Dispositions of Health Facility In-charges Towards Decentralization and Integration of Mental Health Services into Primary Health Care: A Case of Lusaka District.

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ABSTRACT

Introduction: Worldwide, the burden of mental illnesses poses serious public health challenges, with approximately 7.4% of the global burden attributed to mental disorders. However, many primary healthcare systems in countries around the world focus mainly on physical care and neglect to provide mental health care to their populations. In Zambia, the prevalence of mental disorders is approximately 20%, with common mental disorders including acute psychotic episodes, schizophrenia, alcohol-related problems, and organic brain syndromes. These are mainly seen in Chainama, the only mental institution in the country. The institution is highly stigmatized, and previous studies have shown that the general population does not access services at this facility as intended, leading to considerations of decentralizing these services to be integrated into primary health care. This study sought to understand the dispositions of primary health facility in-charges towards decentralization and the integration of mental health services into primary health care.

Methods: This study was cross-sectional and employed both quantitative and qualitative techniques. A total of 76 primary health care facility in-charges from seven subdistricts of Lusaka district provided data through a questionnaire, and 56 participated in focus group discussions.

Findings: The study found that in-charges had a positive disposition (52 in-charges: 68.3 percent) despite having inadequate knowledge (56 in-charges: 73.7 percent) of the subject matter and the decentralization process. While their current practices towards mental patients were found to be acceptable, the study also found that the majority (52.6 percent) of the in-charges foresaw more barriers to the integration of mental health, citing skilled staff, infrastructure, and drugs as main barriers.

Conclusion: The study concludes that integration requires more investment and sensitization for its success.

Keywords: decentralization, dispositions, mental health, in-charge, integration, primary healthcare.

BACKGROUND

Health is now widely conceptualized as having both physical and mental dimensions. Historically, as far back as 1948, the WHO constitution recognized health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity' (WHO, 1948). However, many primary

healthcare systems in countries around the world focus mainly on physical care, neglecting to provide mental healthcare to their populations.

Globally, approximately 450 million people suffer from mental and behavioral disorders, with approximately one person developing such disorders during their lifetime (Uddin et al., 2019). Worldwide, the burden of mental illnesses poses serious public health challenges, with approximately 7.4% of the global burden attributed to mental disorders (Whiteford et al., 2019: Whiteford et al., 2013). In 2010, mental and substance use disorders were the fifth leading cause of disability-adjusted life years (183.9 million) (Whiteford et al. 2013). In 2015, 17.9 mil-lion years were lost to disability due to mental disorders in Africa, an increase of 52% from 2000 (Sankoh et al., 2018). Munakampe et al. (2020) stated that the prevalence of mental disorders in Zambia was approximately 20 per cent. Common mental disorders in Zambia include acute psychotic episodes, schizophrenia, affective disorders, alcohol-related problems, and organic brain syndromes (Mayeya et al., 2004:16).

The World Health Organization Comprehensive Mental Health Action Plan 2013–2030 emphasized the need for accessible community-based mental health services. These should adopt a biopsychosocial approach to care and should be developed and delivered in close collaboration with multiple sectors and stakeholders to address the full range of needs of people living with mental health conditions (WHO, 2022). Further, the WHO adds that, for most of the world, the approach to mental health care remains very much business as usual. The result is that too many people living with mental health conditions do not receive the care they need and deserve.

The latest analysis by the WHO's Mental Health Atlas of country performance against the action plan confirms that progress has been slow (Mental Health Atlas, 2022). For example, in 2013, 45% of countries reported having mental health policies and plans aligned with human rights instruments. The action plan set a target to increase the figure to 80% by 2020 (later extended to 2030); however, nearly halfway into the plan, the figure had only risen to 51% (Mental Health Atlas, 2022). The coverage for the care of psychosis worldwide is estimated to be as low as 29%. Some areas have had more success: the global age-standardized suicide mortality rate for 2019 has dropped by 10% since 2013. However, this is far shorter than the 33% reduction target for 2030. Overall, there is still a long way to go before the world meets the targets set out in the Comprehensive mental health action plan 2013–2030.

Primary healthcare is the first level of contact for individuals, the family, and community with the national health system, the closest and easiest form of care available, located near people's homes and communities (Whiteford et al., 2013). However, Funk et al. (2008) noted that in many countries, psychiatric institutions are the only form of mental health care available to the population. These institutions are often located in major towns and cities, a long way from where people live, and consequently, many individuals fail to seek the care they need. For example, mental healthcare has been a neglected part of the health system in Zambia, with services concentrated at provincial government hospitals and not at the primary care level (Mwape et al., 2012). The stigma surrounding mental disorders and Chainama (the specialized psychiatric facility in Zambia) is a significant barrier to mental health service utilization (Lungu, 2015). In cases where people seek treatment in psychiatric facilities, they often find themselves very isolated, have to live far away from their families, are removed from their emotional and social support networks, and no longer maintain their daily living activities and jobs, often compounding economic precariousness for the family as a whole.

According to Whiteford et al. (2013). Mental healthcare, available in primary healthcare, means that people are able to access the treatment and care that they need near their homes, and thus, keep their families together, maintain their support systems, remain integrated and active in the community, and continue to contribute to household productivity. Furthermore, because primary care facilities are in or near people's communities, many indirect health expenditures associated with seeking care further afield (e.g., transportation to facilities located in urban areas, loss of productivity related to the time spent in

accompanying the patient to hospital, etc.) are avoided, making primary healthcare the most affordable option for patients, the community, and the country (Whiteford et al., 2013).

In terms of clinical outcomes, it has been found that, for many mental disorders, primary healthcare can deliver good care and certainly better care than that provided in psychiatric hospitals. Indeed, recent evidence indicates that mild, moderate, and even severe depression can be effectively diagnosed and treated in primary care settings (Patel et al. 2007).

Kapungwe et al. (2011) noted that abundant evidence from Western countries indicates that people with mental illness are stigmatized and discriminated against not only by the general public, but also by health professionals.

Most studies on mental illness have tended to focus on the attitudes and behaviors of the general community while neglecting the views and actions of specific population groups (Adewuya and Maknjuola, 2005). One particular group that has been largely ignored is healthcare professionals, both in the general and mental health fields (Adewuya and Maknjuola, 2005; Sartorius, 2002). This is a cause for concern, as the few studies that have explored this area have found that such professionals frequently hold negative attitudes towards people living with mental illness (Mavundla et al., 2000; Schulze, 2007; Thorncroft and Rose, 2007). There is generally a dearth of research on mental health in Zambia (Mayeya et al. 2004; Mwanza et al. 2008).

While most countries have centralized mental health service provision as established above, studies have suggested that providing services at the primary care level would significantly improve the provision of community mental health services (Mwape et al., 2012). To our knowledge, no research has been conducted in Zambia to specifically explore the dispositions of the primary health center in-charges towards decentralization and integration of mental health services in primary health care packages. However, an understanding of the dispositions of this cadre of workers is extremely important for the delivery and uptake of mental health services at their level.

Integrating Mental Health in Primary Health Care

The World Health Organization (WHO) endorsed mental health as a universal human right and fundamental goal for healthcare systems in all countries (WHO, 2005). In the Alma-Ata Declaration, the principles of primary health care were about social justice and the right to better health for all, reaffirming the WHO's holistic approach to attaining good health and the importance of primary care. WHO World Health Report 2008 argued that a renewal and reinvigoration of primary care was important, and now more than ever, as mental health problems constitute 14% of the global burden of disease and are one of the leading causes of disability worldwide (WHO, 2008). According to the World Organization and Association of Family Doctors [WONCA] (2008), integrating mental health services into primary care is the most viable way to close the treatment gap for people with mental health problems and ensure that they receive mental health care. Mwape et al. (2012) added that providing services at the primary care level would significantly improve the provision of community mental health services. It would also reduce discrimination of the mentally ill and increase their right to access treatment and care within their own community in the least restrictive environment, with the least restrictive treatment (WHO, 2009).

For Australia, Reform began in 2006, with Australian government funding for ten headspace centers (McGorry et al., 2007). They were scaled up through a series of funding rounds, reaching 110 centers in early 2019. Centers are commissioned through a lead agency and local consortia and have rapidly gained strong local community and political support from all sides and levels of politics. In June 2018, 446,645 young people accessed headspace centers, phones, or online (eheadspace) services, with 2.5 million occasions of service delivered. In 2017-8, 88,500 young people accessed face-to-face headspace center

services, and 33,700 accessed online or via phone. Headspace also offers suicide postvention services in high schools and vocational recovery interventions online and face-to-face. Six early psychosis platforms linked to clusters of local headspace portals built on the primary care model with comprehensive evidence-based care for early psychosis in community settings.

Mental Health in Africa

Comparative studies show varying healthcare philosophies and differences in service provision among countries (Olson, 2006). The cost of providing health services is often cited as a reason for poor provision. For example, Jack-Ide et al. (2012) conducted a study titled Comparative study of mental health services in two African countries: South Africa and Nigeria". The mental health services in South Africa and Nigeria were chosen for comparison, as South Africa is a middle-income (MI) and Nigeria is a low middle-income (LMI) country; both are rated as developing countries that have adopted primary health care as the model of care. Therefore, this study aimed to compare the status of mental health service provision in South Africa and Nigeria. The study found that South Africa has made considerable progress in restructuring its mental health care system to provide mental health care at the community level. Nigeria, despite adopting mental health care as part of its primary healthcare services and having a strong academic history in psychiatry, does not provide services in rural communities. Researchers noted that it was important for Nigeria that mental health care nurses become advocates for mental health policy reforms to improve access and that countries with similar challenges learn from each other about providing care for people who cannot care for themselves, namely, the mentally challenged.

Based on a small inquiry into a number of experienced mental health professionals in sub-Saharan Africa, Alem et al. (2008) discussed the meaning of the community concept of mental health care in Africa. The researchers found a general agreement that mental health services should be integrated into primary healthcare. However, a critical issue for the success of this model is the provision of appropriate supervision and continuing education to primary care workers. The importance of collaboration between modern medicine and traditional healers was stressed, and the paper ends in a plea for WHO to take the initiative and develop mental health services according to the special needs and socio-cultural conditions prevailing in sub-Saharan Africa.

In many countries, the number of mental health professionals is low. For example, in Ethiopia, there are only 18 psychiatrists for 77 million people, and there are no clinical psychologists, no trained social workers, and only one 360-bedded mental hospital located in the capital, Addis Ababa (Alem, 2004). Likewise, to date, all psychiatrists are working in Addis Ababa, although psychiatric nurses provide hospital-based outpatient clinics in these regions (Gureje & Alem, 2000). The situation is similar in other African countries, where the majority of mental health specialists work in the capital cities, leading to the neglect of rural areas (Saxena et al., 2006).

Mental Health in Zambia

Lungu, (2010) in her paper titled "factors contributing to underutilization of mental health services in health centers within Lusaka urban" narrates that mental health services in Zambia started as far back as 1924 when the Colonial Administration decided to address the issue of psychiatric patient care. The care in Zambia was of the custodial type, and patients were put in prison. In 1949, the first mental annex was opened in Ndola, followed by the others. Many more were opened later. Despite these annexes, patients who required specialized treatment were admitted to Zimbabwe's Ingutsheni Hospital. In 1962, the Chainama Hills Hospital was built to cater to both forensic and general psychiatric patients. It was run by Catholic expatriates. From its inception, psychiatric services at Chainama were intended to provide promotive, preventive, curative, and rehabilitative services to the people of Zambia in conjunction with the community in accordance with modern psychiatric practice. Community mental health services commenced in the

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1970s when Professor Alan Harworth established the psychiatric annex at the Matero Main Clinic. This later died, and Chainama remained the only facility for these services.

Historically, mental healthcare has been a neglected part of the health system in Zambia, with services concentrated at provincial government hospitals and not at the primary care level (Mwape et al., 2012). While this is the case, Munakampe (2020) says that in Zambia, the prevalence of mental disorders is approximately 20 per cent. Common mental disorders include acute psychotic episodes, schizophrenia, affective disorders, alcohol-related problems, and organic brain syndromes (Mayeya et al., 2004:16). The potential causes of mental health conditions include stressful family relationships; infections such as malaria, meningitis, syphilis, and HIV; and the use and dependence on alcohol and other psychotropic substances (Kapata, et al., 2010). Poverty increases susceptibility to mental health conditions (Mwape et al. 2012).

The Ministry of Health has taken a step toward introducing mental health services at the primary healthcare level (MOH 2022-2026 Strategic Plan). However, it remains unclear what contributed to the poor uptake of mental health services into primary health care in the initial attempt when Lusaka Urban had 27 health facilities at the time of Lungu's (2010) study.

The main aim of this study was to explore the dispositions of health center in-charges towards the integration of mental health services in the primary health care package in Lusaka District, Zambia. The sub objectives included To assess disposition of Health facility in-charges towards integration of mental health services in their health facilities, To estimate knowledge of Health facility in-charges concerning the decentralization and integration of mental health services in Zambia, To explore barriers and opportunities in the decentralization and integration of mental health services in primary health care package in Lusaka District and To establish current practices of Health facility in-charges towards mental health patients in their health facilities

METHODS

The study used mixed methods employing a parallel convergent design to conduct this research, with the support of evaluative qualitative data collection techniques. This involved non experimental procedures. Data were collected in two phases: a questionnaire and a focus group discussion. We chose to use a mixed methodology so that we could get an analytical description of the problem as well as a deeper understanding of the dispositions of primary health care facility in-charges regarding the decentralization and integration of mental health. The mixed methodology allowed us to gather statistics and then draw deeper conclusions on why certain aspects of integration were viewed as barriers by each participant. Our objectives allowed us to probe the questions quantitatively and qualitatively. Some specific objectives such as estimating knowledge levels of in-charges on mental health and the integration process; or to establish barriers and opportunities needed more than just a yes or no answer, we also wanted to establish the current practices towards mental patients that came to their facilities. Yes and no answers were good in that they gave us statistics on how many participants were knowledgeable, but the qualitative responses enabled us to understand the why and how aspect. This is similar to the objective on barriers and opportunities, which also needed us to draw an understanding of how decentralization and integration of mental health was a barrier or had opportunities as determined by the participants. Hence the mixed method analysis allowed us to draw a deeper understanding of decentralization and integration of mental health services into primary health care.

Participants

The study participants were purposively selected from public primary health care facilities managed by Lusaka District Health Office (LDHO) drawn from across the 7 sub-districts (Munali, Mandevu, Matero, Kanyama, Chawama, Kabwata and Lusaka Central) of Lusaka, Zambia. We focused on the in-charges

because they have a much deeper understanding of their facilities in terms of human resource, level of care, supplies and logistics, infrastructure, disease burden and the community in their catchments being at the helm of their facilities. Public facilities made it easy for the researchers to invite all the 76 facilities to participate as they are under one management and would still be the ones to offer these services once the decentralization was fully implemented. The questions and discussions were attended through the Internet just after the COVID-19 outbreak restrictions were dropped but because there were still some cases being reported, virtual meetings were preferred. The same period had an increase in people seeking psycho social support online. The researchers emailed the sub-district administrators (called Public Health Specialist) attaching clearance letters and the protocol for them to invite facility in-charges under their charge. We followed up using social media (Whats App) to contact their in-charges after feedback from public health specialists, whose identity was withheld. In addition, the researchers conducted 7 information sessions to each sub-district to give details about the study for participants to make informed decisions to participate. Consent was obtained from the facility in-charges to participate in the study. In total, 76 participants consented to participate in this study. Most of the in-charges were female (n=68, p=89.5%) and most of them 50 years and above (n=20, p=26.3%). The in-charges were from different professions: Nurses (n=26), Midwifes (n=47), Environmental Health Technologists (n=1), while other professions were represented by (n=2). In terms of facility status, most in-charges worked at Health Posts (n=36), while those that worked in other facilities were as follows; Health Centres (n=32), Zonal Hospital (n=1), Mini Hospital (n=2), and First Level Hospital (n=5).

Procedure

The participants were informed about the study procedure, such as interventions, data collection, and their right to withdraw. The participants were asked to read and sign an informed consent form before proceeding with the questionnaires. After receiving informed consent forms, the questionnaires were sent to them by researchers identified through the Public Health Specialists. These in-charges responded to the online questionnaire and upon completing the questionnaire, they were put into groups to discuss their experiences and perceived barriers and opportunities of integrating mental health services into primary health care. Not all the 76 in-charges participated in the focus group discussions as we only had 7 group discussions with a maximum of 8 participants totaling 56 in-charges.

The nature of the discussion was explained via a zoom call meeting, in which it was made clear that the participants' identity was not required; therefore, participants were advised to join with a pseudonym and that there was no need for participants to use their camera during the group discussion. Further, it was explained that the discussions would be recorded, but the researchers would only retain a write-up transcript that would be used for the originality of discussion.

Research Instruments.

The instruments used in this study were a questionnaire for quantitative data collection and a Focus Group Discussions (FGDs) Guide for qualitative data collection. The researchers primarily collected data through an online questionnaire which proved effective on in-charges who had tertiary education with the majority (n=39) having a college diploma and (n=2) having a master's degree. Questionnaires also served time during data collection and analysis as the data were collected from different samples. (See appendix 1 for the questionnaire used in this study)

Focus Group Discussion Guide was used in this study to generate qualitative data because it gave more latitude to respondents and interviewers, allowing them to explore issues emerging responses of each in-charge unlike being bound by predetermined issues. The discussions lasted 1 hour but it must be noted that there were delays in starting due to delays in logging in by participants but once a minimum of 6 in-charges was met, the discussion started. While respecting each other's views, debates were allowed and a consensus

was established on key issues.

Data Analysis

For the qualitative data, the thematic analysis approach described by Braun and Clarke (2006) was used to understand participants' dispositions of the decentralization and integration of mental health services into primary health care. Thematic analysis involved developing familiarity with responses, searching for themes, reviewing themes, naming themes, and producing a report of findings.

The researcher read all transcripts, and then consolidated focus group discussion. The researcher manually defined a set of preliminary themes, which did not necessarily conform to the language used in the FGD guide. Qualitative themes were rated only once for each participant describing them, irrespective of the number of times that the theme was identified across the discussion groups. A frequency count was applied to specific variables to identify their commonality in providing a consolidated list of experiences and suggestions, wherein the researcher sought to establish those with higher occurrence. Finally, the analysis involved reviewing themes and sub themes to ensure that the extracts were valid, logical, and reasoned.

Quantitative data collected from the questionnaire were analyzed using descriptive statistics in the form of percentages and frequencies. Statistical Package for the Social Sciences (SPSS) version 23 was used to enhance the analysis. Computer-generated tables of frequencies and percentages were used to describe the variables that were presented in the form of tables and figures. This allowed for the objective interpretation of valid generalizations, conclusions, and recommendations for future studies.

RESULTS

The findings for both quantitative and qualitative reviews conducted on the decentralization and integration of mental health services into primary health care are presented under themes that were derived from the research objectives. The themes were subdivided to furnish relevant data, as contained in the questionnaires and FGD guides.

Knowledge about Mental Health and Decentralization of Mental Health Services

In order to establish the views on dispositions of in-charges on the decentralization and integration of mental health services into primary health care, the researchers sought to assess what in-charges know about mental health, supporting documents, and decentralization process. The following depicts a summary of the knowledge levels.

Table 1. Knowledge about Mental Health and Decentralization of Mental Health Services

	Frequency	**Percent**	**Valid Percent**	**Cumulative Percent**
Knowledgeable	20	26.3	26.3	26.3
Not Knowledgeable	56	73.7	73.7	100.0
Total	**76**	**100.0**	**100.0**	

Table 1: Knowledge About Mental Health and Decentralization of Mental Health Services

Table 1 shows that 73.7% (56) of the in-charges were found to have inadequate knowledge about what mental health was, the documentation and policies or the decentralization process while 26.3% (20) were adequately knowledgeable on the same.

The researchers through FGDs sought to gain more understanding into knowledge in-charges possessed on

mental health by asking them to define or describe what they understood or what they know mental health is. The following is a verbatim of their submissions; (FP01 FGD means female participant number in the focus group discussion and MP means Male participant)

For me I can just define it by the two words mental and health, mental means the psychology of a person and health is being fine physically and mentally. (FP03 FGD)

Mental health is how an individual think, the financial challenges and how they deal with problems and stress. (MP01 FGD)

From my own understanding, I think mental health has to do with the mind, the status of the mind and emotions, I submit. (FP12 FGD)

The researchers also found a few responses that were close to the WHO definition of mental health: state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community (WHO, 1948).

Actually, mental health, when we talk about mental health just to give it a try, mental health is a bit crucial, so usually we consider regular activities, the mind and place and maintaining social connections so if you are facing challenges in the above which means you have a problem with your mental health, thank you so much. (FP14 FGD)

Mental health is a state of wellness of the mind, if one is healthy they will be able to cope with the environment they are in and also interact in a health manner with the people around and also manage themselves when faced with challenges (FP07 FGD)

The researchers probed more to understand if in-charges were aware of any policies or supporting documents on mental health and majority of the respondents gave a straight NO to this question which came through the chat on the zoom call.

Chair, for me it's one of the reasons why we don't report mental health because we do not have any documents to refer to or treatment protocols we don't have so we don't know how to handle these clients so we need capacity building (FP23 FGD).

For me chair, I have never seen one but I heard of the mental health policy sometime back on the news. I don't know how far that has gone (FP54 FGD).

All facilities in Lusaka district had psycho social counselors, and based on this, we sought to understand how these counselors are considered in the facilities; particularly to say psycho social counselors are mental health staff and other health workers do refer clients to the counselors. Discussants recognized the abundance of this carder as a human resource in their facilities, however, they expressed concern on the concentration in the training of counselors as it seemed more biased towards HIV Testing and Treatment Counseling as well as queries ethical practice of psycho social counselors which hindered referrals to them.

Psycho social counselors we can't say they are mental health experts so we don't normally refer to them. Mostly if we can't handle a client we refer to Chainama Hospital for specialized care but even Chainama doesn't give us feedback (FP02 FGD).

Yes, we can say they are mental health staff but the ones we have these days it's like they just concentrate on HIV Testing and Counseling. Those days when we did the psycho social counseling training, mental health was taught in detail and we could handle many cases. One time we gave a psycho social counselor to handle a client the next thing, we heard everyone was talking about the same case so mostly we fear giving

them clients (FP05 FGD).

On decentralization and integration, facilities tend to collaborate between departments especially in limited resource situations and this was what they considered integration.

I think for Integration maybe I can give a familiar example when we talk of integrated outreach were you find that each team will be composed of psycho social counselors, nurses, environmental health technologists so as they go to a certain community they offer services depending on the department they belong then at the end a report will be made so you find that their services will be conducted at the same time (FP16 FGD).

I think integration this is were like in our set up this is where different departments come together to offer services let's say where OPD and MCH come together to offer services (FP43 FGD)

Integration is, if in the ART clinic I attend to TB patients at the same time offer ART services while decentralization is where you bring services at primary level in the community instead of referring patients (FP46 FGD).

Just to sum it all, participants were asked if epilepsy was a mental condition and the majority said YES except for one that said it was a neurological condition. From these responses, the quantitative findings are given context.

Disposition of In-Charges Towards Decentralization and Integration of Mental Health Services

The researchers sought to understand perception and receptiveness of in-charges towards mental health services in their facilities.

Table 2. Disposition of In-charges Towards Decentralization and Integration of Mental Health Services

	Frequency	**Percent**	**Valid Percent**	**Cumulative Percent**
Positively Disposed	52	68.4	68.4	68.4
Negatively Disposed	24	31.6	31.6	100.0
Total	**76**	**100.0**	**100.0**	

Table 2 shows that the majority 68.4% (52) of in-charges were positively disposed towards decentralization and integration of mental health services whereas 31.6% (24) in-charges had reservations with having mental health services in their facilities and thus regarded negatively disposed.

Researchers sought to get in-depth perception of these quantitative findings through qualitative means thus asked the in-charges probing questions in the FGDs. Further the researchers probed further to understand their receptiveness and motivations of such dispositions. This resulted in a majority YES during the questionnaire and focus group discussions in which respondents added;

Yes, all facilities should be offering these services so that many people can access these services nearby. All of us in our training at college or university we did some psychiatry so we can't fail to provide basic care and when the condition is beyond us we can refer (FP44 FGD).

Yes, it's better we have these services because we have a lot of people that come to our facilities for this help but we don't have the capacity. So, for me it's a yes provided we have man power and space without this it's a no (FP07 FGD)

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Others on the NO side clarified their position

For me looking at my facility it's a NO, we don't have space for the services we are offering now so if that was to come it would have no space (FP34 FGD)

For me we need to start with capacity building and ensure drugs are available. We refer clients but they still come back to us for refills for drugs but those drugs are not for our level of care (FP19 FGD).

More reasons for and against mental health are given on the next theme below.

Barriers and Opportunities on Mental Health Services at Primary Health Care Level

Table 3. Barriers and Opportunities on Mental Health Services at Primary Health Care Level

	Frequency	**Percent**	**Valid Percent**	**Cumulative Percent**
Perceived more barriers	40	52.6	52.6	52.6
Perceived more Opportunities	36	47.4	47.4	100.0
Total	**76**	**100.0**	**100.0**	

Table 3 shows perception of barriers and opportunities among facility in-charges regarding integration of mental health services. Majority 52.6% (40) of the in-charges perceived more barriers while 47.4% (36) in-charges perceived more opportunities.

Further probing qualitatively revealed that they want the services in the facilities as shown in table. 2. However, success was dependent on a number of factors which in the perception of some respondents were far-fetched.

In response to the question of barriers, the following were the findings

For me, there are three big things that are needed which we don't have and may not be for our level, 1. Psychiatric experts, 2. Psychiatric drugs and lastly space is a challenge. Where can we put those patients when they become uncontrollable? So, like I said, in my facility we are struggling even for current services we offer now in terms of space (FP19 FGD).

I agree with the other speaker, we need drugs and capacity building so that we know what to do when we have these patients (FP20 FGD).

The other thing is other patients would not be comfortable with mental patients especially, violent ones if we have them in our facilities (FP24 FGD).

On the other hand, the following were the opportunities perceived by in-charges

We all have some basic training so we can offer initial support which we do in my facility and I believe with capacity building and some basic drugs we can do more. If the government can bring specialist staff that is even more advantageous because like I said, what we know are basics. I submit chair (FP51 FGD).

Chair, I concur with the sister, the basics we do offer, and clients appreciate. Actually, Chainama can work with us so that when we refer patients, they do their diagnosis and give drugs, the same can be given to us for the patients to be getting refills from our facility. I remember clients that come from that facility still come to us and we are forced to ask them to go back but you just know the economic status of our

communities, asking them to go back to Chainama Hospital is like telling them to go and die home because they don't have transport at the same time they can't afford to buy the drugs (FP54 FGD).

Actually, the best is to build capacity starting with us in-charges because in most cases we are consulted before referrals. We can even avoid some referrals such as substance use which is very common and we just send them to X hospital to finish up (FP01 FGD).

Current Practices Towards Mental Patients in the Primary Healthcare Facility

Building on the fact that facilities do have clients that ignorantly come over for treatment either of known or unknown mental illness at these facilities owing to distances from their homes. The researchers found out how these patients/ clients are treated and the responses from in-charges were compared with the Ministry of Health Treatment Guidelines for Mental Disorders, 2022 and the following aggregation was developed.

Table 4: Current Practices Towards Mental Patients in the Primary Healthcare Facility

	Frequency	**Percent**	**Valid Percent**	**Cumulative Percent**
Acceptable Practice	61	80.3	80.3	80.3
Unacceptable Practice	15	19.7	19.7	100.0
Total	**76**	**100.0**	**100.0**	

Table 4 shows aggregates of the behavior of health workers towards clients with mental challenges in the facilities. 80.3% (61) of in-charges described acceptable practices in their facilities including stabilizing the patients, offering bed space and engaging relatives to the clients and then referring once the patient is stable. Further they do make follow ups after referral although they indicated that they are mostly not given feedback. 19.7% (15) facility in-charges described practices not in conformity with the standards provided for in the treatment guidelines including immediate referrals.

In FGDs we asked what facilities do when they suspect the patient or client in their facility had symptoms of mental illness. Majority did indicate having to attend to the clients and later refer for further management.

For us we do attend to many mental clients especially substance use. So, what we do is for example he comes intoxicated, we stabilize them then we talk to relatives about the condition so that they understand why they need to go to the first level hospital. After that we write a referral stating the patients details and what we suspect is the problem they should handle. After sometime we make a follow up to see how everything went. In most cases we just find out from relatives because we don't get feedback from the hospital (FP55 FGD).

For us, once we have seen that it's a mental patient we don't even keep them we just send direct to the X hospital. We have no space to do anything so we don't even send to the first level because we know they will also send to X hospital (FP19 FGD).

We asked how many of those that they refer actually report themselves in the referral facilities. It was found that clients hardly do make it at the facilities they are sent to for various economic status of the community and stigma attached to X Hospital.

On that we can't tell the number because we don't get feedback from X hospital for us to know if all of them reach that side (FP43 FGD).

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For us only a few goes because of many reasons but majority say X hospital is far I don't have transport while others say "I am not mad" so really, we can't do much bacuses even ambulances in most cases don't move mental patients they say it's not an emergence (FP28 FGD).

DISCUSSION AND IMPLICATIONS

The purpose of this research was to explore the dispositions of primary health facility in-charges towards decentralization and integration of mental health services into primary health care. This study focused on their level of knowledge, their disposition towards mental health services, their perceived barriers and opportunities and the practices of healthcare staff towards mental patients. The study found that in-charges had a positive disposition despite having inadequate knowledge on the subject matter and the decentralization process. While their current practices towards mental patients were found acceptable, study also found the majority of the in-charges foresaw more barriers that opportunities to integration of mental health citing skilled staff, infrastructure and drugs as main barriers.

Knowledge About Mental Health and Decentralization of Mental Health Services

The study revealed that 74% (56) of the in-charges were found to have inadequate knowledge about what mental health was, the documentation and policies or the decentralization process while 26% (20) were adequately knowledgeable on the same. Contrary to these findings, (Misra, et al., 2021) investigated Knowledge, Attitude and Practice on Mental Health among health workers serving a block of a district of Western India. They found that the 50th percentile knowledge and attitude-practice among health care workers was 63.46% and 72.78% respectively. Overall mean knowledge was 64.12%.

Similar to our findings, in their studies (Cowan, et al., 2012; Blaise, et al., 2015 and Kapungwe, et al., 2012) found that the level of awareness ranged from 33.4% to 78.3% among healthcare providers. In the United Kingdom, a review of historical staffing patterns did take place after decentralization to the NHS trusts, but as Buchan reports, this created a tension between local health managers concerned about costs, and health professionals whose main interest was patient care. Wang et al. (2002) point out that decentralization is unlikely to transfer recruitment and hiring to the local level, while delegation and devolution are most likely to involve a more extensive transfer of these responsibilities.

An action was done in Ethiopia when it was found that health workers at primary level had inadequate knowledge on mental health. Ayano et al., (2017) evaluated Mental health training for primary health care workers and implication for success of integration of mental health into primary care: evaluation of effect on knowledge, attitude and practices. Post intervention, the knowledge of health professionals had increased by 53.19% for psychosis, 42.56% for depression, 19.25% for epilepsy and 54.22% for alcohol use disorders. Similarly, post intervention attitudes increased by 55.32% for psychosis, 40.42% for depression, 36.17% for epilepsy and 43.6% for alcohol use disorders. In addition, post intervention case identification rate increased by 62.78% for psychosis, 55.46% for depression, 21.35% for epilepsy and 41.49% for alcohol use disorders with significant p value ($p < 0.05$).

Disposition of In-Charges Towards Decentralization and Integration of Mental Health Services

We found that the majority 68.4% (52) of in-charges were positively disposed towards decentralization and integration of mental health services whereas 31.6% (24) in-charges had reservations with having mental health services in their facilities and thus regarded negatively disposed. Similar to the findings in our study, Ait-Mohand, et al., (2017) in their paper "Decentralization and integration of mental health care into primary health care: a case study of Rwanda advanced that in order to reinforce the integration of mental health care into service package of district hospitals general practitioners and general nurses are trained to

improve in-patient and outpatient mental health care. In addition, the whole team should be able to take charge of mental health patients in inpatient care. At health centers, at least one general nurse is trained to deal with common mental health disorders.

A similar study among the general primary health care health professionals by Mwanza (2010) found that there was strong support for integrating mental health into primary health care from care providers, as a way of facilitating early detection and intervention for mental health problems. Participants in his study believed that this would contribute to the reduction of stigma and the promotion of human rights for people with mental health problems. However, and still consistent with our expectations found among facility in-charges, health providers felt they require basic training in order to enhance their knowledge and skills in providing health care to people with mental health problems.

Barriers and Opportunities on Mental Health Services at Primary Health Care Level

The study found that the majority 53% (40) of facility in-charges perceived more barriers while 47% (36) in-charges perceived more opportunities. The barriers included; specialized staff, infrastructure, psychotropic drugs and perceived lack of supporting documentation. Consistent with our findings Munakampe, (2020) in her study titled Strengthening Mental Health Systems in Zambia identified key barriers to including inadequate funding, few human resources, poor infrastructure and stigma. Barriers to care at policy, facility and individual or community level could be alleviated by strengthening the mental health system.

Facilities at primary health care level in Zambia receive the essential medicines kit. However, these kits do not include mental health drugs as they are regarded as controlled drugs. Munakampe, (2020) observed that the lack of drugs was seen as a contributing factor to the many referrals that the provincial facilities from lower-level institutions. Generally, most facilities in Zambia are understaffed, while this is so for general staff, mental health staff are even lower with only 5 facilities having a mental health staff in Lusaka. Most of the health workers who decided to take the mental health career path ended up disinterested because they did not have many opportunities to develop their careers. Further, (WHO, 2003) Mental health specialists (e.g. psychiatrists or mental health nurses) must be made available to primary care staff to give advice and guidance on the management and treatment of people with mental disorders.

Current Practices Towards Mental Patients in the Primary Healthcare Facility

The study found that in-charges and the staff in their facilities had practices in conformity with the required standards stated above and thus regarded as acceptable practices. Their description included stabilizing the patients, offering bed space and engaging relatives to the clients and then referring once the patient is stable. These findings are contrary to (Ghuloum, et al., 2022) in their study titled Healthcare Professionals' Attitudes Toward Patients with Mental Illness: A Cross-Sectional Study in Qatar. They concluded that Stigmatizing attitudes toward people with mental illness by healthcare workers were present in Qatar. They were higher among nurses as compared to physicians. Factors associated with higher stigmatizing attitudes could be used in creating appropriate intervention to reduce the magnitude of the problem. In addition, (Khenti, et al., 2017) posited that healthcare professionals' limited experience with and knowledge of mental disorders contributes to their negative attitudes. As physicians are often at the forefront of a health care system as practitioners and educators, their stigmatizing attitudes may also influence other members of the team and future practitioners (Smith, et al., 2017).

Limitations of the Study

This study focused on dispositions of Health Facility in-charges towards decentralization and integration of mental health services in Zambia while not including other health care workers in the target facilities. Further, the study was limited to focus group discussion, and questionnaires as tools for data generation.

Quantitative methods were intended to generate disposition of in-charges and other statistical data about the problem while qualitative methods explained relationships in variables on the problem. There was however one question (asking how integration was), this particular question may have led the respondents to derive their own indicator of effectiveness of integrated services. This could have been avoided by setting out clear indicators of integrated services before drawing up the questionnaire, and then building our questions around these indicators. We may have attempted this but not 100%. Hence, we recommend future studies to consider investigating the indicators of effectiveness of integrated services.

CONCLUSIONS

Integration of mental health services into primary health care facilities had the potential to help alleviate the challenges caused by a centralized approach among mental health patients who needed to access support close to the home as possible. Despite its benefits, decentralization and integration of mental health services in Zambia came at a time when most facilities had no capacity to handle the technicalities of mental health service delivery at primary health care level. Hence our major finding was that in-charges found decentralization to have more barriers than opportunities. Key constraints came from the fact that most facilities had skilled human resources, and required drugs and space to offer these services. However, in-charges had a positive disposition and wanted mental health services in their facilities. These findings offer insight into the challenges that a developing country can face in trying to implement solutions that work in the developed countries. A key concern is that our infrastructure is limited and our ability to adopt these solutions is hindered by our lack of capacity building. Therefore, the need for authorities to capacitate in-charges and other general healthcare staff with screening and brief intervention skills required for mental health at primary health care level. We also recommend that community health administrators, health researchers, government and as well as partners to work on developing dedicated training packages for primary health care facility staff which shall be implemented beginning with facility in-charges. We recommend increased funding and infrastructure allocation to facilities at primary health care level. Further we recommend re-evaluation of the psycho social counselor training package and ethical conduct. As an extension of this study we recommend extending it to other districts to gain a national picture of dispositions of In-charges in primary health care facilities.

ETHICAL CONSIDERATIONS

This study was reviewed by the Blue Research Ethics Committee (BREC), anchored by the Blessings University of Excellence which in turn gave us Ethical clearance (BREC IRB Ref No. 2023-08-0101). The participants signed an informed consent form to participate in this study. See appendix 3 for the informed consent form.

Consent for publication

Informed consent for publication of names has been given for the study.

Data Availability

The data reported and supporting this paper were sourced from existing literature and are therefore available through a detailed reference list.

Competing interests

The authors declare that they have no conflicts of interest.

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Author's contributions

Mulungu C conceptualized and designed the study. The first draft of the study was developed by CM, while IZ, ES, GL and HL reviewed the manuscript to improve the flow of ideas and clarity of concepts. All authors reviewed the draft manuscript and approved the final version of the manuscript.

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