental health nursing	0	1	3.2
without mental health nursing	26	4	96.8
Current Position:			
Staff nurse	24	5	93.3
Sister	1	0	3.3
Charge nurse	1	0	3.3

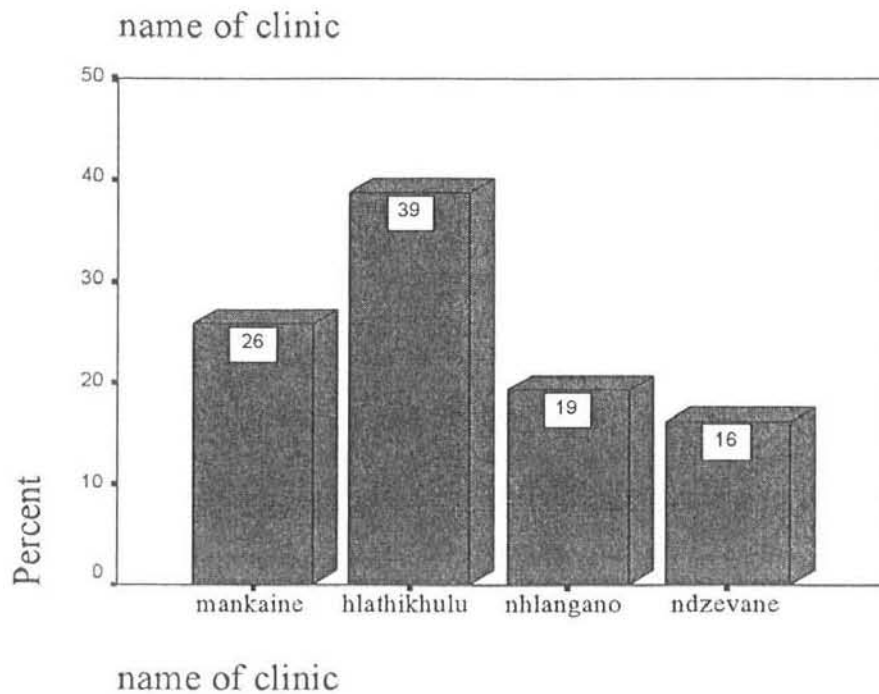


Figure 5: sample size and distribution

The interviews generated the following data about the utilization of the PHC clinics. Data on the utilization of the clinics was not required, however rich data was yielded from the interviews as is the case with unstructured type of interviews.

4.2 CATEGORY I: UTILIZATION OF PHC CLINICS FOR MENTAL ILLNESS:

Primary health care clinics were utilized by mental health clients. This is demonstrated by the clients who present to these settings for treatment and follow up as presented by the following responses:

“...they come here and we ...”

“when a psychiatric client comes here...”

“... some have been here I have attended to about four of them “.

“ well if a patient comes who is mentally ill, what we normally do ...”

Pattern I: Reason for Attending PHC clinics:

Clients that present for care at the PHC usually come in for refill of medication, on exacerbation of the illness and to collect their cards to see the doctor in the health center attached to some of the PHC clinics..

“...for refills with already written prescription ...”

“... come to collect their tablets...”

It is evident from the responses made by the nurses that the PHC clinics were utilized by the mental health clients, however clinics have limited services for the mentally ill because the focus of care in these clinics did not include their care. As a result the emerging theme is:

4.2.1: THEME 1:

MENTAL HEALTH CLIENTS ARE NOT THE PRIMARY CLIENTELE OF THE PHC CLINICS.

4.3. MENTAL HEALTH CARE PROVIDED:

The PHC model recommends three levels of prevention as fundamental to health care. The levels of prevention are thus relevant for the practice of mental health care. Mental health care provided within these levels is described in terms of specific functions of the nurse. Table 2 exhibits information on the extent to which nurses that participated in the study carried out activities of each level of prevention in the PHC clinics as indicated by them.

4.3.1 Description of Primary Mental Health Care Provided:

Data from the questionnaire as presented in table 2 showed that most activities for mental health promotion cited in the study as primary prevention are never carried out in the PHC clinics. This is represented by more than 50% of the nurses participating in the study. Crisis prevention, problem solving and promotion of self esteem are sometimes carried out by 35%, 32% and 32% respectively. The activities that are frequently carried out include screening for mental illness by 19% of the nurses participating in the study, promotion of communication by 22.6%.

The following section presents nurses' descriptions of how they carried out their roles in primary mental health care as practitioners, educators and co-ordinators as revealed during the interviews. The various segments addressing each category being studied, followed by the patterns that emerge and lastly the themes formed from the patterns are presented.

4.4 CATEGORY I: PHC FUNCTIONS:

The main functions carried out by the primary health care nurses for primary prevention relate to their roles as educators and practitioner. Non of the co-ordinator functions included in this study were identified by the nurses as some of the functions that they normally carried out in the PHC clinics. specifically the functions carried out include immunizations, maternal child health, family planning and other activities excluding mental health care nursing. From the responses it is clear that PHC activities are based on the traditional routine care offered in most PHC settings.

"... we immunize the under fives and do growth monitoring and related counseling, we do antenatal care for

the pregnant mothers, and we also have family planning services. Well we actually do a well baby clinic and well mothers”.

“...well in the morning we start the day with prayer... nurses do immunizations of the under fives, in other words they are involved in the well baby clinics. Family planning is also done by us...”

“Well, what I do here is mainly immunizations, health talks, antenatal care, family planning ...”

“... mainly for antenatal care, maternal child health, and family planning services”.

“the main thing that I do here is the PHC activities, that is we educate clients when they come here, topics differ every day and are selected in advance, we have on the board a program of the health talks and who shall give it. Sometimes we change the topics and address a prevailing situation such as an outbreak of malaria, then we concentrate on malaria for that week. We then immunize, do antenatal care and family planning services and child care.”

“...the activity of the clinic ... reduced to providing only immunizations and ANC services”.

Pattern I: Routine PHC Activities

Nurses in the PHC clinics performed the routine traditional functions of a PHC nurse, this is revealed in the above comments made by the nurses in the study. The pattern above reaffirms that the mentally ill clients are not the main focus of care as there were no health topics given for them. As a result there is a recurring theme that:

4.4.1: THEME 2:

PRIMARY MENTAL HEALTH CARE IS NOT THE CORE FUNCTION FOR THE CLINIC NURSES.

The only mental health care nurse who participated in the study seemed to be involved in the provision of mental health education, however it is important to note that only one nurse out of the sample of 31 nurses did mental health education.

4.5 CATEGORY II: PRIMARY MENTAL HEALTH EDUCATION

Mental health /psycho education is planned and given at the clinics. In some cases it is done based on the problems presented by the client.

“...when you give treatment, surely there is something that you tell them”

“... measures involve teaching at the outpatient department about issues in psychiatry, whatever topic I have selected on psychiatry...”

“ You go and teach in a school on a selected topic such as drug abuse...”

“...you will tell them sometimes that they have to do this and that, then there is some teaching because we find quite a lot when we get there, so we do some health education on a specific topic for a short time then we start the routine and work, that is in primary prevention, or else individually each person may ask personal issues then we tell that person what to do...”

“ ... there is something that you tell them, or else a person is coming for the first time , it is not always that a person attending for the first time you will give tablets, you will tell them sometimes that they should do this and that ...”

Pattern I: Client Education based on Nurses Expert Judgement and routine

The education of clients was done by selecting topics for the clients, the topics selected for teaching were not based on the needs of the group of clients, however, individual teaching was based on the needs of the client as presented and seemed to be done in an advisory and instructional manner. The theme that emerges as a result relates to the fact that clients were not involved in the planning of their health talks as portrayed by the only nurse who directly offered care to them.

4.5.1: THEME 3:

NON PARTICIPATORY PRIMARY MENTAL HEALTH CARE EDUCATION.

4.6 CATEGORY III: BARRIERS TO EFFECTIVE PRIMARY MENTAL HEALTH CARE.

Nurses verbalized that there were many factors that inhibited them from carrying out some of the activities related to primary mental health care. These came up as patterns as follows:

Pattern I: Policy Related Barriers

Nurses did not offer mental health care for various reasons, mainly that the job descriptions were the main guiding policies for the type of care they could offer at the level of the clinic. The following were some of their verbalization with regards policies that prevent them in performing some of the activities:

“...the duties that we are permitted to perform do not include mental health care”

“...most important we are guided by the job description because we have the job description for community mental health ...”

Pattern II: Inadequate Knowledge and Skill:

In addition to policies being a directive for the care that nurses could provide at the clinic, there were other limitations that they had and these included inadequate knowledge and skill. Limited knowledge and skill related to the practice of the nurse as well as the curriculum content for both general and mental health nurses. These were seen as being deficient in several areas necessary for effective mental health care provision. The responses below revealed this information:

“...these nurses want to protect themselves because they have not trained in psychiatry...”

“...even in training we basically learn that PHC services basically involve prevention of complications”

“...I last learnt about it (mental health) in the general curriculum. Even that was so little, I don't think really I would be able to handle a mentally ill client with that information.”

“Like you are saying we are general nurses, we all did a little bit of everything but in some areas we don't fit”

“... really I do not have much to say about this area because I last learnt and practiced it in the general training. Even that was so little, I don't think really I would be able to handle a mentally ill client with that information”.

“...it is also advisable that the program considers community mental health care not psychiatric nursing applicable to the hospital with patients in the ward with chronic or acute conditions, there are things that are necessary in the community as I said the basis of community nursing is the prevention part, prevention mainly is teaching, then counseling is necessary, I have seen the students coming from the college for practice here, the students I would put a chair and prepare everything for a counseling session, I say here is a patient who needs counseling, do the counseling, I will be there to help you where I can, but you just discover that the person/ student does not know anything because of lack of practice or else it was not taught at the college, that is what will destroy them more, because talking to the people the communication itself with a person who is not mentally ill or violent, is different”.

“HIV was not integrated in (curriculum) psychiatry before”

Pattern III: Inaccessibility of Mental Health Services:

Mental health services are inaccessible for the mentally ill clients as they have to travel for long distances to be attended. The inaccessibility to mental health services posed a barrier as well to the effective care of the mentally ill clients as a result they had to travel for long distances to receive care. This means that clients could not be offered care in the PHC clinics and therefore primary mental health care provision was affected. The participants remarked as follows :

“Mental health care is not accessible well enough, if I can rate it in percentages, I would say we cover only 20% and the other 80% is not covered because we are at a clinic once a month...”

“... mental health in Swaziland is not treated the way it should because there are no mental health clinics, in the region even”

“Well I can say it is the most neglected in health yet it is the most common... because few clinics if any care about psychiatric clients.”

The patterns above again emphasized the fact that the caring for the mentally ill clients was not the main focus for the PHC nurses and as a result the stated barriers were seen as the cause for the inability to provide care to the clients. The theme that emerges therefore is as follows:

4.6.1: THEME 4:

PRIMARY MENTAL HEALTH CARE IS INCIDENTAL; IT IS NOT THE CORE FUNCTION FOR THE PHC NURSES.

4.7 DISCUSSION OF THE FINDINGS ON PRIMARY MENTAL HEALTH CARE:

The results at this point revealed that the clinics did not provide any mental health care in this level, this is shown by the responses of the nurses not participating in the activities of primary prevention such as crisis prevention, problem solving, promotion of self esteem, screening for mental illness and the promotion of communication. The only nurse who carried out these activities was the community mental health nurse. Nurses revealed that they only carried out the activities that included immunizations, antenatal care, family planning as their main focus of care at the primary level of prevention. The job descriptions are the main guiding principles for the activities carried out by the clinic nurses. This is also true for the only nurse who carried out the mental health care activities, as the guide to the services provided is the job description. The responses made by the nurses concurs with the recommendation by WHO (1978; 1999) that to be able to offer comprehensive services the WHO member countries need to review the policies to fit the adopted health care system. Ebrahim and Ranken, (1988) further stated that problems related to the implementation of the PHC concept were deeply rooted in the policies of each country.

Ebrahim & Ranken recommended that to curb the problems of PHC it is important to reorient the policies of each country to address the elements of PHC.

Evidence from the nurses revealed that the PHC clinics are utilized by the mentally ill clients, however because the care given there is limited they tend to travel long distances to receive the appropriate care, this makes health an unaccessible hard commodity for the mentally ill clients. The other reason for the inability to render services to the mentally ill was stated as being related to a lack of knowledge and skill regarding mental health care. As a result of this revelation by the clinic nurses there is a continuous recurrence of the themes “mental health clients are not the primary clientele of the PHC clinics” and “primary mental health care is not the core function for the clinic nurses respectively. Petersen (1999) observed that there is need for training of the primary health care nurses in South Africa for them to be able to provide mental health care within their settings, this may well be applicable for Swaziland as well. According to Petersen, nurses in the PHC settings should be able to provide primary prevention in collaboration with other community care givers such as the community mental health nurses. It is clear from the results thus far that the mentally ill clients need mental health care services to be provided by the PHC clinics and at community level by the mere attendance to these clinics. Currently nurses function only as educators and practitioners in the provision of primary health care, this means the care rendered is not comprehensive as it does not cater for all clients in the community and makes it possible for the nurse to only practice part of their roles. To be able to meet the expectations of the mentally ill, factors such as the policies (job descriptions), knowledge and skills of the clinic nurses and improving accessibility have to be looked into with critical intent.

TABLE 2: THE EXTENT TO WHICH ACTIVITIES WERE CARRIED OUT.

Activities	FREQUENCY OF ACTIVITIES		
	never	sometimes	always
PRIMARY PREVENTION:			
▶ screening for mental illness	54.8	23.8	19.4
▶ interpersonal relationships skills	54.8	32.3	12.9
▶ increasing self esteem	54.3	32.4	12.9
▶ parenting skills	58.1	29.0	12.9
▶ crisis prevention	51.6	35.5	12.9
▶ problem solving skills	54.8	32.3	12.9
▶ communication skills	51.6	35.5	22.9
▶ mental health education programs	58.1	25.8	16.1
▶ group mental health programs	73.3	20.0	6.7
▶ program for the elderly	76.7	20.0	3.3
SECONDARY PREVENTION			
▶ mental status examination	58.1	29.0	12.9
▶ history taking	51.6	19.4	29.0
▶ formulation of psychiatric diagnosis	63.3	26.7	10.0
▶ individual therapy	64.3	25.8	9.7
▶ group therapy	74.5	19.4	6.5
▶ family therapy	67.7	32.3	10.0
▶ monitoring of symptoms	58.1	35.1	6.5
▶ relapse management	74.2	22.6	3.2
▶ monitoring of side effects	64.5	29.0	6.5
▶ psycho education on medication	61.3	32.3	6.5
▶ psycho education on mental illness	58.1	25.8	16.1
▶ prescribing medication	64.3	22.6	12.9
▶ crisis management	71.0	19.4	9.7
▶ case referral	38.7	29.0	32.3
▶ mental health needs assessment	64.5	19.4	16.1
▶ monitoring illness symptoms	64.5	19.4	16.1
▶ monitoring treatment responses	71.1	16.1	19.4
▶ discharge treatment responses	58.1	19.4	22.4
TERTIARY PREVENTION:			
▶ advocate for community resources	58.5	32.1	9.4
▶ vocational rehabilitation	71.0	25.8	3.2
▶ occupational rehabilitation	71.0	71.0	6.5
▶ development and follow up of support groups	77.4	19.4	3.2
▶ placement of clients into the community	61.3	35.5	3.2
▶ utilization of community resources	67.7	29.0	3.2
▶ case management	71.0	22.6	6.5

4.6.2 Description of Secondary Mental Health Care Provided :

The questionnaire data revealed that nurses who participated in the study almost never carried out relapse management, case management and psycho-education both on medication and illness. More than 50% of the nurses reported that they never carried out these activities. Only 5% of the nurses carried out mental health care secondary prevention functions included in the study. Nurses were frequently involved in carrying out their roles as educators and practitioners. There was no evidence for the coordinator role being played by nurses in the study as some of the functions commonly performed were prescribing medication by at least 32% of the nurses followed by history taking at 29% and discharge treatment at 22.4%. Except for case referral all of the secondary prevention functions appearing in table 2 were never carried out by more than half of the nurses who participated in the study.

The section that follows presents nurses' descriptions of how they carried out their roles in secondary mental health care as practitioners, educators and co-ordinators as revealed during the interviews. The various segments, categories, patterns and themes emerging from the data are presented.

4.7 CATEGORY I: THERAPEUTIC MENTAL HEALTH CARE:

Functions that pertain to mental health care at secondary level are limited. The following responses revealed the care rendered by some of the clinics to the mentally ill clients and the patterns that emerge follow:

Pattern I: Prescription and dispensing of Medication

The care for the mentally ill is limited to dispensing of already prescribed medication by

some of the clinic nurses. The mental health nurse who participated in the study is the only one who sometimes prescribes for the clients who are mental ill in the clinic and hospital where he is attached. The responses below showed this:

“... the only thing I can say is that we provide treatment ...”

“ They come here and we give them the prescribed medication, on their cards...”

“Then there are the patients in the wards, that are admitted for physical symptoms especially here at Hlathikhulu because this is a medical hospital, since you know there is a lot of HIV these days, the HIV epidemic, so usually many patients in the ward with HIA/AIDS also present with psychiatric problems, so really we are utilized a lot in the wards, we are called to see the clients and start them on treatment for psychiatry, though the person may also be on medical treatment as well but may require specific treatment for psychiatry.”

“I screen and give treatment, I will say chemical treatment. I do that because I am allowed by my job description, it allows us here as community nurses that we can prescribe”...

“...the doctor writes out a prescription for them...”

Pattern II: Referral of Mental Health Clients

The other type of therapy provided to the mentally ill clients is referral to either a community mental health nurse, doctor or the psychiatric hospital based in Manzini. Nurses in the clinics refer most of the time when there is a client who presents to them with a mental health problem. The following responses demonstrate this activity:

“ We refer immediately to the psychiatric nurse...”

“Nothing is for the mentally ill. The only thing we do for them is to keep their outpatient cards and they go to see the doctor who is at the hospital...”

“...to the psychiatric center in Manzini”.

“....we just refer them to the psychiatric nurse at the health center”

“...transfer him to the national psychiatric center”

“We also refer a lot, because our scope does not go beyond...”

“... refer those that are beyond their scope of practice to the appropriate places for treatment”.

“In the clinic they send the client here. I also write some letters that they get a free ride in the bus that day and they come for treatment here, so that they get the appropriate treatment”.

“...I refer to the psychiatric center on Wednesday and write that the client has been referred by me. There were problems that I was not made aware of....”

The patterns above are a clear indication for limited care being rendered to the mentally clients. As a result an emerging theme is :

4.7.1 THEME I:

INADEQUATE CARE AND SUPPORT OF THE MENTALLY ILL IN PHC CLINICS.

4.8 CATEGORY II: CLIENT MONITORING AND FOLLOW UP CARE

Pattern I: Limited Resources for Drug Monitoring

There was evidence that resources for monitoring of drugs were limited. From the responses the community mental health nurse was not able to monitor drug therapy using some form of technology or chemical substance as would be expected, in contrast the nurse used observation and experience to monitor the drug responses. It is inferred from the responses that drug monitoring is based on the experience that the community mental health nurse has, however it is not clear on the accuracy of this expert judgement although it appears that the nurse is not fully informed about the importance of laboratory monitoring. The remarks below by the community mental health nurse revealed this:

“We are not able to do that, because the laboratory does not have those tests, usually tests done at the lab are medical oriented. They do not do any for mental oriented. They don’t do any for mental health, I don’t know the extent to which they are taught so that they can be able to do them. But then all in all it depends on experience, really how much experience do you have when you see a patient determine if the client is showing side effects of the drug or not, or do you need to control the dose or stop the drug and change it.

You see experience and education, otherwise if you just start, even if you know these things if you have not seen it practically it is useless.”

“...or what it is, so then the management and monitoring if you don’t have time it tends to be difficult there”.

“ ... patients are not monitored by anyone at home. In reality monitoring and follow up care is difficult.”

“...I see that there are no side effects, the obvious side effects...”

“But then all in all it depends on experience, really how much experience do you have when you see a patient determine if the client is showing side effects of the drug or not, or do you need to control the dose or stop the drug and change it. You see experience and education, otherwise if you just start, even if you know these things if you have not seen it practically it is useless.”

Pattern II: Discharge and Follow up Care

The follow up of clients discharged from the hospital is limited in that when clients are discharged there is limited communication between the nurses at the PHC clinic and the discharging hospital. As a result of this some clients are never followed up because the clinic staff would not be aware of them. The responses to this effect were as follows:

“ Well, I really don’t know, we meet them when they are stable and have cards... so I don’t know what happens to the mild cases.”

“We really have problems with situations like that. Those discharged from the hospital you see them when they come to collect their tablets, and then you say this one was discharged, when you look at the card you discover , hey it is really written from the psychiatric center-“discharged”, the day you become aware of the client is when the client come to collect the medication, there is no communication to say- hey we are sending a person , that means that if a client is discharged from the psychiatric center with no necessary follow up medication, I will never see the client again. If the client needs follow up counseling, because there has never been a time whereby it is said, here is a person we are sending, unless they have problems of locating the home of the client so I help them locate the home”.

As a result of the patterns stated above, there was evidence that care and resources necessary for the care of the mentally ill clients were limited. The theme that emerges therefore is:

4.8.1 THEME I:

INADEQUATE CARE AND SUPPORT OF THE MENTALLY ILL IN PHC CLINICS

4.9 CATEGORY III: BARRIERS TO EFFECTIVE SECONDARY MENTAL HEALTH CARE:

Nurses verbalize that there are various factors that impinge their ability to provide adequate care to the mentally ill clients. These were mainly identified by the community mental health nurse who was offering mental health care in the community. The following remarks expressed the information:

Pattern I: Inadequate staffing:

The shortage of staff was stated as one factor to the provision of mental health care. In some situations staff shortage was related to the fact that there were few nurses assigned in the area and in some situations to the fact that nurses were released for study however did not return to the clinic on completion. In addition to the shortage of nurses there is the shortage of a Doctor, at the time of data collection there was no doctor visiting the community clinics.

“ ... if staffing would be enough, you would be able to have ample time to monitor the people when they come for treatment.”

“ Then if I am alone it is almost impossible to screen for a long time, observing or doing whatever you have to do so we brush through, we just make sure that at least the patient gets the treatment, or whatever, as long as that patient gets it at least if I have seen the client in person, and I see that there are no side effects, the obvious side effects that can be seen by anyone but not know what to do , or what it is, so then the management and monitoring if you don't have time it tends to be difficult there.”

“There is non (psychiatric nurse) at Mankaine. There used to be one last year, she went to school, I don't remember well what happened to her, I am not sure whether she went to school or to the psychiatric canter. She has not been replaced since then”.

“Well there is no psychiatric nurse here, ...”

“ Then there is the problem of staffing, there is not enough staff, imagine if I go out on Monday or Thursdays that there is no one left at the hospital to give them the help that they need, this means that the whole hospital has no psychiatric nurse.”

“The psychiatric nurse went to school but was posted somewhere else on completion. So there is no one today.”

“ In fact the doctor from the psychiatric center is supposed to come at least once a month, but then, he does not come at all, he was last here last year. 1999, if I remember well on the 7th December, here is the schedule (points on the wall). That was the last time, since then he has not come. So if there is a special case where I also find it difficult to manage,

Pattern II: Lack of Transport:

Another factor impinging on the provision of secondary mental health care was related to the inability to reach clients or to transfer clients to the relevant areas as deemed necessary. The responses below reveal this information.

“... if the relatives have transport, because another problem we have is transport.”

“ there is no transport because it is not all the Thursdays where I am able to go to schools or do home visits, because sometimes they would say the transport is going to get medication or else transport is gone to some other place, so I stay at the hospital the whole day not doing anything at all.”

“I don’t have enough time for that, or else even the transport, because one other factor that cripples the place is transport.”

Pattern III: Physical Structures not Conducive to Mental Health Care

The community mental health nurse expressed that the infrastructure used for the provision of mental health care at that time was not sufficient for the necessary care needed for mental health care. The responses below reveal the observations made by the nurse.

“ Then the other thing is the place, the place here, the office, the office is okay for clients coming in to collect treatment and going back home, what if there is a patient that has moderate psychosis, it is not necessary to refer him to the psychiatric center, the person may need observation and time to understand the client’s problem, besides just giving tablets to calm him down. The problem I encounter then is that I cannot take him to the ward as they do not want them, because they say he/ she is aggressive, they do not want them at all here at Hlathikhulu. There is a regulation that says psychotic patients should not be admitted in the medical wards, not at all”.

“... small area for admitting the mentally ill be built in the clinics, is all I can say.”

The patterns above demonstrate the barriers that contributed to limited care rendered to the mentally ill clients as a result of limited resources. The theme that emerges is as follows:

4.9.1 THEME:

LIMITED RESOURCES FOR THE PROVISION OF MENTAL HEALTH CARE.

4.10 DISCUSSION OF FINDINGS FOR SECONDARY PREVENTION:

The results showed that there was limited mental health care provided at secondary level in the clinics. The most commonly carried out activity was case referral at 32%. Clients are frequently referred to the community mental health nurse, doctor or psychiatric hospital. This is contrary to the activities for the other clients being attended at the clinics. The nurses seemed to take the history the clients presenting for care as 29% revealed and then probably referred on discovery that it was a mental health problem. This is in keeping with the revelation made earlier on in the study that mentally ill clients were utilizing the PHC.

Given the presenting data on the mental health care provided in the country it seemed apparent that mental health care is grossly inadequate and to some extent non existent. The results of the study concur with the observation by WHO, that mental health care in some African countries is still inadequate . Furthermore, Abiodun (1990) noted that most of the third world countries were offering inadequate mental health services with most of the care being based on chemical treatment. Kgosidintsi (1996), in Botswana revealed similar results in her study on the role of the community mental health nurse in that country. The role of the clinic nurse in Swaziland is more inclined towards that of educator and practitioner with little evidence of the role of the coordinator role. The theme that repeatedly recur to this effect was “inadequate care and

support of the mentally ill in PHC clinics.

A variety of factors however affected the provision of the limited care that was offered. These further contribute to the limited care and there is need to address these to improve the care, these include lack of transport, poor staffing and poor infrastructure. Kgosidintsi in her study noted similar barriers in Botswana, the study is thus in line with other studies. The study by Kgosidintsi also revealed that community mental health care was technical in Botswana with three main functions, namely; mental status assessment, prescribing of medication and administration of medication.

In view of the fact that a lot of clients present to PHC clinics with mental health problems that go undiagnosed or mismanaged (Abiodun, 1990; Sebit, 1996; WHO, 1999), it would seem necessary that the nurses at this level should be able to provide more than just technical nursing care but go beyond to a level of comprehensive care. Comprehensive care is care that provided by a broad array of professionals including general practitioners, nurses, paraprofessional and even traditional healers. The care by such professionals is obtained from training that equips them with adequate skill to humanize practice to a high level of care (Pillay & Subedar, 1992)

4.11 Description of Tertiary Mental Health Care Provided:

Data from the questionnaire revealed that an estimated number of more than 50% of the nurses participating in the study revealed never carried out almost all the functions of tertiary prevention. About 77.4% never established and/or followed up support groups in the community, 71% never carry out functions of case management , vocational rehabilitation and occupational rehabilitation. A few nurses (9%) commonly function as advocates for community resources.

The following section presents nurses' descriptions of how they carried out their roles in tertiary mental health care as practitioners, educators and co-ordinators as revealed during the interviews. The various segments addressing each category being studied, followed by the patterns that emerge and lastly the themes formed from the patterns are presented.

4.12 CATEGORY I: LACK OF REHABILITATIVE CARE.

Tertiary services include care for the discharged client and also involves rehabilitation of clients during and after treatment, to assist them to be as functional as possible within the limitations of the disease process. There appears to be limited functions performed by nurses to rehabilitate mentally ill clients as well as those discharged back to the community. Nurses at this level exhibited a deficit of all their roles as educators, practitioners and coordinator. In addition there appears to be limited knowledge on the meaning of tertiary preventative measures as depicted in the responses below:

“ In tertiary activities that are there, they are not much because tertiary is taken as the period when the person has stopped taking the tablets. There is little if any because it depends on the client if he/she comes to ask what to do when something like this happens, like a question would be you know at home they do this and that, what can I do otherwise there is no project that I have thought I would do if clients recover and they don't take tablets anymore. What would they do for a living it is difficult for to go to that extent because I don't have enough time for that, or else even the transport, because one other factor that cripples the place is transport.”

“ ... but to say there is anything else planned for the mentally ill such as ...and rehabilitative programs, no we don't do that.”

“...there is no project that I have thought I would do if clients recover and they don't take tablets anymore. What would they do for a living it is difficult for to go to that extent because...”

The responses by the nurses clearly showed that there was no rehabilitative care rendered for the mentally ill clients. The theme that emerges therefore is as follows:

4.12.1 THEME I:

LACK OF REHABILITATIVE CARE FOR MENTALLY ILL CLIENTS DISCHARGED BACK TO THE COMMUNITY.

4.3.6 DISCUSSION OF FINDINGS ON TERTIARY MENTAL HEALTH CARE:

Tertiary mental health care was proved in the study to be limited within the community. This is revealed by the fact that more than 50% of the nurses did not carry out most of the tertiary mental health care activities sited in the study. In addition the remarks stated by the nurses also showed that the nurses did not offer these services and had limited information on what the scope of mental health rehabilitation entailed. Tertiary mental health care involves rehabilitative care for the family and the client during and after treatment. This means that rehabilitation is ongoing. During tertiary care the nurse provides education and support to the family, client and even the community on the course of the disease (Uys, 1991). Rehabilitation involves teaching new skills to clients, re-learning of old skills lost during the course of the illness and maximum utilization of the remaining abilities that the client has in the day to day activities of the client's life. Rehabilitation is deemed necessary to prevent dependence of the mentally disable clients (Kgosidintsi, 1996; Solombela &Uys, 1994; Uys, 1991).

There was evidence that such care was lacking in this study. The results of the study are similar to those presented by Kgosidintsi, which stated that the rehabilitative services available in the country were only offered by private institutions as they were viewed as expensive, where they are offered they concentrate on physical and mental handicap, "no project exists on record for the mentally ill specifically for the rehabilitation of those discharged into the community" Kgosidintsi

noted. Nurses were viewed as the backbone for the provision of rehabilitative care (Uys, 1991), furthermore it seems necessary to teach all PHC professionals to rehabilitate clients as part of their daily routine care (Sokhela, 1999).

4.13 MENTAL HEALTH CARE PROVISION

The section that follows presents nurses' descriptions of how they carried out their roles in mental health care as practitioners, educators and co-ordinators as revealed during the interviews. The provision of mental health care was observed as having many related subjects that were stated as contemporary observations. Theses were patterned, segmented, categorized and formed into themes as follows:

4.13.1 CATEGORY I: Issues in Mental Health care

There are various concerns and observation made by the nurses who participated in the study regarding mental health care in general. These issues emerged from the responses. Though these were not sought for in the study, they have some meaning and contribution to the study questions in that the status of mental health care is thrown into a visible arena by these remarks. The issues remarked on pertain the increase in the numbers of those affected by mental illness;

“...there seems to be a lot of people now that are mentally disturbed in the streets, maybe something has to be done for them and the attention they are getting presently.”

“I do feel that now there are more people who are mentally ill than in previous years, maybe this is because even the population has increased. I think that if we could be forced to do mental health care we could be forced to do the little that we know, that we don't use. We end up feeling very incompetent because we don't practice it often. That is all I can say.”

poor communication patterns in the system (“... there is no communication to say- hey we are sending a

person..."); increase of mental health care needs in relation to HIV/AIDS (" Yes, it is very high (demand for mental health care) and besides being high it requires that even at school you would get an idea about it (HIV/AIDS)...")

Other issues that came up was the fact that the reporting system was not clear. This had an effect on the proper handling of problems and concerns relating to mental health care as a result contributed to poor mental health care provided in the PHC settings (" We are not sure really if we are under the senior medical officer or paramedics or nursing. We are not clear with that, sometimes I attend nursing meetings sometimes medical... that affects things like transport, deliberations and I am not sure where to direct my problems ").

The above issues seem relevant for consideration in the nature of mental health care provided. The emerging theme is:

4.13.2 THEME I:

MENTAL HEALTH CARE PROVISION IS INFLUENCED BY ISSUES THAT ARE INDIRECTLY INVOLVED IN CLIENT CARE .

4.13.2 CATEGORY II: Recommendations for Improving Mental Health Care

The nurses participating in the study came up with several recommendations for improving mental health care during the inter view. These emerged into the following patterns:

Pattern I: Changes in Mental Health Nursing Curriculum

Nurse felt it was necessary to change the curriculum to meet the needs of the mentally ill clients in the community. Related to the curriculum was also the fact that nurses who choose to specialize in mental health care should be committed, this can be revealed by going through the curriculum and then providing care to the mentally ill for an extended period of time before

considering another specialization. The following responses showed this:

“...the nursing student who gets into college to do mental health nursing that it has to come from within, it must not be a second choice, because this is what has pulled down mental health care in the past years”

“.... to have a lot of skills that you have gained from college and in addition you have practiced them...”

“...you know be taught about it because before the curriculum for psychiatric nursing did not address it. HIV was not integrated in psychiatry before, so now if in the programs that are there right now in the colleges this aspect may be emphasized a lot because you find that people are not knowledgeable about it, nurses with general nursing are not knowledgeable about it, as well as doctors...”

“...the nursing curriculum must address community care instead of hospital care...”

Pattern II: Staffing strategies

Means for improving staffing was also raised as being possible through several ways, however in some cases the recommendations did not come up clear but seemed relevant to the study as shown in the remarks that follow:

“ There is need to address the issue of staffing, add more staff...”

“... a psychiatric nurse (in the PHC clinics) would help improve accessibility, she can work like all nurses at the same time be available for the mentally ill clients all the time”.

“The reporting, well I don’t know, what would be done and the fact that there is no psychiatrist, you know the psychiatrist is in a position to address all medical issues affecting mental health care, like now there is no melleril, and melleril is very effective with AIDS patients who are psychotic as they tend to respond poorly to other drugs such as stelazine, chlorpromazine and other drugs”.

The emerging theme is as follows:

4.13.4 THEME 1:

CHANGES RELATING TO THE STAFFING AND CURRICULUM CAN IMPROVE THE MENTAL HEALTH CARE PROVIDED BY PHC NURSES.

4.14 DISCUSSION OF FINDINGS ON ISSUES AND RECOMMENDATIONS:

The results revealed that the nature and means of providing mental health care was influenced by the various issues that pertain to numbers of the mentally ill clients within the community, poor lines of communication and the increased incidence of HIV/AIDS infection in the country. A paper by Abiodun (1990) and WHO, (1999) echo the issues as well as the recommendations raised by the nurses in the study. Abiodun and WHO noted that communication, the curriculum, and resources for mental health care need to be considered in order for PHC to be comprehensive in the incorporation of mental health care. WHO further observed that the presence of several changes in the African countries including the presence of HIV/AIDS will dramatically increase the demand for mental health care. Amongst the recommendations, equipping nurses with knowledge and skill seem to be the most critical for effective integration of mental health care into the PHC services (Petersen,1999). As nurses are the cornerstone of all PHC services improving them also would ensure that care at this level is improved.

CHAPTER V : CONCLUSION AND RECOMMENDATIONS

5.1 CONCLUSION:

The study revealed that the nature of mental health care (promotive, preventive and rehabilitative) provided by nurses as educators, practitioners and coordinators, in the PHC clinics was limited in all areas being examined in varying degrees. The results conveyed that the nature of mental health care in Swaziland was inadequate and to some extent non-existent. The observation that some African countries still offered inadequate mental health care (WHO, 1999) was evidenced in this study. It was also evident that the PHC functions were still based on the traditional functions of immunization, family planning and antenatal care. Nurses in most instances functioned within the role of educator and practitioner with no functions in the coordinator role. The care rendered in the PHC clinics is not comprehensive therefore.

Inadequate mental health care offered at community level suggests that the Alma Ata Declaration that "health is a state of complete physical, mental and social well-being" of a person (WHO, 1978), is being overlooked. In addition the essential component of mental health not being in existence in the PHC clinics limits the functions of nurses as comprehensive care givers to the individual, family and community.

Mental health care in Swaziland was exposed as being behind when compared to other countries like South Africa. This was drawn from the paper presented by Petersen (1999), that South Africa has taken the initiative of training PHC nurses in preparation for the integration of

mental health care into the primary health care services. Such evidence was lacking for this study.

It was revealed from this study that the nature of the care rendered is directed by the:

policies of the country as revealed by the nurses job descriptions

the education that nurses go through.

availability of resources including medical personnel as well as laboratory personnel and the communication patterns.

The result of the guiding factors to mental health care have in turn a direct impact on the; accessibility of health care services

diagnosis and treatment the mentally ill clients.

appropriate and relevant referral of clients.

rehabilitation of the mentally ill clients.

The type of care provided at the PHC clinics of Swaziland as one of the third world countries and WHO member countries has been under a lot of scrutiny by WHO, as revealed in the literature reviewed in the study (WHO, 1999). The proposition by the study that mental health care is not a function of the PHC clinics makes primary mental health care to be non existent in the country as a whole. The value of primary mental health care throughout the world is undeniable as revealed in the literature reviewed in developed and non developed countries such as Britain, U.S.A., China, Hong Kong, Kenya, Botswana and South Africa respectively(Kgosidintsi, 1996; Stockman, 1994 WHO,1999;). There is need to strengthen the services offered, for the country to be at par with other member countries (Abiodun, 1990; WHO, 1999). This will not be achieved unless structural changes and internalization of the values of the adopted health care system are examined.

5.2 RECOMMENDATIONS:

5.2.1 The mental health care provided in the country can be improved by:

- training of PHC nurses to be able to offer mental health care.
- development of a policy to integrate mental health care into the PHC services.
- government facilitating the integration of mental health care into the PHC services as recommended by WHO by funding such a program and supporting its inception.
- Improving the lines of communication.
- the provision of transport for the clinics so as to improve services offered such as home visits.
- providing for more opportunities of training of psychiatric nurses through making available bursaries and scholarships.
- regularly evaluating services rendered at the PHC clinics.
- incorporating adequate mental health care into the curriculum for nurses.

5.2.2 Recommendations for further research:

- to involve clients in the expression of their views on the care that they are receiving in order to involve them as partners in the care provided and to ensure that the care being rendered is relevant for their needs. Such a study would also be the beginning of community participation and partnership as recommended in the WHO strategies for PHC.
- to determine the ideal means for the integration of mental health care in the PHC services, PHC implementation is determined by the budget and policies of each country, it is important to determine strategies that would be realistic and achievable by the country.

References:

- Abiodun, O. A. (1990). Mental health and Primary care in Africa. East African Medical Journal. 67(4) 273-278.
- Bless, C. & Higson - Smith, C. (1997). Fundamentals of Social Research Methods: An African Perspective. 2nd ed., Kenwyn: Juta and Company.
- Brooker, C & White, E. (1990). Community Psychiatric Perspective. London: Chapman and Hall Inc.
- Bugge, C. A. (1999). A Descriptive Survey to Identify the Perceived Skills and Community Skill Requirements of Mental Health Staff. Journal of Advanced Nursing 29(1), 218-228.
- Bums, N. & Grove, S. K. (1987). The Practice of Nursing Research. Philadelphia: W. B. Saunders Co.
- Butterworth, T. (1995). The Current Status and Future Challenges of Psychiatric / Mental Health Nursing. International Journal of Nursing Studies. 32(4). 353-365.
- Chan, S., Mackenzie, A., Fing, D. T., & Leung, J. K. (2000). An Evaluation of the Implementation of Case Management in the Community Psychiatric Nursing Services. Journal of Advanced Nursing. 31(1), 144-156.
- Cormack, D. (ed). (1991). Research Process in Nursing. Oxford: Blackwell.

- Crabtree, B. F. & William, W. L. (1994). Doing Qualitative Research. Newbury: Sage Publication.
- Crosby, R. L. (1987). Community Care of the Chronically Mentally 111. Journal of Psychosocial Nursing and Mental Health Services.25(1), 33-36
- DeLaGanza, S. (1998). Community Clinical Sites for Psychiatric Nursing Students. Journal of Nursing Education 37(3), 142-143.
- Denzin, N. K. & Lincoln, L. S. (1994). Handbook of Qualitative Research. -Thousand Oaks: Sage Publications.
- Drew, N. (1991). Combating the Social Isolation of Chronic Mental Illness. Journal of Psychosocial Nursing and Mental Health Services. 29(6), 14-21.
- Ebrahim, G. J. & Ranken, J. P. (1988). Primary Health Care: Reorienting Organizational Support. London: Macmillan Publishers.
- Field, R. (1993). Patients and Community Psychiatric Nurses Views of a Community Psychiatric Service. C Brooker, & E. White, (Ed), Community Psychiatric Nursing: A Research Perspective, 2,(pp. 180 - 196.) London: Chapman and Hall Inc.

Gray, R., Parr, A. M., Plummer, S. , Sandford, T., Ritter, S., Mundt-Leach, R., Goldberg, D. &

Gournay, K. (1999). A national Survey of Practice Nurse Involvement in Mental Health Interventions. Journal of Advanced Nursing. 30(4), 901-906.

Grazin, N. (1999). Towards an Integrated Mental Health Service: A Situational Analysis of the Lower Orange District. Durban: Health Systems Trust.

Haber, J., Leach, A., Schudy, S. & Sideleau, B. F. (1982). Comprehensive Psychiatric Nursing, 2nd ed.. New York: Mcgraw-Hill Book Company.

Health Policy of Swaziland. (1983).

Howard, P.B. (1996). Mental Health Issues. In M, Stanhope & J, Lancaster. (1996). Community Health Nursing Promoting Health of Aggregates Families and Individuals. Fourth edition. (pp.693-708). Baltimore: Mosby Co.

Hunter, P. (1974). Community Psychiatric Nursing in Britain: An Historical Review. International Journal of Nursing Studies. 11, 223-233.

Kaplan, H. I. , Sadock, B. J. and Grebb, J. A. (1994). Synopsis of Psychiatry. Seventh Edition. Baltimore: Williams and Wilkins.

Katz, A. T. (1979). Community Mental Health: Issues for Social Work Practice and Education. Washington: Council on Social Work Education, Inc.

- Kgosidintsi, A. (1996). The Role of the Community Mental Health Nurse in Botswana: The Needs and Problems of Carers of Schizophrenic Clients in the Community. Curationis. 19(2), 38-42.
- Kigamwa, A. (1996). Psychiatric Morbidity and Referral rate Among Medical in Patients at Kenyatta National Hospital. East African Medical Journal. 68 (5), 383-389.
- Mackenzie, A.E., Holroyd, E.E.& Lui, M. H. L. (1998). Community Nurses' Assessment of the Needs of Hong Kong Family Cares who are Looking After Stroke Patients. International Journal of Nursing Studies. 35 132-140.
- Mechanic, D. (1994). Integrating Mental Health into a General Health Care System. Hospital and Community Psychiatry. 45(9), 893-897.
- Miller, S.J.(1979). Citezenship Participation in Community Settings. Washington: Council on Social Work Education. Inc.
- Morse, J. M. ed. (1989). Qualitative Nursing Research: A Contemporary Dialogue. Maryland: Aspen Publishers.
- Munton, R. (1990). Client Satisfaction with Community Psychiatric Nursing. In C, Brooker (ed). Community Psychiatric Nursing: A Research Perspective. (pp. 72-94). London: Chapman and Hall.
- National Development Strategy: A Twenty five year vision 1997-2022. (1997).

- Owiti, F. R. (1996). Management of Psychiatric Disorders in Kenya. East African Medical Journal 73(10), 629-630.
- Pallock, L. (1990). The Goals and Objectives of Community Psychiatric Nursing. In Brooker, C. (ed). Community Psychiatric Nursing: A Research perspective. P. 113-143. London: Chapman and Hall Inc.
- Patt, I.C. (1990). Evaluating the Effectiveness of Community Based Care. Advances in Nursing. 30.(1).140-143.
- Petersen, I. (1999). Training for Transformation: Reorienting Primary Health Care for the Provision of Mental Health Care in South Africa. Journal of Advanced Nursing. 30(4), 907-915.
- Pillay, Y. G. & Subedar, H. (1992). Primary Mental Health Care: Indications and Obstacles. Curationis. 15(2), 1-3.
- Reed, V. (1987). Community Nursing in Mental disorder. N Malin,. Reassessing Community Care. (pp. 143-179). London: Croom Helm Ltd.
- Reeler, A.P. (1992). Pathways to Psychiatric Care in Harare, Zimbabwe. Central African Journal of Medicine. 38(1), 1-7.
- Schuler, D. & Davis, K. (1999). Primary Care and Psychiatry: Anticipating an Interfaith Marriage. Academic Medicine. 74(1), 27-32.

- Sebit, M.B. (1996). Prevalence of Psychiatric Disorders in General Practice in Nairobi. East African Medical Journal. 73(10), 631-633.
- Sheppard, M. (1991). Mental Health Work in the Community: Theory and Practice in Social Work and Community Psychiatric Nursing. London: The Falmer Press.
- Shives, L.B. (1994). Basic Concepts of Psychiatric Mental Health Nursing. 3rd edition. Philadelphia: Lippincott.
- Smith, J. E. Meyers, R. J. & Delaney, H. D. (1999). The Community Reinforcement Approach with Homeless Alcohol Dependent Individuals. Evidence Based Mental Health Journal. 2(1). 16.
- Sokhela, N. E. (1999). The Integration of Comprehensive Psychiatric/ Mental Health Care into the Primary Health Care System: Diagnosis and Treatment. Journal of Advanced Nursing. 30(1), 229-237.
- Solombela, P. W. & Uys, L. R. (1994). Factors Influencing the Relapse of Outpatients with Schizophrenia in the Kenyatani Area of Transkei. Curationis. 17 (2) 24-28.
- Stanhope, M. & Lancaster, J. (1996). Community Health Nursing Promoting Health of Aggregates Families and Individuals. Fourth edition. Baltimore: Mosby Co.
- Stockman, R. (1994). Mental Health Care in Central Africa and China. British Journal of Psychiatry. 165. 145-148.

Swaziland Nursing Council: Register for Practising Nurses . (1995).

Thatcher, R. M. (1989). Community Support: Promoting Health and Self Care. Nursing Clinics of North America. 24(3), 785-731.

The Government of the Kingdom of Swaziland Policy Statement. (1999).

The Ministry of Health . (1997). Mental Health Services. Mbabane: Health Education Unit.

Uys, L.R. (1991). A Theoretical Framework for Psychiatric Rehabilitation. Curationis. 14(3), 1-5.

Uys, L and Middleton, L. (Ed). (1997). Mental Health Nursing: A South African Perspective. Third edition. Cape Town: Juta & Company. Ltd.

White, E. (1993). Community Psychiatric Nursing 1980 to 1990: A Review of Organization, Education and Practice. In C Brooker, and E White,. (ed). Community Psychiatric Perspective. 2 (p. 1-26). London: Chapman and Hall Inc.

WHO. (1978). Report of the International Conference on Primary Health Care; Geneva.

WHO. (1999). Regional Strategy for Mental Health: Report of the Regional Director. Windhoek: Geneva.

WHO. (1996). Global Action for the Improvement of Mental Health Care: Policies and Strategies. Geneva;
WHO.

Wilson, H. S. (1985). Qualitative Research in Nursing. New York: Addison -Wesley Publishing Company.

ANNEXES

ANNEX I

Swaziland Mental Health Services



ANNEX 2

ANNEX 2

UNIVERSITY OF NATAL

SCHOOL OF NURSING

QUESTIONNAIRE

CONSENT

Title of Study: Mental Health Care Provided by Nurses in the Primary Health Care Clinics of Swaziland.

Researcher: M. Z. Hlatshwayo, RN.

The researcher is a nurse carrying out the study entitled above amongst the nurses involved in mental health care in selected clinics in Swaziland. It is hoped that the study will provide information that will assist in the promotion of mental health care in the country. It involves filling out a questionnaire used to determine the activities of nurses in the provision of mental health care. To answer the questions will take about 15 minutes. There is no right or wrong answer to the questions.

The return of the completed questionnaire will be considered as your consent to the study.

INSTRUCTIONS:

PLEASE ANSWER ALL THE QUESTIONS BY PLACING A TICK IN THE COLUMN THAT BEST SUITS YOUR RESPONSE TO THE QUESTION. For example:

Question	always 3	sometimes 2	never e1
nursing care is fun	✓		

Name of Clinic: _____

Gender: _____

Please list your Nursing Qualifications: _____

Your current position: _____

How long have you been working as a nurse? _____

How long have you been working at a PHC clinic: _____

Please indicate which of the following statements describe mental health care provided at your clinic. USE THE FOLLOWING KEYS: 3- ALWAYS; 2- SOMETIMES, 1- NEVER.

STATEMENT	Always 3	Sometimes 2	Never 1
1. Primary Prevention:			
1.1 Screening for Mental illness			
1.2 Interpersonal relationship skills			
1.3 Increasing self esteem			
1.4 Increasing positive perception			
1.5 Parenting skills			
1.6 Crisis prevention			

1.7	Problem solving skills			
1.8	communication skills			
1.9	Community mental health education programs such as: alcohol and drug abuse awareness campaigns			
	Stress and mental health programs			
1.10	group mental health program such as: School program			
	Program for the elderly			
2.	Secondary preventive programs			
2.1	mental status examination			
2.2	History taking			
2.3	Formulation of psychiatric diagnosis			
2.4	individual therapy			
2.5	group therapy			
2.6	family therapy			
2.7	monitoring of symptoms			
2.8	relapse management programs			
2.9	monitoring of side effects			
2.10	Psycho education on management of medication			
2.11	Psycho education on Mental Illness			
2.12	prescribing medications			
2.13	crisis management			

2.14	case referral			
2.15	community mental health needs assessment.			
2.16	monitoring illness symptoms			
2.17	monitoring treatment responses			
2.18	discharge treatment responses			
2.19	other specify			
3.	Tertiary prevention programs such as:			
3.1	Advocate for community resources			
3.2	vocational rehabilitation			
3.3	occupational rehabilitation			
3.4	development and follow up of support groups			
3.5	Placement of clients into the community			
3.6	Utilization of community resources			
3.7	Case management			
3.8	other/ specify			

THANK-YOU.

ANNEX 3

ANNEX 3

SCHOOL OF NURSING

UNIVERSITY OF NATAL

INTERVIEW GUIDE

- 1.1 how is primary level mental health care carried out in this clinic ?
- 1.2 how is secondary level mental health care conducted in this clinic?
- 1.3 how is the tertiary/ rehabilitative care of clients done in this clinic?

THANK-YOU.

ANNEX 4



UNIVERSITY OF NATAL

Durban

Faculty of Community and Development Discipline
School of Nursing

Durban 4041 South Africa

Telephone +27 (0)31 260 249

Facsimile +27 (0)31 260 154

12th July 2000

The Research Coordinator
Ministry of Health
P.O Box 5
Mbabane
Swaziland.

Dear Sir/Madam,

RE: Request to Conduct a Research Study:

I hereby request to conduct a research study on the topic "Mental Health care provided by nurses in primary health clinics in Swaziland". The study is in partial fulfilment of my masters degree in mental health nursing that I am currently undertaking with the University of Natal.

The aim of the study is to describe mental health care provided by the nurses in primary health care clinics in Swaziland.

The objectives of the study are to describe mental health care provided by nurses as :

- (1) Practitioner
- (2) Educator and
- (3) Co-ordinator in selected primary health care clinics.


The data collection method to be used is individual unstructured interview and a questionnaire amongst the nurses; to be carried out in July in Mankaine, Nhlangano, Hlatthikhulu and Ndzevane clinic.

It is expected that the results will make a contribution to the promotion of mental health care in the country and will therefore be shared with your institution in due course.

Thank- you.

Yours Faithfully


M.Z. Hlatwayo (Mrs)


Supervisor / Mr R. Ganga-Limando.



UNIVERSITY OF NATAL

Durban

Faculty of Community and Development Disciplines
School of Nursing

Durban 4041 South Africa

Telephone +27 (0)31 260 2499

Facsimile +27 (0)31 260 1343

12th July 2000.

The Matron/ Sister in charge
Nhlangano Health Centre
P.O. Box 29
Nhlangano.

Dear SIR/Madam

Re: Request to Conduct a Research Study:

I hereby request to conduct a research study on the topic "Mental health care provided by Nurses in primary health care clinics in Swaziland". The study is in partial fulfilment of my masters degree in mental health nursing that I am currently undertaking with the University of Natal

The aim of the study is to describe mental health care provided by the nurses in primary health care clinics in Swaziland.

The objectives of the study are to describe mental health care provided by nurses as

- (1) Practitioner
- (2) Educator
- (3) Co-ordinator in selected primary health care clinics.

The data collection method to be used is individual unstructured interview and structured interview amongst nurses; to be carried out in July in Mankaine, Nhlangano, Hlathikhulu and Ndzevane health clinics.

It is expected that the results will make a contribution towards the promotion of mental health care in the country and will therefore be shared with your institution in due course.

Thank-you.

Yours Faithfully

M Z Hlatshwayo(Mrs)



UNIVERSITY OF NATAL

Durban

Faculty of Community and Development Disciplines
School of Nursing

Durban 4041 South Africa

Telephone +27 (0)31 260 2499

Facsimile +27 (0)31 260 1543

12th July 2000.

The Matron/ Sister in charge
Ndzevane Health Centre
P.O. Box 50
Ndzevane
Matata
Dear SIR/Madam

Re: Request to Conduct a Research Study:

I hereby request to conduct a research study on the topic "Mental health care provided by Nurses in primary health care clinics in Swaziland". The study is in partial fulfilment of my masters degree in mental health nursing that I am currently undertaking with the University of Natal.

The aim of the study is to describe mental health care provided by the nurses in primary health care clinics in Swaziland.

The objectives of the study are to describe mental health care provided by nurses as:

- (1) Practitioner
- (2) Educator
- (3) Co-ordinator in selected primary health care clinics.

The data collection method to be used is individual unstructured interview and structured interview amongst nurses; to be carried out in July in Mankaine, Nhlangano, Hlathikhulu and Ndzevane health clinics.

It is expected that the results will make a contribution towards the promotion of mental health care in the country and will therefore be shared with your institution in due course.

Thank-you.

Yours Faithfully

M Z Hlatshwayo(Mrs)



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Durban

Faculty of Community and Development Disciplines

School of Nursing

Durban 4041 South Africa

Telephone +27 (0)31 269 2499

Facsimile +27 (0)31 269 1543

12th July 2000

The Matron/ Sister in charge
Mankaine Health Centre
P.O. Box 6
Mankaine

Dear SIR/Madam

Re: Request to Conduct a Research Study:

I hereby request to conduct a research study on the topic "Mental health care provided by Nurses in primary health care clinics in Swaziland". The study is in partial fulfilment of my masters degree in mental health nursing that I am currently undertaking with the University of Natal

The aim of the study is to describe mental health care provided by the nurses in primary health care clinics in Swaziland.

The objectives of the study are to describe mental health care provided by nurses as:

- (1) Practitioner
- (2) Educator
- (3) Co-ordinator in selected primary health care clinics

The data collection method to be used is individual unstructured interview and structured interview amongst nurses; to be carried out in July in Mankaine, Nhlangano, Hlathikhulu and Ndzevane health clinics.

It is expected that the results will make a contribution towards the promotion of mental health care in the country and will therefore be shared with your institution in due course.

Thank-you

Yours Faithfully

M Z Hlatshwayo(Mrs)



UNIVERSITY OF NATAL

Durban

Faculty of Community and Development Disciplines

School of Nursing

Durban 4041 South Africa

Telephone +27 (0)31 260 2499

Facsimile +27 (0)31 260 1543

12th July 2000.

The Matron/ Sister in charge
Hlathikhulu Health Centre
P.O. Box 20
Hlathikhulu

Dear SIR/Madam

Re: Request to Conduct a Research Study:

I hereby request to conduct a research study on the topic "Mental health care provided by Nurses in primary health care clinics in Swaziland". The study is in partial fulfilment of my masters degree in mental health nursing that I am currently undertaking with the University of Natal.

The aim of the study is to describe mental health care provided by the nurses in primary health care clinics in Swaziland.

The objectives of the study are to describe mental health care provided by nurses as:

- (1) Practitioner
- (2) Educator
- (3) Co-ordinator in selected primary health care clinics.

The data collection method to be used is individual unstructured interview and structured interview amongst nurses; to be carried out in July in Mankaine, Nhlangano, Hlathikhulu and Ndzevane health clinics.

It is expected that the results will make a contribution towards the promotion of mental health care in the country and will therefore be shared with your institution in due course

Thank-you.

Yours Faithfully

M Z Hlatshwayo(Mrs)



MEMORANDUM

FROM: Principal Secretary
MOH&SW

TO: Mrs. M.Z. Hlatshwayo
University of Natal
Durban 4041, RSA

DATE: July 26, 2000

Ref:

RESEARCH PROTOCOL: MENTAL HEALTH CARE PROVIDED BY NURSES IN PRIMARY HEALTH CARE CLINICS IN SWAZILAND

Reference is made to your request in which you asked for permission to conduct a study on the above noted subject. Please note that your request has been approved. Subsequent to this clearance, you are advised to seek permission from the leadership of your study sites.

We wish you success with the study and request that you provide the ministry with a copy of dissertation.

Sincerely,


Rudolph T.D. Maziya