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BAHIRDAR UNIVERSITY

COLLEGE OF MEDICINE AND HEALTH SCIENCE

THE NEED AND READINESS FOR MENTAL HEALTH SERVICES INTEGRATION IN PUBLIC HEALTH CENTERS OF NORTH WOLLO, ETHIOPIA: PROVIDERS' PERSPECTIVE

BY SEMIRA MUHIDIN (BSC IN PUBLIC HEALTH)

A THESIS RESEARCH SUBMITTED TO DEPARTMENT OF HEALTH SYSTEM MANAGEMENT AND HEALTH ECONOMICS, SCHOOL OF PUBLIC HEALTH, COLLEGE OF MEDICINE AND HEALTH SCIENCE IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR DEGREE OF MASTERS IN HEALTH SYSTEM AND PROJECT MANAGEMENT

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Abstract

Background – Mental illness is an important public health problem worldwide. It is among the leading causes of disability adjusted lost years globally. The problem is serious especially in low and middle income countries with a large treatment gap. Since mental illnesses can be treated by trained primary care professionals, there is a global movement of scaling up integrated mental health services into primary health care to alleviate the treatment gap. There is lack of clear understanding on the need and readiness for mental health services integration in public health centers of North Wollo Zone.

Objective – To explore the need and readiness for mental health services integration in public health centers of North Wollo Zone in 2020.

Methods – An exploratory qualitative study was conducted to explore the mental health services integration in public health centers of North Wollo Zone, Amhara Regional State, Ethiopia from June 05 to June 30, 2020. Non communicable disease coordinators at zone health department and district/town health offices, health center professionals trained to give mental health services and psychiatric nurse were the study participants. A face to face key informant interview was done with 12 purposively selected study participants using semi structured interview guides. Thematic analysis was used to analyze the data using atlas Ti software version 7.5 after the data was transcribed and translated.

Result–The three central themes identified included: mental health services needs of the community, mental health services provision and readiness to integrate mental health services to health centers. Mental illnesses were prevalent in urban areas, but majority seek care in religious and traditional places instead of modern health care. Mental health services provided in health centers included emergency, referral and follow up. Shortage of trained professionals together with lack of government emphasis and budget were the major problems for integrating mental health services into health centers.

Conclusion – Mental illnesses are problem in the community of urban areas of North Wollo and seeking modern health care for it was rare. There is initiation of some mental health services provision in the health centers. Further work and improvements are highly required on various aspects to integrate mental health services into the health centers.

Acronyms and abbreviations

AIDS — Acquired Immuno Deficiency Syndrome

BDU — Bahir Dar University

DHO – District Health Office

DM – Diabetes Mellitus

FMOH — Federal Ministry of Health

HEW — Health Extension Worker

HIC — High Income Countries

HIV — Human Immunodeficiency Virus

HTN – Hypertension

IRB – Institutional Review Board

LIC – Low Income Countries

LMIC – Low and Middle income Countries

MhGAP — Mental Health Gap Action Program

NGO — Non Governmental Organization

NMHS — National Mental Health Strategy

NWZ – North Wollo Zone

PFSA – Pharmaceuticals Fund and Supply Agency

PHC — Primary Health Care

PRIME – PRogram for Improving MEntal healthcare

SARA – Service Availability and Readiness Assessment

SPH — School of Public Health

THO – Town Health Office

WHO — World Health Organization

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1. Introduction

1.1 Background

Mental health is a state of well-being in which an individual can realize his or her own abilities, interact positively with others, cope with the stressors of life and study, work productively and fruitfully, and contribute to his or her family and community (1). Whereas inability of doing the above manifested by abnormal thoughts, perception, emotions, behavior and relationships with others are called mental disorders/illnesses (2).

Mental illness is a common and important public health problem worldwide. It is among the leading causes of disability adjusted lost years globally (3,4); constituting for 14% of the global burden of diseases (5).

The problem is serious especially in low and middle income countries with a large treatment gap (3). Only one in five people in countries with high income and one in twenty seven in countries with low/lower middle income received at least minimally adequate treatment for major mental disorder (6). Millions of people with mental illness and their families in Ethiopia also endure the varying consequences of mental illness (7).

Despite emphasis have shifted towards integrated mental health services provision in general hospitals and community-based care globally, HIC still have a far higher number of mental facilities, beds and professionals than LMIC. Mental health expenditure per capita in European region is more than 20 times higher compared to African and South East Asian Region (8).

Mental disorders are treatable, many in primary care through training of primary care health workers (6). With the purpose of alleviating the huge treatment gap, there is a global movement of scaling up integrated mental health into primary health care systems in LMICs (5). This integration is guaranteed as an urgent action needed in ensuring accessible, affordable and acceptable services to people with mental health problems and caregivers(6).

This integration program is supported by the mental health policy of Ethiopia (9) and its implementation has started in limited health centers (10–12). The prioritized mental health disorders planned to be integrated and managed at PHC level by the program for improving mental illnesses in Ethiopia are psychosis, depression, suicide, epilepsy and alcohol use disorders (13).

With its effectiveness and efficacy approved (7,14), the integration is planned to be scaled up to all parts of district and PHC facilities in Ethiopia (9).

1.2 Statement of the problem

It is known that mental health's important is as that of physical health's to the overall well-being of individuals, societies and countries (15).

Mental disorders impose an enormous burden on society, accounting for 1 in 5 years lived with disability globally, leading to more than 1 trillion United States dollar per year in economic losses. Suicide mortality, one of the severe consequences of mental disorders, reaches up to 800 000 deaths per year, mainly affecting young people and women in LMIC (16). Globally, more than 80% of people experiencing mental, neurologic and substance abuse disorders are without mental health care (5,16). Mental health conditions contribute to poor health outcomes, premature death, human rights violations, and global and national economic loss (16). The impact of mental illness on caregivers and families is unmitigated and consequences may reach multiple generations (7).

Despite its importance and the increasing disease burden mental disorders are causing, mental health services are poorly developed in Sub-Saharan Africa (17,18). The treatment gap is also substantial in Ethiopia and still persists leaving plenty of victims and their caregivers at increased risk (7). This is true although the fact, that mental illnesses are one of the main reasons for attending PHC (19) and many of them can be treated by training of primary care professionals (6), is known.

The mental health work force is highly varied from less than 2 per 100 000 population in low income countries to over 70 per 100,000 population in HIC. The availability of mental health service facilities in LIC is still very minimal and unsatisfactory; 0.1 health facilities

exist per 100, 000 for (8). There are 0.04 psychiatrists, 0.59 psychiatric nurses and 0.02 psychologists per 100, 000 population of the nation in Ethiopia (20). According to the Ethiopian health center qualification criteria, mental health care is one of the cares expected to be available, and each health center is expected to have at least one psychiatric nurse (21).

Integrating mental health into PHC, where the first contact between community and the health system occurs, can lead to a more patient centered approach, contributing for a quality of the service provided there (22). But mental health was a neglected issue for long time in many LMIC and the integration program is in its infancy in Ethiopia (9).

The lately upgraded specialized hospital is the highest level of health care facility available in the Zone. There is no psychiatrist in the zone and only six psychiatric nurses are working in North Wollo (23). Unless mental health services are integrated to the health centers, increasing access to mental health services for the community and narrowing the treatment gap may be a very difficult intention to achieve in North Wollo.

To the best of the investigator's knowledge there have been quantitave studies investigating and describing prevalence of mental illnesses (24,25), and qualitative studies that explore the mental health services integration through testing and scaling up interventions in health centers enrolled in a program in Ethiopia (20,26). However, there is lack of understanding on the real need of mental health services by the community, such as presence of mental illnesses and seeking modern health care in the community of North Wollo. The situation of the health facilities are also not known whether they are ready for mental health services integration or not. With those initiatives in progress, it is important to study the community mental health need, how the integration process is going and whether the health centers are providing mental health services or not and readiness for integration of mental health services into PHC in different areas.

Therefore, a qualitative study of the need and readiness for integration of mental health services will be appropriate and timely if not late. It will be an input and hopefully contribute a lot for hastening future progress of the implementation of scale up of the mental health integration program in an effective and sustainable manner.

1.3 Significance of the study

The professionals of health facilities and health offices will use the findings from this study to oversee the situation of mental health services integration in their facilities and community and contribute for an effective integration and delivery of mental health care for the community.

The Zone Health Department and the Regional Health Bureau will be sensitized to see and improve their role in the scale up of integrated mental health care into PHC through fulfillment of requirements.

The community and specifically the victims of mental disorders and their families will benefit from the improvements made in mental health services provision that will be resulted from the information the study yields.

Furthermore, the finding of this study will be an input for further studies or other researches that are related to mental health.

2. Literature review

2.1 History of mental health services in Ethiopia

Before the late 6O's, psychiatric services in Ethiopia were given by foreign professionals working at Amanuel Hospital and in St. Paulos Hospital for patients that come from all side of the country (27). Until 1987, there were only two Ethiopian psychiatrists in the country (28).

There is only one dedicated psychiatric hospital in Addis Ababa. The number of psychiatric units throughout the regional states has grown to 57 with the associated increase in number of psychiatric nurses whose training started in 1987 (9).

With the recognized burden of the disease and the difficulty to attain a satisfactory number of psychiatrists in the country, the first National Mental Health Strategy of Ethiopia was designed in accordance with mental health Gap Action Program of World Health Organization to scale up mental health services from limited and centralized mental hospitals to community based mental health services where the community can have easy and non-stigmatized service (9).

2.2 Prevalence of mental illness and health care seeking behavior

Low mental health awareness and stigma associated with mental disorders was illustrated to delay users being diagnosed and receiving appropriate treatment from the study in Georgia (29). In a study from Mexico, patients were often found to oppose behavioral health treatment, and they believed being treated in a hospital will afford better services than treatment in primary care. Knowledge and information issues about service availability were also identified as barriers for integrating mental health service (30). A study of integrating depression services into PHC in Vietnam showed that the PHC professionals' belief that depression was higher in the community than in the patient population. It also suggested that there was a gap in help seeking for depression among community members (31).

The carriers of mental patients participants studied from Sudan said that their patient's sought other types of treatments before coming to the health facility. They thought mental

illnesses were related to the devil and witchcraft and people believed that mental illnesses should be treated by traditional healers, by religious healers, and other agencies other than doctors (32). Across different sites studied in Ethiopia, Uganda, Nepal, India and South Africa, community mental health literacy was found to be low (12).

Common mental disorders were also found to be major public health problems in different parts of Ethiopia (24,25). Most respondents from south west, Ethiopia reported that mental illness was a problem for Ethiopia (42).

2.3 Mental health services integration in PHC

In order to address the problems and support huge neglect of people with mental disorders, WHO launched mhGAP for scaling up of mental health care through integration into PHC and general medical services and community based services (5). Task shifting and community based mental health services (33) recognize the importance of mental health in the sustainable development of all countries and supports the strengthening of PHC as part of the universal health coverage drive. Integration of mental health services (34) and other chronic non-communicable diseases (35) into PHC was seen by service users, their families and health professionals as an improvement in the care offered and a positive experiences even in the presence of some difficulties.

Studies indicated that mental health services were available only in few districts of Nepal (36), Uganda, South Africa (12), and Libya (37). In another study from districts of South Africa, integration of mental health services in Tuberculosis and Maternal and Child Health services of primary care clinics has been implemented to some degree (38). In Libya, only 2% of the studied health professionals reported having training in mental health during the past two years (37). There was no psychiatrist or clinical psychologist from a study in a certain county of Kenya (39). Mental health integration in Ethiopia has shown good results in achievements in health care centers involved in the PRIME project (10). It has shown promising findings in increasing the number of trained professionals, availability of psychotropic drugs and number of mental patients treated (10,11).

2.3.1 Facility level readiness for mental health services integration

It was highlighted from Georgia that there was an overall shortage of staff working in the field of mental health, in terms of both psychiatrists and psychiatric nurses. Moreover, interviews emphasized a low level of knowledge and skills required to diagnose and manage people with mild mental health illnesses, especially in primary care settings (29). Mexican staffs participated in a study reported staff shortages, including a lack of personnel to complete day-to-day tasks and reported being expected to be responsible for extra tasks (30).

Low level of awareness about mental health in the primary health workers was prevalent in Vietnam. Survey participants reported that they would be able to provide better care to patients with depression if there were more staff and demonstrated enthusiasm for more training opportunities and described the need for better training for health workers (31). low managerial discretion in Vietnam (31). A study from Indonesia also confirmed that PHC staff have a high workload due to managing multiple programs which prohibit them from delivering mental health services (40). It was also difficult to achieve trained man power from a study in Kuwait (41).

Low level of awareness about mental health in the primary health workers was also prevalent in south Africa (38). Shortages in personnel and training opportunity in South Africa (38), Kenya (39), Uganda (44) and Libya (37) were some of the identified problems for managing mental disorders in PHC. Even though mental health training was seen as mandatory as indicated by Ayano et al (11). Instead a study from Kenya showed that primary health workers rely on the counselling they received for other illnesses (39). The lack of refresher training in Nepal (36) has also meant that despite the training provided there continues to be a lack of availability of mental health services on a regular basis. High workload and high staff turnover in South Africa (45) and Liberia (46) were also some of the identified problems for mental health services integration. Shortage of staff was also reported from Ethiopia (10,11)

Health care providers' belief that mental illness was a strange behavior and traditional healers were more effective than modern medicine practitioners was seen as an obstacle

for mental health integration into PHC (40,42). The primary health workers were unsatisfied with the level of knowledge they had in mental health and did not regard managing mental illnesses as their primary role. Negative attitudes towards mental health and mental disorders and a limited appreciation of its integration into PHC were noticed (43). In contrast to this results, almost all respondents of a study in Jimma, Ethiopia expressed a positive attitude towards mental health and the idea of integration of mental health care into PHC services (42).

The limited availability of psychotropic medicines was also concern in providing mental health services at all PHCs in Denpasar (40). Inconsistent provision of psychotropic medications at facilities of south Africa (45), Liberia(46), Libya (37), Ethiopia (10,11) and other LIC(12) was a barrier for availability of mental health services. In Nepal, the non-availability of essential psychotropic medicines has meant a lack of availability of mental health services on a regular basis (36). The overall availability of essential medicines for mental health in the PHC facilities of Libya was 1% according to SARA Libya report (37). Psychotropic drugs to health centers had to go through hospitals unlike non- psychotropic ones which were supplied directly from the national drug store and supplier in Kenya (39).

Shortage of resources was also seen as organizational barrier of integrating depression services in to PHC in Vietnam. Although 81% of survey respondents reported that private space was necessary for consulting patients with depression, many PHC professionals indicated that private space was unavailable at their health center in Vietnam (31). Health care providers argued that a special room or space for assessing psychiatric problems was required (40).

A study done in Tanzania showed that shortage of resources affected integration of eye health services into PHC (47). In Libya, only 1% of the included PHC facilities had any mental health guidelines available (37). There were also no specific assessments, or management protocols or guidelines for psychiatric care in the studied PHC facilities of Kenya (39). Problems with quality and quantity of existing private space for diagnosis and treatment of mental patients was noticed also in Liberia (46), Ethiopia (42) and south Africa (45).

A situation analysis study done in five LMIC found out that there were no models of multi-sectoral working or collaborations with traditional or religious healers across all sites (12). A study from Kenya indicated that there was no engagement of the health care providers with traditional healers and faith-based healers except occasional health talks regarding mental health issues during religious gatherings (39). Integration of primary and mental healthcare at the health facility level was failing because programs themselves were not being integrated on the administrative level within district management as to a study from South Africa (38). Lack of inter-sectoral collaboration was also seen while experience of mental health services integration studied in Ethiopia (10).

There was no district mental health plan or implementation of national mental health plan in a study from five LMIC (12). There was also no mental health coordinator in district health offices from Ethiopia, but there was mental health coordinator in district health offices of South Africa (12).

A study in Kenya showed that no mentorship and supervisory support for mental health were available except in the facilities that were run by psychiatric nurses (39). specialist mental health professionals to support the service were also lacking from LMIC (12). The interface between mental health specialists and PHC was limited to paper referrals (12). Lack of clear referral mechanisms and timely supervision were also problems raised in Nepal (36), South Africa (45) and Ethiopia (42).

2.3.2 Health system level readiness for mental health services integration

Mental health has been discriminated by policy makers as respondents of a study in Sudan replied and also described as it has never been a priority in the health services (32). Stakeholder interviews from Georgia assessing mental health needs highlighted the lack of recognition and the political will to enact reforms that would recognize these needs. There was no specific government program or policy targeted at the mental health needs, and no resources have been allocated specifically for mental health care in internally displaced people in Georgia (29).

Respondents from Indonesia declared that the mental health services integration remained poor because it could have taken long time for the mental health policy to be well disseminated to all local stakeholders (40).

According to a study from Sudan; care givers thought the main obstacles to use mental health services were centralization of mental health services, and mental health not being a priority by policy makers (32). The existing policy, legislative and institutional framework for health in Nigeria revealed a complete exclusion of mental health in key health sector documents (48), and where policies exist, they were unclear as South Africa study revealed (45).There was also no operational and specific policy on mental health at the national and county level of Kenya (39). Challenges in south Africa for integrating mental health services included the low prioritization and stigmatization of mental illness; weak managerial and planning capacity to develop and implement mental health care plans at provincial and district level (45) the developed policies being not disseminated well and local stakeholders remained unaware of the policy existence (40).

In Georgia, budget emerged as a major challenge to effectively providing health services, both with respect to securing an adequate government budget for mental health care and to providing facilities with sufficient resources (29). Budgetary constraints and various inequities with respect to the mental health budget were also reported from Mexico (30). The study from Indonesia explained that no specific budget was allocated for mental health services, but that these costs were covered by the general budget of the facility (40).

There was under-investment in integration of different programs into PHC in Tanzania which was interpreted as neglect from the government (47). This was also the case in integration of mental health care in a study from Ethiopia (49), south Africa (45) and other LMIC(50).

What can be summarized from most of the studies in Ethiopia while reviewing the literature for mental health services integration studies are the following. There is scarcity of literature about mental health and mental health service integration in Ethiopia and LIC. Those few studies done were national based studies and/or the study areas included in the study (districts and health centers) for the source of data are either because they were

included in an integration program supported by international institutions such as PRIME and Emerging mental health systems in LMICs. In addition they were studied as a baseline prior to the integration program or as an evaluation of the program. But the current study is planned to explore need and readiness for integration of mental health services into public health centers irrespective of enrollment into a special integration program unlike the other studies.

3. Objectives

3.1 General Objective

To explore the need and readiness for mental health services integration in public health centers of North Wollo Zone in 2020.

3.2 Specific Objectives

- To explore the need for mental health services integration in public health centers of North Wollo Zone in 2020.
- To explore the readiness for mental health services integration in public health centers of North Wollo Zone in 2020.

4. Methods and Materials

4.1 Study design

An exploratory qualitative study design was used to study the need and readiness for mental health services integration in the public health centers of North Wollo Zone. The study design was chosen due to its appropriateness for issues rarely studied such as mental health services integration in LMIC and Ethiopia.

4.2 Study area and period

The study was conducted in health offices and public health centers of NWZ, Amhara National Regional State, Ethiopia from June 05 to June 30, 2020. The zone has an estimated population of 1,763,246. The main town is Woldia, located around 520 km from the capital city, Addis Ababa and 361 km from Bahir dar, the capital city of Amhara National Regional State. There are 11 districts and 5 town administrations in the zone. The town administrations are Woldia, Mersa, Kobo and Lalybela and Gashena town. The districts are; angote, bugna, dawnt, gazo, gedan, gubalafto, habru, lasta, meqet, raya kobo and wadla (23).

There are one specialized hospital, five primary hospitals, 68 health centers and 291 health posts in North Wollo. About 1632 health professionals are working in the government health facilities of NWZ (23).

Within the study site, the highest level health care facility is the only governmental specialized hospital, located in the town of Woldia. It is staffed by general physicians, a surgeon and obstetrician, as well as health officers, pharmacies, laboratory technologists and nursing staff. Health centers provide PHC services comprising preventive health care, treatment of acute illness and delivery services. Health centers are staffed by health officers, midwives and nurses. Health centers are linked to satellite health posts, staffed by two community HEWs. The HEWs form an interface between the PHC system and the community, dividing their time between house-to-house visits, community awareness-raising activities and a limited range of health post-based primary care services.

4.3 Study participants

Mental health coordinators were planned to be interviewed at health offices and Zone Health Department level. But none of the health offices have a separate mental health coordinator, instead non-communicable disease coordinators were responsible for activities related to mental health. Non communicable disease coordinators at district/town health offices and Zone Health Department, health professionals working in health centers who have taken trainings related to mental health and psychiatric nurse who used to work in health center were the study participants. Even though the psychiatric nurse is not permanently working in the health centers, he was assisting formally one of the health centers of North Wollo in issues of mental health services in addition to his hospital work.

4.4 Sample size and Sampling technique

Two out of the three town health offices and five out of the eleven district health offices were selected purposely at first to interview the study participants. The study areas were selected purposively depending on presence or absence of hospital in the district, on the no of health centers in the district (both health offices that have smaller and bigger number of health centers), distance from zone town (nearer and farther health offices), and so on to entertain respondents working from varying areas within the zone.

A total of 15 study participants were planned to be included in the key informant interview. But only 12 participants were included due to saturation of the data. The participants were selected due to their role (non-communicable disease coordinators in district/town health offices and Zone Health Department), the training they took (health professionals working in health centers who took trainings related to mental health), and their profession (psychiatric nurse). The psychiatric nurse used to work in one of the health centers of North Wollo till six months back from the time of data collection before he moved to one of the hospitals in the zone. But he continues to communicate with the health center workers in issues of mental health services.

The three PHC working in health centers and taken trainings related to mental health were selected from the health centers of health offices included earlier.

4.5 Research instrument

Semi structured interview guide was prepared for a face to face interview with key informants to explore the need and readiness for integration of mental health services in health centers. The major ideas included in the interviews were about the presence of mental patients and the habit of seeking health care in the community, the condition of the health facilities in terms of trained man power, psychotropic drugs, and others for mental health services integration. Which mental health services are provided in the health centers was also discussed.

Informed written consent was taken prior to each interview. Audio recording during the interview time was done after permission was gained. The principal investigator was assisted by a degree holder health professional assistant while interviewing the participants through recording their voice and taking notes simultaneously. The study participants were interviewed in their working area usually in their office at convenient place and time for them. Hand shaking, close contact and sharing of materials were avoided and mask was used to cover mouth and nose during data collection to prevent transmission of covid 19. Hand sanitizer was also used to clean hand and used materials like audio recorder after each interview.

4.6 Data management and analysis

Thematic analysis technique was used to analyze the data and discover the need and readiness of mental health services integration into health centers. After data collection, tape recorded data was transcribed in Amharic language written form word for word. Then the participants' verbatim was translated to English and read carefully and thoroughly several times to identify meaning full statements about the descriptions. After that, the formulated meanings were aggregated in to themes and sub themes. The data was interpreted based on the description under each theme and direct quote of the participants' explanation was used. Atlas ti version 7.5 software was used to code and categorize the data to answer study objectives.

4.7 Rigor of the Study

4.7.1 Credibility

To achieve credibility of the data, prolonged engagement through repeated physical and phone contact with the participants was done. In addition, the researcher used one- to –one face to face interview to allow participants reveal their independent understanding of mental health integration. In addition, use of tape recordings of the interviews and transcription of the verbatim was used to increase the accuracy of description of the participant's experiences, hence it increased credibility of the data. During prolonged engagement the researcher was passively active, more of a listener while taking note of the verbal and non-verbal signals. Probing questions were used to ensure that the data generated is true and consistent with participant's views. Transcription verification was done with three participants while reading the transcription for the participants. Peer review of the data analysis, interpretation and conclusion of the study was done by peers who have been doing qualitative studies for their MPH.

4.7.2 Dependability

The researcher used probing during data collection and transcription verification with the participants. The generated information was correlated with the available literatures, so as to provide sufficient information and produce evidence that can be laid open to external evaluation.

4.7.3 Confirm ability

Confirm ability was achieved through reflexivity. In the process of data analysis the researcher suspended her own pre conceived ideas and beliefs about mental health integration and concentrated on the information that was given to the researcher by participants to avoid misinterpreting the phenomena. To capture rich and detailed information, researcher allowed each participant to tell his or her independent experience and understanding deeply, until no new information rise out. Quotations from participants were used.

4.7.4 Transferability

To achieve transferability, the researcher described in detail about the setting and participants by which research was conducted. This was done to give the readers enough information for them to judge the applicability of the findings to other settings.

4.8 Ethical consideration

Ethical clearance and approval was obtained from the IRB of Bahir Dar University. Supporting letter was written by BDU to NWZ health department office. Further permission was obtained from NWZ health department office for the respective district health offices and health centers. The study participants were informed about the objectives of the study and were informed as they have the right to withdraw at any time. Written consent was obtained from the study participants. Confidentiality of information was assured by not writing/calling the name of participants to be seen by any reader. Voice recording was used only after the interviewees' willingness is assured.

4.9 Dissemination and utilization of results

The result of this study will be submitted to BDU College of Medicine and Health Science School of Public Health. A copy of it will be offered to NWZ Health Department, Amhara Regional Health Bureau, other governmental organizations and NGOs especially who are working on mental health. It will be also presented at different conferences and workshops and will be sent for publication at scientific journals.

5. Result

5.1 Demographic characteristics of the participants

A total of 12 participants were included in the interview. 11 of them were male. The participant's age was between 23 and 55. Seven of them worked in district and town health offices and one in zone health department as non-communicable disease coordinators. The other three were nurses working in health centers and have taken training related to mental health. There was also a psychiatric nurse included in the study. Only one of the participants was diploma, nine of them were BSc degree and two of them were master's degree holders.

Table 1: Description of Participants of the study of need and readiness for mental health services integration in North Wollo in 2020

Code of informants	Sex	Age	Profession	Educational level	Role at work
KII 1	M	38	MPH	Masters degree	NCD coordinator at ZHD
KII 2	M	40	BSC Nurse	Degree	NCD coordinator at DHO
KII 3	M	35	Diploma Nurse	Diploma	Professional at Health center
KII 4	M	52	Health service mgt	Degree	NCD coordinator at THO
KII 5	M	55	Psychiatric nurse	Degree	Prior Professional at Health center
KII 6	M	38	MPH	Masters Degree	NCD coordinator at DHO
KII 7	M	40	BSC Nurse	Degree	Professional at Health center

KII 8	M	53	BSC nurse	Degree	NCD coordinator at DHO
KII 9	M	30	BSC Nurse	Degree	Professional at Health center
KII 10	F	23	Health officer	Degree	NCD coordinator at DHO
KII 11	M	45	Laboratory technologist	Degree	NCD coordinator at THO
KII 12	M	29	Health officer	Degree	NCD coordinator at DHO

ZHO – Zonal Health Department DHO –District Health Office THO – Town Health Office

The response of the study participants was read thoroughly, deeply and repeatedly till an understanding of the ideas was gained. The themes emerged while analyzing the response of participants are 1) Mental health service needs of the community, 2) Mental health services provision and 3) Readiness for mental health integration.

5.2 Mental health services needs of the community

While the professionals were discussing the mental health services integration in North Wollo, some parts of their speech focused on the need of the community for mental health services. This theme emerged from three subthemes under it; perceived prevalence and causes of mental illnesses in the community, seeking health care for mental illnesses and the importance of mental health services integration for the community.

5.2.1 Perceived prevalence and causes of mental illness in the community

Perceived prevalence of mental illness in the community was explored and eight of the twelve respondents highlighted that it was prevalent in the community with increasing magnitude while the rest four pointed out that mental illness was not a common problem in the community of North Wollo. The mental illnesses raised by the respondents to be

prevalent in the community were substance abuse, depression, epilepsy, psychosis and suicide.

A NCD coordinator at a town health office associated the increment of mental illnesses with return of migrants from Arab countries back to their country.

> *"Yes, it [mental illness] is increasing somehow in number from what it was. Especially from those youths who return from Arab countries. It is seen widely from those who come from abroad countries. It [mental illness] has now a different digit.* (I 4, NCD coordinator at THO)

Other interviewees attributed the existence of mental illness to wide spread usage of addictive substances in the community. The abundant presence of lack of job in the youth was also described to aggravate the risk of developing mental illnesses like depression in the community.

> *"The problem exists. There is no doubt that the problem exists. People around here use alcohol, chat and have addiction…."* (I 6, NCD coordinator at DHO)

> *"….. Its future is dangerous. Especially Woldia… majority of the youths spend their day chewing chat, majority of the youths do not have job. Half of them have tried their chance abroad and returned, have lost hope. (showing a face who has lost hope) I think these situations aggravate the problem [mental illness] in the future.... majority of the youths do not have job and they lose hope and become distressed. We have seen who hang themselves to death. This will be the result of it [mental illness]."* (I 4, NCD coordinator at THO)

Mental illnesses were one of the top ten diseases among the diseases patients seek care for in one of the health centers of north wollo. The speech of a psychiatric nurse illustrated this;

> *"Earlier when I used to work in the health center, there were a lot of cases. We were not only serving this surrounding, the zone, but there were also [patients] who come from Mehoni and others [areas] from region 1. Since it is the surrounding where chat is highly available, a lot of substance addicted individuals used to come.*

More than 50 [individuals] used to come from there. There were a lot of cases. For example, it used to be 3rd, 4th, and 5th of the top ten diseases." ... (I 5, psychiatric nurse, former worker at health center)

The contrasting view towards the prevalence of the disease was seen in some of the respondents as they argued that even though mental illnesses existed in the community, its number was not that much. The number of mental diseases seen and recorded daily from the health facilities was low. There was also a good practice of visiting the community to screen for mental illnesses from staffs of health centers and health offices.

"It [mental illness] is a problem. But when we see it [in magnitude], I think it is in low level. The problem in terms of numbers, large number is not recorded daily. But still the problem exists. When we see it in terms of its magnitude, what I [think] it is in low level." (I 2, NCD coordinator at DHO)

"There is no till now. There is epilepsy rather. But there is no mental illness that much in this area. I have worked here for many years and I have not seen. We used to go [to the community] earlier. We were out. I went to the community when I was trained for mental health long ago and there is nothing I found. We have look in each village, there is no this kind of thing at all. I was upgrading in psychiatry. We stayed one year and four months, and due to corona, I am back. After I come, I was looking forward eagerly for this kind of cases, but I haven't found one case. And now we are working just in all departments like including injection room and OPD doing other cases." (I 3, mental health trained PHC worker)

5.2.2 Seeking health care for mental illnesses

As the health professionals' experience, majority of the victim community did not believe in modern mental health care and hesitated to go to health facility when they faced mental illnesses prior to trying traditional and religious means. The reason for not going/taking to modern health facilities when they faced mental illness as per the respondents' understanding were the belief about the causes of mental illness in the community were related to spiritual things. So they hided the mental patients in their house or took them to religious or traditional places since they believed the modern medicine would not cure it.

"The community does not believe that mental illness will be cured in health institution, and in health center. They do not have believes. Usually they go to traditional means, holy water uumm mostly it is to there. They believe it is from devil (seytanism), they relate it with the devil. They take them to holy water, or to church students (debtera)…." (I 8, NCD coordinator at DHO)

"….this kind of things [mental illesses] are not believed to be treatable by modern medicine. Due to this, when people become sick instead of going to health facility, they prefer to go to religious places, holy water, and a lot is expected to be done." (I 1, NCD coordinator at ZHD)

"Going to health center to be treated, some [mental patients] go and get treated, but there are those who only sit them in their house and do not bring them to the health facilities. There is what I noticed recently. When we were going village to village for a package I have found someone [who has mental illness]. They didn't bring him to health facilities then. …. So there are those who are hidden. I have come across through people who believe by cultural means only and do not believe that facility treatments cure." (I 2, NCD coordinator at DHO)

"Some part of the victim community prefer to seek modern health care only if the other [spiritual] didn't work. Because it prioritizes its culture. Majority lives in the rural area and is not civilized that much so will come here only after trying cultural means and doesn't work….. Currently, the majority uses cultural means and if doesn't improve, comes to health institution." (I 4, NCD coordinator at THO)

According to a participant, those who visit health facilities for mental illnesses seemed to go to hospitals instead of health centers since they did not know if the service was available there or not. It should also be noted that there was only one psychosocial trained professional in one health center out of the eight health centers in the district where this coordinator worked.

"The community does not have that much [awareness] that it [mental health service] is given in health center. They come to hospital rather. They do not have awareness. They go there [health center] and ask most of the time when they are in

problem, when they lack the drug, when they cannot come to hospital. Otherwise they come to hospital." (I 2, NCD coordinator at DHO)

5.2.3 Importance of mental health service for the community

All of the study participants' responses showed the importance of integration of mental health service into health centers and they believed it would be good for the community, especially the victims, if they could get the services in the nearby health centers. The integration was also believed to decrease the load in the hospitals. A respondent expressed his fear in mental health service integration not being implemented due to lack of focus from the government.

> *"Expanding the service is a good thing if possible. Because now NCDs are increasing in number from before, availing the service in health center for the community, mainly, it increases accessibility. It is good if it can be. Because the load in the hospital decreases. Secondly, the community get the service with no problem. I think better results will come if integrated. But it is not implemented."* (I 4, NCD coordinator at THO)

Providing mental health services by integrating it to the nearby health centers was stated as a benefit for the rural community since they faced difficulties when bringing mental patients to hospitals which were usually far from their living area. Compromised quality of care due to patient load in hospitals, difficulty of the road and transportation fees added up with different difficult behaviors/activities of mental patients made it difficult.

> *"It will be a better thing if they get medical services by going to the nearby health center rather than going to hospital. It will make it better. There are lots of patients in hospital, ummm, they may not get good service. They may not get their follow up when they need, for the rural community it may be difficult to pass through river, there is the distance of the road. I think it will be comfortable for follow up and support, if they can get the medical care at a nearby health center. … [They say] we cannot take him, we are unable to bring to facility, to Woldia. Since it is far it may be difficult. The person may hit others, there may be falling off a cliff. It will make it better if they can get treated at nearby."* (I 2, NCD coordinator at DHO)

> *"It [mental health service provision at health centers] is better in terms of economy and different things, especially for the patients. There may be individuals that drop out due to these reasons, due to its distance, and may not have social [support]. It is very preferable if it can be done, it is useful for the community."* (I 9, mental health trained PHC worker)

A psychiatric nurse emphasized the need for mental health services at the community level. He indicated the benefit of the service at the PHC level as many mental patients suffering and living in the road of the towns could work, would be productive and fruit full for themselves and the community if they could get the treatments they need.

> *"It is good if you recommend, it [mental health services provision] has to be done at the lower, at the community level. It can be done. There are lots [of mental patients]. Many are suffering. The ones in the road can be productive (beyemengedu yalutm [ebdoch] wetetama yehonalu). There are lots of them. It is good if you recommend this things [mental health services integration into health centers]."* (I 5, psychiatric nurse, former worker at health center)

5.3 Mental health services provision

The mental health service provision theme emerged from two subthemes; mental health service provision by trained PHC professionals and mental health service provision by psychiatric nurse. The ideas in the theme described what the mental health service provision look like while there was a psychiatric nurse in the health center or PHC professionals who took short-term mental health trainings. There were four professionals who took comprehensive mental health training and twenty one Professionals who took ART integrated mental health training in NWZ.

5.3.1 Mental health services provision by trained PHC professionals

Participants were asked to narrate about the mental health services provision in the health centers. Respondents were not satisfied with the level of mental health services the health centers were providing. The main mental health service provided in the health centers was referral of patients to hospitals when they were suspected of mental cases. There were also

health centers that give counseling, prescribing medications, follow up services for mental patients and health education was also given in some health centers.

> *"For individuals who have sleeping problem, we give amitriptyline. CPZ and the likes are not allowed to be given by our level. We appoint them and advise them. If they do not get relieved we refer them to Woldia whether it is manic or depression, and they will start there."* (I 7, mental health trained PHC worker)

> *"If they find the case they will refer to hospital because there is no trained professional. Our district in terms of availing mental health service in health center can be said almost in a level of zero. So except referral, they do not get the service that much. After they come to hospital and are seen one to two times, there are individuals who continue their follow up and take their medication from the health center. If the medication exists, some make their follow up there, come to health center, and when referral is needed, there is a time they are referred. But this is not that much."* (I 2, NCD coordinator at DHO)

A respondent was highlighting in his speech that activities involving stakeholders in mental health of the community such as community and religious leaders were not done.

> *"You do not say it [mental health service integration into health centers] is not implemented at all. Because health education is given in some health centers. Treatable cases in health centers are treated, and some are referred. You cannot say it is completely being implemented. Now those related with the community relation, related with religious, church, these things [are not done]"* (I 1, NCD coordinator at ZHD)

There was a response that the PHC workers believe that the service could not be provided by them.

> *"Actually when training is given, it is [expected] that the service should be given. Whatever uuuumm after a follow up in hospital, there is a situation when they go there [health center] for a follow up…. it is minimal in terms of number. And that is, most of the health centers have fear of giving the service. They think the service*

cannot be given by them at least not even counseling. Whatever the service given is low." (I 2, NCD coordinator at DHO)

Another coordinator stated that only emergency management was provided for patients presenting with acute mental cases.

"There is no. when we say treatment, they come once, and they may give them sedatives. We do not call that treatment. There is separate treatment, there are separate drugs. These drugs should be given. Giving sedatives for them and letting them relieve for the moment, I do not think it is treatment." (I 8, NCD coordinator at DHO)

A psychiatric nurse complained on the service given at the health center by PHC professionals, as medications being ordered were mistakenly ordered.

There are those [mental patients] who should stop [their medication], even there are epilepsy patients who should stop, but they just continue taking. Mental problem, for example even if it is schizophrenic if it is paranoid or catatonic (schizophrenic types), there is a time when you should stop [giving medications]. Now they [PHC professionals] just [order the medications for them], what I started, it is just refill and refill. It is very bad." (I 5, psychiatric nurse, former worker at health center)

5.3.2 Mental health services provision by psychiatric nurse

As understood from the speech of respondents, mental health service provision at health center used to be more effective when a psychiatric nurse was working in health center. Great improvements were seen in symptoms of mental patients when they were treated by psychiatric nurse.

"*at that time you know what, those [mental patients] chained by handcuffs [hands and/or legs of some mental patients specially psychotic ones are chained by metals (senselet) so that they will not be lost, harm themselves and others] were even released. The chained ones used to come when I used to work there…."* (I 5, psychiatric nurse, former worker at health center)

Mental patients in the community who visit the health facilities also preferred to be seen by psychiatric nurse.

> "*There are some who come. Because this professional [a psychiatric nurse] is a well-known professional. Because he was the only professional by mental health. He used to do this [treat mental patients] in the health center. But those who used to seek care from him, still now they come. He helps them. Because he doesn't say go there go here but orders the drug for them. But he himself orders the necessary medications to be bought here in the health center."* (I 4, NCD coordinator at THO)

5.4 Readiness for mental health services integration

This theme is about the readiness for mental health service integration through the two subthemes under it; system level readiness and facility level readiness. Government emphasis, budget and partner involvement are the ones that made the system level readiness for mental health services integration. Resources for mental health services integration, mental health plan and monitoring and supervision are the ones that made facility level readiness for mental health services integration.

5.4.1 System level readiness

5.4.1.1 Government emphasis

All of the respondents complained on the lack of emphasis from the government for mental health of the community. A respondent attributed lack of emphasis from higher officials for the tardiness of mental health services integration in health centers. It was also noticed from the interviews that there were not actions taken besides raising the idea of mental health services integration and talking about it by everyone involved. The following responses illustrated this;

> *"I think the problem is not giving focus [for mental health]. The higher officials do not give focus. The emphasis is given for those two non-communicable diseases [DM and HTN]." (I 4, NCD coordinator at THO)*

"eee what I want to say, may be this thing [mental health services integration] get focused, government and all others give it focus so that the health service can be given to victims in the nearby health center. ... The emphasis given from the government is low. So what I want to say is more focus has to be given for this thing." (I 2, NCD coordinator at DHO)

"Yes it is true. It [integrating mental health to the health centers] is being said. Firstly it is just talking. Starting from high level to low level, they just talk. ... It was good if the health center can start. I do not think (ayiiee! ... smiles) ... But there is no one that considers it. ... It is good, it is very good if it can be." (I 5, psychiatric nurse, former worker at health center)

A coordinator stated his opinion that government actions rather should be taken ahead before things become serious due to the abundant presence of causes/aggravating factors for mental illness in the community;

"The problem is government gives emphasis when the problem becomes huge only. After 5 and 6 years, lots of problem will exist in Woldia. With this reality, with the addiction the youth have, with the existing absence of job and loss of hope, [the problem will be huge]. When these things become serious, I am sure the government will act. ..... So it is good to look for a solution before the problem is huge." (I 4, NCD coordinator at THO)

5.4.1.2 Budget

All participants complained on the absence of budget allocated for mental health and other non-communicable diseases also. There was also a gripe from the respondents that they were not given their per diems when they do activities related to mental health such as screening for mental illnesses in the community.

"There is nothing as such (laughing with a soft smile). Normally there is no budget allocated specifically for NCD. There is no budget also for mental health. These activities are run by the general budget of the office. There is no partner that supports these programs so it is not budgeted. When we do screening and other

activities for other NCD diseases, we don't get our per diems (showing a face of dissatisfaction)." (I 6, NCD coordinator at DHO)

"There is nothing. Not only for this specific service, budget is not allocated even for epidemics. This is the problem of the office. There is a problem everywhere. There is no budget which is allocated for this." (I 4, NCD coordinator at THO)

5.4.1.3 Partner involvement

Despite partner involvement for effectiveness of any program is a known advantage, all participants declared absence of partner which worked with them regarding mental health of the community.

"Institutions and committees are not that much [involved]. The political acceptance is not that much, it [mental health integration] is ignored." (I7, mental health trained PHC worker)

"There is nothing that we talked with any stakeholder (moving his head from side to side). By health education with the community, health centers give health education. Every activities are included in health education, and mental problems are one of the issues. Health education is given in health centers but there is no other thing done above this. Beyond this there is no other stakeholder that has approached or asked to work about this. There is also no one that we communicated with." (I 2, NCD coordinator at DHO)

A coordinator at a ZHD tried to illustrate in his saying that the mental health integration could be effective with involvement of partners. He emphasized the need to learn from achievements made in raising awareness and other achievements of prevention and control of HIV AIDS in the country which were due to involvement of partners. It was also said that it had been difficult for the government alone to implement programs which might be due to shortage of different resources and the need to learn from those experienced ones.

"It [mental health integration] is possible, but that does not happen out of nothing. What I say is, how HIV AIDS [awareness] was gained, a lot is done. Most of health

[programs] are run by partner. It can be implemented if there is partner involvement." (I 1, NCD coordinator at ZHD)

"The first thing is due to NGO or other supporters. Unless in support of NGO, the government does not start and run programs by itself." (I 4, NCD coordinator at THO)

5.4.2 Facility level readiness

5.4.2.1 Resources for mental health services integration

Our interviews highlighted an overall shortage of staff working in the field of mental health in health facilities of North Wollo. It was emphasized by the respondents that presence of mental health trained professionals was the main important thing to provide mental health services in health centers. Non-communicable disease coordinators at health offices responded the following;

"The mental health service in our health centers, we have eight health centers. Only one health center has a trained professional." (I 2, NCD coordinator at DHO)

"There is no training at all. It [mental health] doesn't have training. ....." (I 4, NCD coordinator at THO)

All health center professionals trained to give mental health services explained about the importance of the training. They suggested emphasis and improvements in the trainings given, so the given training could be practiced. The following statements illustrate this.

"It helps to screen somehow, but it is not enough, you know it. It was given for five days by a lady from Bahir dar. And it was very good. The training is not enough. But by that training, it can be done if it is given emphasis. But it does not have budget, emphasis is not given to it." (I 7, mental health trained PHC worker)

"But it could have been better if deeper training was given. Firstly the training is short, given only for six days. It is not enough as to me." (I 9, mental health trained PHC worker)

There was a suggestion to avail psychiatric nurses in each health center, for mental health services to be provided there due to the work load, low level of motivation in PHC workers lack of mentorship. Moreover, a low level of knowledge and skills in PHC workers of North Wollo required to diagnose and manage people with mental illnesses was reported. This was illustrated when a psychiatric nurse questioned the quality of the short term mental health trainings given.

> *"But by giving 5 days training! (Laughter with smile)… You are saying you are doing research on this. If he does not know the criteria for psychosis, what is it?! (… Silence) The training they took is just meaning, they are trained vocabularies. I am seeing few of them here. Even those who took 2 credit hour course, I am seeing them. It is a very difficult thing. If they are trained and if they are devoted, they can work. It is not a problem I can also show them. After they take the training and if they are devoted, I can show them well. There is no problem. The main thing is their motivation."* (I 5, psychiatric nurse, former worker at health center)

> *"Those [professionals] who are trained [for mental health services] in the health center are not fixed at those places. For example if an individual is assigned in ART, the first thing is there is turn over. When he joins other environment he will not say I am trained in this thing and let me work. There is no motivation. That is one gap. Plus to that even though they are trained with that, they are assigned to other jobs. So these things are done additionally while they are also doing other jobs. When that is the case, there is, he will be well prepared for the other class he is assigned for, which is ignoring this job."* (I 1, NCD coordinator at ZHD)

The interviewees responded about psychotropic medications that some of them existed in the health centers and additional medications could be purchased by the health center if needed. It could be bought from PFSA by their own budget. Although some drugs were not allowed to be given for health centers, there were drugs that enable treatable cases at health centers to be treated.

> *"Umm the medication may not be available now. …the medication can be purchased, they can. It can be purchased and availed since it is through their health care finance by their own budget. I think drug issue will not be a problem. Ummm*

but there has to be a professional in the health facility that prescribes, that orders, beyond that purchase can be made." (I 2, NCD coordinator at DHO)

The opposing idea about psychotropic medication availability as described by the mental health trained professionals was that there was shortage of important medications in the health centers. Medications for depression and psychosis were not available at all and there were also times when antiepileptic drugs were missing.

"First of all there is no medication. There is no amitriptyline. It is what we call [psychotropic] drug. It does not even exists. There is no medication for it here at all. There is no CPZ. Medicines only for epilepsy exists. They also will not be available for three to four months and then they will come." (I 3, mental health trained PHC worker)

"Now for example in this level, there are no antipsychotic drugs, only amitriptyline [is found]. There is no diazepam, no CPZ, no haloperidol, the drugs that can be given at that level. Even though you can order them using the manual. They will expire if they come also. Since they have health insurance and follow up in hospital, there are individuals that follow up in hospital." (I 7, mental health trained PHC worker)

Despite absence of separate room for diagnosis and management of mental patients in health centers of North Wollo, all of the interviewees stated that it could be prepared somehow. But it might not fulfil the criteria of a room for diagnosis and management of mental illness.

"After lots of trying, DM and HTN service is given in separate room. The others [mental health and cervical cancer] are not given, it is not being done. Because the main problem is every training asks for its own room. And that, as you know the health center is built long ago. It is difficult to have class for each department. Cervical cancer alone, mental health alone, DM and HTN alone, it is difficult to find classes for each. NCD [DM and HTN] service is given in separate room because there is NGO that supports it …." (I 4, NCD coordinator at THO)

"Normally a room for mental patients to be seen will not be a problem. There may be a shortage of class at health centers but it can be solved. But the room may not be that much comfortable." (I 6, NCD coordinator at DHO)

"We have selected one separate class for it. But it is difficult to make it have two doors and the like unless new class is built. So it is not comfortable in that way. But there is a selected class." (I 9, mental health trained PHC worker)

All of the non-communicable disease coordinators described the absence of a specific screening, diagnosis and management guideline but rather there were general guidelines such as the treatment guideline and primary health care guideline available in health centers. Lack of trainings on how to use these manuals was a problem even with the availability of these general guidelines.

"There is no guideline. There is no guideline that come to us and we distribute." (I 2, NCD coordinator at DHO)

Opposed to the coordinators idea, all mental health trained PHC workers stated that they had the manuals and appreciated the importance of it for screening, diagnosis, and management and also referral of mental cases if needed.

"since I put the manuals next to me in OPD, it is possible reading it to screen and diagnose the cases that you suspected, at least to diagnose the cases at your level, and will be easy to refer. It is comfortable. In mental health, it is not only about learning, but if you do the job it is easy and you will understand it. If you do not do it, if you do not practice it, learning only, it will be forgotten." (I 7, mental health trained PHC worker)

"… But the guide books are very good. It is like IMNCI, it leads. Even though the guideline is good, the cases are not seen well [during the training]." (I 9, mental health trained PHC worker)

5.4.2.2 Mental health plan

All but one of the health offices included in the study had mental health plans together with other plans of the office. The respondents were arguing the plan was prepared for the sake of planning and no attention was given for its implementation.

> *"I was given conversion factor and planned it by multiplying with the district population in the mission. I just planned it for the sake of planning only but there is nothing done. As a plan I prepared it like this (showing A 4 paper that has list of mental diseases and numbers in front of each), but there is nothing I am doing (smiles...)." (I 10 NCD coordinator at DHO)*

> *"Actually there is a plan to give mental health service at health centers. We have planned. To increase detection of HTN by 50% and detection of mental patients by 50%. Mental health service is included under the main identified activities for the health centers. And 19 mental patients are planned to be diagnosed and treated annually. We didn't give attention to it since the service is not given that much at health center."* (I 6, NCD coordinator at DHO)

The participants related the problem for not implementing the mental health plans with the absence of separate mental health coordinator in health offices and lack of information on what they should do in relation to integrating mental health.

> *"It [mental health] is together [with NCD & NTD]. There is no one assigned alone. There is no information.... we do not know what the officer should do, on what they should focus, what kind of relation exists."* (I 4, NCD coordinator at THO)

5.4.2.3 Monitoring and Supervision

The interviewees explained that there was a problem of supervision and monitoring mental health services of the health centers. Absence of initiation and follow up from higher officials were some of the reasons described.

> *"In addition there is no one who monitors and focus. There is shortage of monitoring. ...After giving training, they don't check them at all (zor blew ayayuachewm). We do not have [components] about mental health in the check list.*

[You do it] when there is someone who ask you. If the higher officials do not give [emphasis]." (I 4, NCD coordinator at THO)

"During the training they said there will be supervision and took our phone number. There is nothing done but they said they will mentor us. The one who trained us has called me one to two times but they didn't come and mentor us. They said we will come but they didn't come till now." (I 7, mental health trained PHC worker)

Some of the respondents narrated that there were some movements in relation to supervision and monitoring of mental health services but it was limited to idea or in some cases the screening of mental cases was checked.

"Normally we were talking informally with the trained professional. We were saying that the community should be awakened. A committee also has to be formed which will deal with mental issues. But we did not go that far." (I 6, NCD coordinator at DHO)

"There is no specific supportive supervision. But I include it in the integrated supportive supervision check list when it is prepared here. Health facilities are seen every quarter and that time we include it and orient." (I 1, NCD coordinator at ZHD)

6. Discussion

Mental health services integration is one of a task sharing process proposed by WHO aimed at providing mental health services integrated with the other general health services of the facilities by non-specialist health care professionals to reach a wider proportion of the community (51). This study revealed the need and the readiness for mental health services integration in health centers of NWZ.

The need for mental health services of the community were seen from the angle of the perceived prevalence of the mental illnesses in the community and the habit of health care seeking behavior for mental illnesses. Perceived prevalence of mental illness in the community was explored and eight of the twelve respondents said that it was prevalent in the community with increasing magnitude while the rest four pointed out that mental illness was not a common problem in the community. These eight respondents were working relatively in urban areas of the zone when compared to the other participants. Mental illnesses, specifically substance abuse and those related with substance abuse seemed to be abundant in towns rather than rural areas. There might be different reasons including; the life style of those living in the towns, abundant presence of trade places that sell addictive substances, migration of youths from rural areas to urban areas and Arab countries illegally looking for job and might not get job as they planned, and as it is said in the proverb 'the crazy and the rain likes the cities' for the variation of responses about the existence of mental illnesses in the community from those who work in urban and rural areas. But it needs further investigation on the prevalence of mental illnesses in the community.

So probably the problem may not be warranting in rural areas of the zone or the other explanation could be that few level of records/ facility visits may not fully reflect the prevalence of the problem in the community at large. It was also described that there was a high number of visit of mental patients in one of the health centers of North Wollo, making it one of the top ten diseases patients seek care for. This could have been related with the presence of a psychiatric nurse only in that health center at that time instead of other health centers of the zone. Mental patients might be referred to this facility or they or their carriers themselves might be initiated to visit this facility as they knew the presence of the professional, the psychiatric nurse. So other studies may be needed to assess the true

prevalence of mental illnesses in the community. Common mental disorders were reported to be major public health problems in different parts of Ethiopia (24,25), being similar with this study. The mental illnesses raised by the respondents to be common in the community were; epilepsy, substance abuse, depression, and psychosis. Suicide was also reported. It is good that the mental illnesses common in the area of North Wollo are similar with the mental illnesses run by the PRIME program in different LMIC including Ethiopia nationally (13). This may help mental health services integration in North Wollo by using experiences from those health centers/areas that integrated mental health services earlier.

Despite its increment, most of the mental patients did not seek health care in the health facilities including health centers prior to visiting traditional and religious places, as the response of health professionals illustrated. Lack of awareness about mental illnesses in the community of North Wollo was reported. Mental illnesses were attributed to spiritual and religious causes by the community so they preferred to seek care for mental illnesses in the religious and traditional places instead of modern health care. Mental illnesses were also said to be related with lack of job in the youths and return of migrants. A study of integration of depression management services in Vietnam (31) was similar in findings with this study, it pointed out that mental illness was more abundant in the community than the patient population showing most of the mental patients did not seek health care. A study of barriers to mental health integration in Sudan (32) also reported that the community related mental illness to devil and witchcraft and prefer to seek care from religious and traditional experts which is also similar with this study. Lack of knowledge and information issues about mental illnesses were associated with not seeking health facilities in Georgia (29) which is similar to this study findings. Creating awareness for the community about mental illnesses and the mental health services provided in health centers may be a necessary action to start with. Job opportunities and entrepreneurship trainings may also be needed as a prevention and healing mechanism for substance abuse, depression and the like in the youths and returners from migration.

The mental health services provided in health centers included health education, emergency management, follow up and referral of mental patients. The visit of mental patients to health center was seen to have increased when there was a psychiatric nurse in

the health center. Although it is recommended to avail psychiatric nurses in each health center by the Ethiopian Health Center Qualification criteria (21) and was suggested by a respondent, the current reality of the health centers of North Wollo is far from this. It was found out from the report that there was no health center where by a psychiatric nurse existed. The Amhara Regional Health Bureau should plan and work to increase the number of psychiatric nurses and other mental health related professionals according to need of the region in the long run.

Despite the burden of the problem, all of the respondents declared that the emphasis given for mental health of the community from the government was low. It is similar with findings of a study from Sudan (32) and Indonesia (40) as these findings yielded mental health's discrimination in front of the government. All participated NCD coordinators of this study complained on the absence of budget allocation for mental health which is similar with studies from other parts of Ethiopia (34), South Africa (45) and Mexico (30) as there was no specific budget allocated for mental health in the district health offices. Lack of emphasis from the government manifested by absence of budget allocation for mental health and not involving partners seemed to contribute for the sluggishness of the mental health services integration process in North Wollo. So everybody within the system or that has role in it should give focus for mental health and communicate with and involve different partners that can support the mental health services integration in different ways. It is also mandatory to allocate budget for mental health by accommodating the shortage of finance in the country.

As the respondent's reply suggested that there was shortage of mental health trained personnel in the health centers and the trainings given were for few PHC professionals and for few days only. The quality of this short term mental health training was criticized to show limitation of skill in the trained PHC professionals. Turnover, lack of motivation and work load were also problems related with provision of mental health services by PHC professionals in health centers of North Wollo. Similarly to this study, shortages in personnel and training opportunity were one of the problems listed by respondents in studies of mental health integration in other part of Ethiopia (10,11), South Africa (38) and Libya (37). The lack of refresher training in Nepal (36) had also meant for absence of

mental health services in health centers which is similar with the findings from this study as the mental health trained professionals were asking for additional trainings to be given to update their knowledge and ability of treating cases. The available human resources in mental health professions in North Wollo is also below the average in Ethiopia (20). But it is similar with study from Kenya where by no psychiatrist exited in the studied county also (39). So it should be noted that training PHC professionals with the necessary updated mental health trainings is mandatory for mental health services provision in the health centers. How to tackle the lack of motivation of PHC staffs and turnover should be investigated and appropriate measures should be taken.

The participants of the study from health offices and health department were sure of the possibilities of availing psychotropic drugs at the health centers. But interruption of psychotropic medical supply including anti-epileptic drugs was reported from those trained professionals working in the health centers. So there may be a gap in communication and timely supervision and support between the two groups (professionals working in health offices/department and professionals working in health centers). Shortage of budget was also reasoned for not fulfilling the new generation psychotropic drugs in a health center. Inconsistent provision of psychotropic medications at health centers of south Africa (45), Liberia(46), Libya (37), and Ethiopia (10,11) was noticed which is similar with some responses of respondents that there were times at which psychotropic drugs would be missing in the facilities. The NCD coordinators argued that psychotropic drugs like the other drugs can be bought by the health center through PFSA with some restriction of the drugs. In contrast to the current findings, a study from Kenya showed that psychotropic drugs to health centers had to go through hospitals (39). There was a problem of supportive supervision in the studied health facilities which is also in line with a study from Kenya (39). All respondent agreed on weakness of the supervision and monitoring being given when it comes to mental health services, and it needs improvements. But there was a gleam of visiting the community and screening mental illnesses from staffs of health centers and health offices which should be appreciated and improved.

According to the respondents, there was no conducive separate room for diagnosis and management of mental patients in the health centers but was said that it could be prepared

somehow. Problems with quality and quantity of existing private space for diagnosis and treatment of mental patients was also noticed in Liberia (46), Ethiopia (42), south Africa (45) and Vietnam (31). As to the result of this study, there was no specific guideline that can be used for the screening, diagnosis and management of mental patients except with the trained PHC professionals. Other studies also supported this finding. In Libya, only 1% of the included PHC facilities had any mental health guidelines available (37). Similarly, there were also no specific assessments, or management protocols or guidelines for psychiatric care in the studied PHC facilities of Kenya (39). Distributing guidelines which helps to screen, manage and refer mental illnesses is important with trainings on how to use them given side by side for the effectiveness of mental health services integration.

All of the district health offices studied were characterized by absence of a separate mental health coordinator and the mental health plans were just planned for the sake of planning, the achievements was also not monitored as described by the respondents. This finding is also in line with a finding from LMIC of Ethiopia, India, and Uganda but inconsistent with findings from Nepal and South Africa as the last two had a separate mental health coordinator in the district health offices (12). Although it might need further investigation, the last two countries seem to have better mental health services through availing all psychotropic drugs and higher number of mental health workforce. Having a separate mental health coordinator at district alone may not result in an improvement, but it can contribute for it. Not to forget that South Africa and Nepal are from middle income countries of Africa.

7. Limitation of the study

There are limitations to my methods in this study that must be stated. The title could have been studied well more and additional information might have been obtained if focus group discussion was used as a tool. This was not possible due to the difficulty of bringing different health professionals from different places to the same place because of covid 19 pandemic. The study was provider's perspective. The investigator did not interview mental patients or their carriers and they could have offered valuable additional insights into the mental health services integration. But it can be studied in another study.

8. Conclusion

Mental illnesses are a problem in the community of North Wollo Zone. Prevalence of mental illness was increasing in the community of urban areas of the zone, which were attributed to widespread presence of substance addictions, lack of job in the youth population and return of migrants. There was a problem in seeking modern health care for mental illnesses in the community due to lack of awareness about mental illnesses and resulting preferences to visit traditional and religious places. The mental illnesses prevalent in the community were substance abuse, epilepsy, depression and psychosis. Suicide was also reported.

Although there were weaknesses and interruptions in the services, the health centers of North Wollo provided mental health services such as health education, management of emergency cases, referral and follow up to some extent.

There were problems in availability of psychotropic drugs, separate room and guidelines in the health centers; but the more emphasized problem was shortage of mental health trained professionals for not providing mental health services. The mental health trainings given were also criticized in enabling PHC professionals to manage mental illnesses added up with lack of motivation, work load and turnover. The lack of strong monitoring and supervision system due to lack of government emphasis, budget and partner involvement also contributed for the current situation of mental health services integration into health centers.

9. Recommendation

Ministry of health and especially Amhara Regional Health Bureau should give emphasis for mental health of the community and allocate adequate budget for the mental health services to be provided. It should also advocate mental health to involve non-health government sectors and other local and international NGOs in improving the mental health of the community. They should plan and work to increase the number of mental health workforce according to need of the country in the long run.

The Amhara Regional Health Bureau by coordinating with partners should give updated mental health trainings for primary health care workers and health office workers based on their expected roles continuously.

Timely support, supervision and communication from regional health bureau, health department and health offices should be done to fill the gaps for mental health services integration in health centers.

Measures to increase staff number, staff motivation and decrease staff turnover should be taken by the health facilities to prevent mental health trained professionals from leaving the health centers.

The district/town health office workers and primary health care professionals should work together to raise the awareness of the community about mental health and the health care seeking behavior by communicating with community and religious leaders.

Religious leaders and community representatives should teach and advise the community to go to health facility for mental patients in addition to the treatments they get from religious and cultural paradigms.

The community should improve the habit of seeking health care in health facilities including health centers when they face mental illnesses.

The government specifically North Wollo Zone Administration Office should load high tax to marketing addictive substances and/or limited individuals should be allowed to sell at limited places to decrease the widespread presence and usage of addictive substances.

Job opportunities should be created and entrepreneurship trainings should be given for the youths and those who return from Arab countries as a prevention and healing mechanism for some mental illnesses. Centers for substance abuse treatment should also be built.

More studies need to be done on the prevalence of mental illnesses and on mental health services integration in health centers by entertaining different sources of data including mental patients and care givers.

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Appendixes

Appendix I: Information Sheet (English Version)

BAHIRDAR UNIVERSITY

COLLEGE OF MEDICINE AND HEALTH SCIENCE

SCHOOL OF PUBLIC HEALTH

An interview guide prepared to study the need and readiness for mental health services integration in public health centers of North Wollo, Ethiopia.

Good Morning/ Good evening, my name is Semira Muhidin. I am a postgraduate student at Bahir Dar University, College of Medicine and Health Sciences, School of Public Health, Health System Management and Health Economics department. I am here to collect data for my study which is entitled with "the need and readiness for mental health services integration in public health centers of North Wollo". I have got permission to do this research from Bahir Dar University, SPH research ethics Committee and Amhara National Regional State Health Bureau as well as management bodies of North Wollo Zone health department. You are selected to participate in the study from psychiatric nurses, professionals of zone health department, district/town health offices and health centers. The study will be carried out in the form of interview and it will be audio recorded. It may require about 30 to 50 minutes to complete. Your participation/ non-participation will have no effect now or in the future on benefits/promotions you may receive from any one. In between, you have the right to terminate from the study by any reason, related to the study or personal reason. To achieve the study objectives, your honest and genuine participation by responding to the question prepared is very important and highly appreciated. You have also a right to continue or to discontinue as a participant and there is no any influence that insists you to participate unless you are volunteer. We will proceed to the interview after you understand the following points;

Objective of the study: To explore the need and readiness for mental health services integration in public health centers of North Wollo Zone.

Benefit: There will be no financial benefits for you in participating in this research project. However, the information you provide will be very helpful to hasten and improve the integration of mental health services and its effectiveness.

Harm: The participants will not have any harm by participating in the study.

Confidentiality: I would like to assure you that the privacy will strictly be maintained throughout. Your responses to any of the questions will not be given to anyone else and no reports of the study will ever identify you. If a report of the results will be published, only information about the total group will appear.

Persons to contact: If you want to ask the principal investigator about the research at any time, you can contact me through: E-mail: semiramuhidin18@gmail.com or Tel: +251913454409

Bahir Dar University graduates program school of public health

Appendix II: Consent Form (English Version)

I would like to thank you in advance for the priceless time you would spend in this interview and genuine responses to provide.

By signing below you agree that you have read and understood the above information, and you are interested to participate in this study.

Name of the respondent_____

Signature_____

Date_____

Name of the interviewer_____

Signature_____

Date_____

Appendix III: Interview Guide for non-communicable disease coordinators (English Version)

Interview #_____ Date: _____

The Need and Readiness for Mental Health Services Integration in Public Health Centers of North Wollo from the Health Professionals' Perspective

I. General information

Age: --------- sex: ----------

Profession: _____ Educational level: _____

Experience in current job: _____

II. The Need and Readiness for Mental health services integration in public health centers of North Wollo

1. How common are mental disorders in the community? (How common are mental disorders among patients visiting health centers?)
2. How do you see the integration of mental health services in health centers? (Is it possible? Is it acceptable?)
3. What are the roles played by the district in integration of mental health in to primary health care? (Is there anyone assigned to coordinate mental health? What is the role of coordinator?
4. What does the mental health service in the health centers of your district look like? (Who offers mental health services in the health centers? What services are given for mental patients?)
5. Can you tell me about mental health policies you know? (Is it available in the district office? Is it clear? Is it operable? Is there mental health care plan?)
6. How is the budget for mental health allocated? (What percent of the total health budget is allocated for mental health? Is it used properly? Is it enough?)
7. What does the mental health training for health center workers look like? (Do they get enough training? who trains them? Frequency? Why not?)

8. What does the supervision system for mental health activities at health center looks like? (Who supervises mental health activities? How frequent? What are the means of communication with specialists?)
9. What are your relationships with other sectors and stakes in improving the mental health of the population? (Which stakes and sectors are involved? what is the response from stakeholders?)
10. How is the situation of the health centers in terms of the necessary materials to give mental health service? (What about availability of guidelines and manuals for the screening, diagnosis and management of mental patients? What about a separate conducive room?)
11. What are the means of availing psychotropic drugs in health centers?
12. What should be done to improve mental health integration into the health centers? (Who should do what? The government? The health care provider? The community? Anyone else?)

Appendix IV: Interview Guide for professionals who took mental health training and psychiatric nurses (English Version)

Interview #_____ Date: _____

The Need and Readiness for Mental Health Services Integration in Public Health Centers of North Wollo from the Health Professionals' Perspective

I. General information

Age: ---------- sex: ----------

Profession: _____ Educational level: _____

Experience in current job: _____

II. The Need and Readiness for Mental health services integration in public health centers of North Wollo

1. How common are mental disorders in the community? (How common are mental disorders among patients visiting health centers?)

2. How do you see the integration of mental health services in health centers? (Is it possible? Is it acceptable?)
3. What does the mental health services look like in your health center? (Which mental diseases are treated? What services are given for mental patients?)
4. How was the mental health training you took? (Did you get enough training? who gave the training? Frequency?)
5. What does the monitoring and supervision system for mental health activities at health center looks like? (Who supervises mental health activities? How frequent? What are the means of communication with specialists?)
6. How is the situation of the health centers in terms of the necessary materials to give mental health service? (What are the means of availing psychotropic drugs in health centers? What about availability of guidelines and manuals for the screening, diagnosis and management of mental patients? What about a separate conducive room?)
7. What should be done to integrate mental health services into the health centers? (Who should do what? The government? The health care provider? The community? Anyone else?)

Appendix V: Information Sheet (Amharic Version)

ባህርዳር ዩኒቨርሲቲ

ጤናሳይንስ ኮሌጅ

የሕብረተሰብ ጤና ትምህርት ቤት

በሰሜን ወሎ ዞን ለሚገኙ የማህበረሰብ ጤና ጣቢያዎች የአእምሮ ጤና አገልግሎቶችን የማጣመር የሚያስፈልጉ ነገሮች እና ዝግጁነት የሚለውን ጥናት ለማጥናት የተዘጋጀ መጠይቅ

የመረጃ ቅጽ

እንደ ምን አደሩ/ዋሉ፤ስሜ ሰሚራ ሙሂዲን ይባላል፤ በባህርዳር ዩኒቨርስቲ የህክምና እና ጤና ሳይንስ ኮሌጅ፣የህብረተሰብ ጤና ትምህርት ቤት፣ የ ጤና ሲስተም እና ፕሮጀክት አስተዳደር ትምህርት ክፍል የድህረ ምረቃ ተማሪ ነኝ፡፡ እዚህ የመጣሁት ለሁለተኛ ድግሪ መመረቂያ በምሰራው "የአእምሮ ጤና አገልግሎቶችን በማህበረሰብ ጤና ጣቢያዎች የማጣመር አስፈላጊነት እና ዝግጁነት" ለተሰኘው ጥናታዊ ጽሁፌ መረጃ ለመሰብሰብ ነው፡ ይህን መረጃ ለመሰብሰብ ከባህርዳር ዩኒቨርስቲ የህብረተሰብ ጤና ትምህርት ቤት፣ የጥናትና ምርምር ስነ ምግባር ኮሚቴ እና ከአማራ ብሄራዊ ክልላዊ መንግስት ጤና ቢሮ፤ እንዲሁም ከሰሜን ወሎ ዞን ጤና መምሪያ ፍቃድ አግኝቻለው፡፡ ይህንንም ጥናት ለማሳካት የእርስዎ ቅንነት የተሞላበት ተሳትፎ ወሳኝነት አለው፡፡ በዚህ ጥናት ላይ መሳተፍ፣ በፍቃደኝነት ላይ የተመሰረተ ስለሆነ፤ ስጠይቅዎት በመሃል ጥያቄ መጠየቅ፤ጥያቄ መዝለል፤ብሎም ማስቆም ይችላሉ፡፡ በቃለ መጠይቁ ወቅት ድምፅ በመቅረፀ መረጃ ለመያዝ የምጠቀም ሲሆን የሚወስደው ጊዜ ከ 30ደቂቃ እስከ 50ደቂቃ ነው፡፡በጥናቱ ላለመሳተፍ ከፈለጉ አለመሳተፍ ይችላሉ፡፡ በዚህ ጥናት በመሳተፍዎ ወይም ባለመሳተፍዎ ማንኛውንም አገልግሎት ወይም ጥቅም ከማግኘት አይከለከሉም፡፡ ነገር ግን የዚህ ጥናት ዓላማ የተፈለገውን ግብ እንዲመታ የእርስዎ ተሳተፎ እና መልስ መስጠት ይበረታታል፡፡

በዚህ የምርምር ፕሮጀክት ለመሳተፍ ከመወሰንዎ በፊት ይህንን የማብራሪያ ቅጽ በጥንቃቄ በመረዳት ጥያቄዎች ካሉዎት ይጠይቁ፡፡ በተጨማሪም በጥናቱ መሳተፍ ከጀመሩ በኃላ በማንኛውም ጊዜ ጥያቄዎች ካሉዎት መጠየቅ ይችላሉ፡፡

የምርምር ፕሮጀክቱ ዓላማ:- በሰሜን ወሎ ዞን በሚገኙ የማህበረሰብ ጤና ጣቢያዎች የአእምሮ ጤና አገልግሎቶችን የመጣመር አስፈላጊነት እና ዝግጁነት ለማጥናት የተዘጋጀ ነው፡

ጥቅሞች:-የእርስዎ ጥናቱ ላይ መሳተፍ አሁን ለግልዎ የገንዘብ ጥቅም ባይኖረውም፤ የሚሰጡት መረጃ ግን ለጥናቱ መሳካት፣ በጥናቱ በተለዩ ችግሮች መፍትሄ ሲሰጥ የአእምሮ ጤና አገልግሎቶችን በጤና ጣቢያ ለማጣመር ቀላል በማድረግ እርስዎ እና ሌሎች አገልግሎት ሰጪዎች፣እነዲሁም በዋናነት ማህበረሰቡ ተጠቃሚ ይሆናሉ።

ጉዳት:- እርስዎ በጥናቱ ላይ ስለተሳተፉ ከጊዜዎት በስተቀር የሚደርስብዎት ምንም ችግር የለም።

ምስጢር ስለመጠበቅ:- ከዚህ ጥናት የሚገኝ መረጃ በሙሉ በምስጢራዊነት ይጠበቃል።. ለዚህ ጥናት የሚሠበሰበው እርሰዎን የሚመለከት መረጃ በማህደር የሚቀመጥ ሲሆን ማህደሩም በስምዎ ሳይሆን በተለየ ኮድ ሲቀመጥ ኮዱ ከዋናው ተመራማሪ ውጭ ለማንም አይገለጽም።

ጥናቱን በተመለከተ ሊብራራልዎት የሚፈልጉት ነገር ካለ መጠየቅ ይችላሉ። ለበለጠ መረጃ የጥናቱን ዋና መሪ በሚከተለዉ አድራሻ ማግኘት ይችላሉ። ኢሜል፡ semiramuhidin18@gmail.com ወይም ሞባይል ስልክ ቁጥር: +251913454409

Appendix VI: Consent Form (Amharic Version)

የስምምነት ቅጽ

ለሚሰጡኝ ውድ ጊዜ እና ጠቃሚ መልስ ቀድሜ ላመሰግንዎት እወዳለሁ።

ከላይ በዝርዝር የተሰጡትን መረጃዎች እና ቅፁን በደንብ አንብቤ እና ተረድቼ በጥናቱ ለመሳተፍ ተስማምቻለሁ ።

የተሳታፊው/ዋ ስም _____ **ፊርማ**_____ **ቀን** _____

መረጃ ሰብሳቢ ስም _____ **ፊርማ**_____ **ቀን** _____

Appendix VII: Interview guide for non-communicable disease coordinators (Amharic version)

በሰሜን ወሎ ዞን ለሚገኙ የማህበረሰብ ጤና ጣቢያዎች የአእምሮ ጤና አገልግሎቶችን የማጣመር አስፈላጊነት እና ዝግጁነት የሚለውን ጥናት ለማጥናት የተዘጋጀ መጠይቅ

ቃለ መጠይቅ #_____

ቀን _____

I. ጠቅላላ መረጃ

እድሜ፡ _____ ፆታ: _____

መ.ያ: _____ የትምህርት ደረጃ:_____

በዚህ ሃላፊነት የቆይታ ጊዜ:_____

II. የአእምሮ ጤና አገልግሎቶችን በጤና ጣቢያ የማጣመር አስፈላጊነት እና ዝግጁነት

1. **የአእምሮ ህመም በማህበረሰቡ ውስጥ በምን ያህል ደረጃ ይገኛል? (ጤና ጣቢያ ለመታከም ከሚመጡ ህመምተኞች መካከል ምን ያህሉ የአእምሮ ጤና እክል ያለባቸው ናቸው?)**
2. **የአእምሮ ጤና አገልግሎት በጤና ጣቢያ መጣመርን እንዴት ያዩታል? (መጣመር ይችላልን? ተቀባይነትስ ይኖረዋል?)**
3. **ጤና ቢሮው የአእምሮ ጤና አገልግሎትን በጤና ጣቢያ ለማጣመር ምን ሚና ይጫወታል? (የአእምሮ ጤና አገልግሎትን ለማስተባበር በጤና ቢሮ የተመደበ ሰው አለ? ሚናው ምንድን ነው?)**
4. **የአእምሮ ህክምና አገልግሎት በወረዳው/ከተማው ጤና ቢሮ ስር በሚገኙ ጤና ጣቢያዎች ውስጥ ምን ይመስላል? (ለአእምሮ በሽታዎች ህክምና አገልግሎት የሚሰጠው ማን ነው? ምን ምን አይነት አገልግሎት ያገኛሉ?)**
5. **ስለ አእምሮ ጤና ፖሊሲ በኢትዮጲያ የሚያቁትን ሊነግሩኝ ይችላሉ? (በዚህ የጤና ቢሮ የአእምሮ ህክምና ፖሊሲ አለ? ግልጽ እና መተግበር የሚችሉ ናቸው? የአእምሮ ህክምና አገልግሎት እቅድ አለ?)**

6. ለአእምሮ ጤና በጀት እንዴት ይበጀታል?(ለጤና ከሚበጀተው በጀት ምን ያህሉ ለአእምሮ ህክምና ይመደባል?በአግባቡ ጥቅም ላይ ይውላል? በጀቱ በቂ ነው?)
7. ለጤና ጣቢያ ሰራተኞች የሚሰጠው የአእምሮ ህክምና ስልጠና ምን ይመስላል? (በቂ ስልጠና ይሰጣሉ? ማን ያሰለጥናቸዋል? በምን ያህል ጊዜ ልዩነት? ለምን አይሰለጥኑም?)
8. በጤና ጣቢያ ለሚገኙ የአእምሮ ህክምና አገልግሎቶች የሚሰጠው ክትትል ምን ይመስላል? (ክትትል የሚያደርገው ማን ነው? በየምን ያህል ጊዜው? ከአእምሮ ህክምና ልዩ ባለሙያወች ጋር ያለው ግኑኝነት ምን ይመስላል?)
9. የማህበረሰቡን አእምሮ ጤና ለመጠበቅ ከሌሎች አጋር እና ባለድርሻ አካላት ጋር ያለው ግኑኝነት ምን ይመስላል? (የትኞቹ አካላት ተሳትፈዋል? የነዚህ አካላት ምላሽም ነበር?)
10. የጤና ጣቢያው ሁኔታ የአእምሮ ህክምና አገልግሎት ለመስጠት ከሚያስፈልጉ ነገሮች አንፃር እንዴት ነው? (የአእምሮ ህመምን ቀድሞ ለመለየት፣ ለመመርመር እና ለማከም የሚያግዙ መመሪያወች አሉ? ምቹ የአገልግሎት መስጫ ክፍልስ?)
11. ለአእምሮ ህክምና የሚያገለግሉ መድሃኒቶች በጤና ጣቢያ ምንይመስላል?
12. የአእምሮ ጤና አገልግሎትን በጤና ጣቢያ ለማጣመር ምን መደረግ አለበት? (ማን ምን ማድረግ አለበት? መንግስት? የጤና ባለሙያ? ማህበረሰቡ? ሌሎች አካላት?)

Appendix VIII: Interview Guide for professionals who took mental health training and psychiatric nurses (Amharic version)

በሰሜን ወሎ ዞን ለሚገኙ የማህበረሰብ ጤና ጣቢያዎች የአእምሮ ጤና አገልግሎቶችን የማጣመር አስፈላጊነት እና ዝግጁነት የሚለውን ጥናት ለማጥናት የተዘጋጀ መጠይቅ

ቃለ መጠይቅ #_____

ቀን _____

I. ጠቅላላ መረጃ

እድሜ፡ _____ ፆታ: _____

ሙያ: _____ የትምህርት ደረጃ:_____

በዚህ ሃላፊነት የቆይታ ጊዜ:_____

II. የአእምሮ ጤና አገልግሎቶችን በጤና ጣቢያ የማጣመር አስፈላጊነት እና ዝግጁነት

1. የአእምሮ ህመም በማህበረሰቡ ውስጥ በምን ያህል ደረጃ ይገኛል? ጤና ጣቢያ ለመታከም ከሚመጡ ህመምተኞች መካከል ምን ያህሉ የአእምሮ ጤና እክል ያለባቸው ናቸው?
2. የአእምሮ ጤና አገልግሎት በጤና ጣቢያ መጣመርን እንዴት ያዩታል? (መጣመር ይችላልን? ተቀባይነትስ ይኖረዋል?)
3. የአእምሮ ጤና ህክምና አገልግሎት በጤና ጣቢያው ምን ይመስላል? (ለየትኞቹ የአእምሮ በሽታዎች አገልግሎት ይሰጣል? ምን ምን አይነት አገልግሎት ያገኛሉ?)
4. የአእምሮ ህክምና ለመስጠት የተሰጠው ስልጠና ምን ይመስላል? (በቂ ስልጠና ይሰጣሉ? ማን ያሰለጥናችሁ? በምን ያህል ጊዜ ልዩነት?)
5. በጤና ጣቢያ ለሚገኙ የአእምሮ ህክምና አገልግሎቶች የሚሰጠው ክትትል ምን ይመስላል? (ክትትል የሚያደርገው ማን ነው? በየምን ያህል ጊዜው? ከአእምሮ ህክምና ልዩ ባለሙያወች ጋር ያለው ግኑኝነት ምን ይመስላል?)
6. የጤና ጣቢያው ሁኔታ የአእምሮ ህክምና አገልግሎት ለመስጠት ከሚያስፈልጉ ነገሮች አንፃር እንዴት ነው? (ለአእምሮ ህክምና የሚያገለግሉ መድሃኒቶች በጤና ጣቢያ ምንይመስላል? የአእምሮ ህመምን ቀድሞ ለመለየት፣ ለመመርመር እና ለማከም የሚያግዙ መመሪያወች አሉ? ምቹ የአገልግሎት መስጫ ክፍልስ?)
7. የአእምሮ ጤና አገልግሎትን ለማጣመር ምን መደረግ አለበት? (ማን ምን ማድረግ አለበት? መንግስት? የጤና ባለሙያ? ማህበረሰቡ? ሌሎች አካላት?)

Letter of Declaration

I, the under signed, declared that this is my original work, has never been presented in this or any other University, and that all the resources and materials used for the research, have been fully acknowledged.

Principal investigator: Semira Muhidin (BSc in Public Health)

Signature: _____

Date: _____

1st Advisor: Ayinengida Adamu (MPH, Assistant Professor)

Signature: _____

Date: _____

2nd Advisor: Melese Belayneh (MPH)

Signature: _____

Date: _____

Internal examiner: Gebeyehu Tsega (MPH, Assistant Professor)

Signature: _____

Date: _____