

**MENTAL HEALTH, WHERE ARE WE NOW? A SOCIOLOGICAL ANALYSIS OF  
THE INTEGRATION OF MENTAL HEALTH INTO PRIMARY HEALTHCARE IN  
THE KINGDOM OF ESWATINI.**

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## ABSTRACT

This is a qualitative study exploring the integration of mental health into primary healthcare in the Kingdom of Eswatini. Primary healthcare forms the basis of any healthcare service provision. Primary Healthcare for mental health is an essential component of any well-functioning health system. Making mental healthcare available in primary healthcare allows for early detection and early treatment while it is still easier and cheaper. Purposive sampling was used to recruit nurses and a government official in the Hhohho region in the Kingdom of Eswatini. The study found that there are major challenges in the primary health care clinics, and this negatively affects the WHO (2001) proposal on mental health integration into primary health care. This finding is similar to other low-income countries' challenges in mental health integration into primary health care. The impact of neo-liberal policies on healthcare in Eswatini is explored and it is clear these policies impact the ability of the Ministry of Health to provide health care. The study also drew on the symbolic interaction perspective to understand the meanings that nurses attach to mental illness and their experiences mental health care.

## DEDICATION

*I dedicate this thesis to my parents, Mandla and Lungile Dlamini,  
For their endless love and sacrifices for my siblings and I.*

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It would be foolish of me not to acknowledge God, the anchor of my life. I would not have been able to do any of this without Him. He has been too good and too faithful; my mouth will forever sing His praise.

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## LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CHAG	Christian Health Association of Ghana
CMH	Community Mental Health
DOH	Department of Health
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
MDGs	Millennium Development Goals
MhGAP	Mental Health Gap Action Programme
MHaPP	Mental Health and Poverty Project
MHI	Mental Health Integration
MHL	Mental Health Legislation
MHSW	Ministry of Health and Social Welfare
MOH	Ministry of Health
NGOs	Non- Governmental Organisation
PHC	Primary Health Care
SNPH	Swaziland National Psychiatry Hospital
TB	Tuberculosis
UHC	Universal Health Coverage
UN	United Nation
UNESWA	University of Eswatini
WHO	World Health Organisation

# CHAPTER ONE: AN INTRODUCTION

## 1.1 Introduction

This study examines the integration of mental health into the primary healthcare system in Eswatini. The main motivation for this study is the fact that mental illness is escalating globally, and because mental and spiritual health is vital for individuals, and well-functioning societies (WHO, 2003:4). According to the WHO Mental Health Atlas country profile of 2014, Eswatini does not have an existing mental health policy. It does however, have mental health legislation, which was last revised in 1978 (WHO, 2014). There is no recent mental health data in Eswatini, and the health policy, updated in 2006, does not include mental health care strategy or resource allocation towards mental health care (WHO, 2014: 1). The status of mental health care in Eswatini is elaborated on in this chapter. The chapter also provides the research methodology and an outline of the thesis.

## 1.2 Global Mental Health

Mental health is defined “as the state of well-being enabling individuals to realize their abilities, cope with the normal stresses of life, work productively and fruitfully, and contribute to their communities” (WHO, 2003: 4). The challenge that is faced by countries all over the world is that mental health and mental disorders are not given the same degree of importance as physical health, they have been neglected and ignored (WHO, 2003: 4). Mental health and mental illness is determined by multiple social, psychological, and biological factors. Mental illnesses are among the most common conditions affecting health today, both in developing and developed countries (Ganasen *et al.*, 2008: 23). According to WHO (2003: 4), as many as 450 million people suffer from a mental or behavioural disorder, and nearly 1 million people commit suicide every year around the world.

Mental illness is not just a burden on the individual who is experiencing the illness, but also on the community at large, and therefore mental health should be an area of concern for the government (Ganasen *et al.*, 2008). As Votruba *et al* (201: 283) point out, mental disorders and mental illnesses are among the most pressing development issues being faced globally, as they put a strain on families, communities, and economies. Mental disorders in developing countries have been reported to be at least as common as that in developed countries, yet mental healthcare services provided in developed countries are significantly better in terms of quality and the availability of services than in developing countries (Ganasen *et al.*, 2008). Skeen *et al.*, (2010) argue that mental health is a crucial public health and development issue in Sub-

Saharan Africa. This is a region where little progress is made towards achieving the Millennium Development Goals (MDGs). They argue that it is impossible to achieve some of these aspirations without addressing mental health concerns, as they are strongly linked to the dimensions of human development represented in the MDGs (Skeen *et al.*, 2010: 624). As summed up by WHO (2001: 1), “...there is no health without mental health”.

In low to middle-income countries, such as Eswatini, between 76% and 85% of the people with severe mental disorders do not receive treatment, this is compared to 35% and 50% in high-income countries (WHO, 2013: 10). Economic injustice in the developing countries not only influences the provision of mental health care services, but also has an indirect influence on mental health (Ganasen *et al.*, 2008: 24). Many developing countries have deficient mental health care policies that do not allow for the protection of people with mental illnesses. Mental health legislation (MHL) is important as a regulatory framework for mental health services and other providers of treatment and care (Ayano, 2018: 1). It is also important in ensuring that the public and people with mental illness are afforded protection from the often-devastating consequences of mental illness.

### 1.3 Eswatini

The kingdom of Eswatini, previously known as Swaziland, is in southern Africa.

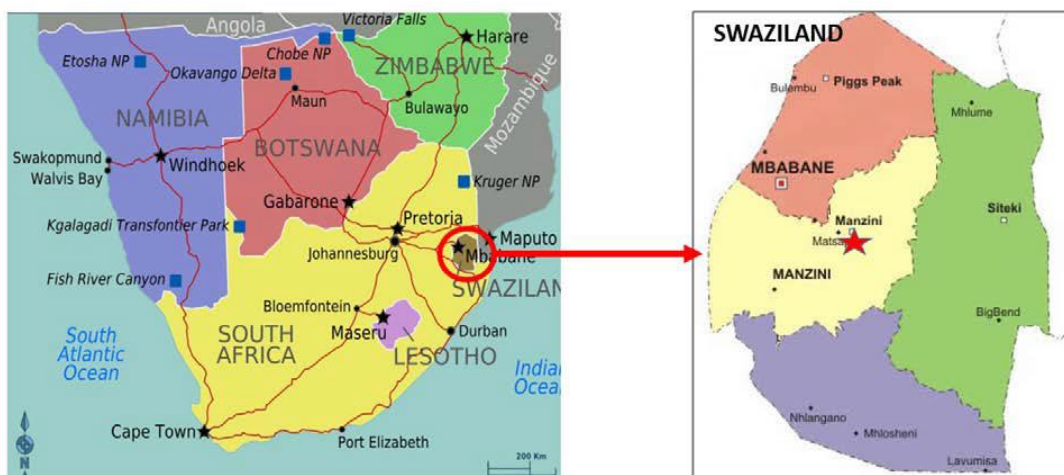


Figure 1 Map of Southern Africa with Swaziland (Google Map)

### 1.3.1 General Health and Mental Health Care in Eswatini

“...The absence of mental illness is not the presence of mental health”

(Keyes & Michalec, 2010: 134).

The country's health care system consists of the formal and the informal sector, and the latter consists of traditional health practitioners and other unregulated health service providers. The health service that is based on western medicine is considered to be formal and consists of public and private health services (MHSW, 2006: 8). The service delivery system of the Swaziland Health Sector is loosely organized in a four-tier system: three national Hospitals (referral); five regional hospitals; primary health care (PHC) facilities including Health centres, public health units, rural clinics and a network of outreach sites; community based care where rural health motivators (RHM), faith-based healthcare providers, traditional births attendants, volunteers and traditional practitioners provide care, support and treatment (Ministry of Health, 2010: 2).

Eswatini has a decentralised healthcare system in four regions and each of these regions has one general hospital, and three of these have psychiatric units (Hlatjwayo, 2000: 12). In addition, there are four community mental health centres that are unevenly distributed in the country. There is only one national psychiatric hospital situated in Manzini, which is in the centre of the country (The Ministry of Health, 2018). The psychiatric units attached to the main hospitals admit a limited number of patients with acute mental disorders, or those requiring supervision (Hlatjwayo, 2000: 12). Other cases are then referred to the National Psychiatric Government Hospital. The Swaziland National Psychiatry Hospital (SNPH) is a 150-bed psychiatric hospital, located at Manzini (WHO, 2011). All the mental health centres provide outpatient community services which involve: psychotherapy, counselling services, health education to the public, and social welfare (Hlatjwayo, 2000: 12). There are limited mental health services provided at (PHC) level in Eswatini. The country's health system faces intricate human resource demands, which are also characteristic of health systems in many other African countries.

A study by Nxumalo-Ngubane (2016), found that the Eswatini government is the primary source of funding for the country's health sectors. However, business and religious organisations contribute to some of the community-based health facilities (Ministry of Health and Social Welfare, 2006: 7). The public pays a subsidised fee for all public health services however, treatment and management of mental illness-related conditions are provided free of

charge. In 1983 the ministry of health introduced the PHC strategy, in its endeavour to deal with the country's major problems: maternal and child health; infectious and communicable diseases; and nutritional deficiency (Nxumalo-Ngubane, 2016: 7, MOH, 1983). While the problems listed did not include mental illnesses, during subsequent years, the country experienced an increase in the number of admissions to the SNPH, an indication that the prevailing physical problems had adverse effects on people's mental well-being (Nxumalo-Ngubane, 2016: 7, MOH, 1983). As stated earlier, according to WHO (2014: 1), Eswatini has no recent mental health data and in the currently existing health policy, updated in 2006, there are no indications of resource allocations towards mental health as well as no mention of a mental health care strategy by the Ministry.

As noted above, although Eswatini has mental health legislation in place that was last amended in 1978, it has neither an officially approved mental health policy nor a mental health plan, and the general health policy does not mention mental health (MHSW, 2006; WHO, 2014). A media article on mental health reported that there are no legal provisions for mental health covered under welfare, disability, and general health legislations (Swazi Observer 2016: 19). This lack of mental health care policy and practice is concerning given the high rate of mental health-related suicides. According to the National Psychiatry's, Dr Violet Mwanjali (quoted in Apanews.net 2017), 125 people committed suicide in the past 12 months, and most of the cases were a result of depression. The report showed that 102 of the suicides were committed by men while 23 of the victims were female and most of these suicides are committed by people between age 13 and 32. This supports Nxumalo-Ngubane's (2016: 18) finding that mental illness in Eswatini is most prevalent amongst 25 to 45 years old. This age group is the most economically active and the high incidence of mental health challenges negatively impacts economic development.

As noted by the WHO (2003: 25), talking about mental disorders means talking about poverty because the two are interlinked, and mental illness generate costs due to long-term treatment and lost productivity. For example, Ganasen *et al.*, (2008: 24) note that in 11 prevalence studies conducted in Lesotho, Zimbabwe, Indonesia, Pakistan, Brazil and Chile; there was a statistically significant relationship between the prevalence of mental disorders and indicators of poverty. Various factors associated with poverty such as: insecurity, low educational levels, inadequate housing, violence, physical abuse and malnutrition underlie the greater vulnerability to mental illness (WHO 2003, Ganasen *et al.*, 2008: 24). This creates a

further burden since there is a lack of resources to draw from when a poor household is faced with illness. If mental health services are not made easily accessible to the public, it is a significant cost to people who must travel long distances to access mental healthcare. This further worsens the economic conditions of the already poor- the group more prone to mental illness and causes a financial strain on the economy (Ganasen, *et al.*, 2008: 24). Like the countries mentioned above, Eswatini has a high prevalence rate of poverty and mental illness as it is in the low to middle-income group (World Bank, 2010).

### 1.3.2 Primary Health Care and Mental Health

Primary Health Care is defined as “what happens when someone who is ill (or who thinks is ill or wants to avoid getting ill) consults a health professional in a community setting for advice, tests, treatments or referral to specialist care” (Greenhalgh, 2007: 2). In addition, it not only includes the care that individuals get before they enter the hospital with serious illness, but also the care that individuals receive after they are discharged. In some countries it includes pharmacy services, optometry and dental care, as well as community-based nursing services (Greenhalgh, 2007: 2). The Declaration of Alma Ata, issued on September 12, 1978, provides a moral vision for PHC that remains valuable in many countries today (Hixon & Maskarinec, 2008: 585). The declaration stressed that PHC should be the main strategy used to deal with health problems in the community (Hlatjwayo, 2000: 13). Walley *et al.*, (2008: 1001) argue that PHC is an approach to achieve both MDGs and the wider goal of universal access to health through acceptable, accessible, appropriate, and affordable healthcare. PHC, if implemented, would advance health equity in all countries rich and poor and, as a result, promote human and national development (Walley *et al.*, 2008: 101). Mental healthcare provided within PHC is the first level of care within the formal health system (WHO, 2008: 17). This is why this study is exploring the lack of integration of mental healthcare into Eswatini PHC.

Inadequate mental health care may be defined in terms of a range of different indicators such as; the number of psychiatrists per population, the availability of psychotropic medications, and the level of integration of mental health services in primary care (Ganasen *et al.*, 2008: 23). Integrating mental health into primary healthcare is widely promoted for a host of reasons, the greatest being providing a more comprehensive health care service (Bhana, *et al.*, 2010: 599). Since 2008, the WHO, through its health Gap Action Programme, has attempted to revitalise efforts to integrate mental health into non-specialised healthcare, like PHC (Ventevogel, 2014: 669). It is acknowledged that integrating mental health services into

routine primary healthcare was one of the significant challenges in the global mental health services (Collins *et al.*, 2011; Ventevogel 2014: 669).

Benefits of integrating mental healthcare into primary healthcare are significant (Funk *et al.*, 2008a: 5). When patients can receive effective care at their familiar clinic setting for their mental and physical health, coordinated between their doctor and their broader health care team, their overall functioning in their life is improved and sustained (Reiss-Brennan, 2014: 59). Literature shows that mental health integration (MHI) enables the elimination of the breach between physical healthcare and mental health care, making them a comprehensive whole (Reiss-Brennan, 2014: 56-57; Ventevogel 2014: 669). Another advantage is that it is more accessible, and a recognition that people with mental disorders often have significant acute and chronic physical problems that may lead to worse health outcomes (Ventevogel, 2014: 669). For example, Hugo *et al.* (2003) in their study found that one of the reasons that prevent people from finding out about their mental illness early is the lack of mental illness detection at PHC.

Eswatini is one of the WHO member states that adopted and implemented the PHC philosophy through different structures and strategies that address it within the country's healthcare system (Hlatjwayo, 2000: 13). In the current health policy, Eswatini aims to "improve the health and social welfare status of the citizen by providing preventive, promotive, curative and rehabilitative services that are of high quality, relevant, accessible, affordable, equitable and socially acceptable." (MHSW, 2006: 10). There is, however, limited documentation of the strategies set for mental healthcare to achieve the objectives of PHC in the country (Hlatjwayo, 2000:13). Literature shows that the PHC endeavours since 1983 have primarily focused on maternal and under five child health and family planning to the neglect of school-age children (Sukati, 1997: 764). There is a dearth of research on mental health in Eswatini, and few studies have been conducted on the integration of mental health into PHC.

#### 1.4 Goals of the Research

The primary goal for this research was to explore and understand the extent of the integration process of mental health into primary healthcare in the Kingdom of Eswatini. The secondary goals were:

- To gain knowledge and understanding of the primary healthcare in Eswatini;
- To examine and analyze the respondent's views on the mental health integration into primary healthcare;

- To examine and analyze the role that the government has played in the process of mental health integration into primary healthcare.

To achieve above goals, the study sought to answer the following key questions:

- What is the status of the Eswatini mental health integration into PHC?
- What level of mental health care is provided at PHC, and what are the mental healthcare experiences of PHC health providers?

### 1.5 Research Methodology

This is a qualitative study that used social constructivism perspective, and thematic interpretative data analysis (Denzin & Lincoln, 2003: 3). A qualitative study provides a detailed description and analysis of the quality, or the substance, of the human experience (Marvasti, 2004: 7). Qualitative research enables an understanding of everyday social reality of participants which offers contextual richness (Yin, 2016: 3). This approach enabled an in-depth understanding and analysis of the MHI in PHC in Eswatini. Data collection was done through semi-structured in-depth interviews, which allow for flexibility of the interview (Baily, 2018: 107) (Appendix A). An interview in qualitative study provides opportunities for mutual discovery, understanding, reflection and explanation, and semi structured interviews involve the use of open-ended questions that act as an interview guide (Baily, 2018: 105; Tracy, 2013: 132).

The study employed purposeful sampling, which means that researchers purposefully choose respondents that fit the parameters of the project's research questions, goals, and purposes (Tracy, 2013: 134). Purposive sampling was used to select five primary healthcare nurses from clinics in the Hhohho Region, and a Director of Health Services at the Ministry of Health. This study used thematic analysis which is a qualitative research method that is widely used across a range of epistemologies and research questions (Nowell *et al.*, 2017). It is a method for identifying, analysing, organizing, describing, and reporting themes found within a data set (Braun & Clarke, 2006; Nowell *et al.*, 2017). The data was grouped into themes and analysed and interpreted drawing on the study's theoretical framework and reviewed literature.

The ethics of social research have to do with the nature of the researcher's responsibilities in this relationship, or the things that should and should not be done regarding the people being observed and written about (Marvasti, 2004: 133). To ensure that this research was conducted in an ethical manner, the following measures were applied:

- Ethical clearance was granted by the Sociology Department and ratified by the Rhodes University Ethics Standards Committee (Appendix B)
- Ethical clearance was obtained from the Eswatini National Health Research Review Board (Appendix C)
- The study was approved by the Ministry of Health with permission to interview PHC nurses and health officials (Appendix D)
- Informed consent (Appendix E)

## 1.6 Dissertation Outline

Chapter 1 provides a contextual introduction to the study, and the research methodology. Chapter 2 provides a review of literature on mental health and mental health integration into primary healthcare. Chapter 3 outlines the theoretical framework underpinning the study. Chapter 4 provides data analysis and findings from the data collection. Chapter 5 includes the conclusion to the study, recommendations, the limitations of the study, and considerations for future studies.

## CHAPTER 2: A LITERATURE REVIEW

### 2.1 Introduction

This chapter reviews the health policy in Eswatini, and it includes the aims and goals of the Ministry of Health in Eswatini. In addition, the chapter discusses the 1978 WHO Alma Ata Declaration which governs primary health care (PHC) in the United Nations (UN) member countries. This provides a background and a better understanding of the main goals and objectives of a PHC system and enables a better analysis of the integration of mental health into PHC in Eswatini, which is the goal of this study. A review of studies on mental health integration (MHI) into PHC in some African countries is also included.

### 2.2 Health Policy in Eswatini

The current Eswatini health policy was updated in 2006, a much-needed update since the last health policy was in 1983, 23 years earlier. The 1983 health policy focused on preventative health services such as: health education, promoting food supply and proper nutrition, improving access to clean water and basic sanitation, promoting maternal and child health, improving treatment of common diseases and injuries, and providing essential drugs (MHSW, 2006: 6). The health policy is under MHSW whose main goal is “to improve the health and social welfare of the people of Swaziland by providing preventative services that are of high quality, relevant, accessible, affordable, equitable and socially acceptable.” (MHSW, 2006: 1). The MHSW had set goals to develop into an efficient and effective service by the year 2015 (MHSW, 2006: 1). According to the Minister of Health in 2006, one of the aims was to develop a policy based on an in-depth analysis of the national health system's responsiveness to current challenges, and key policy issues were identified (MHSW, 2006: 3). The key policy directions outlined in this document include the following: organization and management of services, coordination of sectoral services, human resources, quality assurance, health financing, infrastructure development and equipment management, and the provision of public health and clinical services. These are the areas that the drawers of this policy believed were the most pressing in the country, in the year of 2006. There is no indication as to when the policy will be reviewed. This policy needs another update that should include the integration of mental health into PHC as Eswatini has yet to fully implement the WHO Alma Ata Declaration.

However, the formal health sector in the country is based on the concepts of primary health care and decentralization. Its infrastructure is made up of seven government hospitals, two mission hospitals and one industry supported hospital (MHSW, 2006: 8). In addition, there

are eight public health units, twelve health centres, seventy-six clinics and one hundred and eighty-seven outreach sites. There are seventy-three mission health facilities (health centres, clinics and outreach sites), sixty-two private clinics and twenty-two industry-supported health centres and clinics (MHSW, 2006: 8). Currently, there is no functional referral system for the rationalization of service delivery at the various levels, which lead to congestion at the tertiary (referral) facilities with patients that could have been attended to at lower levels (MHSW, 2006: 8).

As previously mentioned in Chapter 1 and above, the providers of health services include government, religious organizations (mission), industry and private practitioners (MHSW, 2006: 9). The health sector in Eswatini, as in most African countries, is facing challenges such as having a few medical professionals, especially doctors and nurses. For example, the MHSW notes that more than half of the nurses are employed in private facilities. This imbalance between public and private practice, between rural and urban areas inevitably leads to shortages of staff in the public sector and difficulty in filling vacant posts. A positive for Eswatini is that an estimated 85% of the population lives within a radius of 8 kilometres from a health facility (MHSW, 2006: 9). However, the availability of health services is negatively affected by the distribution of resources, especially human resources such as nurses and doctors. As in many developing countries, the distribution of resources tends to favour urban over rural populations. In addition, the health sector's funding is limited and has continued to decline from 9.4% of the national budget in the 1980s to an average of 7.1% from 2001 (Ministry of Finance, 2005; MHSW, 2006).

It is important to note that investment in health is declining at a time when demand for health services is increasing as a result of the HIV and AIDS pandemic. The allocation of public health expenditures is biased in favour of less cost-effective urban-based curative health interventions, and central administration (MHSW, 2006: 10). Approximately 72% of the national health budget is absorbed by curative services in spite of a call by the 1983 National Health Policy for increased investment in preventive and promotive health activities (MHSW, 2006: 10; World Bank, 2006). According to the MHSW (2006: 5), Eswatini has the highest proportion of government health spending dedicated to curative services in all of Sub-Saharan Africa. It spends approximately 3.8% of GDP on health care (including private sector) of which 60% comes from Government and the rest comes from development partners, the private sector, and individuals. Households, however, are increasingly taking on a larger responsibility

of funding health care as government and donor health spending has been shrinking in past years (MOH, 2010; MHSW, 2006).

According to Eswatini Health Policy, two key concerns for the government are Tuberculosis and HIV/AIDS as during the drafting of the policy, these were the main issues at hand (MHSW, 2006: 8). Although malaria is an endemic in some parts of the country, it was seen to be under control as opposed to TB and HIV/AIDS. Non-communicable diseases that cause death in the country are hypertension and heart-diseases, and these can be diagnosed at primary health care facilities (MHSW, 2006: 8). Of interest to the current study, there is no discussion of the mental health policy and care in the country. According to the MHSW (2006: 26), the 2006 health policy addresses priority areas relating to health service delivery and major health interventions, and resources for health. The side-lining of mental health in the health policy raises multiple questions that this research seeks to understand. If the ministry believes that the health policy covers all priority areas in the country, why is it that mental health is not covered? Could it be that mental health is not an area of concern in the Kingdom of Eswatini?

Unfortunately, it is not mentioned how the ministry went about identifying the key concern areas and choosing the priority areas in the country. For example, issues around financing should be given same consideration as other identified areas of concern. As previously mentioned Eswatini, like most low-income countries, relies on external donors to fund the health sector. For a long time, the country has struggled with a high rate of HIV/AIDS and this is one of the illnesses that donors tend to inject much of their money in. As Shiffman (2007) argues that the donor prioritisation of HIV/AIDS has displaced aid for other health issues. The country, like other sub-Saharan countries, has a dual epidemic of TB and HIV, with 71% of all people who have TB also living with HIV (HIV and AIDS in Eswatini, 2018). To tackle the problem, Eswatini started a programme of strengthening and integrating TB/HIV services. These services have been decentralised and are now offered in a 'one-stop-shop', where people can seek screening for TB and HIV testing, as well as being able to pick up their treatment for both at the same time (HIV and AIDS in Eswatini, 2018). Advocates for many developing-world health and population issues have expressed concern that the high level of donor attention to HIV/AIDS is displacing funding for their own concerns (Shiffman, 2007). While concerns have been raised, the precise effects of donor prioritization of HIV/ AIDS on donor funding for other health issues have not been examined. According to Hlatjwayo (2000: 5), there is a high rate of mental or psychosocial problems amongst clients visiting PHC settings who seek treatment for physical complaints. However, the mental conditions are frequently

missed during diagnoses, and therefore inappropriately managed. Even though evidence of this is not documented in Eswatini, from studies done elsewhere, as will be discussed later, there is evidence that the demand for mental health care at PHC settings has increased as a result of poverty, high crime and violence rates, unemployment and many other social problems that have been observed in the region alongside the burden of HIV/AIDS (Hlatjwayo, 2000: 5-6).

### 2.3 The Alma Ata Declaration and Primary Health Care

As discussed in Chapter One, the International Conference on Primary Health Care held in Alma Ata, USSR, made an urgent call for the world community to come together to improve global health (Hixon and Maskarinec, 2008: 585). The Alma Ata Declaration continues to be the socio-political cornerstone that expresses the foundation of PHC (Hixon and Maskarinec, 2008: 585). The Declaration subscribes to the WHO definition of health in saying that health is “a state of complete physical, mental, and social well-being and not merely the absence of disease” and declares health to be a fundamental human right (Hixon and Maskarinec, 2008: 585). The declaration also advocates for countries to look at health in a comprehensive manner. It states that health systems should grow from specific economic, political, and socio-cultural conditions of countries and communities. The health care system should be able to address issues of education, nutrition, food supply and clean water because all these systems work together. This calls for an intersectoral collaboration between all different sectors for adequate health care delivery. Health care workers are also encouraged to collaborate as teams. The Declaration prioritizes healthcare to those in need and therefore calls all governments to be held responsible for the health of their people which can be fulfilled only by the provision of adequate health and social measures.

The Declaration encouraged all countries to formulate national policies and strategies to sustain PHC as part of a comprehensive health system that works with other sectors. As previously mentioned, Eswatini is one of the countries that adopted the Alma Ata Declaration however, there is little documentation available on the implementation of the Alma Ata Declaration. The goals of primary care for all were projected to be attained by the year 2000 (Hixon and Maskarinec, 2008: 3).

#### 2.3.1 WHO Integration of Mental Health into Primary Health Care

Action around MHI into PHC was advocated for in the WHO world health report in 2001. The report aimed to raise public and professional awareness of the real burden of mental disorders and their costs in human, social and economic terms (WHO, 2001: xii). The report

was also aimed at dismantling barriers of stigma, discrimination, and inadequate services which prevents millions of people, globally, from receiving the treatment they need and deserve (WHO, 2001). It provides a new hope for mental health and mental illness in the world, by suggesting ways in which governments can provide better mental health care services to the people. It also provides a new understanding of mental disorders that offers new hope to the mentally ill and their families. It also examines the scope of prevention and the availability of, and obstacles to, treatment. It deals in detail with service provision and planning; and it concludes with a set of far-reaching recommendations that can be adapted by every country according to its needs and its resources. It is a comprehensive review of what is known about the current and future burden of disorders, and the principal contributing factors (WHO, 2001)

WHO (2001: 110-112) recommends that governments should: provide treatment in primary care, make psychotropic drugs available, give care in the community, educate the public, involve communities, families and consumers, establish national policies, programmes and legislation, develop human resources, link with other sectors, monitor community health, support more research. To encompass these recommendations, the WHO (2008: 21-22) identifies seven good reasons for the integration of mental health. First, the burden of mental disorders is huge therefore making mental health care available in PHC level reduces this challenge. Second, mental and physical health problems are interwoven, and many people suffer from both conditions, thus integrating mental health into PHC ensures that people receive holistic treatment. Third, the treatment gap for mental disorders is enormous meaning that the prevalence of mental disorders does not match up to the available treatment. Fourth, PHC for mental health enhances access, making it easier for people to get the help that they need. Fifth, the PHC for mental health promotes respect of human rights, as it minimizes stigma and discrimination, and the violation of human rights that occur in psychiatric hospitals. Sixth, PHC for mental health is affordable and cost effective, less expensive than psychiatric hospitals for both government and the patient. Finally, PHC for mental health generates good health outcomes. This is why the main objective for the current study is to analyse how Eswatini has attempted to implement the WHO recommendation of integrating mental health care into PHC.

#### 2.4 Case Studies on Integration of Mental Health into Primary Health Care

PHC for mental health is an essential component of any well-functioning health system, however, for it to be effective and efficient, primary care for mental health must be complemented by additional levels of care (WHO, 2008). These include secondary care components to which PHC workers can turn for referrals, support and supervision. Mental

health care provided within general primary care services is the first level of care within the formal health system (WHO, 2008: 17). Essential services at this level include early identification of mental disorders, treatment of common mental disorders, management of stable psychiatric patients, referral to other levels where required, attention to the mental health needs of people with physical health problems, and mental health promotion and prevention (WHO, 2008: 17). The above discussions show how the benefits of integrating mental health into primary health care are significant (Funk, Saraceno, Drew & Faydi, 2008: 5). In developed countries, PHC is provided mainly by medical doctors whereas in low- and middle-income countries, nurses provide most primary care (Reiss-Brennan, 2014). For example, as mentioned earlier, PHC is provided mainly by nurses in Eswatini.

The WHO MHI recommendations are based on the fact that contemporary scientific medicine is based on a tradition of treating mental illnesses separately from physical diseases based on the assumption that diseases occur independently of social context (Reiss-Brennan, 2014: 55). Integrating mental health into PHC system has the advantage of being more accessible and recognises that people with mental illnesses are also significant, and that other chronic physical health problems that may lead to worse health outcomes. (Reiss- Brennan, 2014: 699). Many people with undetected mental disorders will first visit a general healthcare; a gateway to care. Integrating mental health into non-specialised healthcare/ PHC can improve both mental health and physical health outcomes. When mental health is treated as separate from physical health, the healthcare experience is fragmented (Reiss-Brennan, 2014: 55). Another reason for integration is to remove the stigma that comes with going to a psychiatric centre or hospital (Reiss-Brennan, 2014: 55, Ventevogel, 2014: 699).

MHI is defined as a “standardized clinical and operational team relational process that incorporates mental health as a complementary component of wellness and healing for life.” (Reiss-Brennan 2014: 55). In a study, *Mental Health Integration: Normalizing Team Care*, Reiss-Brennan (2014) notes how the integration model goes far beyond the doctor- patient relationship as it is a team-based approach where complementary roles include the patient and the family. This means that MHI differs from collaborative care models because it is a standardized system in which a key focus is on primary care providers continuing to provide appropriate levels of mental health care within a high functioning team (Reiss- Brennan 2014: 55). The MHI team ideally includes all the primary care physicians (PCPs) and nurses, mental health professionals, community advocates, the patient, and the family. This multidisciplinary team is organised under the leadership of the clinic physician in partnership with patient and

family. From this we can deduce that MHI is not merely about making mental health services available at primary healthcare, but it involves multiple stakeholders who each have an important role to play. For MHI to be effective, each member of the team is trained in specific responsibilities that contribute to a collective holistic care plan (Reiss-Brennan 2014: 56).

Furthermore, effective integration of mental healthcare into primary care require systematic and pragmatic change that builds on the strengths of both mental health and primary care (Thielke, Vannoy & Unutzer, 2007: 571). As Reiss-Brennan (2014) argues, MHI is a team-based care approach, and until it is recognised and treated as such, the benefits of MHI will not be seen. Team-based care, such as MHI, requires a fundamental change in physicians' mind-sets (Reiss-Brennan, 2014: 56). Many practices claim to have teams, but the physicians provide all the care and delegate tasks to staff or refer to specialist physicians. For example, a MHI innovation has been adopted by a medical group that provides community care for more than 800 000 patients and their families per year in the state of Utah in USA (Reiss-Brennan, 2014: 56). It has been diffused in different primary care settings such as family medicine, paediatrics, and internal medicine, and this has shown positive results.

The Reiss-Brennan (2014) study evaluated the effectiveness and quality of MHI by analysing experiences of patients treated with depression and their interaction with doctors. The specific aims were to identify the key factors in patient and staff social interactions underlying the improved outcomes observed in MHI clinics. The study found that patients treated in clinics where MHI was routinised had experienced team treatment and positive outcomes. It found that MHI adds complementary roles to an established relationship between patients and doctors, and their clinics; which normalises mental health as part of health. There has been a long-standing call for MHI into PHC from early 1970s. Calls have been made to decentralise psychiatric hospitals into basic psychiatric care (Carstairs, 1973). For example, Giel & Harding (1976) argued that one of the ways in which mental health care can be improved is through the integration of mental health services into primary health care. And the Alma Ata declaration of 1978, continues to be the socio-political cornerstone expressing the moral underpinnings of primary health care (Hixon, Gregory & Maskarinec, 2008: 585). In all these suggestions, the emphasis has been on the need for PHC workers' training in the recognition and management of mental disorders, which must be complemented by a system of supervision and support (Reiss-Brennan, 2014: 670).

Despite the calls for MHI into PHC, the reality is that in many countries primary healthcare services have been unable to offer mental healthcare. Research shows that there have been different initiatives within low-income countries to treat mental illnesses but they were unable to be sustained due to lack of funding from government or local partners (Schulsinger & Jablensky 1991; Kleinman, 2013). As a response, the WHO (2008) introduced the mental health Gap Action programme (mhGAP). The WHO (2008) aims to provide health planners, policy-makers, and donors with a set of clear and coherent activities and programmes for scaling up care for mental, neurological and substance use disorders through the mhGAP. The mhGAP manual comes with supportive materials such as a training package for a five-day basic training for case-identification, and a ten-day training for clinical interventions (Ventevogel, 2014: 671). It also has versions of supervision manuals and training materials for community health workers as well as materials for policy guidance. However, the mhGAP has been criticised for various reasons.

Firstly, the programme has been criticised for clustering mental illnesses that are bio-generic such as dementia, and psychosis, with those that are not proven to be generic such as depression and anxiety (Ventevogel, 2014: 672). Another critique is that the mhGAP encourages the medicalisation of society (Ventevogel, 2014: 671). Conrad (1992: 209) defines medicalization as a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders, such as depression and anxiety. Zola (1983:295) defines medicalization as a "process whereby more and more of everyday life comes under medical dominion, influence and supervision." For example, in the past; depression was not recognised as an illness, as for most people it was just a constant feeling of detecting that something was wrong, but they were unable to pin point what exactly the problem was (Nicholson and McLaughlin, 1987). Horwitz and Wakefield, (2007) argue that many dysphoric emotional states that are often tied to life circumstances and socio-economic factors have been progressively re-framed as mental disorders. Research shows that this is something that has been identified as a concern in low-income countries (see Watters, 2010; White, 2013: & Ventevogel, 2014: 671). This could explain why low-income countries, like Eswatini, are said to have high rates of mental illnesses. The medicalisation of society could lead to the classification of many emotional states due to the poor living conditions, unemployment, and other socio-economic factors as mental illnesses needing medical treatment.

However, the concept of medicalisation has also been criticised. In as much as it is used as a tool of social control (Illich, 1975), we cannot negate the fact that some people are unable to label their experiences until they are aware of the medical term for it (Nicholson and McLaughlin, 1987). For example, in a study I conducted in 2017 on the public knowledge and beliefs about mental illnesses in South Africa, a participant expressed that for a long time she knew that she was not okay. She said:

I have experienced mental illness. I knew that something was wrong, I could feel it but was I just overreacting? I was only able to speak to a psychologist when I came to University in 2014. That was the only time a diagnosis was made. I have been suffering from depression since I was 13. When I did eventually open up to my parents they shut me down completely. That did not help me at all. I did not know what to do. I started reading about it on Google. I thought I was or maybe I am being dramatic or maybe it was PMS; but what kind of PMS? I asked myself. I did not know what was happening; I thought that I was being dramatic.

\*(Amanda, Rhodes University, Grahamstown, 2017)

It was not until she went to see a psychologist that she became aware that she had depression and was successfully treated. As Nicholson and McLaughlin (1987:118) argue that displaying the social and contextual nature of knowledge and how medical categories emerge does not necessarily mean the knowledge is false. This means that even though medicalisation researchers may argue that many dysphoric emotional states are now categorised as medical conditions, it does not mean that the medical knowledge is false.

## 2.5 Integration of Mental Health into Primary Health Care in Africa

This section reviews studies on MHI into PHC conducted in six African countries, namely Rwanda, Ghana, South Africa, Uganda, Zambia, and Eswatini

### 2.5.1 Rwanda

The integration of mental health into PHC is not a foreign concept especially in African countries. For example, Smith *et al.*, (2017) investigated the integration of mental health care into PHC in a rural district in Rwanda. They note that the Republic of Rwanda has the highest population density in Africa, with an estimated population of twelve million people covering an area of about 26, 338 square kilometres. The study further notes that when post genocide reconstruction occurred, the government began to decentralise health system management to the districts in order to provide equitable health care that is close to communities. Within a short time, every district in Rwanda had a functioning referral hospital, with each hospital associated with eight to twenty primary care health centres. The health centre package of

activities encompass health promotion and prevention activities, as well as curative care and management of chronic illness (Republic of Rwanda, 2011a). According to Smith *et al.*, (2017: 138), over the past half century, mental health care in Rwanda was primarily provided by one central neuropsychiatric hospital, which was established in the early 1970s by a Catholic charity organisation. The government of Rwanda then later created a Division for Mental Health within the Ministry of Health in 1995 (Smith *et al.*, 2017: 138).

Due to its political and genocide history, the prevalence of mental health disorders in Rwanda is very high and this includes high rates of depression and post-traumatic stress related disorders (PTSD) (Munyandamutsa, *et al.*, 2012). Rwanda has a mental health policy which supports the integration of psychiatric services into general districts of health systems (Republic of Rwanda, 2011b). The government recognizes, through the Mental Health National Plan, that the improvement in access to mental health services is to integrate mental health into primary care services (Republic of Rwanda, 2011b; Smith *et al.*, 2017: 138). This integration of mental health care into primary care uses a task sharing approach by delegating the tasks and responsibilities of mental health care from more specialised mental health clinicians to less specialised primary care providers (Smith *et al.*, 2017: 138). However, like most countries in Africa, Rwanda faces challenges of limited national budget for public mental health care.

In 2012, the international health care delivery organisation, Partners in Health, collaborated with the Rwanda Ministry of Health to implement a structured mentorship programme enabling government employed, PHC nurses to care for patients with severe mental disorders in a rural district (Smith *et al.*, 2017: 136). This included decentralised training and consistent supervision for four priority neuropsychiatric disorders. PHC in resource limited countries often delivered by non-specialist providers such as nurses with little or no training in mental health care should be supported (Smith *et al.*, 2017: 137). However, the study concludes that the supervisory capacity for mental healthcare provision in resource limited settings is challenging, as mental healthcare specialists are most likely to be overburdened clinicians with little supervisory experience or training in public health and clinical interventions.

### 2.6.2 Uganda

In Uganda, PHC provided by general health workers, some of whom are not medically qualified, is the bedrock of the health care system (Ssebunnya, *et al.*, 2010: 129). For some time, there have been attempts to integrate mental health care into the PHC system as a way of improving access to mental health services for the Ugandan population. Like Rwanda, Uganda has decentralized the provision of health services to districts. A deliverable in the Minimum

Health Care Package constitutes the non-communicable diseases which includes mental health and substance abuse as key elements (Ssebunnya, *et al.*, 2010: 129). Kigozi, (2007: 18) states that to effectively implement the integration of mental health into general health care services key activities have been undertaken to rectify the challenges that the Ugandan government has faced. These challenges include: policy and legislations reforms, review of psychiatric education and curricula, development of guidelines and monitoring tools, provision of psychotropic drugs and other therapies, public education and consumer empowerment.

Ssebunnya's *et al.*, (2010) study in a rural district in Uganda analysed aspects of integration of mental health into PHC. Mayuge district is located in the eastern region of Uganda, and is 120km from Kampala, the capital city, and was created in 2000 from another existing district (Ssebunnya, *et al.*, 2010: 129). The district's health system consists of sixteen government dispensaries, three health centres at county level and two health centres at sub-district level. There are also five private dispensaries, two private clinics and one private hospital which is a former leprosy treatment centre. The study found that integration of mental health care is organized into three themes: the mental health system and financing, mental health staffing and training, and management of patients (Ssebunnya, *et al.*, 2010: 129).

The study also reveals that even though MHI into PHC was a priority for the government of Uganda, the district health managers had no mental health plan in action. There was a general assumption that the MHI into PHC occurs automatically even in absence of deliberate efforts to operationalise the policy requirements (Ssebunnya, *et al.*, 2010: 129-130). Like the case study in Rwanda, there was no mental health budget made available in Uganda. The only mental health nurse for the district reported receiving no support supervision from senior mental health professionals from the Regional Hospital, and thus expressed the fear of the degeneration of mental health care knowledge (Ssebunnya, *et al.*, 2010: 130). The study also found that the health managers believed that most health workers had a component on mental health in their curricula during training, however, most PHC nurses admitted never having received any training in mental health. It also emerged that most PHC workers with some basic training in mental health do not regard managing the mentally ill as their primary role, other than identification and referral.

Another emerging factor on MHI into PHC in the above study is on the patient's beliefs and knowledge about mental health. Most participants affirmed that the cultural explanatory model for mental illness still prevails, and most patients and carers are reluctant to seek help at

the health facilities (Ssebunnya, *et al.*, 2010: 130). According to Link *et al.*, (1999), numerous studies in the social psychiatry industry have showed the significant role that cultural beliefs play in shaping societal responses to mental illness. In a study that they conducted on public conception of mental illness, they found that before health professionals get involved in the diagnosing process, primary agents of socialisation like family, friends, colleagues, the community, and the individual himself or herself appraise the early signs of mental disorder (Link *et al.*, 1999: 1329). They are the ones who make decisions on what should be done, if there is anything that should be done about it. Social constructionist theorists have argued that cultural meanings have an impact on the way the illness is experienced, how it is depicted, the social response to the illness, and what policies are created concerning the illness (Conrad and Barker, 2010: 68).

The study by Ssebunnya *et al.*, (2010) found that patients and carers had less confidence in the mental health services provided at the health facilities and they seek help from traditional healers most of the time. As Jorm (2000) argues, the biggest problem is that many members of the public cannot correctly recognise mental disorders and do not understand the meaning of the psychiatric terms. This negatively affects the treatment of mental disorders. For this reason, Jorm (2000: 396) suggests mental health literacy; which is defined as the ‘knowledge and beliefs about mental illness which aid the recognition, management or prevention’. He categorises six different components of mental health literacy: (a) the ability to recognise specific disorders and different types of psychological distress; (b) the knowledge and beliefs about risk factors and causes; (c) knowledge and beliefs about professional help available; (d) attitudes which facilitate recognition and appropriate help seeking; (e) knowledge of how to seek mental health information.

According to Ganasen *et al.* (2008: 25), beliefs about the causation and experience may influence the patient’s beliefs about effective treatments and the type of treatment that the patient is most likely to seek after. Ganasen *et al.* (2008) critiqued Jorm’s (2000) definition of mental literacy in that it fails to specify that the type of mental health literacy that is being referred to is knowledge of evidence-based mental disorders and their treatment. It excludes no evidence-based knowledge of mental illness. They argue that mental illiteracy does not only mean that an individual has little or no evidence-based knowledge of mental illness or of treatment, but it also means that the knowledge and beliefs may be derived from other sources like culture, personal and superstitious beliefs. This should be taken into consideration when looking at MHI into PHC.

### 2.5.3 African Traditional Mental Illness Beliefs

A study on how Xhosa people in South Africa define schizophrenia, found that sociocultural factors such as a religious belief system and more collective or individualistic conceptualisation of self, environmental factors, historical event and political contexts have been shown to influence the content of delusions (Campbell *et al.*, 2017: 2). These researchers found that it is widely accepted in the Xhosa culture that mental illness has its root cause in witchcraft. These cultural beliefs largely inform the way in which mental illness is experienced and treated. They have a broad impact on how schizophrenia is explained and understood in the Xhosa community, in turn influencing help-seeking behaviours and treatment as well as medication compliance.

Bartholomew (2017) argues that the importation of Western psychological knowledge into African settings can effectively limit local health professionals' ability to develop and integrate culturally relevant interventions. He argues that the reliance on the imported Western psychology possesses a false sense of knowledge by failing to be contextually relative. For example, *ukuthwasa* is an identifiable experience in the South African Xhosa culture that includes auditory and visual hallucination that might be considered as a disorder in some contexts but in this culture, it could be seen as a call to become a divine healer (Bartholomew, 2017: 423). Hallucinations are considered as symptoms of mental illness, specifically schizophrenia. Similarly, hearing voices and seeing people who are not there among the Namibian Himba rituals means connecting with your ancestors, and it is not seen as pathological (Bartholomew, 2017: 423). He continues to argue that beliefs in ancestor reverence in some African contexts play a role in understanding mental illness.

The spirituality aspect is one that cannot be ignored, especially in the African perspective as it is closely related to cultural and traditional practices. For example, in Eswatini, culture and religion play a huge role in the governing of the country. It is one of the few countries that is governed by traditional customs (Mabuza, 2007: 1). Every year the people of Eswatini commemorate the *incwala* ceremony (*bagidza incwala*). The Incwala Ceremony commemorated by the Swazi nation sees the blending and marrying of the traditional religion and significant cultural practices in an attempt to relate to the distant Supreme Being (Mabuza, 2007: 7). *Incwala* Ceremony is the passage to that very God through the Veneration of ancestors who are believed to be closer to him (Mabuza, 2007: 7).

Other researchers have addressed the need for integrating cultural concepts of mental illness into the psychological understanding in African contexts (see Link et al., 1999; Bartholomew 2017; Campbell *et al.* 2017; & Ohaeri and Fido 2001). This includes training health professionals in such a way that integrates awareness of traditional healing systems and cultural beliefs to better serve the black community (Bartholomew, 2017: 426). In his study Bartholomew (2017) found that some explanatory features of mental illness are shared across sub-Saharan African cultures. He notes that the main symptoms of mental illness identified across sub-Saharan cultures include talking nonsense, engaging in compulsive yet culturally tolerated behaviour and agitation. Some cultures believe that there are supernatural forces that incite illness, this is why Bartholomew (2017) argues that in our understanding of mental illness, we should not neglect the role played by the ancestors, and, witchcraft, and we should place an emphasis on psychotic behavioural symptoms of madness as understood by Africans. He argues that embracing indigenous knowledge in mental illness is best exemplified in culture-bound syndromes. A total adherence to a biomedical mode of mental health ignore cultural variance in symptom distress by suggesting that a given diagnosis prompts specific, identifiable behaviour across individuals (Bartholomew, 2017).

The Alma-Ata declaration (1978) acknowledges that realization of health requires action of many other sectors in addition to the health sector. Many strategic challenges impeding the success of primary health care are rooted in weak strategic inputs, including intersectoral collaboration which includes African explanations of mental illness (Adeleye & Ofili, 2010: 1). In the health literature, the term intersectoral collaboration frequently refers to the collective actions involving more than one specialised agency, performing different roles for a common purpose (Adeleye & Ofili, 2010: 1). For example, literacy improvement is mainly the task of the education sector; developing appropriate technology is multisectoral but may require key inputs from the technology and industrial sectors; and poverty reduction will draw from strategic initiatives of the economic planning sectors for multisectoral implementation (Adeleye & Ofili, 2010: 2). Thus, PHC strategies fundamentally calls for a multisectoral approach to succeed in dealing with mental illness. inputs.

#### 2.5.4 Ghana, South Africa, and Uganda

Bhana *et al.*, (2010), conducted a study on the extent to which two low-income countries, Ghana and Uganda, and one middle-income country, South Africa, are managing MHI into PHC using the recommendations in the WHO 2001 report. The study used primary and secondary data sources from situational analyses conducted by the Mental Health

and Poverty Project (MHaPP) in all three countries (Bhana, *et al.*, 2010: 599-600). In each country the aim was to understand the current status of mental health policy development and implementation at national, provincial and district level (Bhana, *et al.*, 2010: 601). Each country chose one or more district sites to provide a case study of a district mental health system. In Ghana a district in a rural setting, Kintampo, was chosen as a representative case study as it was typical of widespread levels of poverty and limited mental health provisions (Bhana, *et al.*, 2010: 601). In South Africa, a sub-district within a rural district, Umkhanyakude, was chosen, it has high levels of poverty and unemployment typical of most rural areas in South Africa (Bhana, *et al.*, 2010: 601). In Uganda, two districts were chosen, Wakiso and Mayuge.

South Africa is one of the countries that strive to combat mental health for all as per WHO recommendations. Efforts to address this include policy responses as well as research and service innovations integrating mental health into general healthcare (Schneider *et al.*, 2016: 153). In 1997/1998, the Department of Health commissioned a study on mental health service norms and standards for South Africa. This initially focused on severe psychiatric conditions and was followed by further studies on norms for community mental health services, and child and adolescent mental health services healthcare (Schneider *et al.*, 2016: 155). The Mental Health Care Act of 2002 was made known in 2004 and was a major piece of legislation reform in line with international human rights instruments and World Health Organization (WHO) guidelines (Schneider *et al.*, 2016: 155). In 2012, the Minister of Health convened a series of provincial Mental Health Summits (February–March 2012), which was attended by over 4 000 mental health stakeholders around the country. The purpose of these summits was to generate national consensus around policy priorities for mental health in South Africa (Schneider *et al.*, 2016: 155). The South African Mental Health Policy Framework and Strategic Plan (SA MHP) aimed to realise the integration of mental health care into PHC approach enshrined in the Mental Health Care Act of 2002 (Schneider *et al.*, 2016: 155).

The implementation of this policy has faced many challenges such as the lack of financial and human resources, the limited number of evidence-based treatment protocols for disorders such as depression and anxiety, beyond medication, limited understanding and awareness of and negative attitudes towards mental disorders which may limit health-seeking behaviours by people with mental disorders, and a low level of health-system readiness to integrate mental health care (Schneider *et al.*, 2016: 155). In addition, the implementation of these policy guidelines was found to be uneven across the provinces, given the lack of official status of these guidelines and insufficient directives as to how these should be taken up

(Bhana, *et al.*, 2010: 602). Integration of mental health care into primary health care was further compromised by mental health budgets being allocated at the discretion of the provincial Departments of Health and not ring-fenced (Bhana, *et al.*, 2010: 602; Lund, Kleintjes, Kakuma, & Flisher, 2010: 396). From an economic point of view, it costs the South African society more not to treat mental disorder than to treat it (Schneider *et al.*, 2016: 156). There is a lack of data available for mental health financing in South Africa – particularly for care delivered at the community, primary care and district hospital level – available budget reports have indicated that Government is the main source of funding for care of severe mental disorders in the country (Schneider *et al.*, 2016: 156).

Health care delivery in Ghana is provided by both public and private sectors and funded primarily by government and is supplemented to a small extent by internally generated funds and donations (The Mental Health System in Ghana, 2013: 14). The Ministry of Health exercises control over the whole system including policy formulation, monitoring and evaluation. Under the public health system, the service delivery is undertaken largely by Ghana Health Service, teaching hospitals and the Christian Health Association of Ghana (CHAG) (The Mental Health System in Ghana, 2013: 14). Ghana adopted a mental health policy document in 1994 and it was revised in 2000; it emphasizes decentralization of mental health services and the development of community health care. However, it was found that health professionals at the district level were mostly unaware of the existence and provisions of this mental health policy, or the Mental Health Act of 1972 (Bhana, *et al.*, 2010: 603). These researchers found that similar to South Africa, few resources are allocated to mental health in Ghana, including those with serious mental disorders, with virtually no programmes for such high-risk groups as children, adolescents and older people. It was also apparent that at the level of districts, the care of people with mental disorders was severely constrained by the budget. This was worsened by the fact that mental health care was subsumed under an integrated budget and not ring-fenced.

As discussed earlier, Uganda developed a draft mental health policy in 2000 and mental health is one of 12 key services to be provided as part of the minimum health care package (Bhana, *et al.*, 2010: 603). It was recognized as being part of primary health care, but there were few or no implementation guidelines to enable policy implementation, resulting in little integration of mental health services, or at least poor understanding of integration of mental health with primary health care (Bhana, *et al.*, 2010: 603; Kigozi & Ssebunnya, 2009). The Bhana study analysed WHO 2001 recommendation two to seven which state that governments

should: make psychotropic drugs available; give care in the community; educate the public, involve communities; families and consumers; establish national policies; programmes and legislation; finally develop human resources (WHO, 2001: 110-111).

The study found that all three countries endorsed MHI into PHC but a lack of policy or the failure to enact policy in Ghana or lack of implementation in the case of Uganda makes MHI into PHC difficult in reality (Bhana, *et al.*, 2010: 603). All three countries were reported to have reduced custodian hospital care and attempted to provide care in different forms however in the case of Ghana and Uganda there was a shortage of mental health staff and mental health specialists which hinder the provision of mental health care in general hospitals (Bhana, *et al.*, 2010: 605). However, South Africa has provided training for PHC workers and mental health specialists as they have greater access to training resources than in the low-income countries (Bhana, *et al.*, 2010: 607).

#### 2.5.5 Zambia

Like other African countries, Zambia has embarked on a transformation process aimed at creating a well-functioning, cost effective and equitable district-based health care system (Mwape, *et al.*, 2010: 1). The Mwape study found that PHC was chosen as a vehicle through which to deliver health services to the population as it is believed that most diseases in Zambia were either preventable or could be managed at the PHC level. In response to the Alma Ata Declaration, Zambia established the Basic Health Care Package (BHCP) which was a set of carefully selected high impact interventions offered through the public health system with no added cost to the user, or on a cost sharing basis at different levels of the health care delivery system (Mwape, *et al.*, 2010: 1). The diseases that were believed to cause high morbidity and mortality rates in the country were those that were included in the BHCP.

There was a total of ten priority areas qualified for inclusion on the BHCP, and mental health was not amongst them (Mwape, *et al.*, 2010: 1). Like Eswatini, none of Zambia's strategic health plans and policy documents have addressed and incorporated mental health (Hlatjwayo, 2000: 13; Mwape, *et al.*, 2010: 1). Mental health services appear to have been made inadequately and incorporated into PHC in Zambia, although this is a problem shared with many other low-income countries like Eswatini (Mwape, *et al.*, 2010: 2). There are seven general hospitals in Zambia and only one mental health hospital, Chainama Hospital, in Lusaka, the capital city (Mwape, *et al.*, 2010: 2).

The aim of Mwape's *et al.*, (2010) study was to explore MHI into PHC from the perspective of health care providers in two districts in Zambia, one urban, Lusaka, and rural, Mumbwa. The study found that one of the key barriers to a successful MHI into PHC is that the views and concerns of health care providers around integration have not been fully considered. It was also found that the workers were willing to have mental health added to their list of responsibilities and integrated into PHC. They workers highlighted the benefits of MHI into PHC, one of them being early detection and management, reducing the stigma and better accessibility for mental health services. However, the workers stated that people with mental health problems should not be treated in the same health centre as general patients. This is because many health care practitioners believed that they did not have adequate training for handling mental health issues.

#### 2.5.6 Eswatini

Hlatjwayo (2000) conducted a study on mental health care provided by nurses in the PHC clinics in the country. Thirty-one registered PHC clinic nurses participated in the study and only one had a mental health qualification. The study was conducted in four primary health clinics in Eswatini in the four regions of the country (Hlatjwayo, 2000: 29). The PHC clinics included in the study were officially stated as having a community based mental health nurse and staffed by registered nurses with or without a specialisation in midwifery, community health, nursing, psychiatric nursing and other qualification in nursing (Hlatjwayo, 2000: 29). The study examined how nurses at the PHC clinics provided mental health care (for example, preventive, promotive and rehabilitative) in their role as practitioners, educators and coordinators (Hlatjwayo, 2000: 30). The study found that nurses believed that primary mental health care is not the core function for the clinic nurses, it is incidental.

The nurses did not offer mental healthcare for various reasons, mainly that the job descriptions were the main guiding policies for the type of care they could offer and the level of the PHC clinic (Hlatjwayo, 2000: 44). The job descriptions govern their functions, and the job descriptions are drawn in line with what the Ministry of Health has set out as objectives. Although Eswatini has mental health legislation in place that was last amended in 1978, it has neither an officially approved mental health policy nor a mental health plan, and the general health policy does not mention mental health (WHO Mental Health Atlas country profile 2014, MHSW, 2006). The responses made by the nurses concurs with the recommendation by WHO (1999) that to be able to offer comprehensive services the member countries need to review the policies to fit the adopted health care system (Hlatjwayo, 2000: 46). Another barrier, besides

policy, was that the nurses had inadequate knowledge and skill. There was a limited skill related to the practice of the nurse as well as the curriculum content for both general and mental health nurses. There was no record of any mental health education programs, but the nurses noted that they provide education on drugs and sex to patients.

Secondary mental health care involves mental status examination, history taking, and formulation of psychiatric diagnosis, psycho education on medication, prescribing medication, mental needs assessment, case referral, and many others (Hlatjwayo, 2000: 48). Other barriers to effective mental health care were inadequate staffing, and lack of transport to reach and transfer patients to tertiary health care centres (Hlatjwayo, 2000: 53- 54). Nurses stated that the physical structures in the clinic impeded the delivery of mental health care at the clinic.

Limited resources are a huge factor in the provision of secondary mental care. Tertiary mental health care involves vocational rehabilitation, occupational rehabilitation, advocating for community resources and many more, but these are limited in Eswatini (Hlatjwayo, 2000: 48). Tertiary mental care was proved to be limited within the community. In addition, the nurses had limited information on what the scope of mental health rehabilitation entailed (Hlatjwayo, 2000: 58). The conclusion in this study is that the nature of mental health care in Eswatini was inadequate and to some extent non-existent.

## 2.6 Conclusion

The findings from the studies presented above show that MHI into PHC requires investment in the training of the staff to detect and treat common mental disorders. Reviewed literature suggests that a successful integration requires investment in the training of PHC health practitioners. General health staff must have the knowledge, skills and motivation to treat and manage patients suffering from mental disorders. Thus, a mental health component should be included in the educational curriculum of all social and health workers and ongoing training and support supervision should always be provided on site. The findings indicated that the most PHC workers believe that their role in mental health care is simply the identification and referral of patients. They tend to be uncomfortable dealing with mental disorders and may also question their role in managing mental disorders (Ssebunnya, et al., 2010: 131, Hlatjwayo, 2000). Another shared challenge was the lack of funding for mental health care in the different countries. This proved to be a barrier in providing mental health care in PHC level. Adequate supervision of primary care staff is another key issue which has to be addressed if integration is to succeed (Ssebunnya, et al., 2010: 131). For example, the study conducted by Smith et al.,

(2017) in Rwanda shows the importance of supervision and mentoring. The model applied in Rwanda can be used contextually by other countries. Mental health professionals should go to PHC facilities to monitor and provide technical support supervision at PHC staff. As it is evident in the case studies, many different countries have made various attempts and provisions of MHI into PHC. However, there are still multiple challenges that these countries are facing as MHI into PHC is a process that requires implementation strategies to be put in place. The following chapter will present the theoretical framework that this study draws from.

## CHAPTER 3: THEORETICAL FRAMEWORK

### 3.1 Introduction

This chapter is discussing the theoretical framework underpinning the study. The political economy of health and health care is appropriate in highlighting the role that neo-liberal policies play in the integration of mental health into primary health care. The political economy perspective focuses on the links between health and the economic, political, and social life of people. Another theory that this study draws on is symbolic interactionism, which is a micro-level perspective that addresses how society is created and maintained through repeated interactions amongst individuals (Carter & Fuller, 2015). It is important in understanding how PHC nurses interact with mental health patients based on the understanding they have about mental illness.

### 3.2 Neo-Liberalism and Health Care

The political economy of health looks at the power structure and vested interests that pervade healthcare systems and policy issues around the social determinants of health (Mooney, 2012a: 384). Therefore, it is important to identify who makes decisions about healthcare policy both within and outside the system, and to expose the influence of various actors including the medical professionals, the pharmaceutical industry, private healthcare and private health insurers (Mooney, 2012b: 15). These issues all come under the broad umbrella of the political economy of healthcare. There are too many ‘vested interests’ in and around health care, each party has a strong reason to act in a particular way that protects their money, power or reputation (Mooney, 2012b: 17).

Most African countries, such as South Africa and Eswatini, are pushed to take the neo-liberal approach to health care (Baker, 2010; Bond, 2000). Neoliberalism arose in the developed world in the 1970s, and at its most basic, neo-liberalism asserts that free enterprise policies produce economic growth, which in turn is the basis for all human well-being (Coburn, 2006: 60). Since the 1970s, neoliberal health and social welfare policies around the world have shifted resources from public to private sector, reduced benefits to recipients, and affected the lives of clients and workers alike (Abramovitz and Zelnick, 2010: 97). The cause of global neo-liberal capitalism is driven by dominant groups within nations, by the most powerful nations, and by emerging international organisations reflecting the interests of powerful nations and corporations like the International Monetary Fund, World Bank and World Trade Organisation (Coburn, 2006: 60). As Navarro (2007: 14-15) argues that neo-liberalism advocates for policies such as: (a) deregulation of labour markets; (b) deregulation of financial markets which has

benefited the financial capital; (c) the deregulation of commerce in goods and services which has benefited the high-consumption population at the expense labourers; (d) the reduction of social public expenditures which has hurt the working class; (e) the privatisation of services which has benefited the elite at the expense of the well-being of the working classes that use public services; (f) the promotion of individualism and consumerism; (h) and finally, the promotion of minimal state intervention to promote the interests of the dominant classes and economic unit.

Neo-liberalism sought to promote economic growth by an upward redistribution of income and wealth, a greater reliance on free market and a downsizing of the state (Abramovitz and Zelnick. 2010: 97). In both South Africa and the United States of America, Abramovitz and Zelnick (2010) found that the application of neo-liberal policies in the public and non-profit sectors left agencies/hospitals with fewer resources to meet the needs of the patients. In America, the specific impact included tax cuts, retrenchment of social programs, the shift of social welfare responsibility from the federal government to the states, privatisation, and an attack on social movements (Abramovitz and Zelnick. 2010: 100). Similarly, in South Africa, the government cut public spending, called for deficit reduction, lowered public sector wages, intensified privatisation, and diverted monies from comprehensive, national development (Abramovitz and Zelnick. 2010: 100; Marais, 1999; Adelzadeh, 1996). In both countries, citizens were promised that the benefits of neo-liberalism would trickle down to the average person, but instead the effectiveness of health and human services was reduced, workplace stress increased, and undercut the well-being of both health and human service workforce and the people they served (Abramovitz and Zelnick. 2010: 100).

I draw from this theoretical framework to argue that the inadequate MHI into PHC is largely affected by neoliberal policies forced on countries, particularly developing countries. As discussed in Chapter 2, the African countries' case studies, with the exception of South Africa, health care budget largely depends on donor funding and NGOs due to limited government funding. These countries face similar challenges with MHI into PHC, which are lack of human resources, lack of financial resource, and a lack of prioritisation of mental health by government through policy and legislation. I argue that the main root of these challenges in low-middle-income countries in Africa is the presence of neo-liberal policies and the impact that they have on health and healthcare. As Mooney (2012b: 81) argues, the forces of neo-liberalism in country after country produce a ripple effect. For example, in South Africa, the figures from the department of health in 2011 show neo-liberal policies at work as 8.3% of the

GDP spent on health is split as 4.1% in the private sector and 4.2% in the public sector (Mooney, 2012b: 78). The 4.1% is said to cover 16% of the population (about 8.2 million people) who are largely on (private) medical schemes, and the 4.2% is spent on 84% of the population (about 42 million people) who make use of the public health-care sector (Mooney, 2012: 78). This is not something unique to South Africa as many other African countries are faced with the situation where the private sector is thriving compared to public sector health care. The irony is that the poor that need mental health care the most, are the worst affected by neo-liberal policies.

The elite can afford to see private psychologists and psychiatrists- covered by medical aid or even paying cash- for any mental health needs. They can afford to buy any psychotropic drugs, and any other treatment. Many of the PHC facilities which are largely clinics and community-based care are public health facilities, and many of these are used by poor (WHO, 2008). Research has shown that poverty and various other issues related to it, is closely linked with high mental disorders (Jenkins *et al.*, 2011: 74; WHO 2003, Ganasen *et al.*, 2008: 24). In essence, they are the ones who need these services the most. Integration of mental health into PHC would largely benefit the poor who the government spends less money on. Neo-liberalism's stance on the privatisation of services and promotion of minimal state intervention in turn impacts the working class and the unemployed poor. Thus, in South Africa the split in health-care spending between public and private is not in line with the Constitution which states that everyone has the right to have access to health care services (Mooney, 2012b: 78).

The prioritisation of mental health in most low-and-middle income countries is dependent on the prioritisation of mental health by donors (Shiffman, 2008). For example, the WHO and World Bank advocated for the idea of the burden of disease for priority setting along disease lines, and diseases were ranked in terms of importance by how big a burden they created (Mooney, 2012b: 31). Mooney (2012b: 50) argues that this is problematic in many ways; First, it takes local autonomy away at the individual country level; second it assumes that the measure of health adopted in measuring the burden of disease is universal. This influences the way in which donors give aid to countries, and therefore much of donor funding that has been given to low and middle-income countries has focused on HIV/AIDS, which has been identified as the biggest burden of disease in sub-Saharan Africa (Shiffman 2008; Smith, Ahmed & Whiteside, 2011). As Shiffman (2008) and Smith *et al.*, (2011) argue, the prioritisation of HIV/AIDS could have possibly led to a neglect of other health issues.

As shown in the reviewed literature, the MHI challenges that low and middle-income African countries face are similar. Some of these challenges can be attributed to poor governance, a lack of human and financial resource as a result of corruption, but it can be argued that neo-liberal policies and donor prioritisation and conditions are also contributing factors (Mooney 2012b: 17). The above discussion focused on the burden of disease and there is less attention given to issues of governance and management, and health-care systems (Mooney, 2012b: 50). For priority setting and planning, the issue is not the relative size of the burden, but what can be done about these problems given scarce resources and, often, poor health-service governance (Mooney, 2012b: 51). The major problem with health policy is that often it is dominated by health-care policy as opposed to population health (Mooney, 2012: 30).

Furthermore, the adoption of a medical perspective results in the medicalization of this social institution and in the health policy debate (Illich, 1975; Mooney, 2012: 30). This is reflected in the approach that donors take when dealing with developing countries, they target specific diseases such as malaria, HIV/AIDS and Tuberculosis (Mooney, 2012: 31). What this means is that the emphasis is on improving health outcomes directly, as opposed to building up the governance structures and relevant institutions to deliver good health care (Mooney, 2012b). The principles donors adopt fail to consider the wider perspective of the health-care system as a social institution, and do not consider local values in deciding on investment strategies for health (Mooney, 2012: 30).

Okuonzi (2004) argues that PHC is the conceptual product of a specific political economy, and that PHC will only be successfully implemented in a socio-economic order where human welfare is the central focus and where the market plays a role. He argues that PHC emerged at a time where there was a reorganisation of the world political economic order at the end of the 1970s (Okuonzi, 2004: 3). While the economy was being spurred by the forces of greater economic growth and prosperity, PHC was being shaped by the weaknesses of the global political economy which were: the increase in poverty in the midst of prosperity; the increase in the inequity between and within nations; and the worsening social/health conditions of the poorer countries (Okuonzi, 2004: 3). These weaknesses of the political economy are what gave birth to the Alma Ata Declaration of 1977. It came as a solution to problems caused by the global political economy. Okuonzi (2004: 3) argues that PHC would require an economy where: (a) there was central planning and control of economic factors; (b) democracy was all inclusive and decentralised; (c) high, real community involvement in decision making; (d)

profit-maximisation was not the goal for economic and political systems; (e) the human welfare was the ultimate goal/basis for economic and political systems. The main focus was to transform under-developed economies to permit a self-sustained growth through changing economic and social structures through a structuralist model of economic development. The introduction of neoliberal policies in the 1980s brought strain on PHC system as neo-liberalism advocates for the opposite of what is needed by PHC to be successful. Okuonzi (2004) therefore argues that the current political economy makes it difficult for the world to embrace and successfully implement the goals and ideals of PHC.

### 3.3 Symbolic Interactionism and Social Constructionism

Adams (2004: 283) argues that health is a product of social, economic, political, and religious social structures that are themselves shaped and constituted culturally and in contested political terrain. Researchers and health economists have ignored the cultural issue with the assumption that the concepts of health and illness are the same in all countries. Symbolic interactionism allows for the understanding of what frames cultural understanding and treatment of mental illness. The school of symbolic interactionism thought is derived from a Weberian (1864-1920) tradition where the focus is not on social institutions but on interacting individuals and the meanings they create (Bourgielt, 2006: 38; Carter & Fuller, 2015). Its key principles are based on the understanding that; (a) human beings act towards things on the basis of the meanings that things have for them; (b) these meanings are as a result of social interaction; and (c) the social action is a result of the individuals trying to find their place in society as they recreate meanings through interpreting processes during interaction with others (Jary & Jary, 1991: 509). Symbolic interactionism is a micro-level perspective that address how society is created and maintained through repeated interactions among individuals (Carter & Fuller, 2015). Symbolic interactionism will allow for an analysis of the attitudes, thoughts, and beliefs that PHC health practitioners have toward mental illness, and how those have an impact on the provision of mental health care.

The social construction of illness forms a significant part of research in medical sociology. Social constructionism is defined as “a conceptual framework that emphasizes the cultural and historical aspects of phenomena that is widely thought to be exclusively natural” (Conrad & Barker, 2010: 67). There are three overarching constructionist findings concerning illness that are highlighted by Conrad and Baker (2010:67), and these are: (a) the cultural meaning of illness; (b) the experience of illness as a social construct; and (c) medical knowledge as being socially constructed. What Conrad and Barker (2010) are arguing is that

the way an individual gives meaning to an illness is hugely embedded with culture, which means that different people from different cultures understand illness differently, and this is usually outside of the medical meaning. Link *et al.*, (1999), argue that numerous studies in the social psychiatry industry have showed the significant role that cultural beliefs play in shaping societal responses to mental illness. In a study that they conducted on public conception of mental illness, it was found that before health professionals get involved in the diagnosing process, primary agents of socialisation like family, friends, colleagues, the community, and the individual himself or herself are the ones who appraise the early signs of mental disorder (Link *et al.*, 1999:1329).

According to Cockerham (1981:7), ‘primitive’ (pre-scientific) attempts by early humans to explain both physical and mental disorder were largely based on intuition. Most often, illnesses were ascribed to supernatural powers. The sick were viewed as having lost a vital substance (soul) from their body and possessed by an evil spirit, or they were being punished by gods for violating taboos, or they had been bewitched (Cockerham, 1981:7). To this day, many Africans still ascribe illness, especially mental illness, to supernatural powers. This will be seen in the analysis of mental illness in this research and the different meanings that people have given mental illness. Social constructionists argue that cultural meaning has an impact on the way an illness is experienced, the way society responds to the illness, and how the government will create policies concerning the illness (Conrad & Barker, 2010: 67). They further argue that the way illness is experienced is also socially constructed, this is informed by the symbolic interactionism phenomenology that suggests that reality does not exist in the world instead it is created by individuals who act in and toward their world (Conrad & Barker, 2010: 68). Together with symbolic interactionism, social constructionism provides an analysis of how signs or symptoms get to be labeled or diagnosed as an illness in the first place.

### 3.4 Conclusion

It is evident from the discussion in this chapter that neo-liberalism is devastating for healthcare systems in developing countries. However, policy makers, medical practitioners and politicians in these countries need to be held accountable as well. From a micro perspective, there is a need to view healthcare more as a social institution rather than as a commodity, and the meanings that policy makers, medical practitioners, politicians and individuals attach to health, illness and healthcare must also be considered.

## CHAPTER 4: DATA ANALYSIS

### 4.1 Introduction

The primary goal for this research was to explore and understand the extent of the integration process of mental health into primary healthcare in the Kingdom of Eswatini. This chapter provides a reflection and discussion of the themes that emerged from the interview with a health official and PHC nurses. As previously mentioned, the data was collected through in-depth face-to-face interviews. Due to the sensitivity of the topic as well as time constraints, the interviews were conducted at the participants' place of work (clinics). Some of the participants seemed to be more comfortable to share information in an informal discussion than a structured interview. In one of the clinics I interviewed a group of nurses during their tea break as this was the only time they were available. They seemed to be more comfortable talking about the topic in this manner, as opposed to one-on-one interviews. During the interviews at the clinic, I was able to go around the clinic and view the facilities and the infrastructure with the participants.

The analysis and interpretation presented in this chapter is based on data collected through the interviews and field observation. As stated in chapter one, thematic analysis was used to interpret themes that have been generated from the interview transcripts. Thematic analysis is a method for identifying, analysing, organizing, describing, and reporting themes found within a data set (Braun & Clarke, 2006; Nowell *et al.*, 2017). The themes and categories were generated in relation to the existing structures, and processes of mental health integration from the reviewed literature and the study data.

### 4.2 Research Sites

#### 4.2.1 Ezulwini Satellite Clinic

Ezulwini Clinic is in the Hhohho region under the Lobamba Inkhundla. The Lobamba inkhundla has five chiefdoms, Ezulwini has the largest population of these. According to the Ministry of Tinkhundla Administration & Development (MTAD), tinkhundla are the third level of governance and they are for all intents and purposed of local government institutions (MTAD, 2018). They are the foundation for the bottom-up development planning process and the delivery of local services in partnership with central government. They also provide a platform for traditional leadership (MTAD, 2018). Ezulwini is a semi-urban area that has a large number of young people. It has been classified as the tourism hub of Eswatini because it has the largest number of hotels, tourist attraction sites, nature reserves, cultural centers and

other buildings of national importance. The demand for mental health care is high in this place as it is a semi-urban area. When asked about the need for mental health services, one of the nurses said:

There is definitely a demand. This is a semi-urban area with a lot of drug abuse. Instability in the community due to social issues and weed [marijuana]. Other social issues like high unemployment and poverty are high in this area so there is a high demand

(Nurse 2, interview with author, 2018).

Due to the fact that Ezulwini is tourist hub, there is a high rate of sex work in the area especially around the hotels. Although sex-work is illegal in Eswatini, nurses believe that this also adds to the demand for mental health care:

The demand is high because of sex work, work environment, delinquency, and drug abuse, especially weed

(Nurse 1, interview with author, 2018).

#### 4.2.2 Etitsembisweni Clinic

The clinic is located in Matsapha, close to the University of Eswatini (UNESWA), in the Manzini Region. Matsapha is known as the industrial hub of Eswatini. The clinic is owned by a church and partly funded by the Ministry of Health. As discussed in Chapter Two, churches, religious organisations and NGOs play a huge role in health care provision in the country. The interview at this clinic was conducted with the head nurse, who noted that there is a high demand for mental healthcare in the area because it is situated close to UNESWA. Many of the university students use the clinic. Another contributing factor to the demand is the fact that Matsapha is an industrial area with many textile companies. This means that there are many employees who work for long hours under unfavorable working conditions and are susceptible to stress-related illnesses. Like the UNESWA students, workers frequently use this clinic. In addition to medical treatment, the church offers deliverance services every Wednesday morning:

Every Wednesday there is a deliverance service at the church, so on Wednesday that is when we have many patients for mental health services

(Nurse 3, interview with author, 2018).

Spirituality and religious beliefs play a huge role in the understanding and interpretation of mental illness. Social constructionists, like Conrad and Barker (2010), argue that the way an individual gives meaning to an illness is hugely embedded with culture, which means that different people from different cultures understand illness differently, and this is usually outside of the medical meaning. This shows the role that is played by churches and religious

institutions as agents of socialisation. It is interesting to note that in this case, even though people go for the deliverance services, they still seek medical diagnosis and treatment.

Theorists like Bartholomew (2017) argue that the importation of Western psychological knowledge into an African setting can effectively limit local health professionals' ability to develop and integrate culturally relevant interventions. He argues that the reliance on the imported Western psychology possesses a false sense of knowledge by failing to be contextually relative. It is common in contemporary society to push people towards medical intervention, and in so doing invalidating their cultural and spiritual aspects. However, in Etitsembisweni clinic; students, workers and others seek help from both spiritual and medical sources.

#### 4.2.3 Motshane Clinic

Motshane is about 13,4 kilometres from Mbabane (capital city of Eswatini) in the Hhohho region. It is a semi-urban area with schools, churches, and a number of tourist attraction sites. A group interview was conducted with three nurses who shared their views on mental illness. When asked about the need for mental health care in this area, they stated that since it is a semi-urban area there is a high demand for mental health services, but that they do not assist mentally-ill people at the clinic. One of them said:

We cannot deal with mental patients here... I mean these people are crazy and they know that they cannot be helped, even they themselves know that they are crazy. So what can we do for them here in the clinic? Even you can see for yourself, there is no space here for that. They must go to Manzini.

(Nurse 4, interview with author, 2018).

#### 4.2.4 Nkhamba Clinic

Nkhamba is a rural area about 33 kilometres from Mbabane, in the Hhohho region. It has twenty-five primary and high schools, and several clinics. Nkhamba clinic has recently been renovated and has the best facilities in the area. Two nurses were interviewed at this clinic, and one of them is specialized in mental health care. According to the nurses, cannabis is commonly grown in the area and this contributes to the high prevalence of mental health concerns. They also stated that Eswatini is a country that is known to grow the best cannabis in Southern Africa. When asked about mental health care at the clinic, one nurse said:

There is a huge demand because of the marijuana fields. People end up manifesting strange behaviors and killing each other. This is even a challenge in our schools because boys drop out of school to go and work in the fields, they start making

money, live in the fields and not come for check-ups. They get HIV there then rape school children and give them HIV. It's a cycle of crisis.

(Nurse 5, interview with author, 2018).

The nurses also spoke about what normally happens when someone is found growing cannabis - the police arrest the person and burn his/her field. However, the market is well established and for most people it is their only source of income to care for their families. As one health official in explaining the role of community health training in Eswatini's PHC system, also spoke about the role of cannabis in mental illness:

...Nurses who are trained in community health are able to give community diagnostics. They are able to go out and see the prevalent challenges that are faced by the community for example in areas like Ludlawini they grow cannabis. A community diagnostic will tell you that crime, drug abuse, and violence are prevalent in that area and that leads to high mental disorders..."

(Health official, interview with author, 2018).

Other social factors like high unemployment, poverty, and teenage pregnancy was also given as other causes of demand for mental health care at Nkhamba Clinic.

#### 4.3 Ministry of Health

For this study, interviews were scheduled with health officials from the Ministry of Health. At the time of data collection, the country was in the process of appointing new cabinet Ministers so there was no Minister of Health as his term had just ended. Interviews were scheduled with the Director of the Ministry of Health and the Principal Secretary, but only the Principal Secretary was interviewed. The official revealed that the Ministry of health has a policy on mental health but that it is not adequately implemented. He spoke about the need for management of mental health at PHC level:

Ideally, all clinics should provide mental health care services. Ideally every clinic should have a mental health nurse on the ground because the nurses are our primary agents in healthcare provision.

(Health official, interview with author 2018)

He further explained that the current management of mental health is that clinics and health centres refer patients with mental illness to the National Psychiatric Hospital, and five hospitals which have mental health units. The Eswatini health sector is loosely organized in a four-tier system:

1. Three National (referral) Hospitals



2. Five Regional Hospitals



3. Primary Health Care facilities (Health Centres, Public Health Units, Rural Clinics and a network of outreach sites)



4. Community Based Care where Rural Health Motivators, Faith-based Healthcare Providers, Traditional Births Attendants, Volunteers and Traditional Practitioners provide care, support and treatment (MOH, 2010: 2)

The Principal Secretary noted that all health practitioners are trained on how the health sector is designed to function. Health care is initially provided at community-based care and PHC levels, and then serious cases go to regional hospitals or referral hospitals. However, in reality there is no functional referral system for the rationalization of service delivery at the various levels, and this leads to congestion at the tertiary (referral) facilities with patients that could have been attended to at lower levels (MHSW, 2006: 8). This is supported by the findings of this study whose recurring themes are:

- Lack of human resource at the clinics;
- Lack of knowledge and education about mental health for both health care practitioners and communities;
- Lack of mental health policy;
- Inability to implement the PHC framework.

However, it is important to note that Eswatini does recognise the importance of integrating mental health into primary health care. This is confirmed by the participants' acknowledgement that there is a certain level of mental health integration into PHC. When asked about MHI, one nurse mentioned that:

...It is already integrated. Psychiatric nurses come every second Wednesday of the month where they see what happens here.

(Nurse 2, interview with author, 2018)

Another said:

The integration is already happening just not at the rate we would like to see.

(Nurse 1, interview with author, 2018).

For this reason, the focus in this study is on the factors that negatively affect the integration of mental health into PHC.

## 4.4 Factors that negatively affect mental health integration into primary health care

### 4.4.1 Lack of human resource

Human resources in health care facilities consists of doctors and nurses. Clinics in Eswatini are divided into Type A and Type B. The main distinction is the provision of maternity services (Type B offer maternity services). Meanwhile Public Health Units concentrate on public health services, and provide a base for outreach services, while Health Centres have traditionally provided a more curative and inpatient care as well as Primary Health care services (MOH, 2010: 2).

As shown in the table below, health facilities have been evenly distributed across the country. The MoH prides itself in having an estimated 85% of the population living within a radius of 8 kilometres from a health facility (MHSW 2006: 9).

	Population	National + Regional Hospitals	Health Centres	Public Health Units	Clinics Type A + B	**Total Number of Health Facilities	Health Facilities per 100,000
Hhohho	331 734	2	2	3	62	64	22.6
Lubombo	249 153	1	1	1	43	44	21.7
Manzini	360 248	4	0	2	80	82	25.0
Shiselweni	241 365	1	2	2	33	34	16.3
<b>Total</b>	<b>1 182 500*</b>	<b>8</b>	<b>5</b>	<b>8</b>	<b>218</b>	<b>224</b>	<b>21.9</b>

Table 1: Distribution of Public Hospitals, Health Centres and Clinics by Region

\*Estimated population from 2007 census

\*\*Total Number of Health Facilities excluding public health units, hospitals and health centres

(MOH, 2010: 3)

The adequate distribution of health facilities was confirmed by the ministry of health official during the interview:

Where we see that we have improved is in providing access to a health facility. So, people are now...well the majority of our people, more than 80% are now within 5km to the nearest health facility which is good as far as access is concerned.

(Health official, interview with author 2018)

Although access to health care facilities is a good indicator of progress, lack of resources, especially human resources, negatively affects quality of health care. The findings of the study show that the PHC clinics lack human resources, and this is a contributing factor to the unsuccessful MHI into PHC. Commenting on this one nurse said:

Our biggest problem is human resources. There are not enough nurses to handle the patients.

(Nurse 1, interview with author, 2018).

Another nurse said:

I am the only mental healthcare nurse here, I can't even give a patient the correct attention that they need. A mental health assessment or screening takes a minimum thirty minutes to ask the right questions and analyse behaviour. Here the rule is that a patient needs to spend a maximum of five minutes so that we are able to attend to other patients. Now when there is a queue with patients coughing outside, there is no time for me to ask many questions.

(Nurse 5, interview with author 2018).

The issue of lack of nurses was a common theme as all participants at the clinics stated that there are not enough nurses to handle the patients. This was confirmed by what I observed during the site visits, the queues were long, and the nurses were kept very busy. One of the rules for PHC clinics is that the consultation need to be as quick as possible so that all the patients receive treatment. As one nurse stated that:

Many people, even when referred to the hospital, always prefer to come back to the clinic. So we deal with them week after week.

(Nurse 4, interview with author 2018).

This shows that patients prefer PHC clinics to hospitals, and this could be because clinics are closer and cheaper for the patients to access. The issue of lack of human resources and lack of MHI is not exclusive to the PHC clinic involved in this study. Literature from the studies conducted in six African countries discussed in chapter two shows that the shortage of nurses was a factor that negatively impacted the MHI process. For example, in South Africa, some of the most significant barriers to the delivery of mental health services emerge in part as a result of insufficient resourcing (Schneider *et al.*, 2016: 156). An important fact that emerged was that the nurses seemed to be under the impression that the issue was with the government refusing to hire and disperse nurses across the clinics. However, the health official acknowledged that the government is aware that there is a shortage of nurses and doctors in all health facilities:

Ideally every clinic should provide mental health services. Service provision is determined by the availability of the working tools; medicines, diagnostics, but the most determining factor is human resource. We are aware that the biggest problem is the availability of staff on the ground.

(Health official, interview with author, 2018)

He further explained that the problem was not entirely the government's but that there are no available nurses to work:

We have defined the package the essential health package for Swaziland that defines the services that should be universally accessible according to need in the context of the renewed Primary Health Care (PHC) (MOH, 2010)] but we are not providing accordingly, and limitations are mainly on the HR (human resource) aspect. There are no nurses.”

(Health official, interview with author 2018)

It is unclear whether the issue lies in the fact that there is a shortage of nurses available to work, or whether the government is unable to hire more nurses due to financial constraints. According to the WHO situational analysis of the health workforce in Swaziland (2004) the ratio of doctors and nurses to the population was 1: 5 953 and 1: 356, respectively (MHSW, 2006: 4). However, nurses fall under the critical skill category in terms of employment. Eswatini has various training institutions that produce nurse graduates every year who expect to work once qualified. This means that the issue lies with the government not being able to hire more nurses due to financial constraints. As one nurse, responding to the question whether lack of human resources is due to the unavailability of nurses, said:

Obviously the nurses are there. It's that *akabacashi hulumende* (the government is not hiring them). They say there is no money.

(Nurse 6, interview with author, 2018)

The issue of money from the government is a serious one. During the time of data collection in Ewatini, nurses had engaged in a nationwide strike alongside teachers. Nurses were demanding a 6.5% wage increase in relation to the cost of living adjustment (COLA) (Times of Swaziland, 2018). According to the international organizer of the Communist Party of Swaziland Njabulo Dlamini, quoted in the *Peoples Dispatch*, salaries of civil servants were last raised in 2016 (Peoples Dispatch, 2018). Another spark for the strike was the millions that had been spent on the country's 50/50 celebration of 50 years of independence and King Mswati's 50<sup>th</sup> birthday. The government's wasteful spending and the lack of investment in the health sector communicates a lack of prioritisation for the health of the nation. Public hospitals and PHC facilities are usually out of essential drugs and equipment as the government claims financial difficulties (Times of Swaziland, 2018; Peoples Dispatch, 2018). This, in part, is a result of neo-liberal policies and the impact that they have on health. The neo-liberalists' call for privatisation has deprived patients of basic resources needed to survive, and health care workers of the time and resources needed to serve patients well (Abramovitz and Zelnick, 2010: 98). In addition, the privatisation of resources like health care means that governments find themselves in a position where they cannot be held accountable for poor healthcare as they can claim that responsibility has been given to private owners of institutions. As Abramovitz and

Zelnick (2010) argue that the neo-liberal policy changes place healthcare workers in jeopardy and turn stress into a major occupational hazard for them. They are made to work under pressure due to massive staff shortages and limited medical resources which leads to compromised and poor service for the patients. Nurses experience the negative impact of these policies personally, as confirmed by one nurse:

You find that we have depression, burnout, and all those things because of the work that we deal with here. There is a lot that we deal with.

(Nurse 5, interview with author, 2018).

This negative impact of neo-liberalism in health care is common around the world. For example, Abramovitz and Zelnick (2010) found that the majority of workers in health, education and social services, and patients in the United States and South Africa suffer due to the implementation of neo-liberal policies. This leads to many strikes by civil servants such as the national strike demanding wage increase that was taking place in Eswatini during field work for this study. There is also a negative impact on staff development, specifically on mental health training for nurses in PHC facilities.

#### 4.4.2 Lack of adequate knowledge, skills and training for nurses

According to WHO (2008), integration of mental health into primary health care means that at PHC level, patients are able to access psychotropic drugs, mental health screening, early diagnosis and treatment of any mental illness, and referrals where necessary. Other primary mental care involves interpersonal relationship skills, mental health education, and many others (Hlatjwayo, 2000). Integrating mental health into primary healthcare is done in order to make the services easily accessible to the public. However, integration would be unnecessary if there is no demand for the service. As a result, one of the questions in this study focused on whether there is an existing demand for mental healthcare services. Participants revealed that patients present with mental health concerns, but nurses are unable to provide mental health services as they lack the knowledge, skills, and training in mental health. For example, when asked whether they had received training for mental health, two nurses said:

I have no training other than the basics that were covered in the school course.

(Nurse 3, interview with author, 2018)

It is part of the nursing programme, although one can pick and choose their speciality later, like me I did midwifery, but the basics are part of the programme. Things like psychology, counselling. But one will obviously focus more on what they have specialised in.

(Nurse 2, interview with author, 2018).

Of all the participants only one was a trained mental health nurse, and the majority of the nurses were unaware of what primary mental health services are. When asked about the mental healthcare services provided, one nurse said:

We offer psychosocial support, counselling, and medication refills.

(Nurse 2, interview with author, 2018).

Another said:

We can offer minor cases with assistance in counselling and offer the little knowledge that we have but for instance when a patient comes here and when you talk to them and they start crying and telling you their problems, there's only so much you can do.

(Nurse 4, interview with author, 2018).

Most clinics in this study provide mental health care services mainly to patients who have been diagnosed with mental illness. The service includes provision of repeat prescriptions and counselling. However, the latter is limited by inadequate training in mental health care as discussed earlier. There is less focus on the identification of mental illness through interaction and mental health screening. From observation and interaction with the nurses, it was evident that mental health issues are not the primary focus of PHC clinics and nurses. Outside every clinic there is a board which list the services provided at all government clinics. The services listed are: health education, youth friendly services, family planning services, antenatal care, prevention of mother to child transmission services, postnatal care, curative services, HIV services, TB services, Child welfare services, provision of home-based care services, community sensitisation on clinic activities, attending to emergencies, cancer services, and referral to hospital (see Figures 4.2 & 4.3)



Figure 4.2 and 4.3 Motshane Clinic - Services offered

Mental health care is not included on the list of services offered at Motshane clinic. Thus, upon reading this list of services, patients seeking mental health services may be discouraged or turned away because it appears as though the services are not offered at the clinic. This shows that mental health care is not the core focus of PHC clinics and this has a huge impact on the integration of mental health to the clinics. Primary mental health care then becomes incidental and not a core function of PHC clinics. As stated earlier, the clinics largely provide repeat prescriptions and basic counselling to mental health patients, and not extensive mental health care. In this study, only one nurse has the necessary training in mental health and is able to screen and counsel mental health patients, but she is also limited by lack of resources at the clinic. All the other nurses stated that their core activities at the primary level of prevention include immunizations, antenatal care, and family planning. They were under the impression that mental health care services are the job of social workers and mental health nurses. As one nurse said:

The government needs to increase the number of social workers that are based in the clinic. Nurses are already overworked, even though we give basic counselling we do not have time to go deeper. We are also not trained on that so clinics should have resident mental health nurses who specifically look at mental health issues.

(Nurse 2, interview with author, 2018).

The above finding is similar to Hlatjwayo's (2000) finding in her study on mental health care services provided by nurses at PHC clinics. This shows that eighteen years later, Eswatini is still faced with the same challenges with regards to primary mental health care.

#### 4.4.3 Primary Health Care Framework

The lack of adequate skills and training for mental health integration is due to the fact that mental health patients are not the primary focus of PHC clinics in Eswatini. Primary mental health services will be incidental if the PHC system does not fully embrace the importance of MHI into PHC. According to the health official who was interviewed in this study, Eswatini does acknowledge that mental health should be integrated into primary services. As a result, the country has subscribed to the Universal Health Coverage (UHC) which demands that access to health service that are required by people be made available to the largest extent possible. PHC has been identified as one of the tools that government is using to achieve UHC. However, the PHC system needs to be strengthened in-order for this to happen.

The best way to achieve the UHC, the best vehicle is Primary Healthcare. As a government we are robbing the people of Eswatini because we are not giving them the care they need as we are supposed to in PHC level. We end up giving it at secondary and tertiary level as opposed to PHC level like we should, which then becomes more expensive and not as accessible as in the PHC level.

(Health official, interview with author, 2018)

The PHC system needs to be framed in such a way that it incorporates primary mental health care fully in order for the nurses to be able to offer such services. The lack of adequate skills and training for nurses compromise the primary health care services that they offer, but the underlying issue is the PHC framework itself and the extent to which it embraces MHI into PHC. As noted earlier, there is only one participating nurse with specialisation in mental health care. When asked about the level of MHI into PHC she said:

I think the integration is non-existent because if we look at the clinic structure they consider that a mental health nurse is not necessary. They have general health nurses but, in many cases, they treat the manifestation of mental illness and ignore the root cause.

(Nurse 6, interview with author, 2018)

Another nurse states that:

If mental healthcare is made available in PHC it will ease the burden on the number of referrals and also on the perceptions that people have. Mental hospitals are for severe cases, but here you find that even the basic medication is only available at the mental hospital.

(Nurse 3, interview with author, 2018).

Even though the government recognises and acknowledges that mental health care should be made available in PHC clinics, nurses are still struggling with basic primary mental health care necessities like psychotropic drugs. Nurses mentioned that patients are reluctant to go to the National Psychiatric Hospital because of the stigma attached to it.

This thing of referring people to mental hospital, even for minor cases, in a way you are saying that they are mad which is not true.

(Nurse 3, interview with author, 2018).

The lack of adequate skills and training for mental health integration is due to the fact that mental health patients are not the primary focus of PHC clinics. It is a result of Eswatini's PHC framework with regards to mental health. Primary mental health services will be incidental if the PHC system does not fully embrace the importance of MHI into PHC. There is a need to review the existing PHC structure or framework for it to be reviewed in order to ensure that the integration of mental health happens. As Okuonzi (2004) argues, PHC is the conceptual product of a specific political economy, and that PHC will only be successfully implemented in a socio-economic order where human welfare is the central focus and where the market plays a role. He argues that PHC emerged at a time where there was a reorganisation of the world political economic order at the end of the 1970s and these weaknesses of the political economy are what gave birth to the Alma Ata Declaration of 1977, which is the framework that is adopted by UN member states (Okuonzi, 2004: 3). The main focus was to transform under-developed economies to permit a self-sustained growth through changing economic and social structures through a structuralist model of economic development. The introduction of neo-liberalism advocated for free trade, privatisation, minimal state intervention amongst many others (Okuonzi 2004; see Abramovitz and Zelnick, 2010). Difficulty in implementing the ideals of PHC means that the extent of MHI will also be difficult because primary mental health care is largely dependent on the proper functioning of PHC.

Another factor that hinders the Eswatini government's implementation of mental health integration into PHC is that the Eswatini' healthcare system has for many years been dependant on expatriates, especially doctors. As the health official pointed out:

That is a factor in as far as the organisational structure is concerned. We have Zimbabweans, Tanzanians, Ugandans and DRC doctors. We are cosmopolitan with different training background and come together to run a system which has very little of its own people.

(Health official, interview with author, 2018).

The bulk of local health practitioners are the nurses. However, the challenge lies in that in the health sector people listen to the doctor more than they listen to nurses. Each doctor comes with what they have learnt from their different countries and wants to implement their different ideas. As noted by the health official:

That is one of the reasons why PHC is suffering because the system itself is not being run by us. There is no system born within itself to make it properly aligned with the needs of the population.

(Health official, interview with author, 2018).

This means that MHI into PHC process that is not contextual to the settings in Eswatini will be difficult to implement as it requires local analysis and knowledge of the mental health needs of the population. Nurses are in a better position to provide local knowledge that will inform MHI into PHC process as they frequently interact with communities.

#### 4.4.4 Primary health care nurses' knowledge, attitudes and beliefs

Nurses, all over the world, are the main providers of health care at PHC clinics. This means that their interpretation and meaning that they attach to mental illness will influence the treatment of mental illness. Despite the important role that PHC nurses play in the provision of health to the general population, their attitudes toward people with mental illness are often negative, and the provision and identification of mental health problems by PHC nurses has been shown to be poor because of the inadequate knowledge and skills to deal with mental health conditions (see Williams *et al.*, 2008; Bjorkman *et al.*, 2008; and Horsfall *et al.*, 2010). The nurses' attitudes towards mental health patients was confirmed in this study when one nurse said:

We cannot deal with mental health patients here, they get violent and some need to be restrained.

(Nurse 4, interview with author, 2018)

From this statement one can deduce that the understanding that this nurse has is that mentally ill people are violent and a danger to the public and health care workers. This is, although correct in certain instances, a preconceived notion which leads to labelling and stigmatisation of people with mental illness. Another nurse confirmed this othering by stating that mental health cannot be integrated into PHC because it will be a burden on the nurses, and the structure of the clinic does not allow for mental healthcare patients to attended to:

These people themselves know that they are crazy, so what can we help them with here? They must be referred to Manzini [a psychiatric hospital].

(Nurse 5, interview with author, 2018).

Dube and Uys (2016: 119) argue that the usage of stigmatising terms and psychiatric labelling by health professionals has led to the development and maintenance of stigmatisation. The fact that the nurses have labelled the patients as crazy prior to attending to them says a lot about the attitudes that the nurses hold about mental health, and this will influence how they treat people with mental illness. Personal beliefs are shaped by knowledge about mental health and this sets the measure for provision of mental health services by the healthcare worker (Dube & Uys, 2016: 119). Limited or wrong knowledge about mental health has shown to be the result of the negative attitude towards mental illness and the seeking of psychological treatment (Samouilham & Seabi, 2010:74). Studies show that knowledge of public attitude towards mental illness and its treatment is an important prerequisite to the realization of successful community-based programs (Dube & Uys, 2016; Samouilham & Seabi, 2010; Tibebe & Tesfay, 2015). The recognition of mental disorder also depends on a careful evaluation of the norms, beliefs and customs within the individual and caregiver's cultural environment (Tibebe and Tesfay, 2015:1).

The impact of nurses' knowledge, attitudes, and belief about mental illness on the integration process can be explained through the lens of social constructivism. Conrad and Barker (2016) argue that the way illness is experienced is also socially constructed, as symbolic interactionists and phenomenologists explain that social reality does not exist in the world instead it is created by individuals who act in and toward their world. The way people attach meaning to certain things is based on their individual beliefs and understanding. This means that people act out their illness and give it meaning. A social constructionist approach to illness is based on the distinction between disease, and illness and emphasises that meaning and experience of illness is shaped by our cultural and social systems (Conrad and Barker, 2010:67). This means that the understanding that nurses have on mental illness, which is informed by their culture and beliefs, will impact the way they treat patients.

Studies have shown that community attitudes influence how people suffering from mental illness experience their illnesses (Hugo *et al.*, 2003:717). The ignorance about the diagnosis and management of mental illness, ignorance about the advanced treatment that is available, and the fear of stigmatisation might prevent people suffering with mental illness from seeking professional help (Hugo *et al.*, 2003:717). Problems related to mental health have

received very little attention in developing countries in general, and in Eswatini in particular. This may be due to the fact that mental illnesses are not major causes of death. However, they are responsible for a huge burden of distress and disability, especially among the poor (Doyal & Hoffman, 2009:457). People suffering from mental illness are usually stigmatised in society, and they should not have to be subjected to similar treatment in PHC clinics. Studies have shown that there is still a large amount of ignorance and stigma around mental health, and that many people who have chronic disorders live in ignorance of the fact they have a diagnosable disorder that is treatable (Hugo *et al.*, 2003). In their study, Hugo *et al.* (2003) found that one of the reasons that prevent people from detecting their sickness early is the fact that there is a significant problem of non-detection in general practitioner or primary care setting. A great contributor to this is PHC nurses' attitudes and belief towards people with mental illness. This calls for the implementation of the mental health policy and an update of the mental health legislation.

#### 4.4.5 Lack of mental health policy and mental health legislation

Mental health policy provides a framework for the development of the mental health system, and it conveys the government's commitments organised in a set of values, principles, objectives, and areas for action to improve the mental health of a population (Mugisha *et al.*, 2017: 4). Literature suggests that the link between poverty and mental illness can be dealt with through national policies and implemented plans that are based on a comprehensive multi-sectoral approach to the problem (Flisher *et al.*, 2007: 506). Mental Health Legislation (MHL) provides a regulatory framework for mental health services for the public, and people with mental illness are afforded protection from the consequences of mental illness, which can be devastating for the individual and her/his family (Ayano, 2018: 1). It also provides a legal framework for enforcing policy objectives and can enforce integration by legislating for congruence between physical and mental health care, and by introducing specific provisions that promote de-institutionalisation and the provision of care in PHC settings (Mugisha *et al.*, 2017:). Eswatini does not have a mental health policy. This was confirmed by the health official when asked about the ministry's policy on mental health, he said:

There is none (laughs). There is a draft which has not been ascended.

(Health official, interview with author, 2018).

There seems to be an ongoing debate regarding the importance of mental health policy within the ministry of health. The health official stated that some people in the ministry are of the belief that a mental health policy is not necessary because mental health is part of Non-

communicable diseases and they argue that if the ministry has a policy on Non-communicable diseases (NCDs) it will cover mental health. On the other hand, the mental health practitioners and activists are advocating for mental health policy and this on-going debate is what is delaying the drafting and implementation of a mental health policy. As the health official stated:

Mental health practitioners and activists are saying that a mental health policy is necessary because mental health is a big issue with many different conditions. If you put it under NCDs you are shadowing it under diabetes, heart conditions; which is true...”

(Health official, interview with author, 2018).

Mental health policy can shape how mental health is integrated into PHC. The lack of mental health policy means that there is no framework that regulates how mental health care will be provided especially at PHC level. According to Mugisha *et al.* (2017:11) mental health policies can define the specific MHI objectives, as a lack of a fully-fledged mental health policy creates multiple dilemmas such as: (a) difficulty in defining and attracting resources for a sector without a fully-fledged policy, (b) difficulty in defining the required structure and the required resources to deliver the services expected. Thus, it is important that low to medium-income countries invest in the development of mental health policy and practice, and this should involve consultations with experts and key stakeholders in these processes to foster participatory development of management principles and goals (Mugisha *et al.*, 2017: 11). The health official had the following to say on the complex process of drafting the mental health policy:

As you know we are technocrats, we craft it (policy) and send it to the minister who will then fit it where needs be. Because mental health involves different stakeholders it needs to be taken to Cabinet where different sectoral ministers can have a say such as the minister of Education, Minister of Social Works, Deputy Prime Minister (DPM)’s office for children, the police, the courts.

(Health official, interview with author, 2018).

The health official stated that because the drafting of the mental health policy requires an intersectoral collaboration as it is a multi-sectoral issue that involves different stakeholders, it could be a contributing factor to the delay of the progress on the issue. However, the health official took the blame, on behalf of the ministry of health for the absence of a mental health policy, as he said:

I will take the blame and say that the Ministry of Health has not shown leadership in this regard. Great leadership is needed from the Ministry’s end to advocate for mental

health policy. We have not made it a priority in the Ministry by taking leadership for development and implementation of the mental health policy.

(Health official, interview with author, 2018).

The health official remained hopeful however, that with the appointment of a new cabinet maybe the current health minister will have a plan in place and the ministry can work together to push for the process of drawing up a mental health policy. The lack of adequate mental health policy also impacts the nurses as they are unclear on what primary mental health services they are meant to be providing for patients. As one nurse stated:

Maybe it is a policy issue as well. The lack of a governing policy or framework for mental healthcare makes it hard for us to know what we ought to be doing.

(Nurse 3, interview with author, 2018).

Another nurse noted that:

The government needs to include in healthcare delivery policies that in every clinic there should be mental health provision. They need to address the issue of policy; the mental health Act must be diagnosed and implemented across the country.

(Nurse 6, interview with author, 2018).

Nurses did not offer mental health care for various reasons, the main one is that the list of services provided at PHC clinic does not include mental health care (see figures 4.2 & 4.3). Majority of the nurses that were interviewed are midwives, and they mostly focus on this area of specialisation. This means that patients who need mental health care services are often referred to psychiatric hospitals. There is this underlying notion that nurse who specialised in mental health should be the ones to attend to mental health patients, as one nurse said:

The government needs to hire more nurses who have specialised in mental health.

(Nurse 4, interview with author, 2018).

Another said:

Nurses from the psychiatric hospital used to come every second Wednesday to assist with mental health patients, they don't anymore. We don't know why.

(Nurse 4, interview with author, 2018).

This is because of a lack of clear policy that regulates or informs the framework that shapes the job description of PHC clinic practitioners. Of all the clinics that were visited, only one had a resident mental health nurse, who also expressed that he is unable to give patients the correct mental screening due to the clinics being understaffed. This means that in most of

the clinics only basic primary mental healthcare services are provided and others are referred to the psychiatric hospital which places further burden on the referral hospitals.

Mental health legislation ensures that “people with a mental disorder get the best possible care and treatment appropriate to their needs, in the least restrictive environment and in the least intrusive manner consistent with the effective delivery of that care and treatment” (Ayano, 2018: 2). For example, community mental health (CMH) is a treatment philosophy that is based on the social model of psychiatric care, and it advocates that a comprehensive range of mental health services should be readily available to all members of the community (Ayano, 2018). In addition, integration of community-based rehabilitation into PHC services and specialist CMH programmes are the common models of successful community-based mental health services. As stated above, MHL is important especially in low-and-middle income countries where specialised mental health care professionals are extremely scarce, and there is no integration of mental health services into PHC (Ayano, 2018). Most of the specialised mental health care professionals are concentrated in large cities, and this creates a huge gap in mental health care service delivery between rural and urban communities. The integration of mental health into PHC will improve access to mental healthcare by increasing accessibility, reducing associated stigma and human rights abuse, and will also help in early detection of mental illness.

Mental health legislation and policy allow for the promotion of community health, and this is a fundamental in the Eswatini’s health system. As the health official stated:

Ideally clinics should be dominated by nurses who are trained in community health. Yes, we need midwifery but when you are trained in community health you are like an all-rounder... they are able to go to the community and not wait for the people to come to us; because when they come to us it is already too late.

(Health official, interview with author, 2018)

The Ministry of Health’s strategy is that rural health motivators (RHMs, also referred to as *bagcugcuteli*) who are part of the community function as a link between the community and the clinic. They look at what is happening on the ground and assess the community issues. They refer patients to clinics for health conditions that are beyond their capacity, or they request the PHC nurses to visit the community. This system is structured in such a way that the success of PHC is heavily reliant on the community health providers, and this includes faith-based healthcare providers, traditional births attendants (TBAs), and volunteers and traditional practitioners (MOH, 2010: 2). However, the health official noted the challenges in this system:

They (*bagcugcuteli*) have knowledge on what is happening in the community, but a rising concern is whether they are well equipped to deal with issues, and particularly on mental health issues, and I can tell you now that the answer is no.

(Health official, interview with author, 2018)

The existing gap in Eswatini is that the community-based care is ignored which creates a greater burden on the PHC practitioners, and eventually on the regional and referral hospitals. According to the health official, the Eswatini Ministry of Health aspires to have a system that functions like the Cuban health system, which is easily available to the community. They do however, acknowledge that there are major differences between the Cuban health system and the Eswatini health system that would be harder for Eswatini to overcome.

From this we observe that the Eswatini Ministry of Health has a system that is set out on paper but fails at the implementation level. According to Ayano (2018: 4), the presence of MHLs plays a crucial role in community integration of persons with mental disorder, integration of mental health at primary health care, the provision of high quality health care and the improvement of access to care at the community level. Although the Ministry of Health is responsible for drafting mental health policy, there are other forces at play such as the global fund. And as discussed earlier, neo-liberal health and social welfare policies around the world have shifted resource from the public to the private sector, reduced benefits to recipients, which affects the lives of patients and workers (Abramovitz & Zelnick, 2010: 97). The impact of neo-liberalism is made worse by epidemics, as the health official noted how Eswatini is one of the countries that was doing well in PHC until it was affected by the HIV/AIDS:

When HIV came we were constrained resource wise because HIV came and killed our very same health care workers.

(Health official, interview with author, 2018)

In addition to the deaths of many health professionals, the HIV/AIDS epidemic opened the door to external funding which comes with conditions. Global funders come with the intention of assisting countries combat HIV/AIDS, but some of them come to push their own agenda. As Mooney (2012b) argues that global institutions fail to use their considerable powers to make substantial differences in health and health inequalities. They fail to act decisively on poverty and income inequalities because they are driven by neo-liberalism. Another problem with global institutions is that they do not represent local people adequately as they are supported by foreign governments (Mooney, 2012b: 385). Mooney's claim was confirmed by the health official:

Funders like PEPFAR which is American, the biggest financiers of health problems, come with these conditions which are politically motivated, so you need to listen to what the political masters are saying and dance to their music. Unfortunately, that hit us on the principles of PHC.

(Health official, interview with author, 2018).

The entrance of global funders means that the Ministry of Health is forced to consider their mandate instead of focusing on the national health policy. According to the health official, “it is difficult to say no to these organisations,” since the financial aid is needed. As previously mentioned, Eswatini spends approximately 3.8% of GDP on health care (including private), and 60% comes from Government, accounting for approximately 2% of GDP, while additional funding comes from development partners, the private sector and individuals (MOHSW, 2003; MOHSW, 2006: 6). Regardless of the many challenges in the Eswatini health system, the health official was optimistic because of the then upcoming Global Conference (25-26 October 2018 – Astana, Kazakhstan) to renew the Alma Ata Declaration’s PHC commitment to achieve universal health coverage and sustainable development goals. He hoped that Eswatini Ministry of Health would send representatives to the Global Conference which would remind policy makers and practitioners of the importance of PHC and help in the process of mental health integration into PHC.

#### 4.5 Conclusion

From the findings it is evident that the lack of MHI into PHC is due to many factors, which include dated mental health legislation and policy, limited nurses and other health practitioners, no mental health care training for PHC nurses, and the nurses’ negative attitudes towards mental health patients. Lack of training means that nurses are unable to adequately offer mental health service to patients. There is also no clarity on the nurses’ roles and responsibilities, as a result the participants hold the view that only nurses who have specialised in mental health care should offer primary mental healthcare in clinics. Another factor affecting MHI into PHC is neo-liberalism and the negative impact on Eswatini national institutions such as the health system. Neo-liberal policies have opened the door for global institutions to enter the country and shape the health care mandate. The ministry of health has different strategies for the functioning of PHC however, because of the influence of neo-liberalism the government has not been able to implement their strategies.

## CHAPTER 5: A CONCLUSION

### 5.1 Introduction

This chapter provides a concluding discussion of the study. It will also outline recommendations that were given by nurses, and the authors personal recommendations from observation while doing the study. The limitations for this study will be discussed, as well as recommendations for future research on health care policy and practice in Eswatini and other African countries.

### 5.2 Conclusion

The primary goal for this research was to explore and understand the extent of the integration of mental health into primary healthcare in the Hhohho region in Kingdom of Eswatini. The WHO world health report in 2001 advocated for mental health to be integrated into PHC for all UN member states. The report aimed to raise public and professional awareness of the real burden of mental disorders and their costs in human, social and economic terms (WHO, 2001: xii). The report was also aimed at dismantling barriers of stigma, discrimination, and inadequate services which prevents millions of people, globally, from receiving the treatment they need and deserve (WHO, 2001). It provides a new hope for mental health and mental illness in the world, by suggesting ways in which governments can provide a better mental health care services to the people. Integration of mental health into PHC is the first recommendation given by WHO. Primary care for mental health forms a necessary part of comprehensive mental health care, as well as an essential part of general primary care (Funk, *et al.*, 2008a: 15). Primary care for mental health is fundamental, however, it must be supported by other levels of care including community-based and hospital services, informal services, and self-care to meet the full spectrum of mental health needs of the population care (Funk, *et al.*, 2008a: 15).

Integrating mental health into PHC means that the public has better access to mental health care as PHC is the first level of contact for the community with the health system. PHC is known to be the closest and easiest form of care available and usually located near people's homes. It also allows for early detection and early treatment of any mental illness while it is still easier and cheaper to manage. The government of Eswatini prides itself in having an estimated 85% of the population live within a radius of 8 kilometres from a health facility (MHSW, 2006: 9), however, this is futile if people are not able receive the health services that they need (like primary mental health care) at these health facilities. The ministry of health in Eswatini acknowledges the importance of integrating mental health into PHC and the

significance it plays in providing better mental health care for the public. Although the importance of MHI is acknowledged, there are various factors that stand in the way of the integration process in Eswatini, and as reviewed case studies show, MHI is also a challenge in other African countries.

This study found that a lack of human resources was an impeding factor on MHI into PHC in Eswatini. In many of the clinics, nurses expressed that they are under-staffed, and overworked. More importantly, there is a shortage of nurses who are specialised in mental health care. The nurses were not clear whether they are responsible for providing PHC mental health care or government should employ nurses who are mental health specialists. However, some of them acknowledged that the national nursing diploma course includes mental health as a subject for all trainee nurses.

Another related finding was lack of knowledge, training and skills for primary mental healthcare. This study found that nurses did not have adequate knowledge and skills on primary mental health care. Some nurses said that primary mental healthcare is limited to dispensing drugs to mental health patients, who have been prescribed medication by psychiatrists and other mental health care professionals in psychiatric hospitals. Referral to psychiatric hospitals is one of the functions of PHC practitioners, and the others include mental illness screening, and mental health education (Hlatjwayo, 2000: 48). The study found that the level of skills on primary mental health in PHC need urgent prioritisation by the government. Nurses work based on the roles and responsibilities outlined in their job descriptions, which are informed by the goals and objectives of the national health policy. Although the Eswatini DoH acknowledges the importance of MHI into PHC, there are no clear implementation strategies. There is also no mental health policy or mental health legislation that shows the government's plan to address mental health in the country. This is one of the contributing factors to the poor integration of mental health into PHC. Mental health policies, plans and laws should reinforce the development of a strong primary healthcare system as well as the integration of mental health within that system (Funk, *et al.*, 2008b: 6). The presence of mental health policy in particular can define the specific objectives to be strived for in integrating mental health (Funk, *et al.*, 2008b: 6).

An important contributing factor to mental health care provided at PHC level was the nurses' attitudes and beliefs towards mental illness. The fact that the majority of nurses have a four-year Diploma in nursing indicates that PHC clinics are well covered by nurses who have

psychiatric nursing training, regardless of what they choose to specialise in. However, personal attitudes and beliefs influence how a nurse will respond to a mentally ill patient. This is shaped by socially constructed ideas about mental illness which are influenced by culture, religion and other beliefs.

A major finding of this study was the influence of neo-liberal policies on health care. Neo-liberalism seeks to promote economic growth by an upward redistribution of income and wealth, a greater reliance on free market and a downsizing of the state (Abramovitz and Zelnick. 2010: 97). In order for the government to implement MHI into PHC, it is important to consider the role of neo-liberalism in health care and health care policy. Navarro (2007b) argues that national health policy should be inclusive of the political, economic, social, and cultural determinants of health. Low and middle-income countries are pushed towards private care through the World Bank and IMF led structural adjustment programmes (Mooney, 2012b).

### 5.3 Recommendations

The government should invest in extensive mental health training for PHC nurses, as they need a clear understanding of primary mental healthcare, and the kind of services that should be provided at PHC level. The knowledge, attitudes and beliefs held by nurses about mental illness play a significant role in the provision of primary mental health care services, so training workshops can bring knowledge and sensitisation that will counter these negative beliefs and stereotypes. Funk *et al.*, (2008) also recommend that continued professional development training courses of primary healthcare workers should also include a strong mental health component.

Another recommendation is that the Eswatini MoH should consider providing psychologists, social workers, and counsellors at the PHC facilities. This will not only provide the much-needed mental health care at PHC level, but it will ease the burden of care for the nurses. All nurses in this study complained about being overworked due to under staffing. Many health systems in low-income countries make use of community health workers. Studies show that training community health workers in mental health lead to a significant increase in people who come to the clinics for primary mental health services. A recommendation is that MoH train community health care workers in mental health to ease the burden on PHC nurses. Community health care workers are often well positioned for broader and more empowering roles such as mobilising and organising the vulnerable members in the community. This will also help with public mental health education.

Another recommendation is that the MoH needs a mental health policy to direct mental health care at PHC levels, as well as in the rest of the health system.

A final recommendation is that the MoH should focus on preventative measures such as education on mental health, and work in collaboration with other sectors like the Ministry of Labour in reducing unemployment. Mental health education can be incorporated into the existing health education in schools, and more research on mental health in Eswatini should be carried out, as this will inform health policy and allow for effective intervention strategies. One of the challenges experienced in this study was the insufficiency of literature on mental health in Eswatini. The issue of mental health requires an intersectoral collaboration between the different ministries in the cabinet as most of the challenges and effects are integrated.

#### 5.4 Limitations and recommendations for future studies

It is important to note that during the time when data was collected, nurses and teachers were engaged in a nation-wide strike. All nurses in public health facilities were instructed by the Swaziland Democratic Nurses' Union (SDNU) not to provide any service to the public. In some healthcare facilities nurses were not present at all, while in some places nurses were on a go slow. The strike was as a result of the demand for a 6.5% wage increase by the nurses. The strike lasted for about two weeks. This affected the data collection process as during the scheduled days of site visits, nurses were unavailable, and the researcher was told to return the following day. This happened on two occasions. Even during the interviews, in some areas the environment was hostile due to the ongoing strike, so the nurses were not as welcoming or opening-up and this affected the data collection process, and the quality of the information gathered. Because of the strike, some clinics were short-staffed as some nurses may have chosen to actively participate in the protest action. This meant that there was a lot of work to do and the nurses were unable to prolong the interview time because of this. The study was conducted in the clinics in the Hhohho region and cannot be generalised to the rest of the country. Another limitation is that only nurses and one health official were interviewed, interviewing other health professionals and policy makers could have enriched the study.

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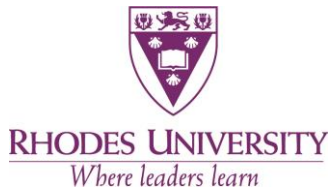
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# APPENDICES

## Appendix 1



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### **Participant Consent form (Interviews)**

I want to thank you for taking the time to meet with me today. My name is Zenanile Zoe Dlamini, a Master of Social Sciences degree student registered with Rhodes University. I am doing a research on the integration of mental health into primary healthcare in the country. I would like to talk to you about this clinic and the mental healthcare service offered here.

This research project will assist the researcher in understanding how mental health has been integrated into mental health in the country, looking at the accomplishments and challenges that the government has faced, and how this can be improved for future interventions. The interview should take about 10- 15 minutes. All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent.

There are no benefits or risks to you of participating in the study. Your participation is entirely voluntary, and you are free to decline the invitation altogether or to withdraw at any time without having to give any explanation. Confidentiality will be ensured, as research codes will be used.

All information you volunteer will be treated with the strictest of confidence. Publication of results will only show grouped information. No personal or company names or any identifying information will be published. If you are interested results can be given to you after the study is completed. All the data gathered from this study will be fully owned by the Ministry of Health and made available to the Ministry for any further use.

Remember, you do not have to talk about anything you do not want to and you may end the interview at any time. Are there any questions about what I have just explained?

You will be given a copy of this consent form to keep for your own records.

By signing this form you are agreeing with the following:

### **Declaration**

1. I confirm that the purpose of the research and the nature of my participation have been explained to me verbally or in writing.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason - however I commit myself to full participation unless some unusual circumstances occur, or I have concerns about my participation which I did not originally anticipate.
3. I understand that data collected during the study, will be used by the researcher and that my personal details gathered during this research, especially my name or identity, will be kept private.
4. I agree to be interviewed and to allow audio or video recordings and transcriptions to be made of the interview.
5. I have been informed by the researcher that the tape recordings will be erased once the report is written.

Thank you for taking the time to read this information letter. Should you require any further information regarding the study or your rights as a study participant you are free to contact me on the following telephone number 26879433061 or email me using the following address: [zoe.samketii@gmail.com](mailto:zoe.samketii@gmail.com)

**Signature of participant:**

**Signature of the researcher:**

**Date:**

## Appendix 2

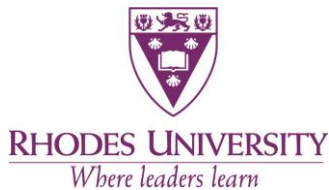
### KEY INTERVIEW QUESTIONS FOR PHC NURSES

1. Introductory remarks
2. What role does primary health care play in mental health?
3. What kind of mental healthcare services are provided at this clinic?
4. Have you received mental health training? If not...
5. Is there a demand for mental healthcare at this clinic?
6. Do you think that mental healthcare should be integrated into PHC services in Eswatini, why?
7. In what ways do you think this integration can be done?
8. How do you think the government can better support PHC Clinics in the Kingdom, more especially when it comes to MHI?

### KEY INTERVIEW QUESTIONS FOR GOVERNMENT OFFICIALS

1. Introductory remarks
2. What is the Ministry of Health's policy on mental health?
3. How is mental health managed in the country?
4. The WHO advocates for the integration of mental illness services into PHC, do you think this should be done in Eswatini?
5. What are the challenges faced in terms of providing mental healthcare services in the country?

## Appendix 3



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[www.ru.ac.za](http://www.ru.ac.za)

**Date:** 2018-08-31

Dear Zoe Dlamini

**Tracking Number:** SOC2018/49

**Title:** Mental Health, where are we now?: A sociological analysis of the integration of mental health into primary healthcare in the Kingdom of Eswatini.

This letter serves to notify you that the ethics application submitted to the Sociology Department Ethics Sub-committee and the Rhodes University Ethics Standards Committee (RUESC) is approved with stipulation from RUESC that you obtain permission letters from sisters-in-charge (or other officials) at the clinics included in your study.

Please ensure that the ethics standards committee is notified should any substantive change(s) be made, for whatever reason, during the research process.



Ms J Chisaka (Chair)

Tel: 027 46 603 8890

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Professor M Drewett (Sub-committee member)

Tel: 027 46 603 8360

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Ms B Sishuta (Sub-committee member)

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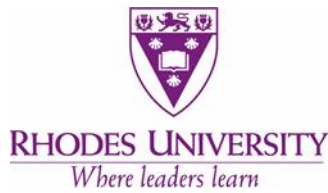
## Appendix 4



### Research Protocol clearance certificate

Type of review	Expedited	<input checked="" type="checkbox"/>		Full Board		
Name of Organization	STUDENT (MASTERS)					
Title of study	Health, where are we now? : A sociological analysis of the integration of health into primary healthcare in the Kingdom of eSwatini.					
Protocol version	1.0					
Nature of protocol	New	<input checked="" type="checkbox"/>		Amendment		Renewal
List of study sites	MOTSHANE CLINIC, EZULWINI SATELLITE CLINIC, NKHABA CLINIC, MOH HEAD QUARTERS					
Name of Principal investigator	ZENANILE ZOE DLAMINI					
Names of Co- Investigators	N/A					
Names of steering committee members In the case of clinical trials	N/A					
Names of Data and Safety Committee members in the case of clinical trials	N/A					
Level of risk (Tick appropriate box)	Minimal			High		
	<input checked="" type="checkbox"/>					
Clearance status (Tick appropriate box)	Approved	<input checked="" type="checkbox"/>		Disapproved		
Clearance validity period	Start date	27/09/2018		End date	2019	
					7/09/2019	
Signature of Chairperson						
Date of signing	27/09/2018					
Secretariat Contact Details	Name of contact officers		Ms Stmange			
	Email address		<a href="mailto:kaluamasi@zmail.com">kaluamasi@zmail.com</a>			
	Telephone no.		(00268) 24040855/24044905			

## Appendix 5



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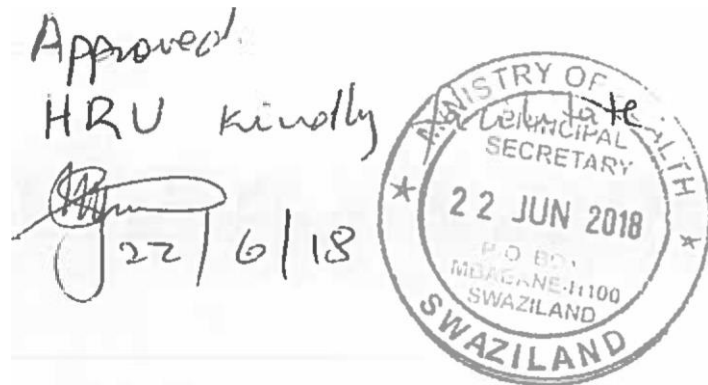
2018-06-19

Ministry of Health

P O Box 5

Swaziland

Dear Sir/Madam



RE: PERMISSION To CONDUCT STUDY AT THE MINISTRY OF HEALTH

Research Title: Mental Health, where are now?: A sociological analysis of the integration of mental health into primary healthcare in the Kingdom of Eswatini.

My name is Zenanile Zoe Dlamini and I am a student at Rhodes University, in the Department of Sociology, studying towards a Master of Social Sciences degree in Development Studies under the supervision of Ms Janet Chisaka ([J. Chisaka@ru.ac.za](mailto:J.Chisaka@ru.ac.za)). I am conducting a study on the integration of mental health care into the primary health care (PHC) system in Eswatini. The aim is to understand this process of integration, and the type of mental health problems that are handled at the PHC level. I am seeking permission to conduct interviews with five nurses and three health care providers, such as counsellors, at the PHC facilities in Hhohho Region. I would also need to interview two officials in the Ministry of Health, ideally those who deal with the mental health policy.

I have obtained ethical clearance from the Department of Sociology Ethics Sub-Committee, and I will also apply for ethics clearance from the Rhodes University Ethics Standards Committee.

Thank for your time and consideration. For any further queries you may contact me on the following number +27723475232 or this email [zoe.samketii@gmail.com](mailto:zoe.samketii@gmail.com) or my supervisor [j.chisaka@ru.ac.za](mailto:j.chisaka@ru.ac.za).