SUMMARY

Background and research question

The global burden of disease of mental illness is on the rise, disproportionally affecting Low and Middle-Income Countries (LMICs) with limitation of mental health workforce challenges. This has concomitantly affected the mental health service provision in various regions particularly Kenya where psychiatrist to patient ratio is 1:500,000. The situation in the rural areas is even worse as the trained professionals tend to live in the larger cities or migrate to urban settings. Given this inequitable distribution of human resources, the Lancet series on Global Mental Health has recommended mobilization and recognition of Informal Health Providers (IHPs) through task-sharing initiatives such as taking up tasks that were previously undertaken by higher cadres to increase access to mental health care in resource-limited settings. IHPs have flexible working hours, are available at nearly all times, accessible geographically and play a key role in providing services to a number of mentally ill patients in rural areas. As a result, various studies have recommended their inclusion in mental health service provision through collaboration with the formal health sectors. Their willingness to work with formal health providers relates to the fact that this process might improve the health and quality of life of their patients. Whether this interest is true for specific regions, circumstances need to be investigated. Little research has been done to find out if evidence-based interventions for priority mental disorders will indeed result into improved quality of life of patients seen by IHPs. Therefore, this thesis aims at answering the main question below that relates closely to Traditional health Practitioners (THPs) as opposed to Community Health Workers (CHWs) who have some relationship and guidance from the formal sector but lack formal training, hence their involvement in this research.

Under what conditions can collaboration between formal and informal health providers take place?

Part 1: Characteristics of patients seeking care from THPs

Part one describes the characteristics of patients seeking care from IHPs while looking at the prevalence and determinants of priority mental disorders such as depression and establishing the association between quality of life domains and mental illness. Evidence suggests that it is important to first gather epidemiological data, especially if there is little existing empirical data in order to guide any form of intervention.

Two studies were used to answer this sub-question;
What are the characteristics of patients seeking care from THPs?

The first study (chapter 2) used a quantitative approach to assess the prevalence of depression for patients seeking care from THPs. Traditional and faith healers screened a total of 1515 and 2566 patients for depression respectively and revealed a high (22.9%) and almost an equivalence of prevalence of depression between traditional and faith healers’ patients. Their ability to correctly identify a patient with Major Depressive Disorder (MDD) was 46% while the likelihood that the patient would actually have depression was 79%. The significance of this study lies in the fact that the findings are similar to those detected in health care settings as well as the fact that with training, THPs can make a correct diagnosis of MDD. We found that one out of every 3 depressed patients exhibited signs of suicide either through ideations or an attempt.

Study two (chapter 3) used a similar approach, but provided insight on the quality of life of depressed versus non-depressed patients. It demonstrated that depression has a profound impact on quality of life for patients seeking treatment from THPs in the rural areas. There was also a negative association between suicidal ideation and self-reported quality of life. Findings from these two studies show that patients seeking care from THPs suffer from priority mental illnesses and deficits in quality of life domains, exacerbated by increase in rates of depression may affect the functioning of an individual which would increase the burden of mental illness in this population.

Part 2: Barriers and solutions for collaboration

Part two focuses on the barriers and options for collaboration between formal and informal health providers while developing a constructive dialogue between the two sets of provider. It aims at answering the following sub-question;

What are the barriers and options for collaboration between the formal and informal health providers?

We qualitatively explored the barriers and potential for collaboration between formal and informal health providers and quantitatively evaluated one of the products of collaboration known as dialogue. Moreover, in order to promote a feasible relationship between the two systems, it is crucial to build trust by making initial contact with the different practitioners as they historically have a greater antipathy towards each other, in order to explore options for collaboration.

Through this study, it was noted that although THPs have a basic understanding about mental illness, they still attribute it to witchcraft and poor upbringing. They also lack the required training...
to deal with patients suffering from mental illness and thus their knowledge and skills is acquired through daily interaction with these patients. In addition, referral gaps to higher levels of care were evident since they could only comfortably refer patients among themselves. However, this study provides options through forming practical collaborations and dialogue between the formal and informal health providers as suggested by the participants. They stated that this was important in order to enhance their working relationship for the benefit of the patient and also develop mutual respect for each other. After evaluation of dialogue, all participants revealed that they joined the dialogue in order to come together with a group of people committed to improving the lives of patients, an indication that both formal and informal health providers have a common goal and are ready to work collaboratively to improve the lives of patients.

Part 3: Quality care and promoting its continuity

This section uses three studies to discuss training of IHPs to provide quality care and follow-up for patients suffering from mental disorders; and making appropriate referrals for patients with suspected mental disorders by addressing this sub-question;

To what extent does quality care training and follow-up of IHPs improve the mental health outcomes of their patients, and promote continuity in mental health care?

The first study in this section (chapter 5) was conducted to quantitatively measure changes in mental health outcomes over time after provision of evidence-based interventions. Almost 60% and 80% of the patients showed significant reduction in symptoms of depression at 6 and 12 weeks respectively after treatment which is similar to studies conducted in health care settings using psychosocial interventions. This is an indication that these interventions could be used by THPs to produce significant mental health outcomes and reduce the burden of care related to untreated conditions for families and caregivers.

The next study (chapter 6) quantitatively measured changes in quality of life indices at at baseline, 6 weeks, and 12 weeks. It demonstrated that psychosocial interventions provided by THPs were linked to improved quality of life of depressed patients at 3 months. Improvements were seen in all domains of quality of life (physical, psychological, social and environmental) which was similar to three recent systematic reviews. This implies that the interventions provided to these populations could also be useful for other related mental disorders and use quality of life assessment as a treatment outcome in order to improve the overall functioning of THP patients and the community.
The last study (chapter 7) used a qualitative approach to explore IHPs’ views about the challenges they face during practice, after being trained on how to screen and refer patients with suspected mental illness to health care facilities. Initially, a total of nine FGDs (three for traditional healers, three for faith healers and three for CHWs) each consisting of eight to ten participants were conducted. However, a fourth FGD for CHWs was conducted to achieve saturation of all new information. Results from this study illustrate the commitment of IHPs with limited training to a task-sharing model under difficult situations to increase access to good quality mental health care for patients in remote settings. The most common challenges were resource barriers including lack of adequate staff and psychotropic medications or patients being unable to pay for the drugs offered at the health facility as well as lack of transport for patients to visit the health facilities. Perhaps in Kenya, a successful task-sharing scale-up model may involve capacity building for most IHPs, who are spread across villages, to promote accessibility, as well as providing emergency transport services such as motorbikes or ambulances for severe cases of mental disorders. Moreover, if continuous monitoring for distribution of medications is established and maintained, and the number of cases detected at the community level translated into demand for medication, this would improve treatment adherence, strengthen the mental health system and reduce the treatment gap related to lack of resources.

Another interesting finding was the comparatively warm reception by formal health providers for patients referred by IHPs, and respect between the different providers, compared to presence of mistrust before this collaborative initiative. This shows that collaboration through task-sharing approaches between informal and formal health providers can reduce mistrust and promote understanding among them.

Conclusions and policy recommendations

In the literature, it is clear that studies recommend training and dialogue to reduce mistrust. In this thesis, I suggest that a step-by-step approach is critical for dealing with mistrust. The initial steps are simple, non-confrontational and involve independent discussions with each of the providers. This is followed by the exchange and sharing of ideas for collaboration among health providers through joint meetings to promote local knowledge and give participants new insights to improve patient care. In summary, bringing together formal and informal health providers requires a non-biased practice, similar to that of a mediator since the process would benefit not only the
patients but also the providers from both formal and informal sectors in terms of knowledge acquisition and interaction with each other.

Our results also highlight the potential for investment of mental health service delivery in the informal sector. The significant improvements in mental health and quality of life of patients, reached through provision of psychosocial interventions by THPs is beneficial and provides a necessity for mental health promotion in the informal sector. Therefore, with human resource consideration in LMICs, continued efforts should be made to enhance collaboration between formal and informal providers rather than allowing parallel programmes, since IHPs could be used to improve practice and reduce the huge mental health treatment gap.

Policy makers can also take into account the results of this study to develop new policies in which collaboration between formal and informal providers is enhanced in the perspective of quality of life of the patients and quality care for IHPs. Future research should build on this work by implementing rigorous randomized controlled trials in order to determine the efficacy and cost-effectiveness of training THPs to deliver psychotherapeutic care to reduce symptoms of mental disorders and improve the quality of life of patients in this population, before large-scale implementation to other similar settings.