CHAPTER 8
DISCUSSION AND CONCLUSIONS
8.1 Discussion and conclusions

This chapter discusses the main findings of the thesis by responding to the primary question using the research sub-questions stated in chapters 2 to 7:

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

The implications for policy, practice and recommendations for future research are also addressed.

8.1.1 Characteristics of patients seeking care from THPs

In order to gain an understanding of the characteristics of patients accessing the services of THPs, we studied the prevalence of priority mental disorders such as depression and compared their quality of life among these patients. Two studies were used to answer the following sub-question:

What are the characteristics of patients seeking care from THPs?

Results from study one revealed a high (22.9%) and almost an equivalence of prevalence of depression between traditional and faith healers’ patients. This is in congruent with a study conducted in urban regions of Kenya (Mbwayo et al., 2013) and in other LMICs such as Sudan (16%) (Sorketti et al., 2012) and Pakistan (24%) (Saeed et al., 2000). On the contrary, a study conducted in Tanzania found higher rates (56%), although with symptom presentation rather than using DSM-IV or a similar criteria (Ngoma et al., 2003). Prevalence estimates in Uganda were also much lower due to use of a specialized group of THPs managing mental health problems and thus did not include other physical conditions (Abbo et al., 2009). However, it is important to note that cultural variation in different counties may contribute to the variability of symptom presentation and prevalence of depression (Kirmayer, 2001; Schieffelin, 1985) especially if the estimates are not based on a diagnostic criteria.

The use of a standard tool by THPs to subjectively assess for depression in the current study aided them to appropriately classify the specific symptoms. This was confirmed by a mental health specialist and 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.

Suicidal behavior was also often detected in the depressed populations. We found that one out of every 3 depressed patients exhibited signs of suicide either through ideations or an attempt.
shows that depression is a significant risk factor for suicidal attempts or ideations. Takahashi (2001) asserts that many depressed patients commit suicide before having ever accessed appropriate treatment. He also states that it is much more likely for suicide to be undertaken by an individual with a mental disorder than for someone mentally competent to commit suicide (Takahashi, 2001). This study thus provides an opportunity for THPs to duly assess for suicidal behavior for early detection and prevention of suicide and other mental disorders.

Similarly, study two 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. These results are consistent with research that has demonstrated a similar relationship between depression and quality of life (Holubova et al., 2016; Lynch et al., 2016; Pyne et al., 1997). Quality of life comprises of various domains such as social relationships, physical abilities, mental health functioning, role functioning and engagement in daily activities (Kolovos et al., 2016). Therefore, deficits in these domains, exacerbated by increase in rates of depression may affect the functioning of an individual which would increase the burden of depression.

With a scarcity of formal mental health workers and an excess of THPs, the reliance of patients with depression among THPs provides a strong evidence to harness this human resource since the results presented reflect the realities of community members with priority mental disorders in rural settings. The findings also call for a closer collaboration between THPs and mental health professionals so as to further detect and manage other priority mental illnesses for patients presenting to THPs in the communities and make appropriate referrals to health facilities.

### 8.1.2 Barriers and solutions for collaboration

This section is composed of discussions from chapter 4 that addressed the following sub-question;

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

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. Antipathy and mistrust
between THPs and the formal health providers which has been found in prior studies (Audet et al., 2015; Campbell-Hall et al., 2010; Chinsembu, 2009; Kayombo et al., 2007) were also inherent. In fact, IHPs stated that the formal health providers disregarded their practice and assumed that they had little role to play in patient care. The formal health providers on the other hand mentioned that there were no structures in place that would allow cross-referral so that they understand how to link patients to access health care.

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.

In other non-communicable studies, authors have noted that dialogue can help alleviate mistrust, provide knowledge and build confidence among providers (Kayombo et al., 2007). There are also other suggestions that this partnership can improve access to care and reduce the burden of mental illness in communities through education and adequate community involvement since THPs are commonly sought out (Campbell-Hall et al., 2010; Kaboru et al., 2006; Robertson, 2006; Schoonover et al., 2014). Therefore, the lack of sufficient information on the process of initiating collaboration between the formal and the informal sectors makes the step by step process employed in this study imperative in initiating, enhancing collaboration and reducing the mistrust inherent between the two sectors. The knowledge and referral gaps identified by participants during the discussions are addressed in the subsequent chapters.

8.1.3 Quality care and promoting its continuity

Chapters 5 to 7 discuss three studies that address the following research-sub-question:

To what extent does training IHPs on evidence-based care lead to mental health outcomes among patients?

Chapter 5 is concerned with assessing the outcomes of psychosocial interventions as delivered by THPs. Nearly 60% and 80% of the patients showed significant reduction in symptoms of depression at 6 and 12 weeks respectively after treatment. This is similar to studies conducted in health care
settings using psychosocial interventions (Bortolotti et al., 2008; Corney and Simpson, 2005; Linde et al., 2015; Simpson et al., 2003), demonstrating that these interventions could be used by THPs to produce significant outcomes. This could tackle the issues of internal and external migration of psychiatrists and their minimal placement in the rural areas where community members readily access THP services. It may also increase productivity, reduce the cases of severe mental conditions mostly seen in primary health settings, hospitals, psychiatric units and referral hospitals as well as the burden of care related to untreated conditions for families and caregivers.

It is also important to take note of the different aspects of quality of life as mentioned in chapter 3 and study the impact of these interventions on quality of life. Chapter 6 elaborates on the outcomes of quality of life indicators and 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). Similarly, three systematic reviews have revealed that psychotherapy, employed in the current study has a positive impact on the quality of life of patients with depression (Kolovos et al., 2016; McKnight and Kashdan, 2009; Papakostas et al., 2004). 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.

Whereas these are important findings to report, a previous review has concluded that there is a failure of many projects to provide systematic follow-up to IHPs after their initial training (King R and Homsy J., 1997). This thesis addresses this gap in chapter 7 by exploring the challenges faced by trained IHPs while referring individuals with suspected mental disorders for treatment, and potential opportunities to counter these challenges so that they learn to function in a system that addresses mental health needs and enhance continuity of care.

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. This is in tandem with other studies conducted in LMICs, that found lack of resources as the main obstacle to creating an effective task-sharing initiative (Padmanathan and De Silva, 2013). More specifically, a study conducted in Kenyan hospitals showed that people seeking mental health care are unable to pay for
essential psychotropic medication at the primary care clinic (Mendenhall et al., 2016). Distance and transport costs have also been linked to low acceptability of treatment in rural areas especially where patients have to go to hospitals to receive care (Zachariah et al., 2006).

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. Continuous supply of drugs forms an essential component of a community-based mental health service provision (Eaton, 2008).

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 (Campbell-Hall et al., 2010; Musyimi et al., 2016b). This shows that collaboration through task-sharing approaches between informal and formal health providers can reduce mistrust and promote understanding among them. The positive uptake of this model by the informal sector is thus a huge step to reducing the mental health treatment gap. Burns has recommended that IHPs can be integrated successfully into the pathway to care of patients with mental illness and into an adequate community and population-based system that allows identification of possible cases for further intervention (Burns, 2015).

8.2 Reflections on the theoretical framework

Based on the adapted biopsychosocial-spiritual model discussed in the introduction, we hypothesized that the introduction of psychosocial interventions on patients with spiritual and biopsychosocial history led to improved quality of life of patients. This model attempts to explain the complexity of the mind and body connection while focusing on the social, psychological, and even spiritual dimensions of health and health interventions (Sulmasy, 2002). The importance of this model in this study is the growing evidence of belief in the spiritual dimension of mental illness among patients thus enhancing the participation of IHPs in mental health care delivery (Osafo, 2016). Humans are intrinsically spiritual since all persons are in relationship with themselves, others, nature, and the significant or sacred (Puchalski et al., 2009). Therefore, this model provides a guide for collaboration between the formal and the informal health providers since it holistically
addresses both intrapersonal and extra personal relationships and incorporates the foundations of each sector (formal = biopsychosocial; informal = spiritual).

IHPs assessed and provided appropriate psychosocial interventions to patients suffering from depression. This combined with the spiritual dimension of their usual practice had a key role in improving the mental health of their patients and their families. Indeed, depressed patients demonstrated significant improvements in terms of their symptoms and in all domains of quality of life at 3 months. However, it is important to note that the IHPs cannot entirely provide some aspects of treatment such as prescribed medications, therefore referral chains as demonstrated in chapter 7 were established so that responsibilities could be shared.

This adapted model can be applied elsewhere with registered IHPs and may be more useful in rural areas with inadequate mental health professionals, in order to better understand and manage patients with mental illnesses at acute stages. Although few studies have examined the implications of using holistic approach to improve the mental health and quality of life of patients among the IHPs, there is still need for more research on investigating the relationships between quality of life and other mental disorders as well as their outcomes.

8.3 Reflections on the main research question

Figure 1.3 delineates the processes involved in forming dialogue discussions between the formal and informal health providers and promoting quality care among IHPs. Despite the issues of mistrust, feelings of inferiority and weak referral systems that were hindering collaboration between the knowledgeable formal health workers and THPs, all providers were open to collaboration and willing to improve the lives of their patients if appropriate mechanisms to facilitate these processes are established. These gaps and possible channels informed the introduction of an evidence-based practice through training IHPs to provide quality mental health care. A particularly interesting finding was the revelation of psychosocial interventions that do not only have an impact on the mental health of THP patients but also on their quality of life. This supports the incorporation of quality of life measurements and interventions during mental health care among patients with minimal access to care.

Further results elucidate factors that might inhibit the successful implementation of a task-sharing initiative that involved referral of suspected patients with mental illness. We found that even though challenges exist, mechanisms should be put in place to ensure continuous supervision of IHPs for purposes of promoting mastery of concept and skills, and sustainability. In a recent multi-
site study that evaluated the acceptability and feasibility of task-sharing initiatives among non-specialist health workers, participants stated that supportive supervision should not be equated to an evaluation but rather an ongoing activity with no intentions of terminating it (Mendenhall et al., 2014).

All these processes demonstrate the ability of IHPs to not only provide psychosocial interventions but also to refer patients for further care. Their role in providing this holistic care could be the key to discussing and persuading patients whose beliefs do not tie well with conventional treatment. Therefore, there is a need to include IHPs in mental health care and formal health systems in order to increase access to quality care for disadvantaged populations and prevent parallel health systems inherent in many LMICs.

To our knowledge, this is the first study across continents to empower IHPs particularly THPs to deliver evidence-based interventions. Other published work have tested the effectiveness of traditional forms of healing which have sometimes been considered to be ineffective (Phang et al., 2010). Evidence from this study provides a basis for harnessing IHPs in resource-constrained settings to deliver quality interventions, and strengthening referral pathways through supportive supervision with an aim of improving the mental wellbeing of IHP patients.

8.4 Wider implications

The implications for academic knowledge, policy and practice are discussed in this section.

8.4.1 Implications for academic knowledge

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, followed by joint meetings as stated below;

1. Initial independent discussions with each of the health providers (traditional healers, faith healers and formal health workers) to identify barriers and options for collaboration. The involvement of CHWs is specific for each country, since in most countries, CHWs are the most visible IHPs due to their engagement with various non-governmental organizations and ministry of health teams and combine both biomedical and indigenous cultures (Brown et al., 2006). As a result, they may not show resentment towards other providers.
2. Organize meetings involving specific categories of IHPs (e.g. traditional or faith healers) and formal health providers in order to openly address issues that are particular to each set of providers and reach a point of agreement with respect to the collaboration process. The number of meetings and next steps will depend on a consensus by all participants. However, for countries where cross-referral does not take place between traditional and faith healers, it may be important to address collaboration barriers in this group before involvement of formal health providers, in order to cultivate transparency.

3. This step involves participation of both formal and informal health providers, a process that could be referred to as “dialogue formation.” The discussions at this stage are informed by prior meetings and emphasizes on the importance of working together with clear cut roles for each health provider to improve the lives of patients.

The exchange and sharing of ideas for collaboration among health providers in each of the discussions promoted local knowledge and gave the participants new insights to improve patient care. In terms of openness, trust relations were starting to develop as demonstrated in chapter 7 that illustrates respect between the different health providers. This evidence shows that building trust is a continuous process that can be enhanced through efforts to bring the health providers together. The adapted biopsychosocial-spiritual model that strengthens collaboration between the formal and informal health providers could also be applicable in settings where health providers are only using spirituality dimensions to improve the overall wellbeing their patients.

Training IHPs on identification of mental disorders, provision of psychosocial interventions and to refer patients with suspected mental disorders is a huge component of knowledge acquisition especially for the IHPs who are informally trained and rely on interaction of patients with mental illness to learn about treatment. This practice may be termed as "try and error" and could be detrimental to the health of patients seeking care from IHPs. The greatest impact resulting from training of IHPs would be felt on the patients and the families due to the huge socio-economic burden of the illness.

Other lessons learnt during implementation of the programme included scientific and technical knowledge of the team from the different institutions who were instrumental in running the implementation of this research work. For instance, 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. It is also important to note that the practice among IHPs may not necessarily be documented like that of the formal health providers. Therefore, their guidelines will mostly be mentioned during discussions and approaching them as important health providers in the community settings forms a foundation for engaging them in identifying opportunities for collaboration.

8.4.2 Implications for policy

With the support of the policy makers, IHPs could be recognized and used as vital human resources to improve the mental wellbeing of patients. From the basis of this study, policy makers can take into account the results of this study 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. With these positive results, policy makers could develop new policies on how to improve collaboration between the two sectors. In some countries where banning of traditional healers is encouraged due to malpractice such as physical beatings to exorcize the spirits and chaining to calm agitated patients, the ministry of health could play a key role in establishing country-specific Traditional Health Practitioners’ Bill. This bill makes provisions for training, enhances the registration of approved and qualified healers in traditional health practice through provision of valid practicing license and regulates the practice of THPs while taking the necessary disciplinary measures to maintain proper professional standards.

Additionally, as a measure to solve some of the task-sharing challenges, IHPs suggested the importance of community awareness to sensitize the community on IHPs’ new role in mental health care, further training of both formal and informal health providers to meet the increasing demand, continuous supply of medication in health care settings and provision of emergency services for referring patients with severe forms of mental illnesses to receive further care. The policy makers could be made aware of these suggestions so that the task-sharing model is acceptable, successful and sustainable.

The above mentioned strategies are opportunities for strengthening health systems in Kenya and other LMICs. A good health system equates to access to essential high quality health services, available human resources among the underserved populations and ensuring good governance to promote transparency and accountability in health activities at both national and community levels.
8.4.3 Implications for practice

Our results highlight the potential for investment of mental health service delivery in the informal sector. These findings outline the feasibility of promoting dialogue composed of supportive and interactive relationships and increasing access to individuals in resource-constrained settings through training, to provide evidence-based care and make appropriate referrals for patients with mental disorders. More specifically, 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.

8.5 Reflections of validity

Both internal and external validity of the research findings are discussed below. Overall, the use of mixed methods approach, in the various studies and involvement of researchers from different parts of the world to provide insights to study implementation improved the validity of this research work.

8.5.1 Internal validity

Several measures were applied to enhance internal validity. We used triangulation; (i) by data source, where data was collected from different people and at different times; (ii) by method, where focus group discussions and standardized tools were used; and (iii) by data type that combined both quantitative and qualitative data.

The presence of self-evaluation bias was minimized through using several researchers, field notes, observation, focus group discussions, and methodological triangulation. Focus group discussion questions and the guidelines on how to conduct the discussions were developed using the context-specific meaning-making concept (Wilkinson, 2003), by a team of community mental health researchers including a psychiatrist, psychologist, nurse, individuals with a background in community development and a lay person. In addition, since data was collected in the local language, the discussions were transcribed verbatim and translated by a multilingual speaker. To
confirm the quality of the translations, the final versions were reviewed by an independent social scientist with a background in medical anthropology and conversant with the local language.

Analyst triangulation was also included at the analysis stage (Lincoln & Guba, 1985). Initially, two independent researchers reviewed all data for emergent themes, developed a thematic structure through an iterative process and re-coded data into the emergent themes. Later, all coding was discussed, any discrepancies resolved and 100% agreement reached. Cross-checking findings using existing literature was also used as a way of validating our findings (Roberts, 2006).

For qualitative data, all questionnaires used in the current study had been validated and used in similar settings. Moreover, we pilot tested them before study commencement in order to ensure the questionnaires were appropriate for that population.

8.5.2 External validity
To enhance external validity and generalization of qualitative findings, we used prior literature to relate our findings. The results for the different chapters are similar to what was found in other LMICs. Although the research was conducted in a rural setting, we found similar results in urban settings for instance, the prevalence of depression was similar to that found in an urban setting in Kenya. However, further research using population surveys to explore if the findings are different is recommended.

8.6 Recommendations for future research
The recommendations for future research are presented based on the study findings and on limitations for the research work.

8.6.1 Recommendations for future research: Based on study findings
Results from this study present an important contribution to the literature because they provide assessment of priority mental disorders, how they relate to quality of life and the impact of psychosocial interventions on mental illness and quality of life among individuals in remote settings. However, further studies are needed to better understand the nature and severity of other mental disorders and their effect on multiple dimensions such as quality of life. Population-based studies may also be crucial for determining the prevalence of mental disorders to increase generalizability.
It is necessary for formal and informal health providers to continuously engage in respectful
dialogue and open two-way dialogue to understand each other and build mutual respect and trust,
to move forward with medical pluralism and increase mental health outcomes in patients. Research
on scaling up this approach to other similar settings is also required.

Future research should also 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. Positive results from such a trial may
provide a scope for scaling up research to train IHPs all over Kenya and provide services to
vulnerable populations that currently have limited or no access to psychosocial care.

8.6.2 Recommendations for future research: Based on limitations

Despite the interesting findings, it is worthy to mention some limitations in this research work
which should be noted during interpretation of findings and generalization to other settings. First,
this study used focus group discussions without taking into consideration the perspectives of key
informant interviews who might have revealed confidential information that would be difficult to
tease out in a group setting. In future studies, these informants should be included in order to
explore new ideas relevant to study implementation.

Second, a control group was not included and therefore comparison with usual treatment or other
treatments was not possible. Comparison was restricted to outcomes in other similar settings,
recent literature and discussions on the significant findings and associations. Future research
should consider employing evidence-based designs such as randomized clinical trials to test the
effectiveness of quality interventions in resource-constrained settings while controlling for
confounders and factors that may be unknown.

The last limitation is related to self-reporting which may have resulted into recall bias or social
desirability. The inclusion of multiple informants to ascertain findings with sensitive information
should be considered. However, this should be implemented with caution to prevent mistrust
feelings resulting from seeking a second opinion.