

MENTAL HEALTH POLICY IMPLEMENTATION
AS AN INTEGRAL PART OF PRIMARY HEALTH
CARE SERVICES IN OSHANA REGION, NAMIBIA

A THESIS SUBMITTED IN FULFILMENT
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ABSTRACT

Despite the 1990 health system reforms in Namibia, mental health still receives low priority. Pressed with limited resources, health policies are directed at communicable and life-threatening diseases. On primary health care level, there is either an absence of or fragmented mental health services. As a result, when patients suffering from common mental disorders visit the curative health services, delays are experienced in the identification and diagnosis of their conditions, which in turn leads to poor treatment and rehabilitation outcomes that often result in permanent disability that places a heavy burden of care on the family. It is against this background that a descriptive study of the implementation of the mental health policy was launched in 2005 in the Oshana region of Namibia in order to assess the extent of the policy's implementation.

The aim of the study was to explore and describe the extent to which the mental health policy has been implemented and to identify the challenges faced by nurses in primary health care settings. A quantitative, explorative, descriptive design was used, in terms of which a total population of sixty-four (64) nurses from (13) health facilities and (12) health programme administrators in the Oshana region were included in the study. Data were collected using open and closed-ended questions to policy implementers whereas health programme administrators answered an open-ended self-administered questionnaire only.

The results of the study showed that there is a lack of supervisory support by general health service managers at all levels, from facility managers to regional health managers; restrictions that prohibit primary care nurses from prescribing common psychotropic medications; a shortage of mental health professionals to provide ongoing supervision and support to Primary

care practitioners; and lack of training among the policy implementers in the identification and management of mental disorders.

Hence, basic mental health services such as counselling, follow up and after care of discharged patients, including home visits are not available in 94% of health facilities in the region. This study found that although 77% of the research participants were trained in mental health; none of them expressed confidence with regard to delivering mental health services to their clients. These results were found to be consistent with those of previous similar studies conducted in South Africa, Zambia, and Uganda. The challenges to mental health policy implementation that were identified by the participants include conflicting policies and the lack of guidelines for identifying and managing mental health disorders.

The study recommends that, health care providers should be provided with additional in service training in mental health in order to enhance their knowledge and skills to enable them to provide mental health care to their patients. The study further recommends that further research can be done to explore the possibility of having a separate division at both regional and district levels be created to oversee mental health policy implementation in the region. These recommendations are crucial for addressing the challenges inherent in the implementation of Namibia's mental health policy.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immune deficiency syndrome
HIV	Human immunodeficiency virus
MoHSS	Ministry of Health and Social Services
NEMLIST	Namibia Essential Medicines List
NGOs	Non-governmental organisations
PHC	Primary health care
STIs	Sexually transmitted diseases
TB	Tuberculosis
WHO	World Health Organization

DEDICATION

This thesis is dedicated to my grandmother, Naemi Ndivashii Shilyatukeni-Nghishiiko, for her continual encouragement and support and for having brought me up in the fear of the Lord and teaching me the value of hard work. May her soul rest in perfect peace.

DECLARATION

I, Daniel Opotamutale Ashipala, hereby declare that this study is a true reflection of my own research, and that this work, or part thereof, has not been submitted for a degree from any other institution of higher education.

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Date.....

DANIEL OPOTAMUTALE ASHIPALA

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CHAPTER 1

1. INTRODUCTION AND BACKGROUND TO THE PROBLEM

1.1. INTRODUCTION

Health care services in Namibia are provided by the government of the day through the Ministry of Health and Social Services (MoHSS) and the private sector. These health care services are a combination of promotive, preventive, curative and rehabilitative services. In order to render these services, the MoHSS is divided in 13 operational health regions corresponding to the 13 delimited political and administrative regions. These regions are further divided into 34 districts. The districts are managed by District Coordinating Committees which are responsible for providing basic health care services. In the Oshana region, the delivery of health care services is offered through a comprehensive primary health care approach, which is both the foundation and cornerstone for the provision of basic health care. Basic health care services are rendered to patients at health care facilities and include dressings, screening, routine vaccination, family planning, tuberculosis (TB) treatment, ante natal care, postnatal care and growth monitoring, health education and counselling.

For long time, mental health services were only available at the mental health units at the Windhoek Central Hospital and the Oshakati Intermediate Hospital. These services followed a curative approach (curative based) whereby the patient was admitted and received treatment and, when the condition became stable, he or she would be discharged (MoHSS, 2005). Access to mental health care was limited because the treatment and follow-up services were only available at regional and district hospitals, despite the fact that more than 60% of the Namibian population live in rural areas (Maloboka & Mbarandonga, 2011, p. 16).

However, the literature seems to suggest that this trend/pattern of curative-based health care, where patients with mental health needs have to travel from remote areas to urban facilities, is no longer seen as the most appropriate for health care provision. This follows the adoption of a PHC approach for the entire population of Namibia at a cost that the community and the country can afford (WHO, 2009).

1.2 BACKGROUND TO THE PROBLEM

Prior to independence in 1990 health care services in Namibia were fragmented along ethnic lines and were largely curatively oriented (MoHSS, 2010). After independence the Government of the Republic of Namibia, through health services rendered by the (MoHSS) extensively restructured the health care services. This was done to redress the pre-independence fragmentation. The restructuring of Namibian health care delivery led to the adoption of a comprehensive (PHC) approach, which is the basis for the provision of health care services to all communities (MoHSS, 2010).

Thus, PHC services are offered according to the elements of PHC approach as proposed by the World Health Organization (WHO) (Dreyer, 2010):

- immunisation against major infectious diseases
- maternal and child health care including family spacing
- basic housing and basic sanitation
- prevention and control of local endemic diseases
- education and training on prevailing diseases in communities and methods of preventing and controlling them

- appropriate treatment for common diseases and injuries and minimising the aggravation of disabilities from physical, mental, social and spiritual impairments
- community participation in health and social matters
- promotion of adequate nutrition and supply of safe water (WHO, 1978).

The purpose of a PHC approach was to implement the health policies of the Government of the Republic of Namibia and to enable service providers to plan integrated and holistic health services in health facilities at the community level, so that these could, in turn, provide comprehensive health services including health centres and district hospitals. It was also intended to link these facilities to a rational hierarchical referral system. This would consequently enable the development of a comprehensive continuum of preventive and promotive health care organised with regard to the life cycle from conception to old age.

Good progress was also made in the utilisation of and access to service delivery, with an estimated 80% of the population living within ten kilometres of public health facilities (MoHSS, 2010). In addition, 21% of the population lives more than ten kilometres from a health facility and has to travel long distances to reach a health facility that provides comprehensive health care services (MoHSS, 2005).

According to the MoHSS (2010), Namibia's road network infrastructure is among the best in Africa; however, the human resources and managerial expertise for administering the health sector are inadequate. Moreover, existing infrastructure and equipment favour curative care and many hospitals are fairly new or still under construction. In addition, the facilities are unequally distributed among the regions. On average, in rural areas there are about 5,780 people per PHC clinic and 58,825 per district hospital. Recent hospital statistics in Namibia

describe heavy congestion as many people come to hospital directly before they visit the clinics or health centres in their vicinity.

Mental health services are considered to be a basic service offered as a package to clients. One way in which to address the challenge of mental health care has been proposed by the World Health Organization and that is that mental health care it should be decentralised and integrated into the existing PHC system with the necessary tasks being carried out as far as possible by general health workers rather than specialists in psychiatry (WHO, 2011).

Accordingly, it was envisaged that mental health services would be addressed under the elements that are appropriate for the treatment of common diseases and injuries and to minimise the aggravation of disabilities caused by physical, mental, social and spiritual factors (WHO, 2008d). The inclusion of mental health services in PHC is important for the following reasons:

Mental disorders make up five of the ten leading causes of health disability and, by 2020, it is predicted that unipolar depression will be the second most disabling health condition in the world (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006). The fact sheet produced by the WHO (2004) suggests that mental illness is on the increase worldwide and today as many as 1,500 million people worldwide are estimated to be suffering at any given time from some kind of neuropsychiatric ailment. Three-quarters of these people live in developing countries.

Mental health conditions are among the major causes of disability in the Namibian population. The 2006–07 Demographic and Health Survey (MoHSS, 2007) found that the disability rate in Namibia was 3.1% of this, 15% (7,360) comprised people registered as living with mental health problems.

According to MoHSS statistics, schizophrenia is the leading mental health diagnosis in outpatient settings – schizophrenia being more likely to be associated with disability. Such figures are considered to be underestimated and do not reflect the real situation because of the poor detection rate, as only some of those with mental health needs get identified by nurses and doctors. The best estimate for Namibia comes close to the international figures: approximately 15% of the population has mental health problems of which 3% has a serious/major mental health problem and 10% a common mental disorder. Added to this, 2% of children has either serious mental health problems or learning or behavioural problems (WHO, 2009).

In Namibia, mental health services are offered by both the private sector and the public hospitals. In this study only public health services were considered. In the public health sector curative mental health facilities are available and the existing mental health services in the country focus mainly on institutionalised care at the Windhoek Mental Health Care Centre and the Oshakati Psychiatric Unit. Mental health care is little developed in the regions except for inpatient care in the two hospitals mentioned. Accordingly, the geographical spread of mental health facilities does not meet the needs of the population with mental health requirements. Moreover, little community care has been developed except for a few nongovernmental organisations (NGOs) operating in selected areas. Furthermore, there is a severe shortage of specialised staff; that is, doctors and nurses who are able to render proper mental health services (MoHSS, 2010).

As a result, overall access to primary preventive mental health care services remains very low especially by the rural population which forms over 65% of the Namibian population. This pattern of health care is likely to lead to the majority of people not being able to receive proper mental health treatment. This is primarily due to the scarcity of specialised human resources in the mental health field and the lack of health care professionals at PHC level. Moreover, the

staff that are in place seem to lack the necessary capacity and the confidence to include mental health activities in their daily work. As a result, many mental and neurological disorders are attended to by traditional healers and church ministers with sufferers being chained up and prayed for.

Owing to the challenges in mental health service provision, in March 2005 the MoHSS launched a National Policy on Mental Health. One of the key strategies of the policy was to develop decentralised mental health services that are integrated within the existing health services through PHC, including an established referral system and outreach to the community (MoHSS, 2005).

The aim of this policy is to achieve and maintain a high standard of mental health and wellbeing in the population of Namibia. It is also intended to contribute to the mental fitness and wellbeing of all citizens by introducing promotive and preventive activities and thereby improving the detection of, and care for, people suffering from mental illness in order to ultimately reduce psychopathology. The policy provides a framework in terms of which mental health programmes are designed, implemented, monitored and evaluated using the multi-disciplinary, multi-sectoral approaches within the context of PHC to provide the Namibian people with the highest achievable mental health services (MoHSS, 2005). This goal is to be achieved through the development of a comprehensive community-based mental health service that is decentralised and integrated into the general health service.

The main features of the Namibian mental health policy implementation are the training of mental health workers, the decentralisation and integration of mental health services with existing health services and the development of a network of organisations, services and referral systems. For that to happen, PHC for mental health must be supported at all levels of

care, including community-based and hospital services, informal community care services and self-care (WHO, 2007a). Communities are the focal points for action and all planning and allocation of resources must take into account the needs of the communities such as the prevention of neurological disorders and psychopathology (WHO, 2005a).

According to the WHO (2008a), possible challenges faced by nurses in implementing the existing policy could be due to limited human resources and inadequate training. Other possible challenges facing the implementation of the policy could be the insufficient promotion of advocacy and activism within communities and the mental health and disability movement to lobby for the implementation of the mental health policy (WHO, 2008a).

Possible challenges to implementing the policy could be a result of the low priority given to mental health at both regional and national levels and the limited bargaining power of national mental health coordinators in promoting the prioritisation and resourcing of mental health services (WHO, 2005a).

The failure to address the above-mentioned gaps in policy implementation is likely to result in the gross absence of systematic preventive activities which will result in not enough attention being given to the promotion of mental wellness (WHO, 2005b). In addition, failure to implement mental health policy is likely to lead to the unavailability of local mental health services, which will in turn result in a low awareness of mental health conditions with regard to early identification and diagnosis. The delayed identification and diagnosis of mental health conditions is likely to lead to the poor treatment outcomes and failing rehabilitation that often lead to permanent disability, and which places a heavy burden on the family (WHO, 2005b). Currently, it would seem that mental health disorders pass through the fingers of PHC providers unnoticed, as little is done to identify them and nothing is being done or offered in terms of

management; thus leading to continued ill health, dysfunction and poor quality of life (Alibusa, 2011).

1.3 PROBLEM STATEMENT

Despite the efforts of the MoHSS in March 2005 to develop and launch a policy on mental health services, it would seem that the policy has not been implemented effectively. Accordingly, it is unclear whether this policy has been properly and effectively implemented within the PHC approach. This statement can be substantiated by the researcher, who while working as a registered nurse in the PHC facilities did not observe the progress and effects that should have been made through the implementation of the policy. If the policy had been properly implemented, then the effect of the implementation of this policy such as mental health service availability, follow-up treatment, rehabilitation and referral would have been visible. This was not the case, however. As a result, many mental and neurological disorders are attended to by traditional healers and church ministers. This has, for example, happened in Rundu where mentally ill patients are taken to pastors instead of seeking help from the hospital (*The Namibian*, 2012). It is also not clear if registered nurses are ready to implement the mental health policy in the context of PHC services.

In Namibia, between 1990 and 1996, mental health training for nurses formed part of comprehensive training. Subsequently, the course leading to a specialisation in psychiatric nursing was discontinued and was replaced by an introductory course in mental health nursing science as part of comprehensive pre-registration training for nurses at the University of Namibia. Mental health is a specialised service and nurses who are to provide such services are also supposed to specialise in mental health.

One of the possible consequences of the absence of mental health care in PHC is that many of the efforts to improve patients' conditions are subsequently wasted by insufficient after care leading to failing rehabilitation (WHO, 2008c). Another possible consequence of the absence of mental health in PHC is that it is likely to create wastage of effort, costs and subsequent psychotic relapse among patients with mental disorders.

The consequences of mental health care services not being integrated in the mainstream of PHC can be attributed to the absence of mental health policy implementation into PHC services. The fact that little or no attention is given to mental health care integration into PHC in the Namibian health care system calls for urgent action to be taken to address this problem.

In order to expect improvement in the implementation of mental health policy in PHC in the Namibian health care system, it is imperative to look at the factors responsible for the absence of mental health care in PHC. The above phenomenon has led to the formulation of the research questions for this study: What are the challenges facing nurses in implementing mental health policy in PHC services in the Oshakati district of the Oshana region? What do the nurses working PHC services need to enable them to implement the mental health policy in their PHC services?

1.4 PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of the study was to explore and describe the implementation of the mental health policy in PHC services and to identify the challenges faced by nurses in PHC settings.

The objectives of the study were to:

- explore and describe the extent to which registered nurses and health programme administrators are implementing Namibia's mental health policy in the Oshana region
- identify the challenges hindering the implementation of Namibia's mental health policy into the PHC services in the Oshana region.

1.5 SIGNIFICANCE OF THE STUDY

Ministry of Health and Social Services (MoHSS)

This study may be beneficial for the MoHSS in the sense that it will improve the ability of Namibia's registered nurses to integrate mental health services into their PHC services, thereby fostering quality care being rendered to communities.

The insights gained from this study may be useful for the implementation of a mental health policy that will ensure a high standard of care being rendered to the mentally ill. It will also enlighten the nation and the MoHSS in particular on the findings relating to the current status of mental health policy implementation in the PHC sector and its current implications for the health sector as a whole.

Nursing education

The research findings will assist the researcher in determining the need to design an in-service education training programme for registered nurses in mental health care services. The research results that will subsequently be generated from this research will act as indicators for future extensive research in this area. Student nurses are trained in mental health in Windhoek and Oshakati at the Faculty of Health Sciences of the University of Namibia; hence, the lecturers

who are responsible for the training and education of students can use these results to strengthen their teaching theory and practice.

1.6 OPERATIONAL DEFINITIONS

1.6.1 Primary health care (PHC)

Basic, essential health care is aimed at disease prevention and health promotion. Such services should be made universally available, accessible, acceptable and appropriate to the needs of communities (WHO, 1978).

1.6.2 Mental health

Mental health may be defined as a state of wellbeing in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2004, p. 12).

1.6.3 Mental health services

Mental health services are any facility that treats patients with mental illness and offers a variety of mental health-related services to the community. These centres treat various mental health issues, including substance abuse, anxiety, manic depression and schizophrenia.

1.6.4 Policy

A policy is a plan or course of action, as of a government, political party, or business, intended to influence and determine decisions, actions and other matters related to its standards or specifications. McClure and Jaeger (2008) state that policy is “directives intended to shape decisions and actions of individuals, organizations, and government agencies”. Yet, to Ohegbu

(2008) it means simply “guidelines to regulate participation”. Rubin (2010) offers us a more general definition by stating that “policy” typically refers to political laws or regulations yet can also mean a rule or practice followed more locally.

1.6.5 Policy implementation

Policy implementation may be defined as the accomplishment of objectives through the planning and programming of operations and projects so that agreed outcomes and desired impacts are achieved.

1.6.6 Care

Care is the exclusive aspect of nursing that provides for patients’ bodily comfort through the laying on of hands and provides an opportunity for closeness. It includes phenomena related to assistive, supportive and enabling behaviour toward or for another individual (or group) with evident or anticipated needs to ameliorate or improve a human condition or way of life (Leininger, 2006). It also includes action directed at assisting or helping another individual (or group) toward healing or wellbeing (George, 2011). In this study, care means efforts aimed at the reduction of discomfort and disability rather than cure. The symptoms and their disturbing qualities are mitigated and the individual returns to acceptable levels of social functioning and thus disability is reduced or eliminated.

1.6.7 Mental health nursing care

Mental health nursing care is a direct intervention by a nurse on behalf of a patient. It involves observation, evaluation, diagnosing, assessing, treating, counselling and serving as an advocate. The symptoms and their disturbing qualities are mitigated and the individual returns to acceptable levels of social functioning. Mental health nursing care eliminates or reduces disability.

1.6.8 Registered nurse

The registered nurse is seen as a person with unique knowledge who is licensed to practise nursing and is registered in terms of sections 20 and 64 of the Nursing Act No 8 of 2004. She or he communicates this knowledge through different means to patients/clients, colleagues and other members of the health care team (Government of the Republic of Namibia, 2004).

1.7 PARADIGMS AND PHILOSOPHICAL UNDERPINNING OF THE STUDY

LoBiondo-Wood and Haber (2006) describe a paradigm as a set of assumptions about the basic kinds of entities in the world, about how the paradigmatic entities interact, and about the proper methods to use for constructing and testing the theories of these entities. According to Brink, Van der Walt and Van Rensburg (2008), a paradigm helps the researcher to be organised in his or her thinking, observing and interpreting processes. In essence, a paradigm frames the way in which a discipline's concerns are viewed, and the direction that the research project takes by clearly structuring the questions which must be posed. It eliminates that which is external to the conceptual boundaries of the paradigm, it provides a link to certain types of research method, and it suggests criteria with which the researcher can judge the appropriate research tools and which can be used to evaluate the quality of research efforts (Brink et al., 2008). The philosophical basis of the study is positivism. Positivism holds the view that the scientific method is the only way to establish truth and objective reality. This study is based on the following assumptions:

Ontological

An ontology is defined as a patterned set of assumptions about reality. The fundamental ontological assumption of positivism is that there is a reality out there that can be studied and known. The nature of reality is that it is relatively constant across time and setting, and can be

effectively studied, explored and known. The related assumption of a phenomenon is that there is a belief that this phenomenon is not random events but rather has causes. It is part of the researcher's duty to discover this reality which, in this case, is the implementation of the mental health policy (Wagner, Kawulich, & Garmer, 2012).

A positivist view seeks to be objective as far as possible, and attempts to hold personal beliefs and biases in check. This also involves the use of orderly, disciplined procedures that are designed to test the researcher's ideas about the nature of the phenomenon being studied (Wagner et al., 2012).

Epistemological

According to Brink et al. (2008), epistemology is the knowledge of that reality that pertains to the challenges faced by the nurses in implementing the mental health policy. Furthermore, because the knowledge of the reality can be tested empirically, the data will be objective and therefore independent of the values of the researcher. The instrument that was used to collect the data was pre-tested to ensure that the results being collected produce truth (Wagner et al., 2012).

Axiological

Positivism checks values and biases as a way to validate the truth. Nursing as a profession constitutes certain values. In this study the scientific methods that were used attempt to achieve neutrality during the inquiry process (Wagner et al., 2012).

Methodological

According to Brink et al. (2008), methodology may be defined as the particular ways of knowing about a reality. The main objective of scientific enquiry in nursing is to understand and describe the practice of nursing in order to be able to control and improve current practice.

Hence, a functional approach reflects the primary service character of nursing as a science. A functional perspective will be used, as the usability of the generated knowledge will serve as a criterion for the truth. Methodology is deductive in nature with a fixed design in tight control over constructs; where the emphasis is placed on measuring quantitative statistical information that may seek generalisation. Accordingly, a quantitative approach was used to conduct the study, because quantitative research is used to “answer questions about relationships among measured variables with the purpose of explaining, predicting, and controlling phenomena” (Wellman, Kruger, & Mitchell, 2007). This will be discussed in more detail in chapter 3.

SUMMARY

This chapter presented an overview of global, regional and national estimates of the mental health burden. It also introduced the purpose and the objectives of the study and stated the problem to be addressed and the significance of the study. In addition, it dealt with the assumptions on which the study was based, as well as clarifying a number of concepts.

CHAPTER 2

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.1 INTRODUCTION

The purpose of the literature review was to convey current information about mental health policy implementation (Burns & Grove, 2005, p. 95). Conceptualisation in terms of the literature review involves integrating the study into a larger conceptual framework which, for researchers, is the body of scientific knowledge in respect of the specific discipline; in this case mental health nursing. In other words, the literature review conveys what is currently known about mental health policy implementation as an integral part of PHC services. In addition, by using various sources it examines different opinions concerning the components of mental health policy implementation. A questionnaire was subsequently developed on the basis of the literature reviewed in the study.

Relevant literature both outside the continent and in Namibia was scrutinised in order to provide additional insight into the research topic for this study. The literature in this review was obtained from published sources that identify achievements or lessons learnt, as well as the barriers shaping Namibia's process of integrating mental health into PHC services. The literature review was conducted under the following headings:

- the concept of mental health
- background to mental health in Namibia
- primary health care
- conceptual framework of the study.

2.2 THE CONCEPT OF MENTAL HEALTH

Mental health is a state of complete wellbeing that enables the fulfilment of one's full potential in occupational, social and relational functioning (MOHSS, 2005). It is a positive sense of wellbeing in which every individual realises his or her potential and can cope with the normal stressors of life. It is also concerned with individual ability to work productively and fruitfully, and applies when an individual is able to make a contribution to her or his community (De Haan, 2011).

The absence of mental illness enables us to feel positive about ourselves and other people and makes possible emotional and social wellness. This influences the way we think, do, feel and behave, the way we respond to the challenges of everyday life and how we cope with events, for example changing jobs, physical illness and the loss of loved ones. In addition, mental health has to do with one's ability to be productive in the workplace, school and family and in overall daily routine work (De Haan, 2011). An individual with good mental health has the ability to meet the demands of life, for example the ability to use their talents to make decisions, welcome new ideas and experiences, plan ahead and have no fear of the future.

An individual with a good mental health status believes in his own worth and the dignity and worth of others. He is capable of dealing with the inner world of thinking and feeling. Good mental health entails at least average intelligence, effective contact with reality, moderate or favourable levels of self-esteem and the acceptance of failure or loss without reacting in an exaggerated manner (Mohr, 2013). The individual with good mental health is capable of making their own assessment of their abilities and has the capacity to set realistic goals.

A good sense of mental health enables an individual to think clearly, solve the problems they face in life, enjoy happy relationships and feel spiritually at ease. It is not merely the absence of a mental disorder. An individual who lacks a good sense of mental health will not be able to experience emotions freely or to express these emotions in a manner which is acceptable. In the same vein, he or she will not have adequate independence from the group while still being able to satisfy group expectations of him or her (De Haan, 2011).

Mental health is therefore, crucial to the overall wellbeing of individuals in our society and the country at large. This raises the issue that mental health should be seen in a new light as a guiding star for better health. This is a key to development that will reduce suffering, while at the same time increasing alertness, and the capacity to cope with and enjoy life. If the mental health needs of a country are ignored then individuals who are suffering with mental health issues will not be able to make a significant contribution to society. Therefore, no health services or system is complete without attention being paid to the mental health needs of the population; it cannot be effective without incorporating concern for people's mental welfare.

The broader meaning of mental illness will now be discussed within the context/scope of the topic being investigated with a view to understanding, firstly, the need to prevent mental ill health; secondly, the rehabilitation and treatment of affected individuals and families; and thirdly, the promotion of mental health. In order to deliver these services successfully, the Ministry requires a mental health policy to address mental illness among the Namibian population. Mental illness is a state in which an individual suffers disturbances in perceptions, beliefs and thought processes, irritability and fatigue; and disturbances in concentration and mood changes (Maloboka & Barandonga, 2011). Mental illness entails the diseases of the mind that affect a person's thought, feelings or emotions, and behaviour and relations with others. An individual with mental illness thinks, acts and talks differently from others in a disruptive

or disorderly, confused or disorganised manner. Examples of mental illness are depression, bipolar disorder and schizophrenia. Individuals with mental illness suffer from progressive organic disease of the brain that causes an individual to possess abnormal personality traits that handicap the individual and/or others. Patients with mental illness tend to lose touch with reality and engage in excessive consumption of and dependency on alcohol and drugs. Mental illness poses a threat to both the individual and the family in the sense that the patient will continue to live a poor quality of life, while at the same time the family will have the burden of care (emotional and physical stress). The major effect of mental illness is that it creates a burden on the family, community and society at large. Mentally ill people are made vulnerable to poverty and cannot contribute to the development agenda of any given nation (WHO, 2011). The WHO emphasises that public health facilities should incorporate mental health promotion and chronic disease prevention efforts, through prompt treatment, outreach services, follow-up services and rehabilitative services, thereby developing comprehensive mental health plans to enhance the coordination of care (WHO, 1978).

2.3 BACKGROUND TO THE MENTAL HEALTH POLICY IN NAMIBIA

The PHC recognises that mental illness and mental disorders are a public health problem and place a burden on the health care delivery system. In 1995, the mental health programme was established under the Primary Health Care Directorate which was charged with the responsibility to design and formulate services geared to the prevention of mental ill health, the rehabilitation and treatment of affected individuals and families, as well as the promotion of mental health. In order to deliver these services successfully, the Ministry required a mental health policy (MoHSS, 2005).

The goal of the mental health policy is to achieve and maintain a high standard of mental health and wellbeing in the Namibian population, and to reduce the stigma attached to people with mental disorders. The policy defines the guiding principles, objectives and strategies for the implementation of a mental health programme nationwide. The mental health policy, therefore, specifies the functions to be performed by the relevant sectors and other stakeholders, with the MoHSS coordinating these stakeholders. This policy emphasises the importance of the provision of community-based mental health care services and embraces the strategies of early diagnosis, prompt treatment using effective medicine at every level of health care delivery and the provision of rehabilitation. This is to be achieved through the development of a comprehensive community-based mental health service that is decentralised and integrated into the general service (MoHSS, 2005).

2.3.1 MENTAL HEALTH POLICY DEVELOPMENT IN NAMIBIA

Like other countries in Africa such as South Africa, Zambia and Ghana, Namibia also carried out a needs assessment or mental health situational analysis in 1996 in order to inform the development of its policy process (MoHSS, 2005). However, the report from this need assessment is not available in order to determine the essence of it in terms of the manner in which it shaped the development and implementation of Namibian mental health policy development. In Zambia, for example, the data on the general and mental health social and policy environment, health stewardship, mental health burden, stakeholder needs and human financial needs, both available and required, were examined as part of a comprehensive country-level profile. Subsequently, the information was supplied to the drafters of the policy together with the key data needed to provide the necessary services at all levels of care in the country (Faydi et al., 2011). However, in Namibia this was not the case.

2.4 PRIMARY HEALTH CARE (PHC)

The concept of PHC refers to essential health care based on scientifically sound and socially acceptable methods and technology, which are made universally accessible to individuals and families in communities through their full participation. PHC is provided at a cost that the community and the country can afford in order for them to maintain health at every stage of their development in the spirit of self-reliance and self-determination (WHO, 1978). This care is to be provided as an integral part of primary health services of that country's health system. It is the central function and main focus of the health system and is integral to overall social and economic development (Dreyer et al., 2008). Such care is delivered at the first level of contact with individuals, the family and the community within the national health system, thereby bringing health care as close as possible to where people live and work. It also constitutes the first element of a continuing health care process (De Haan, 2011).

PHC came into effect with the adoption of the Alma-Ata Declaration in 1978, which identified a PHC approach as a strategy for health for all. Subsequently, in the last two decades, countries have embarked on implementing PHC. Since 1978 then, there has been considerable diversity in country experiences of PHC implementation (WHO, 1978). As a result of dissatisfaction with progress and pressure from international institutions, most countries including Namibia embarked on implementing health sector reforms such as decentralisation in order to provide an enabling environment for PHC implementation. While useful lessons can be drawn from country experiences, it is evident that none of the countries has fully achieved health for all (Schaay & Sanders, 2008).

The pillars of PHC in Namibia are similar to the global pillars. These are the right to health equity, pro-poor, community ownership, good stewardship and good governance. The

principles of PHC include community empowerment for meaningful participation, the enhancement of first-level care, strengthening national referral services and intersectoral collaboration (Schaay & Sanders, 2008).

In Namibia, the major gaps in health care delivery currently are the availability, accessibility and efficient management of service provision (MoHSS, 2010). On the urban fringe and in the rural areas this translates to time, cost, comfort, convenience and safety, all of which may affect care-seeking practices and the demand for modern health care. A health system where the lower-level facilities offering cost-effective services function poorly often results in an overload of the higher hierarchy of health facilities where health provision is more expensive, thereby overburdening the national health budget. It also decreases the efficiency and effectiveness of health services and health programmes because delays in simple health interventions result in life-threatening complications leading to high fatality rates. Currently, the health facility network in Namibia does not match the geographical terrain or population factors. In addition, health inequalities are perpetuated by differences in the economic standards of the people (Schaay & Sanders, 2008).

According to Dreyer et al. (2008), PHC approach comprises directions for the implementation and selection of elements for disease prevention and health promotion and curative and rehabilitative services that address priority health problems integrated in a way that makes them accessible at appropriate levels of care at an affordable cost. Such services include:

- immunisation against major infectious diseases
- maternal and child health care including family spacing
- basic housing and basic sanitation
- prevention and control of local endemic diseases
- education and training on prevailing diseases in communities and methods of preventing and controlling them

- appropriate treatment for common diseases and injuries and to prevent disabilities from becoming physical, mental, social and spiritual impairments
- community participation in health and social matters
- promotion of adequate nutrition and supply of safe water.

The provision of mental health services is included as one of the elements of mental health to be addressed. Most PHC delivery takes place through outreach points, clinics, health centres and district hospitals. More serious health conditions are generally referred to and treated at higher (secondary and tertiary) levels. Health centres and district hospitals offer secondary care, while tertiary care, which is the most specialised, is offered at the main referral hospitals in the major cities including Windhoek and Oshakati (MoHSS, 2005).

This hierarchy allows for different facilities to be staffed and equipped appropriately to provide different kinds of health services. Greater cost-effectiveness is also achieved by channelling problems to the levels where they are best treated (MoHSS, 2008). In Namibia, health care services are developed on the foundation of PHC, which has facilitated the development of a four-tier health delivery system that includes clinics, health centres, district hospitals, and regional and central referral hospitals.

2.5 CONCEPTUAL FRAMEWORK

Nearly all research studies in the social and behavioural sciences, regardless of programmes, require a rationale or base for conducting research. This rationale is often called the conceptual framework (Radhakrishna, Yoder, & Ewing, 2007, p. 62). Sekaran (2013) defines a conceptual framework as a conceptual model of how one makes logical sense of the relationships among several factors identified as being important. A typical conceptual framework provides concepts in the area under study and the relationships between them. Concepts are typically

represented by labelled circles or boxes, and relationships are represented by arrows (Jennifer & Frances, 2004, p. 36). Developing a conceptual framework can assist the researcher to identify key concepts which can be used to clarify thinking about the structure of the literature review in preparation for writing the review (Jennifer & Frances, 2004). It also helps the researcher to understand theory and concepts and the relationship between them.

In essence, the framework attempts to integrate key pieces of information, especially variables, in a logical manner, thereby conceptualising a problem that can then be tested. The conceptual framework usually frames the bigger picture of a study, identifies categories for the literature review and directs the research objectives (Van Dyk, 2008, p. 12). A typical conceptual framework provides a schematic description of relationships among independent, dependent, moderator, control and extraneous variables so that a reader can easily comprehend the theorised relationships (Radhakrishna et al., 2007, p. 62).

The conceptual framework that was selected for this study is a bottom-up approach to policy implementation that will explore the status of mental health policy implementation as an integral part of PHC services in the Oshana region (Gilson, Loewenson, & Pointer, 2008). The researcher used this approach to policy implementation which was developed by public policy analysts Gilson et al. (2008), because it was found to be suitable in giving a clear picture of the way public policy can be properly and effectively implemented. In addition, this approach gives a clear picture of all the role players in policy implementation, making it one of the best models/framework for this study

The bottom-up approach to policy implementation will address objective 1 and 2 of the study, that is, to describe and explore the extent to which of mental health policy has been implemented in the PHC services in Oshana region. This bottom-up model of policy

implementation contains a component on policy implementers. In addition, bureaucratic authority, policy implementers and multiple and, sometimes, conflicting top-down policy directives are other components that will also address objective 1 of the study. Accordingly, objectives 1 and 2 were addressed by the two components, namely, policy implementers and bureaucratic authority.

Although the framework also contains other components, such as national managers and politicians, they did not form part of the study because Namibia has only one national manager who coordinates mental health activities. Nevertheless, data collected from one individual will pose a challenge in generalising the findings to the population under study, as they may not be a true representation of the population being studied. Accordingly, the study focused mainly on the roles of registered nurses and health programme administrators in implementing this policy and, as a result, the politician component in this framework was not discussed or included in the study.

Objective 3 of the study was to identify the challenges hindering the implementation of Namibia's mental health policy in the Oshana region. To address part of this objective the bottom-up approach to policy implementation contains a component on multiple and sometimes conflicting top-down policy directives, which will assess the effect of conflicting top-down policy on mental health policy implementation.

This study on mental health policy implementation as an integral part of PHC services in the Oshana region was based on the conceptual framework derived from the bottom-up approach to policy implementation by Gilson et al. (2008). In this study the framework consists of five sections/components. However, only four components were discussed namely, policy implementers, bureaucratic authority, top-down and sometimes conflicting top-down policy

directives, and national managers. The diagrammatic representation of the various components of this conceptual framework is found on the next page (figure 2.1).

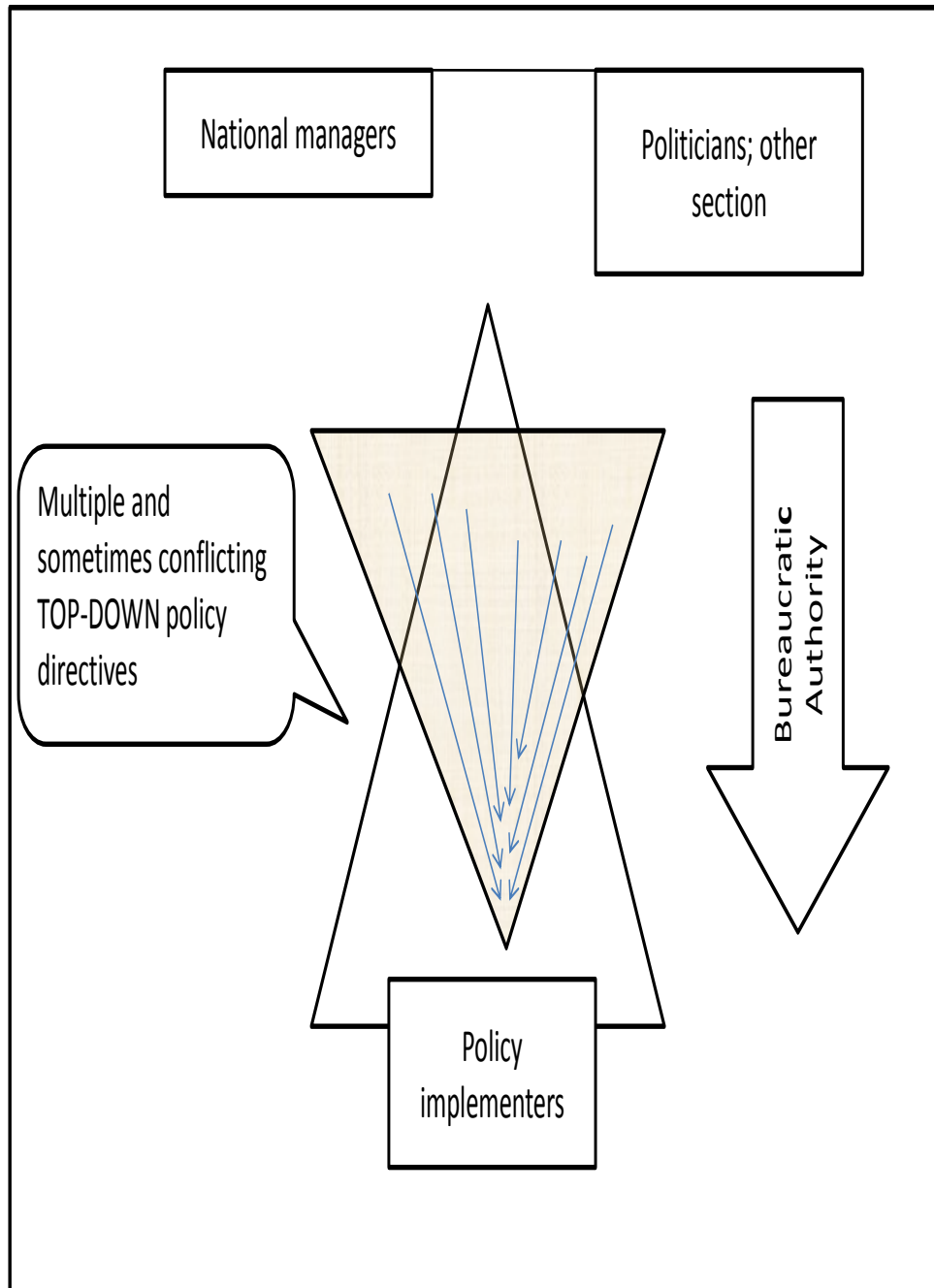


Figure 2.1 Framework for the study

Source: Gilson et al. (2008)

2.6 BOTTOM-UP VIEW OF POLICY IMPLEMENTATION

The conceptual framework for this study is based on the bottom-up model of policy implementation. A bottom-up view of policy implementation is an approach to a problem that begins with details and works up to the highest conceptual level: "bottom-up parser"; "a bottom-up model of the reading process", or bottom-up programming. A bottom-up approach pieces together the systems that give rise to grander systems, thus making the original systems subsystems of the emergent system (Goldstein, 2010).

These subsystems are elements which are linked together to form a larger subsystem, which then in turn are linked, sometimes at many levels, until a complete top-level system is formed. This strategy often resembles a "seed" model, whereby the beginnings are small but eventually grow in complexity and completeness. However, "organic strategies" may result in a tangle of elements and subsystems, developed in isolation and subject to local optimisation as opposed to meeting a global purpose (Goldstein, 2010).

Equally important for implementation, however, are the ways that a wide range of other actors and stakeholders, including the public, public sector bureaucrats and health professionals, understand and respond to policy changes. Even when not acting as an organised lobby, individuals in these groups have the power to subvert and undermine implementation efforts.

Bottom-up implementation is an approach to programme implementation in which progress is made through the composition of available elements, beginning with the primitive elements provided by the implementation language and ending when the desired programme is reached. At each stage the available elements are employed in the construction of new elements which are more powerful in the context of the required programme. These new elements will in turn

be employed at the next stage in the construction of still more powerful elements and so on until the available elements can be employed directly in the construction of the desired programme.

Gilson et al. (2008) argue that for successful implementation of the policy to take place, a bottom-up approach to the implementation will be essential. Gilson and her colleagues identified the following key role players in the implementation of policy: implementers, multiple and some conflicting top-down policy directives, bureaucratic authority, national managers and politicians, and other sections. Gilson et al. also strongly believe that consultations with stakeholders, such as those stated here, are necessary for policy implementation to ensure that the resources required for implementation are in place and any policy directives that are likely to interfere with the implementation of policy are done away with.

2.7 KEY COMPONENTS OF A BOTTOM-UP POLICY IMPLEMENTATION FRAMEWORK

This section will discuss the various components of the bottom-up policy implementation framework. These include the policy implementers, bureaucratic authority, multiple and sometimes conflicting top-down policy directives, national managers and politicians in terms of the roles they play in policy implementation, what they need in order to implement the policy, and the problems they face in implementing the mental health policy.

2.7.1 POLICY IMPLEMENTERS

Policy implementers are the individuals in a given organisation who are responsible for putting the policy into action. They are trained workers who work day by day in an effort to put the policy into effect. However, gaps are commonly observed between what was planned and what actually occurred as a result of a policy (Buse, Mays, & Walt, 2005). The full implementation of policy requires implementation at multiple levels – national, state, district and facility level. However, national policies are often broad framework documents that are not always accompanied by guidelines or plans that specify implementation mechanisms or the roles and responsibilities of specific agencies.

As the name implies, the implementation of policy when following a bottom-up view of policy implementation always commences at the bottom level of any given organisation. In this study, the bottom level relates to the registered nurses who are providing PHC services and who are considered to be policy implementers. Policy implementers are orientated to the content of the policy. They very often receive training/in-service training in order to strengthen them so that they get insight into the action required by the policy. Policy implementers should be supplied with all necessary resources, such as a budget, transport, a focal person and space, in order for them to be able to implement the policy.

In this study, the policy implementers are the registered nurses responsible for providing mental health services to consumers at the facility level. The bureaucratic authority, on the other hand, comprises health programme administrators who are responsible for guiding the implementation of the policy. In order to bring about the effective and efficient implementation of the policy, health programme administrators should conduct regular supervisory support visits to the facility level. Other components such as national managers and politicians are there

to provide support and directives in terms of resources and capacity building. Sometimes, multiple and occasionally conflicting top-down policy directives are issued which may hinder the policy implementers in their work (Gilson et al., 2008). Zimbabwe has managed to implement a national policy for mental health to address the mental health issues in that country (Tsiko, 2006). Mental health care services in Zimbabwe are centralised in the PHC system and actual treatment of severe mental disorders is available at the primary level (Mudzingwa, 2007). PHC workers have the capacity to handle patients with severe psychosis and refer only those that they feel require specialised services. Regular training of primary care professionals is carried out in the field of mental health. In the last two years, after the implementation of mental health policy, about 2000 personnel have been provided with training. There are training facilities for the nurses, occupational therapists, rehabilitation workers and social workers. Training workshops for mental health are also organised from time to time at the district and provincial levels (Mudzingwa, 2007).

In Uganda, mental health services were decentralised in the 1960s, and the mental health unit is located at the regional referral hospital. These units are managed by psychiatric clinical officers. However, these services have been plagued by low staff morale, a chronic shortage of drugs and a lack of funds for community activities. Many people have little understanding of mental disorders and do not know that effective treatment and services are available. Accordingly, up to 80% of patients go to traditional healers before reporting to the health facilities. Despite the positive aspects in implementing the mental health policy, some challenges were experienced such as a lack of specialists, a lack of skills among in the general health workers to provide mental health care, and a critical shortage of mental health professionals to manage the expanded mental health units (Kigozi, 2007).

2.7.1.1 POLICY IMPLEMENTATION

While many countries have undertaken the reform of their mental health systems, the extent and type of reforms vary tremendously. Thus far, no country has managed to achieve the full spectrum of reform required to overcome all the barriers (WHO, 2009).

According to Anand, Pandurangi, and Nimesh (2009), integrating medical and mental health care has long been advocated, and although there has been unanimity that such an integrated service is desirable, there have been many challenges to the actual implementation and practice in all countries. For example, PHC physicians may be concerned about losing control of their practice or being stigmatised by seeing too many psychiatry patients. In one of the earliest training attempts conducted in India, it was indicated that only 10% of the trained general practitioners were thought to be likely to use the training in their practice.

The same study conducted in India by Anand et al. (2009) revealed that public health system efforts at integration could lead to unanticipated effects, such as the withdrawal of PHC providers from the system. Since the late 1970s, there have been attempts in India to integrate mental health care with PHC in rural areas through the training of multipurpose health workers, as in the Raipur Rani experience, and in training general practitioners so that they can deal with all patients presenting with mental health needs in various health care settings.

A study done by Kamran and Najma in India in 2007 revealed that common mental disorders are responsible for up to 10% of the total global disease burden. The growing evidence base for the efficacy and cost-effectiveness of treatments for these disorders raises the possibility of delivering huge health and economic benefits that can only be achieved by integrating mental health care with PHC services. However, experience gleaned from this study by Kamran and

Najma (2007) shows that delivering these treatments in resource-constrained settings is challenging because an adequate budget will be required to cover issues such as salaries, training of staff and transport. The study also revealed that at least one-third of all patients seen in PHC in low- and middle-income countries present with common mental disorders. The majority are not recognised nor are they effectively treated owing to a lack of knowledge in identifying mental health disorders.

Italy has managed to implement its mental health policy successfully, but it has left its PHC untouched. For the management of mental illness, Italy developed three alternatives to mental hospitals (WHO, 2008b). These include psychiatric beds in general hospitals, residential, in-hospital facilities staffed by full-time or part-time staff, and non-residential, outpatient facilities, which include day hospitals, day centres and outpatient clinics. This reform led to a reduction in the number of mental hospital residents by 53% and mental health admissions declined from 50% in 1975 to about 20% in 1994 (WHO, 2008b).

Belize has managed to implement its mental health policy within nationwide district-based mental health care. This was implemented in 78 district hospitals with a view to providing mental health care in an integrated setting. Before the implementation of this nationwide district mental health care, training was conducted for psychiatric nurses and primary care practitioners. Psychiatric nurse practitioners were trained to conduct outpatient clinics and home visits, which led to a reduction in the number of psychiatric hospitalisations and increased access to outpatient and community-based mental services (WHO, 2007b).

Iran managed to implement a mental health policy for that country whereby community health workers are responsible for active case finding and referral. General practitioners, on the other hand, have mental health care as part of their general responsibilities at health centres, with

specialists being based at district or provincial health centres for complex cases. This move has resulted in a significant proportion of the population being covered by accessible, affordable and acceptable mental health care (WHO, 2005c).

South Africa implemented its mental health policy in Mpumalanga province. All its PHC facilities provided an integrated service with two different models being used to integrate mental health in PHC (WHO, 2009). The nurse's primary function is to conduct routine assessments of patients with mental disorders, dispense psychotropic medication or recommend medication changes to medical officers and provide counselling. The integrated PHC services in Mpumalanga resulted in an increase from 0% to 83% of primary care clinics providing mental health services after 10 years of integration (WHO, 2009).

In all these models, nurses are responsible for detecting mental health problems, managing chronic mental disorders, including dispensing psychotropic medication or recommending medication changes, counselling, making referrals, and intervening in crisis situations. A district mental health coordinator (trained as a psychiatric nurse) and a medical officer offer support when needed. Implementing mental health policy into PHC services in Italy, Belize, Iran and South Africa has shown a reduction in the number of mental hospital residents and mental health admissions.

According to Gilson et al. (2008), in the bottom-up model of policy implementation, communicating with the people who are implementing the policy is equally necessary to build their support for implementation and to deal with their concerns. A good lesson on mental health policy implementation can be drawn from South Africa and Uganda where the re-orientation of district and regional management teams was carried out in light of the importance of integrating mental health care into PHC at both district and regional levels in order to ensure

support at district and regional management level (Petersen, Ssebunnya, Bhana, & Baillie., 2011).

Gilson et al. (2008) further stress that greater collaboration in the development of policy is essential to present a vertical process where a policy will reach down to implementers at the lower levels. A good example is Zambia, where the implementers were expected to implement the policy but they were not properly consulted on how the policy should be implemented (Faydi et al., 2011). Gilson et al. (2008) further argue that successful policy implementation will also depend on the degree to which the policy is evidence-based during the policy development. It is has also been proven that the bottom-up model of policy implementation is helpful in the implementation of policy that has objectives which are not clear and polices that are viewed as a non-singular domain but simultaneously serve a broad range of regulations which are still under the domain of the national government (Basir, 2011).

Hunter (2003) identified common barriers to effective health policy implementation which include the following: the circumstances external to the implementing agency impose crippling constraints such as a lack of adequate time, sufficient resources and the required combination of resources; the fact that the tasks are not fully specified in correct sequence; and there is imperfect communication and coordination.

2.7.2 MULTIPLE AND SOMETIMES CONFLICTING TOP-DOWN POLICY

DIRECTIVES

Multiple and sometimes conflicting top-down policy directives refer to the different policies within an agency/organisation or ministry that are being implemented (Nsingo, 2006). The implementation of health policy can sometimes be hindered by conflicting or intersecting

policies, because there are different parties involved in creating a policy. In addition to programmes that may be inconsistent with policies, it has also been discovered that policies might be affected by other policies that provide conflicting guidance on related topics. For example, while the Namibia mental health policy emphasises that psychotropic medication should be available in the primary health setting; the Namibia NEMLIST does not make any provision for some of this medication to be available at health centres and clinics (MoHSS, 2005).

The following story illustrates the complexity and interconnectedness (McClure & Jaeger, 2008) of information policies, and how they may conflict. As I will discuss later, “national security” is one information policy goal. Following the terrorist attacks on the World Trade Center on 11 September 2001, the United States passed a law called the USA Patriot Act, which included many provisions intended to increase surveillance on and detection of possible terrorists. Two types of evidence that federal agents wished to investigate were reading habits, including the books that were borrowed from local public libraries, and information searches on the internet. The Patriot Act made it much easier for federal police to request circulation records and examine internet searches at libraries. It also forbade the libraries from announcing that they were under investigation.

At the same time there were policies at the state and local level that conflicted with these federal powers of investigation. Before the attack, 49 out of 50 states had some kind of law that prohibited this kind of investigation in the interests of privacy and freedom of thought. Over the last few years at least two states have added or strengthened laws protecting client privacy, showing some resistance to the federal law (Donald, 2010).

2.7.3 BUREAUCRATIC AUTHORITY

Bureaucracy can be explained as rule by bureaus or by a group of appointed officials (Nsingo, 2006). It now refers to an administrative system – government or private – that carries out policy through standardised procedures and is based on the specialisation of duties (Nsingo, 2006).

In this study, the bureaucratic authorities include health programme administrators and other administrative office bearers, such as directors and undersecretaries, as well as the permanent secretary of a specific ministry, who are responsible for providing support and guidance to the implementers in order to implement the policy. Bureaucracy is characterised by a team of career officials that is appointed to take charge of government administration. Such officials are also classified as supplementary official policy actors as they receive their mandate to act from the political bureaucracies that are responsible for appointing them (civil servant/the bureaucracy) (Nsingo, 2006).

Nsingo (2006, p. 75) further states that the involvement of bureaucrats in policy formulation may affect its implementation, as the senior bureaucrats may lose control over their subordinates because they are likely to concentrate more on policy formulation than on guiding and helping their subordinates to function. As a result, they may not monitor policies to see if the desired results are being achieved as they should.

Health policies are supposed to reflect the needs of the people and, therefore, continuous consultation with the people is a requirement for policy responsiveness. Nsingo (2006, p. 76) states that bureaucrats are often faced with constraints, such as policies that may have been formulated but that have no financial backing for appropriate implementation.

In Tanzania, despite the availability of resources, health programme managers were not able to carry out the activities required for implementing certain policy. This was because managers were resistant to the rushed top-down way the policy had been imposed on districts (Gilson et al., 2008, p. 2). This situation is not unusual, and suggests that resources and guidelines are important, but alone they are not enough to sustain implementation.

Policy implementation can be influenced by the relationship between organisations and their various target groups. For example, for a national policy, the provincial government is considered a target group. As an implementing organisation of the national policy, the provincial government's target groups include district- and community-level government cadres and so forth, as well as the intended policy beneficiaries. Because these actors have different levels of authority over other actors, the interaction among them may be characterised as collaborating with each other, working in opposition, or making efforts to improve the levels of implementation. Once the policy has been approved by politicians, policies are handed back to the bureaucrats for implementation. While they are implementing these policies, they also monitor the whole process and finally evaluate it in order to measure their effectiveness. Equally important for implementation, however, are the ways that a wide range of other actors and stakeholders, including the public, the public sector, bureaucrats and health professionals, understand and respond to policy changes. Gilson et al. (2008) point out that policy has to be formulated by national managers at a ministerial level in consultation with the political party in power, as it is the part that determines what policies should be in place in order to promote the social welfare of the citizen.

2.7.4 NATIONAL MANAGERS, POLITICIANS AND OTHER SECTION

National managers are programme administrators at national level whose duties include planning, developing and formulation policy, as well as the quality implementation of policies to ensure service delivery (MoHSS, 2005). However, this component was not included in this study because, in Namibia, there is only one national manager responsible for implementing this policy. In addition, there would seem to be inadequate infrastructure at national level to warrant this inclusion.

It is risky to assume that putting good policies in place will guarantee their automatic flow into successful ground-level implementation. Moreover, in the context of policy implementation, several gaps exist. A study done by Spratt (2009) indicates that the issuance of implementation guidelines does not necessarily mean that policies will be translated into programmes. The crucial missing step is that of strengthened provincial-level planning and micro-planning mechanisms.

A study was conducted in Nigeria Jack-Ide and Middleton (2013) to explore mental health nurses' experiences of providing mental health services in an attempt to understand policy implications, and identify the difficulties and challenges related to delivering mental health care services. The study found that mental health services for River State and the surrounding states in the Niger Delta are provided only at the neuropsychiatric Rumuigbo Hospital in Port Harcourt city, River State, Nigeria. Moreover they are provided only in curative-based health care institutions. The challenges nurses face in implementing the mental health policy result from a lack of political support, a lack of training and inadequate allocation of resources for hospital renovations, a lack of equipment and a lack of funding for drugs, the cost of which makes them unaffordable.

Namibian mental health policy also emphasises that mental health is a component of the overall health care system. It enumerates practical steps for moving away from the current centralised, curative, hospital-based mental health services to services that are comprehensive and integrated into the general health care system based on a PHC approach and strongly supported by intersectoral collaboration and community participation. The key to change depends on the availability of the right quality and quantity of trained human resources and the proportionate allocation of financial resources (Mudzingwa, 2007).

In Zimbabwe, 2000 PHC workers were trained on issues related to how to deliver an integrated PHC service. Accordingly, these PHC workers now have the capacity to handle patients with severe psychosis and refer only those that they feel require specialised services. Regular training of primary care professionals is carried out in the field of mental health to continuously build the capacity of PHC workers in providing mental health services in an integrated setting.

A recent situational analysis in Namibia regarding mental health services availability in PHC in Namibia suggests they have not yet been fully incorporated into the existing PHC services (Maloboka & Mbarandonga, 2011). In light of this, a systematic review of the published literature on mental health services in the world was carried out, with the aim of assessing how Namibia has fared in this regard over the past years. Specifically, the aim was to identify the progress made, as well as the remaining challenges in the quest for improving access to high quality mental health care through decentralised, integrated and community-oriented care. It also looked at future mental health services research priorities.

2.8 SUMMARY

This chapter presented an overview of global, regional and national estimates of the implementation of mental health into PHC services. This chapter reviewed the literature relating to the framework for the study and discussed the implementation of mental health care in PHC from the perspective of other countries. In the next chapter, the research design or methodology for the study is discussed.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The main purpose of this study was to explore and describe the implementation of the Namibian mental health policy in the Oshana region of Namibia with a view to identifying the challenges nurses face in integrating mental health services in their PHC. This chapter describes and justifies the research design and methodology used in this study. To that end, both the research design and the method adopted in the study will be described in detail; that is, population and sampling, data collection, data analysis, validity and reliability, as well as the observance of ethics. By describing the research methodology, the researcher constructs a platform from which to explore the knowledge gained from the sample group in order to describe the implementation of mental health policy as an integral part of PHC services in the Oshana region (Burns & Grove, 2005, p. 232).

3.2 RESEARCH DESIGN

A research design is intended to assist the researcher in seeking answers to the research question; thus, the purpose of the research design is to determine the plan for answering the research questions (LoBiondo-Wood & Haber, 2006, p. 202). A design is a general plan or blueprint that describes how the research will be conducted. It focuses on the kind of study proposed and its desired result. It begins with a problem or question that is posed in the context of the research and determines what kind of evidence will address the research question adequately (LoBiondo-Wood & Haber, 2006, p. 202). This study followed an approach that was quantitative in nature and that used both explorative and descriptive designs. These allow

for the exploration of factual reasoning and information collected from participants working at PHC facilities in the Oshana region (Burns & Grove, 2005, p. 232).

3.2.1 Quantitative design

A quantitative approach is a research approach involving a systematic objective process that has roots its positivism and makes use of deductive logic. Its results appear in the form of numeric data which are obtained from subgroups in order to generalise the findings to the population that is being studied. They are eventually reported in statistical language (De Vos, Strydom, Fouche, & Delpont, 2007, p. 75). In this study, a quantitative approach was used where constructs were defined as variables and given numerical values. This allowed for a quantitative analysis of frequencies using non parametric statistical methods. Leedy and Ormrod (2005, p. 94) explain that quantitative research is used to “answer questions about relationships among measured variables with the purpose of explaining, predicting, and controlling phenomena”. This study utilised a quantitative methodology. However, there was a qualitative component (see questionnaire B). The reason for using open and closed questions in questionnaire B was to create triangulation with the findings in questionnaire A and the findings.

3.2.2 Exploratory design

An explorative research study is conducted when little information is available about the phenomenon under investigation (De Vos et al., 2007). In the context of this study, there is limited information relating to the implementation of the mental health policy in PHC services. Consequently, this study seeks to produce insightful information regarding the status of mental health policy implementation so that challenges to this implementation can be identified and strategies can be identified and be implemented.

Exploratory research begins with the phenomenon and then investigates its true nature: how it manifests itself and what other factors are relevant to it (Polit & Hungler, 2007). The research evaluated information perceived to be essential so that the objectives of the study could be addressed. Although studies about policy implementation have produced valuable information on the phenomenon, it has not been investigated in the Namibian context, where scarce information is available.

3.2.3 Descriptive design

A descriptive design is used to investigate a phenomenon and the manner in which it manifests itself (Polit & Hungler, 2007). The researcher sought to describe the extent to which registered nurses and health programme administrators are implementing Namibian mental health policy in the Oshana region. The research presented here defines descriptive components for a quantitative study of the mental health policy implementation, as well as the challenges hindering the implementation of mental health policy in Oshana region, Namibia.

3.3 Research setting

Oshana is the smallest region (5,290 km²) of Namibia with a population of 167,797 people. The region has only one district (Oshakati), which comprises three towns, Oshakati, Ongwediva and Ondangwa, which are governed by municipal councils. The region is situated in the centre of northwest Namibia and shares borders with the following regions: Oshikoto to the east, Omusati to the northwest, Ohangwena to the north and Kunene to the south.

The region comprises 16 health facilities, one of which is an intermediate hospital with a capacity of 750 beds. The district also has 28 outreach points. This research was carried out at

all the health centres and clinics in the region. The reason for conducting the study in the Oshana region was because it is one of the regions with a huge burden of orphan and vulnerable children as a result of the HIV/AIDS epidemic. According to a national demographic health survey (MOHSS, 2007), orphans and vulnerable children now constitute 37% of the population. Orphans and vulnerable children are more likely to have mental health needs and seek treatment at PHC clinics. Hence, it is necessary to find out whether nurses working in these health facilities are capable of implementing the mental health policy. In addition, according to the 2008 sentinel survey (MOHSS, 2008), the Oshana region has a high rate (22%) of HIV relating to pregnant women which is likely to lead to serious physical, psychological and social trauma.

According to the report on a Namibia school-based student health survey (MOHSS, 2004), Oshana has a high suicide rate of 13% among all its youths, while statistics for alcohol and drug abuse stand at 26.4% of all youth in the region. Drug and alcohol-induced mental disorders are therefore a major concern. It was on the basis of the above that the researcher decided to conduct his study in that region.

3.4 RESEARCH METHOD

Research methodology focuses on the research process and the tools and procedures utilised. Beginning with the tasks it must accomplish, namely, data collection and sampling, it focuses on the individual steps in the research process, trying to employ objective, that is, unbiased, procedures (De Vos et al., 2007). As a quantitative approach was to be employed, the researcher chose a survey as the procedure for obtaining the data needed. This data has to be gathered from the large and remote geographic location that was home to the population of the study. The survey was used to determine the participants' individual responses to mental health policy

implementation. In this study, quantitative descriptive statistical methods were used. Graphs, tables and pie charts were used to present the data and the Statistical Programme for Social Studies (SPSS) version 22.0 was used to analyse the data.

3.5 STUDY POPULATION

A population is any defined group that is selected as a subject for research (Oyedele, 2003, p.120). A study population includes all the members, or units, of a group that can be clearly defined in terms of their distinguishing criteria, whether they are people, objects or events (Burns & Grove, 2005).

This study consisted of two populations: firstly, 64 registered nurses working in PHC facilities, whose duty it is to provide mental health services at the facility level: and secondly, 12 health programme administrators who are responsible for coordinating mental health activities, as well as guiding the implementation of mental health policy at the regional level. All the participants were health care providers working in clinics and health centres.

3.6 SAMPLING

A sample is a small portion of the total set of the population; together they comprise the subject of the study. Sampling is the most feasible way of studying large populations, given resource, time and financial limitations (De Vos et al., 2007). Although the size of the target population has been accurately established, as stated above, it is comprised of at least 64 registered nurses. A sample of 64 registered nurses responded to the questionnaire distributed during the study. Some registered nurses who received the questionnaire were either too busy or unwilling to respond for personal reasons. For the purpose of this study the sample and the population were

the same. Because the sample size was small, the researcher decided to include everybody and, consequently, sampling was not used in this study.

3.6.1 Inclusion criteria

To be included in this study, the subject had to be a registered nurse working in PHC because it is in their job description to implement this policy.

3.6.2 Exclusion criteria

This study excluded all registered nurses not working in PHC settings in Oshana region from participating in the research investigation. The category of enrolled nurse and midwife was also excluded from the study since the implementation of mental health policy is not in their job descriptions.

3.7 DATA COLLECTION INSTRUMENT

According to Saunders, Lewis, and Thornhill (2009), the two most commonly used primary data collection methods are the questionnaire and the interview. Questionnaires are considered to be the most reliable and essential tools for gathering information effectively (De Vos et al., 2007). Moreover, they are generally much less costly than interviews and require less time and energy to administer. In addition, questionnaires, unlike interviews, offer the possibility of complete anonymity. Sometimes a guarantee of anonymity is crucial in obtaining candid responses, particularly if the questions are highly personal or sensitive in nature (De Vos et al., 2007). The researcher thus chose to use a questionnaire to collect data for this study. Two questionnaires were used. The one designed for registered nurses (see Appendix 2A) comprised 23 closed and open-ended questions, while the other questionnaire was designed for the health programme administrators consisted of four open-ended questions only (see Appendix 2B).

The reason for using open-ended questions in Questionnaire B in this study was create triangulation with the findings in questionnaire A and the findings

The questionnaire consisted of six sections:

SECTION 1: BIOGRAPHIC INFORMATION

Items covering aspects of bibliographic data and the experiences of registered nurses

SECTION 2: MENTAL HEALTH SERVICES OFFERED AT YOUR CLINIC

Items covering the mental health services offered at clinics, as well as items to assess nurses' preparedness to offer mental health services, the availability of these services and nurses' knowledge of the integration of national policy of mental health into PHC services.

SECTION 3: AVAILABILITY OF PSYCHOTROPIC MEDICATIONS

Items covering the availability of psychotropic medications in PHC

SECTION 4: REFERRAL HOSPITAL RELATIONS

Items relating to registered nurses' experiences and knowledge of referral hospital relations with regard to the referral of mental health patients

SECTION 5: TRAINING ON MENTAL HEALTH

Items related to nurses' training in mental health

SECTION 6: MENTAL HEALTH CARE POLICY

Items covering issues related to mental health care policy

According to De Vos et al. (2007), the advantages of using self-administered questionnaires are that the respondents have enough time to think about their answers carefully. Another advantage of the questionnaire is that a wide geographical area can be covered in the survey and respondents can complete the instrument at their own pace, which was the case in this

research. Accordingly, the questionnaire has been identified as the best means for collecting relevant, precise and unbiased information for this study.

3.8 VALIDITY

According to De Vos et al. (2007), validity is the degree to which an instrument actually measures what it intends to. Different kinds of validity may be established: content validity, face validity, criterion validity and construct validity. Content validity is concerned with the adequacy of the sampling to address the content of an instrument (De Vos et al., 2007). Face validity refers to whether the instrument appears to measure the relevant construct, and concerns the superficial appearance or face value of a measurement procedure.

In this study face validity and content validity were determined, while criterion validity and construct validity did not apply. To establish face validity, the questionnaire was submitted to the two supervisors for this thesis. They were asked to evaluate the questions and the thesis outline in relation to the objectives of the study (Polit & Hunger, 2007). Confirmation from them assured that the questions actually assessed the test characteristics identified by the researcher. The responses were then compared with a gold standard measurement of the desired characteristics being assessed (Hulley et al., 2007).

In this study, content validity was achieved through the extraction of an assessment tool from the mental policy as way to measure compliance with the policy. In addition, the content validity of items was also achieved through a critical review of the instrument by experts in the area of study, as well as the review of literature used in the study. To establish content validity, existing literature and policies on mental health were referenced.

The questionnaire was designed to measure the phenomenon (mental health policy implementation) and its components, and accordingly it was found that all the components of policy implementation were relevant to the research questionnaire (Burns & Grove, 2005).

Internal validity is the removal of possible sources of error by controlling extraneous variables.

The validity of the instrument is maintained by using a similar questionnaire for every participant. In a descriptive design the threats to internal validity include selection, in that people selected for the study differ in an important way from those not selected for the study.

This was controlled by making use of all the available participants (Burns & Grove, 2005).

External validity is the ability of the data to be generalised to a larger population (Maree, 2010).

In this study it was concluded that the results could be generalised to all health programme administrators and registered nurses working in PHC settings in the Oshana region. However, one threat to external validity that was noted was interaction between selection and treatment.

Moreover, the number of participants approached who refused to be involved in this study was recorded in order to judge the threat to external validity. The reason for this is that, as the percentage of non-participation increases, the external validity increases. The participation of participants was improved by means of a pre-discussion in which the importance of the data received was justified and the participants were encouraged to become involved in terms of making a contribution towards the implementation of the mental health policy in PHC. By distributing similar questionnaires to the entire group of participants at one time, the demand effect was reduced. This effect means that participants come to know the questionnaire and change their attitude according to what they think is demanded of them (Maree, 2010).

3.9 RELIABILITY

Reliability is related to the consistency or repeatability of a measure (Maree, 2010). In order to

ensure reliability, a pilot study (inter-rater reliability) was undertaken in this study to determine the accuracy and consistency of the research instrument. This was enhanced by the researcher's familiarity with the environment in which the study was conducted. Reliability improves automatically when a researcher is familiar with the research environment. Subsequently, items that were unclear during the pilot study were rephrased. This is why it is important to have an expert review the questionnaire, and to discuss the reliability of the questionnaire before using it (Burns & Grove, 2005). Reliability refers to the objectivity, stability, equivalence and internal consistency of the instrument.

In this study, a pre-test using clients with similar characteristics to the sample was conducted to evaluate the clarity of the items and the consistency of the responses. To ensure reliability, data were collected from a sample of six registered nurses at Orwetoveni clinic in the Otjozondjupa region. This site was selected because it is outside the Oshana region and thus would avoid contaminating the sampling pool. Inadequacies in the instrument were then refined and the time it took for each questionnaire to be completed was noted. Questions that needed to be adjusted were altered accordingly.

- The conditions under which the questionnaires were completed were standardised.
- The effects of external events were minimised, for example the researcher made use of consistent scoring of items and a pilot study was used.

3.9.1 Stability

The reliability of the data can be seen when a large group of participants produce similar results, such as within the sections on policy implementers and bureaucracy. In these sections there was a high degree of agreement among the participants for each item (Maree, 2010).

3.9.2 Equivalence

Inter-rater reliability was maintained by distributing the same questionnaire to all participants (Maree, 2010); the difference in the questionnaires between Group A and Group B being that the question addressed either registered nurses (Group A) or health programme administrators (Group B).

3.9.3 Internal consistency

Internal consistency was used to evaluate whether or not the items on the scales used in the questionnaire reflected the concepts. In other words, the items within the scale had to correlate or be complementary to one another (LoBindo-Wood & Haber, 2006). Internal consistency was established in this study through the correlation of various items on the questionnaire (Burns & Grove, 2005). The reliability of the questionnaire was increased by the use of items that strongly correlated with the variable being measured. The questionnaire was easy to use, which reduced the chances of participants becoming tired, frustrated or confused whilst answering the questionnaire. This, in turn, ensured the consistency of answers throughout and a higher participation rate (De Vos et al., 2007). Internal consistency was obtained by using factors related to the five components outlined in the bottom-up view of policy implementation: policy implementers, bureaucratic, top down and conflicting policies, national level managers and politicians.

3.10 PILOT STUDY

According to Yin (2003), a pilot study helps the researcher to refine the data collection plans with respect to both the content of the data and the procedures to be followed. It also provides

some conceptual clarification for the research design. To determine whether the research process and instrument would produce the desired data, a pilot study was carried out for two groups, that is, registered nurses and health programme administrators in the Otjozondjupa region. These two groups were selected on the basis of their day-to-day duties in respect to the implementation of the policy. Registered nurses are the ones who provide the mental health services, whereas the health programme administrators are responsible for coordinating mental health activities and guiding mental health policy implementation. By conducting a pilot study, a researcher orientates himself and identifies possible defects in the planned study (De Vos et al., 2007).

The instrument was pilot tested with a sample of six registered nurses in the Otjiwarongo district of the Otjozondjupa region. This enabled the researcher to assess the relevance and accuracy of the questionnaire in terms of information retrieval and relevance. As described above, the aspect of inter-rater reliability was established during the pilot-testing phase.

3.11 PILOT STUDY REPORT

The questionnaire was prepared and sent to supervisors for checking. The supervisors queried some issues that were unclear, but gave approval for the pilot study after those issues had been addressed and the relevant content reformulated in the questionnaire.

REGISTERED NURSES

The pilot study was carried out in the Otjiwarongo district in the Otjozondjupa region between 2 and 9 May 2011. The researcher went himself to the clinic and met the registered nurses in person, subsequently explaining the aim of the study and what was required from the nurses. After this clarification he handed out the questionnaires and collected them after they had been

completed. In this case, the participating facility did not have mental health services available, nor did it have information, education and communication materials available to promote awareness of mental health patients. The questionnaire was administered to minimise time.

The first questionnaire was directed at both programme administrators and the registered nurses. However after the small-scale pilot study it was discovered that there was a need to separate the questions for the two categories in line with their everyday work. Therefore, questions 1, 2, 3, 4, 5, 6, 7, 8 and 9 were found to be applicable to registered nurses at the facility levels only. Consequently, these were deleted in the questionnaire that was later administered to the health programme administrators. Question 5 in the registered nurse questionnaire, which required respondents to state whether psychotropic drugs were available at the facility, was the only open-ended question. After conducting the pilot study it was suggested that all psychotropic drugs be listed in the questionnaire and that respondents be asked to tick all medicine that is available.

Questions in the open-ended section of the questionnaire were subsequently changed and arranged in such a way that if a respondent said no then he or she proceeded to the next question. In addition, in the proposed revised questionnaire respondents were asked whether or not they experienced specific problems.

Question 22, which asked participants whether there is a policy on mental health available, was left out because although a policy document may be available it does not necessarily mean that the implementation of the policy had taken place. Some words used in the phrasing of questions were difficult to understand and were substituted with simpler words. However, words that do not have simple synonyms were left unchanged.

HEALTH PROGRAMME ADMINISTRATORS

The pilot study was carried out in the Otjiwarongo district of the Otjozondjupa region between 2 and 9 May 2011. The researcher went himself to the Regional Office and met the health programme administrator in person. During this meeting he explained the aim of the study and what was required of them. After this clarification he handed out the questionnaires and then collected them after they had been completed.

It was subsequently found that questions 5 and 6 on the programme administrators' questionnaire asked virtually the same thing and, hence, it was deleted. In addition, the participants complained that the questionnaire took too much time for them to complete. Most of these people are the key administrators of programmes and they felt that they did not have the time available for attending issues not directly related to their function. On average, the questionnaire took between 40 and 45 minutes to complete. Therefore, it was decided to reduce this time by half in order to ensure that respondents would supply reliable data.

From the findings produced by the pilot study, it became apparent that collecting data from 6 nurses would not prove difficult. The researcher just sent the questionnaire to the region and the health programme administrators there handed out the questionnaire for him and collected the questionnaires once they had been completed. This cut cost and saved time. However, it did happen that when the researcher went to collect the data at the pilot site a health programme administrator or nurse would not be available for a scheduled appointment and the appointment would have to be rescheduled once or even several times.

3.12 DISTRIBUTION INSTRUMENTS FOR DATA COLLECTION

Table 3.1 Registered nurse and health programme administrators

Occupational groups		
	Questionnaires sent out	Responses (n)
Registered nurse	61	52
Health programme administrators	12	12
Total (n)	73	64

Sixty-four questionnaires were posted to the Chief Health Programme Administrator for Family Health in the Oshana region, who then distributed them to the health facilities on behalf of the researcher during her regional management team supervisory visit to the health facilities. She then posted 61 questionnaires from the registered nurses and 12 questionnaires from the health programme administrator back to the researcher.

When questionnaires are accompanied by an explanatory letter, it ensures a high level of response (Saunders et al., 2003). The Chief Health Programme Administrator coordinated the work on behalf of the researcher and clarified the purpose of the data collection during the data collection period. Questionnaires were handed out to the participants at each facility during the scheduled facility visit, and after completion they were collected by the District Primary Health Care supervisors and returned to the researcher by courier within a period of four weeks. The entire data collection exercise took four weeks. Delays were caused mainly by the reluctance of participants to complete the questionnaires citing lack of time. However, the district PHC supervisor did her best to encourage people to complete the questionnaire. Questionnaires were completed anonymously, allowing the respondents to give honest answers without fear of

victimisation. Moreover, information gained in this way is regarded as more reliable (De Vos et al., 2007).

3.13 DATA ANALYSIS

Data analysis is a way of looking at underlying themes and other patterns that characterise the case more broadly than a single piece of information (Leedy & Ormrod, 2005). The views of registered nurses and health programme administrators on the implementation of mental health policy were analysed with the help of a professional statistician from the Statistics Department of the University of Namibia. The purpose of the data analysis was to answer the research questions asked by the researcher and which prompted the study (Burns & Grove, 2005). Data were analysed and presented according to the different items in the questionnaires (A) and (B) within the framework of the study. Questionnaire A consisted of open- and closed-ended questions and was intended for registered nurses who are health care providers in PHC clinics and health centres. Questionnaire B was devised for health care administrators and consisted of open-ended questions. In this study, data analysis was done in two parts: Firstly, the data for questionnaire A was presented as descriptive statistics and evaluated with quantitative, computerised statistical techniques, using SPSS version 22.0. To evaluate the data, the researcher enlisted the assistance of a professional statistician. The information obtained with the structured questionnaire was assembled as a database.

- The questions were coded using the SPSS programme.
- Data from the questionnaires were entered with the SPSS programme.
- Data were compared and contrasted.
- Descriptions were formulated to represent the synthesis of informational material (Langford, Borbasi, & Jackson, 2008).

Secondly, data analysis for questionnaire B was carried out by using a thematic analysis and the data collected from the questionnaire was used to do a content analysis. Content analysis was done on the information collected from the open-ended questions. The basic technique of content analysis entails counting the frequencies of a certain order of words, or phrases. By doing so, key words and themes were identified. Content analysis can be done on mass media materials, unstructured questionnaires and open-ended questions, as was the case is in this section of the study (Wellman et al., 2007). After content analysis, the data from questionnaire B were categorised and grouped to provide descriptive statistics which were compiled on the basis of the participants' responses to the questionnaires.

DESCRIPTIVE STATISTICS

The data collected by means of the questionnaires were summarised and organised using descriptive analysis, consequently giving the data meaning and developing insight that was used to explore and describe the extent of mental health policy implementation as an integral part of PHC services in the Oshana region. This method was appropriate for a quantitative descriptive research design (Burns & Grove, 2005). The use of descriptive analysis allowed the data to show clearly the areas that are hindering the implementation of mental health policy as an integral part of PHC services in the Oshana region. Descriptive statistics were concluded on the responses of the 52 (100%) registered nurses to questionnaire A and 12. (100%) health programme administrators to questionnaire B. Descriptive statistics will be presented as frequencies (f) that refer to the number of responses (n) on items. Content analysis was used to analyse the information from the open-ended questions (B).

3.14 ETHICAL MEASURES

Conducting research implies the acceptance of responsibilities. A researcher is responsible to fellow researchers, to respondents, to society as a whole and, most importantly, to himself (De Vos et al., 2007). A high professional standard regarding confidentiality was strictly maintained. De Vos et al. (2007) identify ethical issues that are of the utmost importance for the researcher. Permission to conduct the study was sought from the MoHSS (*see Annexure B*). Authorisation was also obtained from the managers of the hospital and from the regional director of the Oshana region (Annexure C).

Completion of the questionnaire served as consent (see attached questionnaire). The consent form attached to the questionnaire had to be completed and signed by both the participant and the researcher to serve as consent for participation in the study. Confidentiality was assured by using an anonymous questionnaire. The rights of the participants, including voluntary participation and withdrawal at any time without repercussions, were emphasised (*see Annexure E*). The procedures to be followed, the time involved for each and the total time required were fully explained. The ethical issues that were observed during the conduct of the study are discussed below.

3.14.1 Permission

Permission to conduct the study was sought from the University of Namibia Post Graduate Studies Committee. The written proposal was also reviewed by the research committee of the MoHSS to ensure that it conformed to the ethical standards of scientific research. Before individuals were recruited as participants, their written consent was obtained.

3.14.2 Participant protection

According to De Vos et al. (2007), a researcher has an ethical obligation to protect a participant against any form of harm that could result from their participation in a study. It is the obligation of the researcher to inform a potential participant about the research study beforehand, and to protect participants conscientiously and completely. It is difficult to determine whether a participant could potentially incur harm during a study and the possibility should not be rationalised away by saying that the study might benefit them in some way.

3.14.3 Informed consent

A researcher is obliged to obtain informed consent from all participants. Accordingly, the researcher provided adequate information about the purpose and procedures of the study, as well as about the rights of the participants. Information was also supplied to establish the credibility of the researcher (De Vos et al., 2007). Participants were also informed that they could withdraw from the study at any time. In this study, informed consent was sought when the questionnaire was administered, using a participant information leaflet (*see Annexure 1*).

3.14.4 Deception of participants

The researcher is guilty of deception if he or she provides information to another person that is not true (De Vos et al., 2007). De Vos et al. further explain that the difference between deliberate and unintentional deception should be clarified, as it is possible for a researcher to be unaware of the falsity of a piece of information imparted (De Vos et al., 2007). Such a possibility needs to be discussed candidly with participants during or immediately after a query concerning the truth of any information is raised. To ensure the participants in this study would not be deceived, the researcher provided an information leaflet containing all the information

about the research as well as an official letter from the University of Namibia outlining the research topic for this research.

3.14.5 Right to privacy and voluntary participation

In an increasingly public and transparent world, scientists need to be extremely vigilant that their actions or statements do not violate a subject's rights to privacy. The right to privacy is expressed more concretely through the following principles.

A person has the right

- to refuse to be interviewed
- to refuse to answer questions
- not to be interviewed at meal times
- not to be interviewed at night
- not be interviewed for a long duration (De Vos et al., 2007).

De Vos et al. (2007) believe that privacy is a participant's right to decide to whom, when, where and to what extent his attitudes, beliefs and behaviour may be revealed. While privacy is synonymous with self-determination and confidentiality, self-determination refers to an individual's right to decide voluntarily whether or not to participate in research (Polit & Beck, 2004). It is the responsibility of the researcher to obtain informed consent from a participant whenever information of a private nature is solicited in a study. In this study participants were given information about the objectives of the study through an information leaflet. Their informed consent was then sought after they had read and understood the purpose and objectives of the study. The participants were assured that their responses would be kept private and confidential.

3.14.6 Anonymity

Informants have the right to remain anonymous. That right should be respected both when it has been promised explicitly and also when no clear agreement to the contrary has been made (Mouton, 2003). Anonymity is preserved when a person's acts or statements are revealed without a disclosure of his or her identity (De Vos et al., 2007). In this study the participants' responses were anonymous because no name of any participant or company was recorded on any questionnaire.

3.14.7 Confidentiality

All participants in the study were assured that the information and opinions they shared would be treated with the strictest confidentiality. They were assured that data would only be used for the stated purpose of the research and that no other person would have access to interview data. This condition is reflected by De Vos et al. (2007), who state that confidentiality entails that information shared by someone is not divulged to others. No name of participants or their organisations was recorded on any questionnaire; only information pertaining included in responses to the questionnaire was used.

3.14.8 Benefits

It was explained to participants that there would be no benefits for the respondents participating in this research. However, the researcher encouraged them to give candid and honest responses. They were also informed that the data gathered would be used to describe the extent of mental health policy implementation as an integral part of PHC services and not to impugn the respondents' practical experiences.

3.15 SUMMARY

A quantitative, exploratory and descriptive design was followed in order to explore and describe the views of registered nurses and health programme administrators regarding the extent of mental health policy implementation as an integral part of PHC in the Oshana region. The purpose of the study was to assess, explore and describe the implementation of mental health policy in the Oshana region that the survey found to be lacking. The study population comprised 64 participants (n = 64), who completed one of two different self-administered questionnaires. This data gathering exercise was followed by content analysis. The principles of validity and reliability that were taken into consideration during the research process were discussed as well as the ethical issues. These included permission to conduct the study, participant protection, informed consent and confidentiality. Chapter 4 will discuss the results of the study.

CHAPTER 4

DATA ANALYSIS AND INTERPRETATIONS OF THE RESULTS

4.1 INTRODUCTION

This chapter of the thesis presents the findings of the research on the implementation of mental health policy as an integral part of PHC services in the Oshakati district, Oshana region, Namibia. Through the implementation of the mental health policy, good governance at all levels of mental health care delivery can be assured. The purpose of this chapter is to present and illustrate the findings of the study and report the results objectively.

4.2 PRESENTATION OF FINDINGS

The research findings will be discussed under the same headings as found in the questionnaire. Section A of the questionnaire for registered nurses (policy implementers) was analysed separately.

QUESTIONNAIRE A – POLICY IMPLEMENTERS (REGISTERED NURSES)

4.3 BIOGRAPHICAL INFORMATION

The biographical information of both instruments was analysed together. This information pertained to participants' age, position held at the health centre and clinics, highest qualifications, years of experience, and professional rank.

4.3.1 CATEGORIES OF PARTICIPANTS

Table 4.1 Categories of participants (n = 64)

Groups of participants		
	Responses (n)	Percentage (%)
Registered nurse	52	81.3
Health programme administrators	12	18.8
Total (n)	64	100.0

The biographical information has been grouped into two groups; namely, registered nurses and health programme administrators. The total population of this study was made up of 64 (100%) participants (Table 4.1). Registered nurses made up 52 (81.25%) of the 64 (100%) participants, while health programme administrators made up the minority of 12 (18.75%) of 64 (100%) participants of the total population group.

4.3.2 AGE OF PARTICIPANTS (ITEM 1)

Table 4.2 Age of participants (n = 64)

Age of participants		
	Responses (n)	Frequency %
20–30 years	16	25.0
31–40 years	15	23.4
41–50 years	18	28.1
51–60 years	15	23.4
Total (n)	64	100.0

The participants' ages (see Table 4.2) were reported as being between 20 and 60 years. From the data obtained it was noted that the greatest number of participants, that is, 18 (28.1%) out of 64 (100%) currently working in the Oshakati district of the Oshana region were between the age of 41 and 50 years, with the second largest age group of 16 (25%) falling into the 31 to 40 year age group. Participants were not required to give their specific age as a way to ensure confidentiality.

4.3.3 PROFESSIONAL RANKS OF PARTICIPANTS (ITEM 2)

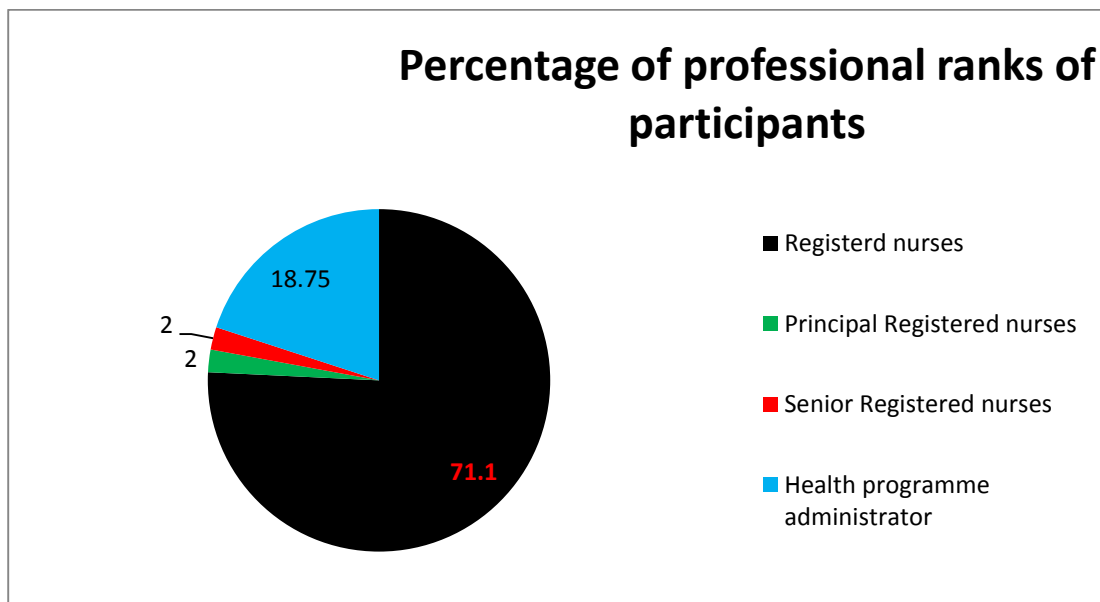


Figure 4.1 Professional rank of participants (n = 64)

The above figures indicates that 96.2% of nurses who took part in the study fell into the category of registered nurses, while 1.9% were principal registered nurse and the other remaining 1.9% were senior registered nurses. This distribution is a result of the fact that the study focused mainly on the registered nurses because they are the only category of nurses at PHC clinics and health centres that is trained in basic mental health.

4.3.4 HIGHEST QUALIFICATIONS OF PARTICIPANTS (ITEM 3)

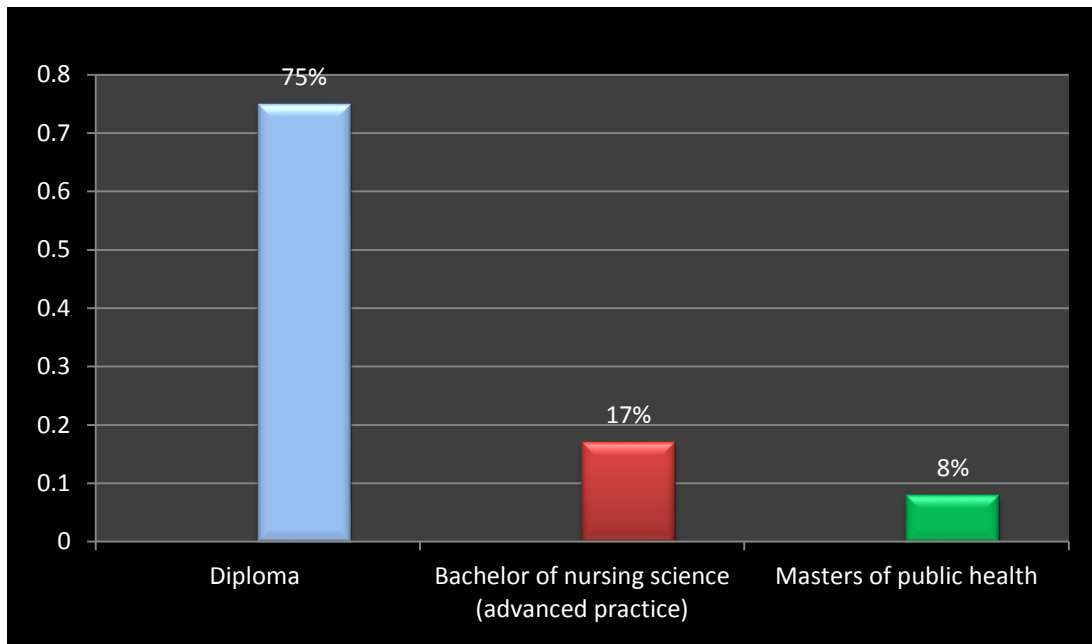


Figure 4.2 Highest qualifications of participants (n = 64)

By determining the participants' level of qualifications, the researcher gained insight into their academic status. It is important to consider academic qualifications when studying mental health policy implementation. From the data in Figure 4.2, it would seem that more than half (75%) of the surveyed PHC providers had obtained a basic diploma that included training in mental health nursing to enable them to deliver mental health care in a PHC setting. About 18% of respondents had an additional qualification at the degree level and 8% had a postgraduate diploma.

4.4 MENTAL HEALTH SERVICES

4.4.1 MENTAL HEALTH SERVICES AVAILABILITY IN PRIMARY HEALTH

CARE (ITEM 4)

Table 4.3 Mental health services availability in primary health care (n = 52)

Response	Frequency	Percent %
Valid yes	3	5.8
no	49	94.2
Total	52	100.0

The mental health policy was launched and implemented with a view to promoting the incorporation of mental health services in PHC services. It was for this reason that the researcher attempted to look at whether mental health services are available as part of the PHC services in the Oshana region.

The findings of this study revealed that, according to 49 (94.2 %) of the respondents, there are currently no mental health services available in the Oshana region for patients who might present to clinics and health centres with mental health needs. The rest of participants indicated that there are mental health services available in the PHC services of Oshana region, which accounted for 5.8% (3) of participants in the study. It becomes evident from the above findings that mental health services are not available at most of the health facilities in the Oshana region. According to this policy, services such as follow-up services to treatment, home visits, counselling, referral to hospital for further management, and outreach services should be made available.

4.5 MENTAL HEALTH TREATMENT GUIDELINE AVAILABILITY (ITEM 5)

A guideline is a document that provides guidance to the user on how to manage a case or a client. Guidelines provide for uniform in-service provision or in the implementing of a policy such as, in this case, a health policy. This policy emphasised that guidelines should be developed to give guidance to the registered nurses on how properly manage clients with mental health disorders. It was for this reason that the researcher chose to find out whether there were guidelines in this regard.

Table 4.4 Mental health treatment guidelines (n = 52)

Responses	Frequency	Percent %
Valid yes	4	7.8
no	47	92.2
Total	52	100.0
Total	52	100.0

The study has shown that 92.2% of surveyed registered nurses indicated that there are no treatment flow charts or treatment guidelines to guide health care providers in the identification and management of mental illness. Guidelines are considered to be one of the crucial aspects of mental health, and are a cornerstone for mental health care services if mental health is to be fully integrated into the PHC, because without such guidelines the implementation is unlikely to be successful. These guidelines provide health care workers at all levels with comprehensive technical information. Furthermore, they undergo periodic revision according to needs and, based on mental health policy directives, they are intended to serve as a detailed and solid instrument for policy implementation.

However, PHC providers at the clinics do have access to the standard treatment guidelines produced by the MoHSS, which include treatment guidelines for the major psychiatric conditions such as schizophrenia and depression (MoHSS, 2011). Staff also have access to the Namibia Essential Medicine List (NEMLIST) (MoHSS, 2008) and sometimes a copy of the British National Formulary is available, which they can also use to manage patients with mental disorders.

4.6 AVAILABILITY OF PSYCHOTROPIC MEDICATIONS (ITEM 6)

The policy that was launched states that psychotropic medications should be made available in primary health care settings and should be prescribed by registered nurses working at these health facilities. Hence, the researcher found it necessary to investigate whether this is happening or not.

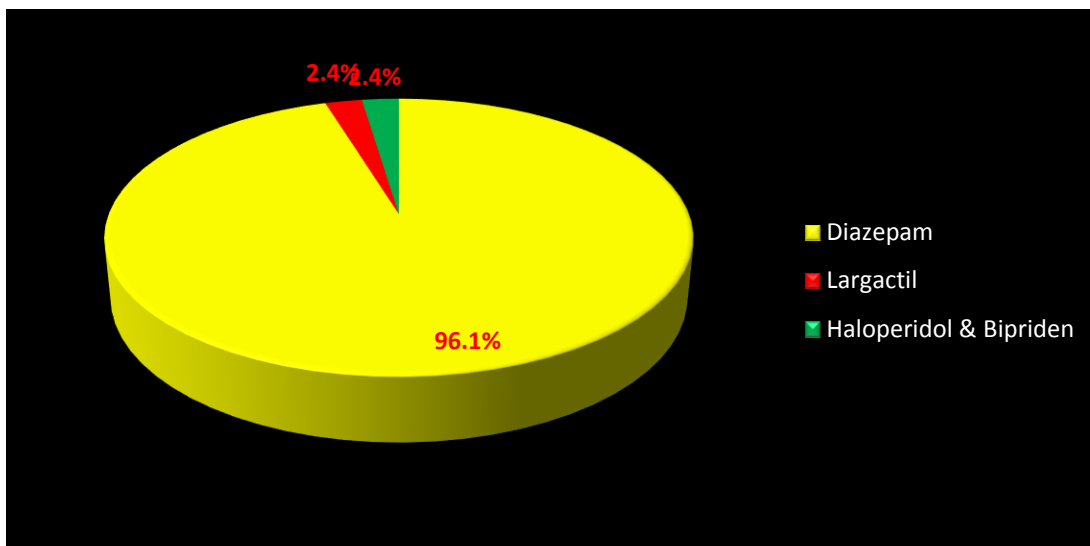


Figure 4.3 Availability of psychotropic medications (n = 52)

PHC workers in charge of facilities are not allowed to prescribe psychotropic medications, except for diazepam with some restrictions. Beyond this, they are required to refer such patients to a higher level of care; in this case is the Intermediate Hospital Oshakati.

In Oshana, there are currently none of the psychotropic medicines available at the clinics and health centres except for diazepam, which is the only psychotropic medicine that can be prescribed by a registered nurse. Moreover, at clinics diazepam is not indicated for the treatment of patients with mental health disorders but to stabilise patients suffering from convulsions and anxiety.

Respondents attributed the absence of psychotropic medicine to the medicines restriction as set out in the NEMLIST and the Medicine and the Substance-related Act, which specifies the level of care at which the medicine may be ordered and prescribed. Diazepam was the only medicine reported by respondents to be available in the 40 (96.1 %) health facilities in the region. The other 2.2% of psychotropic medicines available were largatil, haloperidol and biperiden, which were reported to be available only in some health centres.

4.7 MENTAL HEALTH INFORMATION, EDUCATION AND COMMUNICATION LEAFLETS AT HEALTH FACILITIES (ITEM 7)

The mental health policy was launched with an emphasis on the provision of information, communication and education (IEC) to consumers, in order to create awareness among the population with a view to creating an understanding of mental illness. It is for this reason that the researcher decided to ascertain whether such materials to promote an understanding of mental illness were available.

Table 4.5 Mental health information, education and communication (n = 52)

		Frequency	Percent%
Valid	yes	31	60.8
	no	20	39.2
	Total	51	
Total		52	100.0

Accordingly, the study found that 30 (60.8%) of the respondents stated that there is information at their health facility to educate the general public on different mental health problems, specifically relating to their signs and symptoms and when to report them to the nearest health facility. The above findings show that most health facilities in the Oshana region have the necessary materials for raising awareness of mental health problems. Another 20 (39.2%) respondents indicated that there are no printed materials at their health centres for educating the community on mental health-related problems.

The implications of these findings are that nurses have nothing to use to increase awareness and that might lead to a lack of awareness. More research is thus needed in this direction to determine the effects this might have on the community. Low understanding of mental health problems among the community could lead to the delayed identification of mental health disorders. This, in turn, could later lead to delayed treatment which is likely to place a heavy burden of care on the family. The lack of information at all levels may prevent people from seeking the advice and treatment they need, and result in the stigmatisation of and discrimination against the affected people and their families.

4.8 REFERRAL HOSPITAL RELATIONS (ITEM 8)

The mental health policy was developed to help address mental health referral issues. The policy emphasises that the referring facility should also be notified on how the patient was managed. In addition, the patient should be discharged through the same referring hospital. In other words, the policy promotes the back and forth referral tracking of patients with a view to promoting the effective management of mental disorders. The researcher saw fit to investigate the referral relations in Oshana region to determine the effect of policy implementation in relation to referral hospital relations.

REFERRAL HOSPITAL FOR MENTAL HEALTH SERVICES

Table 4.6 Referral hospital for mental health (n = 52)

		Frequency	Percent %
Valid	yes	1	1.9
	no	49	94.2
	Total	50	
Missing	System	2	3.8
Total		52	100.0

The study shows that 94.2% (49) of participants indicated that they refer patients with mental health disorders to Oshakati Intermediate Hospital for treatment. Only a small percentage of registered nurses, 1.9% (1), indicated that they do refer their patients to their closest health centre for treatment.

4.8.1 MODES OF REFERRAL (ITEM 9)

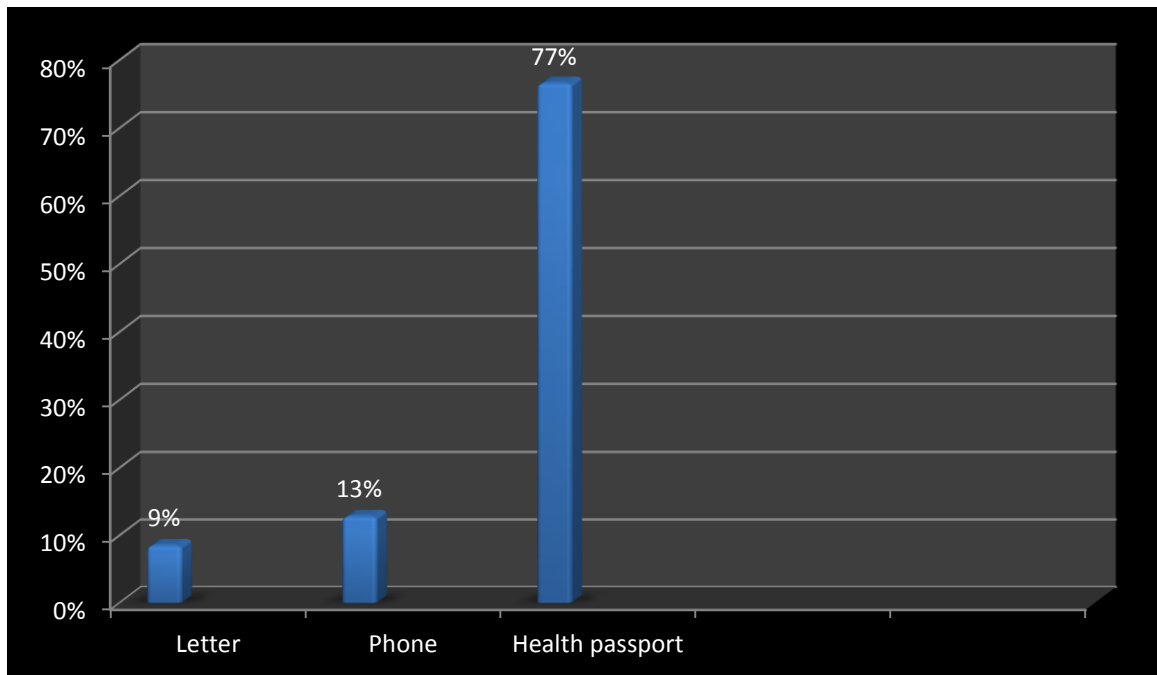


Figure 4.4 Modes of patient referral (n = 52)

This study has revealed that 76.6% (see figure 4.4) of the health facilities in the Oshana region are using health passports when referring patients with mental illness, while only 12.8% make use of a phone.

The referral system at the health facilities in Namibia consists of three levels of health care delivery: primary, secondary and tertiary. In simple terms, if you only have a simple complaint such as a headache, you go to a clinic, which is well equipped to render PHC. Should the headache persist in spite of care given at the clinic and become more serious, then the PHC institution will refer you to the next level of service, the secondary level. This level will determine whether you are so seriously ill that referral to tertiary level is justified. In this region that would be the Intermediate Hospital Oshakati.

The resultant risk of feedback via a passport is that the information only reaches the referring facility if and when the patient comes back for follow-up treatment. This study suggests that the current referral system is not well established. When clients are referred to another facility without any formal documentation, they risk being refused services or having services delayed while the referral facility reassesses them as totally new clients (MoHSS, 2011). Thus, having a systematic referral process would mean that clients could be referred to a higher level (or another) facility. This is therefore an important aspect of ensuring quality health care for patients with mental health disorder.

The study revealed that the majority of respondents (41 or 93.2%) indicated that they feel that the referral hospital is well equipped enough to provide mental health care to their patients. The rest of the participants hold a different view in that they do not feel that the referral hospital is adequately equipped to handle patients with mental health disorders.

The study revealed that 80.8% of the respondents believe that there is poor communication between the health facilities and the referral hospital. Only a small percentage of health providers indicated that there is good communication as far as the coordination of referral is concerned. However, referred patients are sent without notification to the regional hospital and the medical offices do not use the forms to provide feedback to the referring health facilities but make use of patient passports, which never provide sufficient information about client medical history. The study has further indicated that no clinic visits are conducted by the referral hospital.

4.9 SUPERVISORY SUPPORT VISIT (ITEM 10)

Supervision remains one of the most important activities in policy implementation. The mental health policy that was launched states that there should be periodic supervisory support carried out by health programme administrators at the regional level to guide and support registered nurses at the clinic level on how to implement the policy. This study seeks to understand whether supervisory support visits are being carried out in Oshana region or not. The table below gives the findings relating to supervisory support visits in Oshana region.

Table 4.7 Supervisory support visit (n = 52)

Responses	Frequency	Percent %
Valid yes	1	2.0
no	49	98.0
Total	50	100.0
Missing system	2	
Total	52	100.0

The findings revealed that 49 (98%) respondents stated that no supervisory support visits are being carried out at clinics and health centres in the Oshana region, with the aim helping PHC staff to implement the mental health policy. This finding is in contrast with the view of Gilson et al. (2008), who argue that, according to the bottom-up model of policy implementation, regional managers have a duty to guide and supervise policy implementers at all levels of health care delivery.

Such supervision and guidance is achieved by having a team at the regional level that visits health facilities on a quarterly basis to assess the progress made and give on-the-job training as

necessary. These visits would ensure that standards and protocols are followed at the facility level and would promote an organisational culture that expects such standards and protocols to be implemented (MoHSS, 2011). This would provide opportunities to expose staff to a wider scope of ideas and relevant experiences, including on-the-job training for some providers (MoHSS, 2011). It can also act as a motivator for the service providers, especially if the supervisor is supportive.

According to the mental health policy, national and regional managers should be regularly available to primary care staff to give advice and guidance on the management and treatment of people with mental disorders (MoHSS, 2005). This is not happening in the Oshana region where this study was conducted.

4.10 DUTIES OF THE REGIONAL MENTAL HEALTH COORDINATOR (ITEM 10)

Programme coordinators play a vital role in ensuring the effective implementation of public policies. The mental health policy emphasises that a mental health coordinator should be appointed to oversee mental health activities at both district and regional level. This person is supposed to compile progress reports and activity plans for the region. This research investigated whether the regional mental health coordinator is in place. The findings on this information are given in the table below.

Table 4.8 Duties of the regional mental health coordinator (n = 52)

Responses		Frequency	Percentage %
Valid	yes	3	6.8
	no	41	93.2
	Total	44	100.0
Missing	system	8	
Total		52	100

This study shows that 41 (93.2%) of the respondents maintain that there is no regional mental health coordinator in the region to provide support or oversee the implementation of the mental health policy. The mental health policy for Namibia clearly stipulates that a regional mental health coordinator should be available at the regional level. He or she has a duty to annually summarise programme activities for the region, indicating whether there have been any deviations from plans and the possible causes for this. In consultation with the regional management teams, it can then be decided whether the activities should be modified to reach the programme targets more effectively. Currently, there is no focal person for the mental health programme who can track the progress of policy implementation. The mental health policy should be monitored in accordance with the five-year strategic plan and annual actions.

4.11 TRAINING IN MENTAL HEALTH (ITEM 11)

Mental health services should form part of health care delivery. Currently, however, it would seem the service needs to be integrated and seen as a service that forms an integral part of comprehensive health care services. Therefore, the development of human capital remains a key priority in the implementation of this policy. This policy emphasises that competent and well-trained human resources in the field of mental health need to be attracted and retained.

The study explored whether nurses working in a PHC setting had basic training in mental health. The detail of this information is outlined in the table below.

4.11.1 NURSES' TRAINING IN MENTAL HEALTH

Table 4.9 Nurses' training in mental health (n = 52)

Responses	Frequency	Percent%
Valid yes	40	76.9
no	12	23.1
Total	52	100.0

To maintain the levels of knowledge and technical competence achieved during basic training, health care workers should be continually exposed to current and new information. This study assessed whether PHC workers had received any formal training related to the mental health services they offer. The study showed that 40 (76.9%) of the 52 surveyed registered nurses had received basic training in mental health during their pre-service training. According to Gilson et al.'s (2008) bottom-up view of policy implementation, any policy will require strong investment in the training of staff; in this case to enable them to be able to detect and treat mental health disorders.

Before implementing their mental health policy, South Africa and Uganda followed a similar pattern to that used by Zimbabwe. Accordingly, they held a series of training for all nurses working in primary health care. This was done to ensure support at both the district and the regional management level (Petersen et al., 2011).

This study seems to be in agreement with Gilson et al. (2008), who believe that, in order to attain full and successful implementation of policy, sufficient resources for implementation are required at multiple levels: national, state, district, and facility.

According to Nsingo (2006), for any policy implementation to be successful, those involved in the implementation need to be thoroughly trained first on the policy content so that they will have sufficient information (Nsingo, 2006). This includes knowing whom to work with and the appropriate beneficiaries of the policy.

4.11.2 NURSES' PREPAREDNESS TO DELIVER MENTAL HEALTH SERVICES IN A PRIMARY HEALTH CARE SETTING (ITEM 13)

Mental health policy emphasises that mental health services should be provided by registered nurses in a primary health care setting. This study explored whether registered nurses were ready to implement the policy in primary health care settings. The information about the preparedness is given in a figure below.

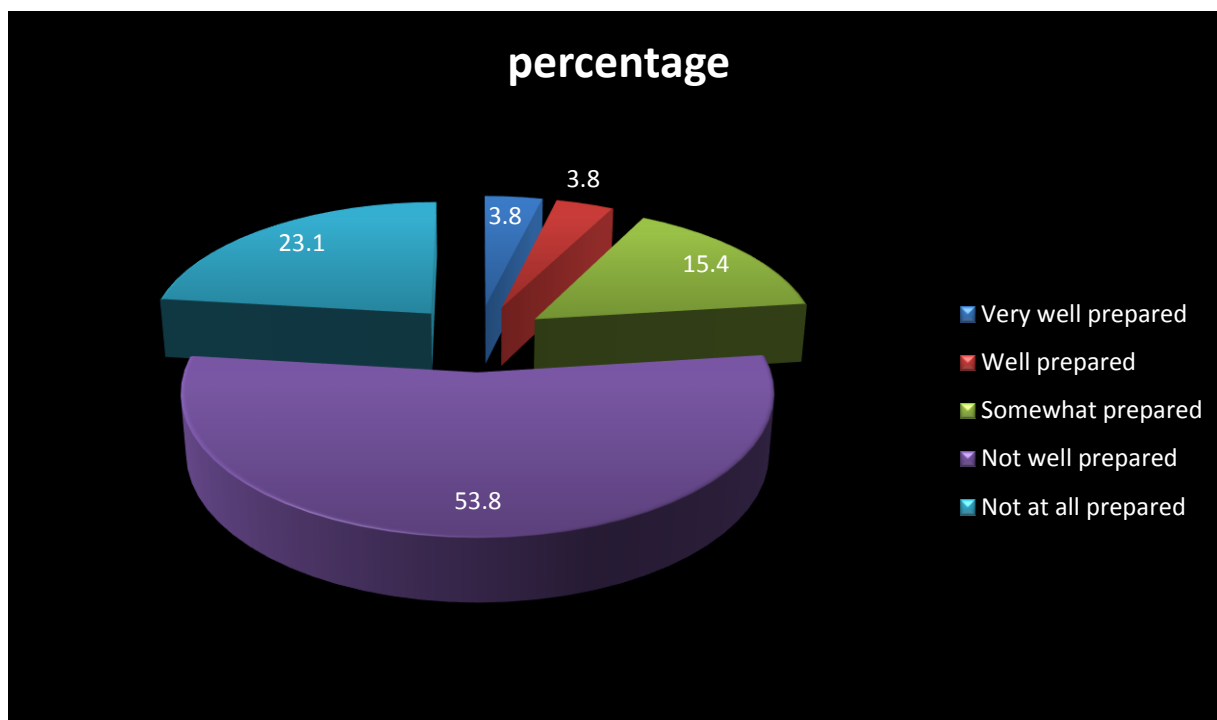


Figure 4.5 Nurses' preparedness to deliver mental health services in primary health care setting (n = 52)

A total of 40 (53.8%) respondents in this study indicated that they were not prepared to deliver mental health services as part of the package they provide to their patient. Health providers felt that they require training in addition to their basic training in order to enhance their knowledge and skills when providing health care to people with mental health problems. The results revealed a general lack of preparedness among health workers to have mental health added to their list of care responsibilities, or to have it integrated with PHC.

These findings of this study are similar to those of a study done in Zambia, where health care providers needed training in order for them to be able to minister to people seeking mental health care at PHC level (Mwape, Sikwese, Kapungwe, Mwanza, Flisher, Lund, et al., 2010). PHC workers in Zambia have the capacity to handle patients with severe psychosis and refer only those that they feel require services. Zimbabwe, on the other hand, has managed to centralise and integrate its mental health services as an integral part of PHC services.

4.12 MENTAL HEALTH POLICY

4.12.1 NURSES' BELIEFS ON HOW THE MENTAL HEALTH POLICY SHOULD BE IMPLEMENTED IN PHC SETTINGS (ITEM 12)

According to Gilson, (2008), the knowledge of policy implementers plays a crucial role in policy implementation. This study explored registered nurses' beliefs on how the policy should be implemented in a primary health care setting. The information about the nurse's beliefs on how the policy should be implemented is given in table 4.10 below.

Table 4.10 Nurses' knowledge of the existence a national policy on mental health (n = 52)

Responses	Frequency	Percent %
Valid yes	12	27.3
no	32	72.7
Total	44	100
Missing system	8	
Total	52	100

The study discovered that only 12 (27.3%) of the registered nurses believe that there is a working policy for mental health in Namibia, while 72.2% of respondents believed that there is no working policy for mental health. This is yet another sign that seem to support Gilson et al.'s (2008) view that when the implementation of any policy follows a vertical top to bottom implementation, instead of a bottom-up implementation where there is regular consultation with the policy implementers, it is likely to be inadequate.

If the health care workers (implementers) have a good working knowledge of the content of the policy and what is required from them as implementers, then it is assumed that they will be able to implement it easily. However, if the health care workers have no clue as to what the policy seeks to address then it will be difficult for them to implement it.

4.12.2 NURSES' KNOWLEDGE ON HOW THE MENTAL HEALTH POLICY SHOULD BE IMPLEMENTED IN A PRIMARY HEALTH CARE SETTING (ITEM 14)

The mental health policy was developed and launched in 2005. According to this policy, mental health services were to be provided by registered nurses in a primary health care setting. This study explored what knowledge registered nurses hold on how the policy should be implemented in a primary health care setting. The information about the nurse's knowledge on how the policy should be implemented is given in table below.

Table 4.11 Nurses' beliefs on of how the mental health policy should be implemented in a PHC setting (n = 52)

Responses	Frequency	Percent %
Valid There should be dedicated mental health (MH) care in in- and outpatient facilities	5	33.3%
Patients should be referred to MH services at district hospital	1	6.7%
Patients should receive care in PHC settings	9	60.0%
Total	15	100.0%
Missing system	37	
Total	52	100.0%

The study revealed that nine (60%) of the health care providers surveyed believed that for the mental health policy to be effectively, patients must receive mental health care in a PHC setting. Only five (33.3%) of the surveyed respondents indicated that there should be dedicated mental health services in the in- and outpatient departments of health facilities.

It is evident from the above findings that the respondents felt strongly that mental health services should be made available in PHC facilities. The results revealed largely favourable attitudes among health care providers towards the integration of mental health into PHC. Many participants also indicated that integration would facilitate the detection and management of mental disorders as mental health care would be brought closer to their communities.

4.12.3 FIVE-YEAR STRATEGIC PLAN FOR MENTAL HEALTH POLICY

IMPLEMENTATION (ITEM 14)

The mental health policy emphasises that its implementation should comprise a five-year strategic plan that clearly spells out the activities of the policy that have to be implemented, as well as the costs and challenges that the implementation of this policy may face. The study investigated whether there is such a strategic plan for this policy in place. The information about this topic is given in the table below.

Table 4.12 Five-year strategic plan for mental health policy implementation (n = 52)

Response		Frequency	Percent %
Valid	yes	2	5.0
	no	38	95.0
	Total	40	100.0
Missing	system	12	
Total		52	100.0

While the mental health policy stipulates that there should be a five-year strategic plan and other related guidelines that will enhance mental health policy implementation, only 5% of the participants indicated that such a document is available; while 95% indicated that they were not familiar with any strategic plan in the field of mental health (see Table 4.10). A strategic plan is supposed to highlight key activities, progress made, challenges, opportunities and achievements in the policy implementation process as a way of facilitating policy implementation.

QUESTIONNAIRE B – BUREAUCRATIC AUTHORITY (Health Programme Administrators)

4.13 INTRODUCTION

In this section the analysis of the open-ended questions will be discussed. Content analysis was done from the information collected from the open-ended questions. The basic technique of content analysis entails counting the frequencies of a certain order of certain words or phrases. By doing so, key words and themes were identified. Content analysis can be done on mass media materials, unstructured questionnaires and open-ended questions, as was the case is in this section of the study (Wellman et al., 2007). Twelve questionnaires were distributed to the health programme administrators. The frequencies related to the themes will be presented in the way which they will be appeared in the figures. The demographic information has already been analysed together with that of the policy implementers in Questionnaire A.

4.14 THE WORLD HEALTH ORGANISATION HAS SAID THAT MENTAL HEALTH SHOULD BE PART OF PHC. WHAT ARE YOUR VIEWS ON THIS STATEMENT? (Item1)

The statement by the WHO, which advocates for mental health to be part of PHC, was well understood by most of the participants. According to the findings of this study, the 12 (100.0%) participants stressed that a holistic approach is one of the key elements in PHC. Therefore, mental health should be delivered as part of a comprehensive PHC approach like all other PHC programmes. The majority of participants, that is 53 (58.3), revealed that mental health services should not only be directed at the treatment of mentally ill patients in health care institutions, but should also to include the prevention of mental illness in the communities.

4.15 THE MENTAL HEALTH POLICY WAS LAUNCHED AND, ACCORDING TO THE POLICY, THE SERVICES MUST BE IMPLEMENTED IN PHC SERVICES. WHAT IS YOUR ON THAT PROCESS UP TILL NOW?

Table 4.13 Views on the WHO statement that mental health should be form of PHC (n = 12)

View points	Frequency (F)	Percent %
Should be a holistic approach in PHC	7	58.3
Mental health care should not only be directed at the treatment of mental illness but should also be prevention orientated	5	41.6
Total	12	100.0

Twelve (100%) of the study respondents stated that the implementation of the mental health policy was very slow because there is no specific programme in terms of which it is being administered. Table 4.13 below shows that all the respondents indicated that there is an acute shortage of skilled health care professionals who can provide for the continued consolidation of in-service training for existing staff in the form of support and supervision. This shortage has led to the inaccessibility of the services that are available.

All 12 (100%) participants revealed that there is no specific programme or focal person under which mental health services fall. These should, according to the policy have been created; indeed the policy emphasises that a focal person be identified to coordinate mental health issues (MoHSS, 2005). The participants who completed this self-administered questionnaire pointed out that there is a lack of public mental health leadership both at district and regional level for guiding the review of policy implementation. Accordingly, there is no one available to do the

monitoring and evaluation, conduct the progress/review meeting, or draw up the quarterly and annual reports that are emphasised in the policy (MoHSS, 2005).

According to the mental health policy, successful implementation will require a well-trained workforce. Hence, the training of mental health staff is a priority in order to provide skills-based technical support to the community (MoHSS, 2005). All the participants in this study (12) cited the conspicuous absence of mental health needs on the public health agenda, and resource allocation to the programme, such as infrastructure and transport, is non-existent.

Table 4.14 Barriers to mental health policy implementation (n = 12)

Responses	Frequency	Percent %
Lack of guidance received from national level or any kind of correspondence	12	100.0
No specific programme under which mental health services falls	12	100.0
Inadequate structures and allocation of resources to mental health in the public sector e.g. transport, staff and proper facilities	12	100.0
Lack of training and orientation for the policy implementers and programme officers to build their capacity on issues relating to mental health policy implementation	12	100.0
Few mental health professionals (psychiatrists, psychologists, psychiatric nurses, counsellors etc.) in the public sector	12	100.0
TOTAL	12	100.0

4.16 IN YOUR EXPERIENCE HOW DOES THE IMPLEMENTATION OF THE NATIONAL POLICY ON MENTAL HEALTH DIFFER FROM OTHER HEALTH POLICIES THAT ARE ALREADY IMPLEMENTED IN YOUR REGION?

According to the results of this study, all 12 (100%) respondents believe that mental health policy services are not fully integrated as part of PHC services. The implementation of other policies in the region, such as those related to tuberculosis (TB), Prevention of Mother to Child Transmission and the Expanded Programme on Immunization, are clearly visible in comparison with the mental health policy. The 12 health programme administrators indicated that little had been done in the way of orientation since the inception of the mental health policy. In comparison, policies for the other programmes had been preceded by the intensive training and orientation of policy implementers to enable them to implement such policies properly. In the Oshana region, no orientation or training had been conducted since the inception of the mental health policy to guide the nurses and programme managers on what needed to be done. In addition, other policies, such as that on TB, had been translated into programmes on the ground with a focal person to ensure that policies were properly implemented. Moreover, the other policies are strongly supported by development partners such as the United Nations International Children Education Fund, Project Hope, Malaria, and International Training Education Communication on Health, Family Health International and the Global Fund. Such support includes the supply of cars, money and personnel to ensure that implementation takes effect. The 12 respondents pointed out that no correspondence had been received with regard to mental health policy implementation in comparison to the other health policies.

Table 4.15 Implementation of the national mental health in relation to other health policies (n = 12)

Responses	Frequency(n)	Percentage %
No correspondence are received from national level regarding mental health policy in relation to other programmes like TB, where is satisfactory correspondence is regarded as	12	100.0
No orientation or training had been conducted since the inception of the mental health policy	12	100.0
No specific mental health focal person either at regional or facility level had been identified	12	100.0

4.17 REASONS WHY THE MENTAL HEALTH POLICY HAS NOT BEEN IMPLEMENTED (ITEM 4)

Question 4 sought to investigate the respondents' views on why the mental health policy has not been implemented. This section investigates the suggestions made by respondents for strategies that could be followed to facilitate policy implementation. Seven (58.3%) of the health programme administrators believed that intersecting policies in health services delivery are hindering the implementation of the mental health policy. On the other hand, three (25%) respondents attributed it to the lack of resources (i.e. human, equipment, facility, logistic and finance). The rest, who were in the minority (2, i.e. 16.6%) attributed the lack of policy implementation to the absence of public health leadership.

Table 4.16 Reasons why the mental health policy has not been implemented**Reasons why the mental health policy has not been implemented (n = 12)**

Responses	Frequency (F)	Percentage %
Intersecting policies or guidelines	7	58.3
Lack of resources (human, equipment, logistic and finance)	3	25
Lack of public health leadership in mental health field	2	16.6
Total	12	100.0

4.18 SUMMARY

This chapter presented the findings on facility profiles, focusing on mental health policy implementation as an integral part of PHC services. The items addressed included mental health services availability in a PHC setting, the availability of psychotropic medication, training in mental health, and supervisory support, among others. The chapter also presented the findings relating to mental health policy implementation, concentrating on registered nurses and health programme administrators. The following chapter presents the discussions, conclusions, recommendations and limitations arising from the research.

CHAPTER 5

DISCUSSIONS, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

5.1 INTRODUCTION

In this study, a quantitative, descriptive and explorative design was used in order to determine the extent to which registered nurses and health programmes administrators are implementing the Namibian mental health policy. The role of policy implementers was described and the main components of a bottom-up model for policy implementation were identified in the literature. From this information a questionnaire was created which was used to conduct a survey. The questionnaire used for the purpose of this study identified key areas of concern relating to the lack of implementation of mental health policy in PHC services in the Oshana region of Namibia. In this chapter, the research findings are discussed and conclusions are drawn in the context of the purpose and stated objectives of the study. From these conclusions, a number of recommendations are formulated and presented while acknowledging the limitations of the study. These limitations are highlighted and placed in context.

5.2 DISCUSSION OF FINDINGS

In discussing these findings, it has been observed that integrating mental health services into PHC is critical to improving and promoting mental health of the Namibian population. Therefore, these results show that well-articulated plans are called for in order to address the challenges to mental health policy implementation in Namibia if the burden associated with mental disorders is to be reduced.

This study agrees with the bottom-up model of policy implementation of Gilson et al. (2008). These authors state that in order to bring about full and successful implementation of a policy, sufficient resources for implementation at multiple levels are required – national, state, district, and facility level.

This study discovered that while health care workers on the ground were expected to implement the policy, crucial aspects needed to implement the policy, such as a budget, human resources, guidelines, medication, information education and communication, infrastructure and mental health leadership, are not in place to help the implementers to function.

Furthermore, the absence of a good referral system between primary and secondary care in the Oshana region severely undermines the effectiveness of the mental health care delivered at PHC level (WHO, 2007 a). It has been established that although the policy as a document is in place in most health facilities there has been very little support for its implementation at any of the levels. As a result, mental health services are not available in 94% of the health facilities in the region.

According to Nsingo (2006), for any policy implementation to be successful, those involved in the implementation need to be thoroughly trained firstly on the policy content so that they have sufficient information (Nsingo, 2006). This includes knowing whom to work with, their roles in implementing the policy and who are the appropriate beneficiaries of the policy.

This study discovered that 40 (77%) of the nurses who completed the questionnaire had been trained in mental health during their pre-service training; however, none of them expressed confidence in delivering mental health service to their clients. This situation was attributed to the lack of knowledge and skills needed to deliver mental health services to clients, such as

identifying and treating mental illness. These results were found to be consistent with those of previous similar studies conducted in South Africa, Zambia and Uganda, except for the fact that their implementers were trained to enable them to implement the policy. Many of the participants suggested that they would like to be trained and be clinically supervised in the area of implementing the mental health policy.

According to Gilson et al.'s (2008) model of bottom-up policy implementation, it is risky to assume that putting good policies in place will guarantee their automatic flow into successful ground-level implementation. While the policy implementers are expected to implement this mental health policy, it was the duty of the regional health programme administrators to see to it that registered nurses (implementers) at the health facility level are well supported and supervised to implement the policy. In this study, 49 (98%) participants (registered nurse) indicated that they had never been supervised in the area of mental health to enable them to implement the policy. According to Buse et al. (2005), there is a trend in policy implementation of ignoring the policy implementer, where it is common to observe a gap between what was planned and what actually occurred as a result of a policy.

According to Gilson et al.'s (2008) bottom-up model of policy implementation, it is argued that it is essential to communicate with the people implementing the policy in order to build their support for the implementation and to deal with their concerns. This has been observed in other countries such as Zambia, Zimbabwe, Uganda and South Africa, where registered nurses were given the opportunity to attend in-service training, workshops and refresher courses. According to the studies conducted in Zimbabwe, Zambia and Uganda, the way in which the mental health policy was implemented in Namibia is totally different from these countries in the sense that implementers in Namibia were not involved in certain necessary activities in the same way that implementers in other country were.

The results of this study supported the conceptual framework of this study which claims that policies are likely to be affected by other policies that provide conflicting guidance on related topics. For example, while the Namibian mental health policy emphasised that psychotropic medication should be available in the primary health setting, the NEMLIST does not make any provision for some medication to be available at the health centres and clinics (MoHSS, 2005). As a result, programme implementers could choose one policy to implement in this case, while ignoring others which, in this case, is the mental health policy (Dreyer, 2010).

It was indicated in this study that training would equip general health care workers with the skills needed to manage cases of mental illness appropriately. Accordingly, the detection and management of mental health problems should be improved so that people will be more willing to access care, care will be brought closer to the communities, there will be more human resources and there will likely be fewer patients. The research respondents indicated that training in mental health would also prevent them from referring uncomplicated cases to hospitals, as is the current practice in the region.

Currently, mental health disorders pass through the hands of PHC providers unnoticed, little is done to identify them and nothing is done or offered in terms of management. This results in continued ill health, dysfunction and poor quality of life (Alibusa, 2011).

5.3 CONCLUSIONS

The results of the study indicated some significant findings. There is clear evidence that the policy has not been implemented as described in the policy. Moreover, a number of challenges hindering the implementation of the policy were found. The challenges to mental health policy

implementation that were identified by the participants include conflicting policies and the lack of guidelines for identifying and managing mental health disorders.

The results of the study showed that there is a lack of supervisory support by general health service managers at all levels, from facility managers to regional health managers. In addition, there are restrictions that prohibit primary care nurses from prescribing common psychotropic medication; there is a shortage of mental health professionals to provide ongoing supervision and support to primary care practitioners; and there is a lack of training among the policy implementers in the identification and management of mental disorders.

In conclusion, the implementation of mental health services in PHC is critical to improving and promoting the mental health of the Namibian population. Therefore, these results call for articulated plans to address the challenges of mental health policy implementation in Namibia in order to reduce the burden associated with mental disorders.

5.4 RECOMMENDATIONS

It is recommended that the study of mental health policy implementation as an integral part of PHC services in regions be continued. As current data are minimal, further studies could perhaps increase the scope of mental health policy implementation within the regions. Studies should also be performed to determine the strategies or guidelines that may be used to facilitate the implementation of mental health implementation as an integral part of PHC services. In this context the following recommendations are made to various interested parties:

Ministry of Health and Social Services (MoHSS)

- The involvement of consumer, family and other organisations should be increased in order to lobby for the implementation of the policy at regional and district levels
- The MoHSS should strengthen the national manager's role, including planning, policy development, policy formulation and implementation of policies, to ensure proper service delivery. Quarterly inspections by the Permanent Secretary should be done in this regard at all clinics and health centres.
- The MoHSS should ensure that basic psychotropic medication is made available at primary and secondary care levels. Governments need to ensure that sufficient funds are allocated to purchase the basic essential psychotropic medicines and make sure they are available in primary care settings, in accordance with the policy adopted.
- The MoHSS should provide in-service education and refresher courses on the regional level to enable registered nurses and health programme administrators to implement the mental health policy.
- In carrying out their duty of supervising PHC staff, regional managers should themselves be adequately supervised, monitored and supported by mental health specialists (professional for secondary level) if implementation of the mental health policy is to succeed.
- Regional management teams should facilitate the identifications of a focal person to take care of mental health services at regional, district and facility levels to assist with the integration of mental health into PHC services.
- A budget should be provided for building the capacity of PHC workers in the promotion of mental health, the detection of common mental disorders, and the treatment of patients in their communities. In addition, a working referral system, both up and down,

between the Oshakati mental health unit and the surrounding clinics and health centres in the Oshana region should be established.

- Future research should be done to explore the feasibility of having separate divisions at both regional and district levels to oversee mental health policy implementation in the region.

Nursing education

- Institutions of higher education should during clinical sessions emphasise the aspects of mental health policy that should be integrated.

5.5 LIMITATIONS OF THE STUDY

Some limitations were encountered during this study as described below:

1. Data collection instrument

One limitation concerns the research instrument, as the questionnaire contained only closed and open-ended questions. By implication this meant limited response options.

2. Data collection

As a result of the fact that the research investigation was conducted in only one region, Oshana, the population and sample have limited statistic value and therefore results could not be generalised. To generalise the findings a bigger study needs to be done. Additionally, the data source was the self-administered questionnaires of nurses and programme administrators regarding their own practice and knowledge, rather than direct observation or assessment of practices and knowledge. Participants may have interpreted questions differently when

completing the questionnaires, thus the aim of the specific question may have been lost, because of how it was interpreted.

REFERENCES

Anand, K., Pandurangi, F., & Nimesh, G.D. (2009). Report of the Indo–US Health Care Summit 2009 – Mental Health section. *Indian J Psychiatry*, 51(4), 292–301.

Alibusa, S. W. (2011). *Mood disorders in PHC*. Department of Health, MoHSS. Windhoek, Namibia

Basir, C. (2011). *Public policy: Implementations approaches*. Islamabad: The Statesman Institute.

Brink, H. I., Van der Walt, C., & Van Rensburg, G. (2008). *Fundamentals of research methodology for health care professionals*. Cape Town: Juta.

Burns, N., & Grove, S. K. (2005). *The practice of nursing research* (3rd ed.). Tokyo, Philadelphia: W.B. Saunders.

Buse, K., Mays, N., & Walt, G. (2005). *Making health policy: Understanding public health policy series*. Berkshire, UK: McGraw Hill Education Open University Press.

De Haan, M. (2011). *The health of Southern Africa* (9th ed.). Cape Town, South Africa: Juta Academic.

De Vos, A. S., Strydom, H., Fouche, C. B., & Delpont, C. S. L. (2007). *Research at grassroots for the social sciences and human service professional* (3rd ed.). Pretoria: Van Schaik.

Donald, O. C. (2010). *Culturally competent practice: A framework for understanding – A framework for understanding diverse groups and justice issues* (4th ed.). Canada: Nelson.

Dreyer, M. S. (2010). *Pharmacology for nurses and other health workers* (2nd ed.) South Africa: Pearson Education.

Donald, O. C. (2010). *A framework for information policies with examples from the United States*. Lincoln, NE: University of Nebraska.

Faydi, E., Funk, M., Kleintjes, S., Ofori-Atta, A., Ssbunya, J., Mwanza, J., & Flisher, A. (2011). An assessment of mental health policy in Ghana, South Africa, Uganda and Zambia. *Health Research Policy and Systems, 9*, 5–17.

George, J. B. (2011). *Nursing theories: The base of professional practice* (6th ed.). USA: Pearson Education.

Gilson, L., Loewenson, R., & Pointer, R. (2008). *Talking implementation gaps through health policy analysis*. Harare, Zimbabwe: EQUIPNET TARSC.

Goldstein, E. B. (2010). *Sensation and perception*. USA: Wadsworth.

Government of the Republic of Namibia. (2004). Nursing Act No 8 of 2004. Windhoek, Namibia.

Hulley, S. B., Cummings, S. R., Browner, W. S., Grady, D, Hearst, N. & Newman, T. (2007). *Designing clinical research*. Philadelphia: Lippincott, Williams & Wilkins.

Hunter, D. J. (2003). *Public health policy*. Cambridge: Polity Press.

Jack-Ide, I., Uys, L. R., & Middleton, L. E. (2013). Mental health care policy environment in Rivers State: Experience of mental health nurses providing mental health care services in neuropsychiatric hospital, Port Harcourt, Nigeria. *International Journal of Mental Health, 7* (1), 8.

Jennifer, R., & Frances S. (2004). Conducting a literature review: Library source & semices *Managing Research New, 27*(6), 33–39.

Kamran, S., & Najma, S. (2007). Treatment of common mental disorders in primary care in low- and middle-income countries. *Transactions of the Royal Society of Tropical Medicine and Hygiene, 101*, 957–958.

Kigozi, F. (2007). Integrating mental health into PHC: Uganda experience, Kampala, Uganda. *South African Psychiatry Review, 10*, 17–19.

Langford, R. W., Borbasi, S., & Jackson, D. (2008). *Navigating the maze of nursing research: An interactive learning adventure*. Missouri: Mosby.

Leedy, P. D., & Ormrod, J. E. (2005). *Practical research: Planning and design* (8th ed.). New Jersey: Pearson Prentice-Hall.

Leinger, M. M. (2006). *Culture care diversity and universality theory and evolution of the ethnonursing method: A worldwide nursing theory* (2nd ed., pp. 281–306). Boston, MA: Jones and Bartlett.

LoBiondo-Wood., G. & Haber, J. (2006). *Nursing research, methods and critical appraisal for evidence based practice* (6th ed.). St Louis, MI: Mosby Elsevier.

Lopez, A. D., Mathers, C. D., Ezzati, M., Jamison D. T., & Murray, C. J. L. (2006). *Global burden of diseases and risk factors*. New York: Oxford University Press and the World Bank.

Maloboka, B., & Barandonga, A. (2011). *Situational analysis of Namibia mental health system*. Windhoek. Namibia.

Maree, K. (2010). *First steps in research*. Pretoria: Van Schaik.

McClure, C. R. & Jaeger, P. T. (2008). Government information policy research: Importance, approaches, and realities. *Library & Information Science Research, 30*, 257–264.

Mohr, W. K. (2013). *Psychiatric mental health nursing: Evidence-based concepts, skills and practices* (8th ed.). New Jersey: Lippincott, Williams & Wilkins.

Ministry of Health and Social Services (MoHSS). (2004). *Report on the Namibia school-based student health survey*. Windhoek: Government of Republic of Namibia.

Ministry of Health and Social Services (MoHSS). (2005). *National Policy for Mental Health*. Windhoek: Government of Republic of Namibia.

Ministry of Health and Social Services (MoHSS). (2006–2007). *Namibia demographic and health services*. Windhoek: Government of Republic of Namibia.

Ministry of Health and Social Services (MoHSS). (2008). *Report of 2004 National HIV Sentinel Survey*. Windhoek: Government of Republic of Namibia.

Ministry of Health and Social Services (MoHSS). (2008). *The Health Sector and Health Sector reform in Namibia*. Planning division. Windhoek: Government of Republic of Namibia.

Ministry of Health and Social Services (MoHSS). (2008). *Namibia Essential Drug List (NEDLIST)*. Windhoek: Government of Republic of Namibia.

Ministry of Health and Social Services (MoHSS). (2010). *PHC Guidelines for Namibia*. Windhoek: Government of Republic of Namibia.

Ministry of Health and Social Services (MoHSS). (2011). *Namibia Health Facility Census (HFC) of 2011*. Windhoek: MoHSS and ICF Marco.

Ministry of Health and Social Services (MoHSS). (2012). *Namibia Essential Drug List (NEDLIST)*. Windhoek: Government of Republic of Namibia.

Ministry of Health and Social Services (MoHSS). (2012b). *Annual report for 2011–2012 Intermediate Hospital Oshakati (IHO)*. Oshana Regional Health Directorate.

Mudzingwa, K. (2007). Zimbabwe: *The mentally-ill not outcasts*. Retrieved May 27, 2010 from <http://allafrica.com/stories./20070201467.html>.

National Department of Health. (2008). *Nursing Strategy for South Africa 2008*. Retrieved March 2012 from <http://www.doh.gov.za/search/index.html>.

Nsingo, S. (2006). Public Policy (POP7359). Windhoek: University of Namibia, Centre for External Studies.

Ohegbu, A. N. (2008). Globalization and national information policy in Nigeria. *Library Philosophy and Practice* (December), retrieved June 1, 2010, from <http://unllib.unl.edu/LPP/lpp2008.htm>

Oyedele, V. (2003). *Educational research and statistical methods: Study guide item: 429 (CAR 7309/7129)*. Windhoek: Centre for External Studies. University of Namibia

Mwape, L., Sikwese, S., Kapungwe, A., Mwanza, J., Flisher, A., Lund, C., & Cooper, S. (2010). Integrating mental health into PHC in Zambia: A care provider's perspective. *International Journal Health System* 4, 21.

Petersen, I., Ssebunnya, J., Bhana, A., & Baillie, K. (2011). Lessons for case studies of integrating mental health into primary health care in South Africa and Uganda. *International Journal of Mental Health*, 5.

Polit, D. F, & Hungler, B. P. (2007). *Nursing research: Generating and assessing evidence for nursing practice* (8th ed.). London: Lippincott Williams and Wilkins.

Polit, D. F., & Beck, C. T. (2004). *Nursing research principles and methods* (7th ed.). Philadelphia: Lippincott Williams and Wilkins.

Powell, A. E., Davies, H. T. O., Bannister, J., & Macrea, W. A. (2009). Understanding the changes of service change: Learning from acute pain services in the U.K. *Journal for the Royal Society of Medicine*, 102(2), 62–68.

Radhakrishna, R. B., Yoder, E. P., & Ewing, J. C. (2007). *Strategies for linking theoretical framework and research types*. Pennsylvania: Pennsylvania State University.

Saunders, M., Lewis, P., & Thornhill, A. (2009). *Research methods for business students* (5th ed.). England: Financial Times/Prentice Hall.

Schaay, N., & Sanders, D. (2008). *International perspective on PHC over the past 30 years*. Durban, South Africa: South African Health Review Health Systems Trust.

Sekaran, U. (2013). *Research methods for business: A skill building approach* (4th ed.). Carbondale: John Wiley.

Spratt, K. (2009). *Policy implementation barriers analysis: Conceptual framework and pilot test in three countries*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

The Namibian. (2012). Chained in the name of healing. Retrieved May 31, 2012 from www.thenamibian.com.na/2012/11apr/04-08.htm

Tsiko, S. (2006). Mental health care promotion vital. *The Herald*, 17 October. (CISNET Zimbabwe (CX164884). Retrieved May 27, 2010 from <http://allafrica.com/stories>

Van Dyk, A. (2008). *Research in health science*. Study guide item: 906 module 3. Windhoek: University of Namibia, Centre for External Studies.

Wagner, C., Kawulich, B., & Garmer, M. (2012). *Doing social research: A global context*. London: McGraw-Hill.

Walt, G., & Gilson, L. (1994). Reforming the health sector in developing countries: The central role of policy analysis. *Health Policy and Planning*, 9(4), 353–370.

Wellman, C., Kruger, F., & Mitchell, B. (2007). *Research methodology*. Cape Town: Oxford.

World Health Organization (WHO). (1975). *Organization of mental health services in developing countries*. Sixteenth report of the WHO experts committee on mental health, December 1974. Geneva, World Health Organization (WHO Technical report services, no 564).

World Health Organization (WHO). (1978). Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR

World Health Organization (WHO). (2004). *Promoting mental health: Concepts, emerging evidence, practice: Summary report a report from the World Health Organization*. Department of Mental Health and Substance Abuse in collaboration with the Victorian, Health Promotion Foundation (Vic Health) and the University of Melbourne.

World Health Organization (WHO). (2005a). *Module mental health policies, plans and programs* (updated version). Geneva, WHO.

World Health Organization (WHO). (2005b). *Mental health information systems*. Geneva: WHO.

World Health Organization (WHO). (2007a). *Developing effective mental policies and plans in Africa: 7 key lessons*. Geneva: WHO.

World Health Organization (WHO). (2007b). *Integrating mental health services into PHC*. Geneva: WHO.

World Health Organization (WHO). (2008a). *Challenges of implementing mental health policy and legislation in South Africa*. Geneva: WHO.

World Health Organization (WHO). (2008b). *The World Health Report: Primary health more than ever*. Geneva: WHO.

World Health Organization (WHO). (2008c). World Health Organization and World Organization of Family Doctors (WONCA): Integrating mental health into primary care: a global perspective. Geneva: WHO.

World Health Organization (WHO). (2008d). *Mental Health Gap Action Programme: Scaling up care for mental, neurological and substance use disorders*. Geneva: WHO.

World Health Organization (WHO). (2009). *Improving health systems and services for mental health: Mental health policy and service guidance package*. Geneva: WHO.

World Health Organization (WHO). (2010). *Mental health and development: Targeting people with mental health conditions as a vulnerable group*. Geneva: WHO.

World Health Organization (WHO). (2011). *Mental Health Atlas 2011*. Geneva: WHO.

ANNEXURES

ANNEXURE 1: PARTICIPANT INFORMATION LEAFLET

Researcher: Mr Daniel Opotamutale Ashipala

Course: Master of Nursing Science

Title: Mental health policy implementation as an integral part of primary health care services in Oshana region, Namibia.

INTRODUCTION

You are invited to participate in this research project. This leaflet will help you make to an informed decision on whether or not to participate. It is good for you to fully understand why the research is being done and what it involves before you agree to participate. However should you have any unanswered questions do not hesitate to contact the researcher directly.

I am herewith inviting you to participate in a research study on the implementation of mental health policy as an integral part of PHC services in Oshana region.

The purpose of the study is to identify obstacles faced by nurses in integrating mental health in PHC services. The study is beneficial to you in particular and other members of health disciplinary team in general as the information acquired from this study will be used to improve the quality of care rendered to patient suffering from mental illness. The research protocol was submitted to the post graduate studies committee (PGSC) of the University of Namibia, and was approved and authorised.

It was also submitted to the office of the permanent secretary and it was also approved. Permission has also been granted by the Regional director of Oshana region and by the Senior Medical Superintendent of Intermediate Hospital of Oshakati (IHO).

No physical, spiritual, emotional or social harm is involved in this study. The study is ethical bound therefore issues of anonymity; confidentiality and freedom will be ensured at all time. Your participation in this study is totally voluntary. You have the right to withdraw at any time if you wish to do so or refuse to answer question if you like without any penalty.

** If any further information is needed please contact:

Researcher: Mr Daniel Opotamutale Ashipala Cell 0812949629/0814831706
Tel 067-3009021/22/59/88

You may also contact my supervisors.

Prof Agnes van Dyk 0811270140 061 – 206 3828(w)
Ms Wilma Wilkinson 0812832703 061 – 206 3825(w)

ANNEXURE 2: CONSENT FORM

Researcher: Mr Daniel Opotamutale Ashipala

Study Title: Mental Health Policy implementation as an integral part of Primary Health Care services in Oshakati district, Oshana Region, Namibia.

I am herewith inviting you to participate in a research study on implementation of the mental health policy as an integral part of Primary Health Care services.

The purpose of the study is to identify the challenges hindering the implementation of Namibia mental health policy into PHC services in Oshana region. The study is beneficial to you in particular and other members of health disciplinary team in general as the information acquired from this study will be used to improve the quality of care rendered to patient suffering from mental illness. No physical, spiritual, emotional or social harm is involved in this study. The study is ethical bound therefore issues of anonymity; confidentiality and freedom will be ensured at all time. Your participation in this study is totally voluntary. You have the right to withdraw at any time if you wish to do so or refuse to answer question if you like without any penalty.

If you have any question about the study or participating in this study, please feel free and ask.

The questionnaire will take ± 45 minutes to be completed.

I have discussed the above points with study subjects and I in opinion that they understand risks, benefits, obligations involved in participating in this project.

I hereby freely consent to take in part in this research study.

Signature of Subject

Date

Researcher

Date

ANNEXURE 3: RESEARCH QUESTIONNAIRE**A - POLICY IMPLEMENTERS****MENTAL HEALTH POLICY IMPLEMENTATION AS AN INTEGRAL PART OF
PHC SERVICES IN OSHANA, NAMIBIA**

Thank you so much for your willingness to complete this questionnaire about mental health services in your clinic.

Please tick in appropriate box and fill in where dotted lines are given.

DEMOGRAPHIC DATA

1. Professional rank.....
2. Age.....
3. Highest Qualifications.....

MENTAL HEALTH SERVICES OFFERED AT YOUR CLINIC:

4. Does your clinic have mental health services available? If the answer is no then move to question 11. And if the answer is yes move to question 5.

Yes No

5. Which of the following are available at your facility (tick all that apply)

- | | | |
|----|---|--------------------------|
| a. | Follow up services | <input type="checkbox"/> |
| b. | Counselling therapy | <input type="checkbox"/> |
| d. | Outreach services | <input type="checkbox"/> |
| e. | Referrals to hospital for further treatment | <input type="checkbox"/> |
| f. | Home visits | <input type="checkbox"/> |

6. Does your clinic use a flow chart for the identification and management of mental health problems?

Yes No

7. Does the clinic have the mental health treatment guideline available?

Yes No

8. What drugs are available for mental health treatment in your clinic? Please tick all that apply.

(a) Moducate

(b) Largatil

(c) Haloperidol

(d) Biperiden

(e) Diazepam

9. Are there any information, education and communication (IEC) leaflets in the facility to promote the awareness of mental health for the patients and public?

Yes No

REFERRAL HOSPITAL RELATIONS:

10. To which hospital do you refer patients for mental health needs?

.....

11. How do you refer patients from the clinic to the hospital?

Referral letter Phone other.....

12. In your opinion do you think the hospital where you refer patients is well equipped to provide mental health care?

Yes No

13. Are you satisfied with the communication between this hospital regarding patient referrals and follow up care?

Yes No

14. Has the referral hospital conducted any site visits to your clinic for purposes of strengthening mental health care or the referral system?

Yes No

15. Does the referral hospital conduct any mental health clinical services in your primary health care clinic?

Yes No

16. If yes, what kind of professional member is included in the visit team?

Psychiatric Doctor

Psychiatric Nurse

Social Worker

Clinical psychologist

17. Is there a Regional Mental Health coordinator in this Region who coordinates mental health care services?

Yes No

18. Does the Regional Health coordinator conduct supervisory support visit to the district, Health Centres and Clinics?

Yes No

TRAINING ON MENTAL HEALTH

19. Did you receive any training in mental health during your pre-service nursing training ?

Yes No

20. If yes, how much? (Choose either one or the best answer)

a. No course material in nursing school

b. Some discussion in some of my courses (not very much)

c. One semester course in nursing school

d. More than one semester course in nursing school

e. Clinical Placement

21. How well prepared do you feel to provide mental health care services in this primary health care setting?

(a) Very well prepared

(b) Well prepared

(c) Somewhat prepared

(d) Not well prepared

(e) Not at all prepared

MENTAL HEALTH CARE POLICY

22. Do you believe there is a national health policy with regard to mental health care delivery? If the answer to this question is no continue to question no. 23.

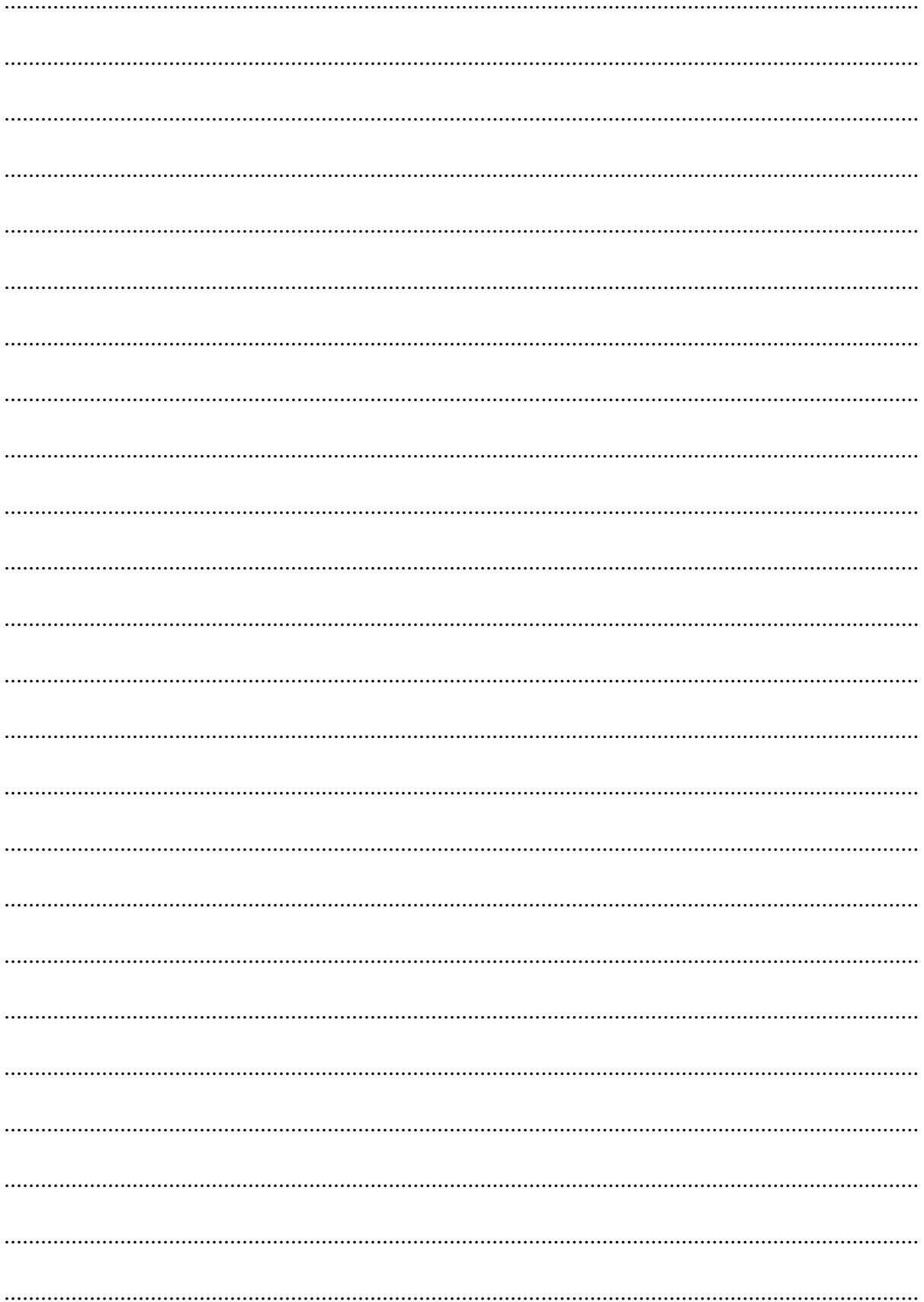
Yes No

23. What do you believe to be the national policy of the MOHSS with regard to delivering mental health care? (Choose only one best answer)

- a. there should be a dedicated mental health inpatient and outpatient facility in each district
- b. patients are to be referred for mental health services to the district hospital
- c. patients are to be seen by a psychiatrist upon request
- d. Patients are to receive mental health care services in the primary health care setting, with referrals as appropriate to higher levels.

25. Is there a five year strategic plan that enhances the implementation of mental health policy?

Yes No



**ANNEXURE 4: LETTER OF PERMISSION FROM UNAM POSTGRADUATE
STUDIES RESEARCH COMMITTEE**

UNIVERSITY OF NAMIBIA

Private Bag 13301, 340 Mandume Ndemufayo Avenue, Pionierspark, Windhoek, Namibia



FACULTY OF MEDICAL AND HEALTH SCIENCES

**Letter of permission:
Post graduate students**

To: Post graduate students
From: Prof A van Dyk

Date: 5 April 2011

Dear Student: Mr D Ashipala(sn)

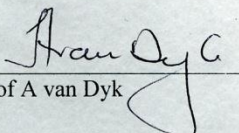
The post graduate studies committee has approved your research proposal.

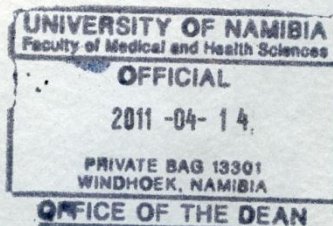
Assessment of the mental health policy implementation as an integral part of Primary Health Care services in Oshana Region, Namibia

You may now proceed with your study and data collection.

It may be required that you need to apply for additional permission to utilize your target population. If so, please submit this letter to the relevant organizations involved. It is stressed that you should not proceed with data collection and fieldwork before you have received this letter and got permission from the other institutions to conduct the study. It may also be expected that these organizations may require additional information from you.

Please contact your supervisors on a regular basis.


Prof A van Dyk



**ANNEXURE 5: LETTER REQUESTING PERMISSION TO CONDUCT RESEARCH
ON MoHSS PREMISES**

Mr. Daniel O. Ashipala
P.O. Box 80001
Ongwediva
Namibia
Tel: 067 – 302109
Fax: 067 -302109
Cell: 0812949629/0814831706
13 April 2011

The Permanent Secretary
Ministry of Health and Social Services
Private Bag 13198
Windhoek
Namibia

Dear Sir

**RE: APPLICATION FOR PERMISSION TO CONDUCT RESEARCH ON THE
PREMISES OF THE MoHSS (HEALTH CENTRES AND CLINICS) IN OSHANA
REGION**

I am a Namibian citizen of 30 of age, currently enrolled with the University of Namibia for the Master of Nursing Science (MNSC) in the faculty of Health Sciences in the School of Nursing and Public Health. This postgraduate course is likely to be completed by 2012.

Currently I am employed by the Ministry of Health and Social Services as a Senior Health Programme Administrator (SHPA) at Otjiwarongo Regional Health Training Centre (ORHTC) in the Directorate of Policy, Planning and HRD. Students registered for master degree are expected to conduct research on Health matters in order to identify and provide scientifically based solutions to client care and health services problems.

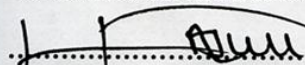
In addition, to design health education, health promotion strategies, critically evaluate health care services based on situational analysis and thereby improving the overall health status of the inhabitants of our country.

It is against this background that I am seeking permission from your good office to conduct my academic research investigation in your health facilities regarding the topic: **Assessment of Mental Health Policy Implementation as an integral part of primary health care services in Oshana Region.**

Attached is an approved version of the research proposal as approved by senate.

I would be grateful if my application receives your favourable consideration and your kind cooperation will be highly appreciated.

Yours in Health and Education


.....
Mr. Daniel Opotamutale Ashipala

**ANNEXURE 6: PERMISSION LETTER FROM THE OFFICE OF THE
PERMANENT SECRETARY OF THE MoHSS**

9 - 0/0001



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: (061) 2032510
Fax: (061) 222558
E-mail: eshaama@mhss.gov.na

Enquiries: Ms. E.N. Shaama

Ref.: 17/3/3

Date: 11 May 2011

OFFICE OF THE PERMANENT SECRETARY

Mr. D. O. Ashipala
P. O. Box 80001
Ongwediva

Dear Mr. Ashipala

Re: Assessment of Mental Health Policy implementation as an integral part of Primary Health Care Services in Oshana Region, Oshakati District, Namibia

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
 - 3.1 The data to be collected must only be used for completion of your Master of Nursing Science Degree (MNSc);
 - 3.2 No other data should be collected other than the data stated in the proposal;
 - 3.3 A quarterly report to be submitted to the Ministry's Research Unit;
 - 3.4 Preliminary findings to be submitted upon completion of study;
 - 3.5 Final report to be submitted upon completion of the study;
 - 3.6 Separate permission should be sought from the Ministry for the publication of the findings.

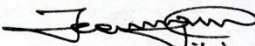
"Health for All"

Yours sincerely,


MR. E. KAHUURE
PERMANENT SECRETARY



**ANNEXURE 7: PERMISSION LETTER FROM THE OFFICE OF THE SENIOR
MEDICAL SUPERINTENDENT OF INTERMEDIATE HOSPITAL OSHAKATI
(IHO)**

		Private Bag X5501 Oshakati			
REPUBLIC OF NAMIBIA MINISTRY OF HEALTH & SOCIAL SERVICES OSHANA REGION DIRECTORATE OF HEALTH		Phones: +264(65)2233000 +264(65) 221 380 Faxes: +264(65) 224564 +264(65) 221 390 E-mail: supt.ihosh@nway.na			
INTERMEDIATE HOSPITAL OSHAKATI					
Enquiries:	Ref: 17/3/3	Date: 19 May, 2011			
Mr. Daniel O. Ashipala PO Box 80001 ONGWEDIVA		<table border="1"> <tr> <td> MINISTRY OF HEALTH & SOCIAL SERVICES P/Bag 5501 </td> </tr> <tr> <td style="text-align: center;"> 2011 -05- 19 </td> </tr> <tr> <td> Oshakati Namibia OSHAKATI HOSPITAL </td> </tr> </table>	MINISTRY OF HEALTH & SOCIAL SERVICES P/Bag 5501	2011 -05- 19	Oshakati Namibia OSHAKATI HOSPITAL
MINISTRY OF HEALTH & SOCIAL SERVICES P/Bag 5501					
2011 -05- 19					
Oshakati Namibia OSHAKATI HOSPITAL					
REQUEST TO CONDUCT RESEARCH ON THE PREMIES OF THE MINISTRY OF HEALTH AND SO- CIAL SERVICES [OUTPATIENT DEPARTMENT].					
Your letter on the above issue refers.					
The Intermediate Hospital Oshakati Management granted you a permission to conduct research, on condition that you must adhere to the rules and regulations of the institution and as per conditions as stipulated in the authorization letter from the Permanent Secretary.					
During your research period, you must under the supervision of the Registered Nurse in charge of the department concern.					
Yours Sincerely					
 DR SHANNON KAKUNGULU MEDICAL SUPERINTENDENT		MEDICAL SUPERINTENDENT OSHAKATI HOSPITAL MINISTRY OF HEALTH AND SOCIAL SERVICES NAMIBIA			
Cc: CCRN Registered Nurse in charge of the Section					
Medical Superintendent: Dr. Shannon Kakungulu Chief Control Registered Nurse: Ms. Kashupi Hirma Chief Control Officer: Mr. Ifugula Ben					