Increasing the capacity of health surveillance assistants in community mental health care in a developing country, Malawi.

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Abstract

Mental health services in Malawi are centralized in the three tertiary units which are located one in each of the three regions of Malawi and this means that most people with mental health problems do not get help. With severe shortages of mental health professionals in the country, integration of mental health into existing primary and community health services is the most feasible way of increasing access to services for people with mental health problems. This paper discusses a pilot program of integrating mental health in the activities of Health Surveillance Assistants (HSAs) who are community health workers in Malawi.

Background and significance

About 14% of the global burden of disease has been attributed to neuropsychiatric disorders, mostly due to the chronically disabling nature of depression and other common mental disorders, alcohol-use and substance-use disorders, and psychoses[1]. A WHO recent report (2008) renews the call for integration of mental health into primary care[2]. This approach enables the largest number of people to access services, at an affordable cost and in a way that minimizes stigma and discrimination. The focus of intervention is shifted from hospital-based to the community, involving people with mental health problems, family members and volunteers, supported by local health professionals. In 2009, Malawi was identified by WHO as one of the countries in Sub-Saharan Africa with limited resources for people with mental health problems and where there is a great need to scale-up services through community support and services. Research data in Malawi shows that 28.8% of people attending primary care have a common mental disorder including depression[3]. Cases of suicide are also escalating in Malawi mainly due to HIV/AIDS pandemic[4]. While the concept of community mental health teams is well established in most developed countries, developing countries like Malawi face challenges in implementing community mental health services as a result of shortages of mental health professionals. A targeted and effective investment in human resource is the fundamental key to meeting this challenge[1]. Although Malawi has been training psychiatric nurses for over twenty years, most are absorbed into general nursing duties and only few carry out mental health activities. The activities of those psychiatric nurses who do undertake mental health care in the community are hindered by transport problems and as a result most primary care units have one monthly outreach clinic conducted by psychiatric nurses. District supervisory reports done in 2009 from the 28 districts of Malawi and a situation analysis done in the northern region of Malawi[5] have shown that most districts in Malawi carry out very minimal community mental health activities for people with mental health problems. The development and integration of mental health into existing community health structures is key if any improvement is going to be made in increasing access to support for people with mental health problems. Equally, the challenge is to develop mental health services at community level that are suited to and reflect the local social and cultural beliefs and understandings of mental illness[6]. Addressing peoples' psychological distress as 'mental health problems' is a new and alien approach for much of the population and so an acknowledgement of such a transition of ideas needs to be incorporated if the developments are to be acceptable to the community. The approach needs to offer a 'health' model as a valuable and practical alternative perspective, perhaps in conjunction with traditional beliefs and practices, to avoid its rejection or its adoption as a purely pharmaco-therapeutic intervention.[7]

Goal of pilot program

To integrate mental health in the activities of Health Surveillance Assistants (HSAs) so that they are able to carry out community based mental health promotion, detection and cadre-appropriate interventions of people with mental illness and epilepsy in Malawi.

Rationale

Mental disorders if not detected and treated early have an enormous cost, as they can increase the risk of suicide, impair family and social relations and overall productivity at work. Data from different studies shows that mental health problems are as common in developing countries as in established market economies with prevalent rates of common mental disorders reaching up to 20%[8]. Illness behaviour and stigma, including holding alternative explanatory beliefs over the origin of their distress (e.g. bewitchment or violation of taboos), makes most people with mental health problems avoid seeking help from health services. This is more in evidence in developing countries where the problems are compounded by shortage of mental health professionals. Poor detection and management of people with mental health problems means that most remain untreated and disabled leading to low productivity, high suicide rates, broken social relationships and contributing to the cycle of poverty. Community interventions in the form of mental health promotion and early detection are critical if disability and mortality secondary to mental health problems are going to be reduced. In 2020, mental disorders are projected to increase to 15% of the global disease burden, and unipolar major depression could become the second leading factor in the disease burden[9]. In 2002, unipolar depression was estimated to be the 4th leading cause of disability in Malawi after HIV/AIDS, cataracts and Malaria10. Despite the high prevalence and burden of mental disorders, and the fact that the Government of Malawi made a commitment outlined in the National Mental Health Policy of 2000 to integrate mental health into primary care and set up community services, very little has been implemented and there is need to explore how this can be achieved.

Specific Aims

The main aim of the program is to build the capacity of HSAs to respond effectively to the mental health needs in their community.The short term aim of the pilot program is

to monitor and evaluate mental health activities carried out by Health Surveillance Assistants in their communities after undergoing a three days training in mental health.

The longer term aim of pilot program is to implement a system of effective community based psychosocial interventions for people with mental illness including epilepsy in Malawi. If found to be relevant and cost effective it should be feasible to scale it up to a national level as it would be embedded in the current health curriculum for HSAs.

Scope for a community-based model in Malawi:

A community-based intervention for people with mental health problems that includes individual as well as family interventions delivered by community health workers could result in relatively low delivery costs, less duplication of services and appropriate identification of those who are most likely to benefit. An opportunity for developing and implementing such an intervention in Malawi is provided by HSAs who have been part of the government's National Health Program for many years. HSA's are a cadre of community-based health workers in Malawi who carry out health promotion activities, individual care and support for a range of physical health issues within their community. They have successfully carried out vaccination and cholera campaigns and a program of directly observed therapy for T.B. patients among others. HSAs' potential to influence and respond to challenges of mental health problems in the community is untapped and by the scope of their work, they are well placed to recognise and respond effectively when individuals are experiencing severe psychological distress. This could include advocating for human rights of people with mental health problems and epilepsy and referring on to mental health services if required in line with the Mental Health First Aid approach[11]. HSAs receive an initial 10 week training course with no mental health component and some people have argued that it is not feasible to integrate mental health in the activities of HSAs because of their workload. The feasibility of integrating mental health in the activities of community based health workers has been demonstrated by a number of studies including one done in Pakistan[12] where 24 Lady Health Workers (LHWs) "Pakistan's maternal health community based workers" were trained to successfully impart a parenting program to 163 women at their homes in rural Rawalpindi. The experience from this study was that for mental health interventions to be accepted by community based health workers, it has to facilitate, rather than add to, their workload. Integration of mental health in the activities of HSAs will facilitate their work because people with mental health problems fail to take their children for vaccinations, are likely to be non-compliant if on TB drugs and have problems implementing preventive measures for malaria among others. Successful implementation of the pilot program has the potential to be scaled up to national level. This will not only lead to increased access to health services by people with mental health problems and improved mental health outcomes, but will also improve other health outcomes.

One community-based program in northern Malawi (Vwira Mental Health Project) initiated by the Northern Ireland Association for Mental Health (Niamh) has shown remarkable success as a result of community-based mental health activities. The program is using volunteers and community health workers in supporting people with serious mental illness in Ekwendeni and surrounding areas. Since its establishment in 2007, 22 clients have gained full levels of functioning and no cases of relapse have been reported.[13] The program has been well accepted in the community; no client has had to return to hospital, all were compliant with their drug regimen, and stigma associated with institutional care has been significantly reduced. Interventions such as these are likely to be adopted by professionals and policy makers if they are shown to be efficacious, cost-effective, integrated in existing community health services, and linked to other high priority health problems[14]. The major impact of mental illness is borne by individuals and their families. In addition to the difficulty of coping on a daily basis as a result of impairments in adaptive functioning, care givers experience increased stress and the effects of associated stigma. Disability, be it physical, mental or both, has a strong correlation with poverty, a correlation which operates in both directions; poverty leads to disability and disability in turn increases poverty[15].

Project Area and participants

The project is being conducted in Zomba District. Zomba District is located in the southern region of the Republic of Malawi and has a total land area of 2,580 km representing 3% of the total land area of Malawi. It is cradled by districts of Chiradzulu, Blantyre, Mulanje, Phalombe, Machinga, Balaka and the Republic of Mozambique to the east. The District has a total population of 583,167 with a population density of 230persons/km2. The main ethnic groups are the Mang'anja, Yao and Lomwe and it is dominated by two religious groups; Christianity (78%) and Islam (20%). The economy is dominated by agriculture with maize production being the main activity, while tobacco the main cash crop. Health services are provided mainly at health posts, health centres and hospitals. Medical treatment is also provided by traditional practitioners and traditional birth attendants. Crude Birth Rate is estimated at 48 births/1,000 inhabitants. Total Fertility Rate stands at 5.3children/woman. Infant Mortality Rate is 48 deaths/1,000 live births and Child Mortality is 14.4%, which is among the highest in the country16.

The health delivery system in Zomba district is divided into seven clusters of Chingale, Thondwe, Zomba Central, Ngwelero, St Luke, Likangala and Jali. Three clusters (Chingale, Thondwe and Zomba Central) were randomly selected to participate in the pilot program. All health centres falling under these three clusters have been included in the pilot program. HSAs and Assistant Environmental Health Officers (AEHOs) reporting to these health centres were trained. AEHOs were included because they work closely with HSAs and they are the focal persons between HSAs and District Environmental Health Officer (DEHO).

Curriculum, trainings and supervision

The Project adopted a collaborative approach to curriculum design and development. Mental health professionals from Malawi and the U.K, representatives of the Mental Health Users and Cares Association of Malawi (MeHUCAS), Federation of people with Disabilities of Malawi (FEDOMA), Health Surveillance Assistants and representatives from the District Health office were actively involved in designing and developing the curriculum. Additionally we reviewed a number of training packages for primary and community mental health workers developed in different countries. The curriculum workshops developed a model for the HSAs to understand individuals experiencing distress which involved

a culturally attuned stress-vulnerability framework. This was designed to enable HSAs to support and empower individuals to identify solutions to their difficulties, with the premise of listening and responding supportively rather than seeking to make a psychiatric diagnosis. The programme also addressed issues of risk of harm to self or others by providing HSAs with the knowledge and skills to manage such risks in the community context. Curriculum materials derived from real-life clinical examples encountered in Malawi and were made linguistically accessible to HSAs.

The curriculum covers three main areas of: understanding mental health and mental illness, working with individuals with mental health problems and working with communities. Topics covered in the first unit of understanding mental health and mental illness include concepts of mental health and mental illness, impact of mental health problems, help-seeking and the organisation of care for people with mental health problems, role of HSAs in care of people with mental health problems. Unit two; working with individuals with mental health problems, covers needs and treatments for people with mental health problems, Mental Health First Aid and the HSA role in recognising and responding to people with a range of common and severe mental health problems. The third unit; working with communities, deals with mental health promotion, promoting health, combating stigma and advocating for people with mental health problems. Partly by, facilitating groups and mobilising community resources.

The training duration is three days delivered in two phases. The first phase is of two consecutive days covering units one and two and the second phase which is scheduled to take place after six months covers unit three and will also serve as a platform for the HSAs to share their experiences over the preceding six months. Format of the trainings is in the form of short lectures, group discussions and role plays. Mental health professionals including psychiatric clinical officers, psychiatric nurses and one psychologist do the facilitation.

The trained HSAs will be supervised on monthly basis in their clinic catchment areas. The project manager who is also a trainer will carry out the supervision. He will be using a motorbike to visit HSAs clinic catchment areas for supervision and data collection (client and promotion activity report form). It is our view that such sessions enable health workers especially HSAs and the supervisor to develop indigenous solutions to difficult problems or issues in the field. Sharing of difficulties and recognition of successes helps motivate the HSAs. Supervision is important to help HSAs negotiate difficult situations and to understand their limitations in working with families with complex needs. The project team (10 trainers) will randomly select participants for an interview to monitor the quality of the intervention being delivered. This monitoring will also ensure that any adverse effects from the intervention are discovered by the investigators and remedial steps taken to address them.

Project monitoring and evaluation tools

The measuring tools for this program will include pre and post questionnaires completed by HSAs on first training session (day 1&2) and on day 3 after six months respectively. Baseline data on HSAs' acceptability of the programme, HSAs' pre-course knowledge, confidence and some preliminary indicators on progress and impact of the programme are assessed during the trainings. Data collected on days 1&2 was recorded on SPSS and on Excel database. The excel database identified HSAs' answers to pre-set questions from the course evaluation and the analysis simply listed number of positive responses to each question and presented as a percentage of total HSAs.

Two specially designed monitoring and evaluation tools; Client Intervention and Mental Health Promotion Activity Report Forms, will be completed by HSAs during the pilot program to assess the impact of the program. The Client Intervention form is being used to record client details, presenting problem and intervention done by the HSAs on clients with mental health problems whom they encounter in their communities while the Mental Health Promotion Activity forms are being used to record all mental health promotion activities conducted by the HSAs in their respective communities. Analysis of the two forms and the questionnaires will give us an indication on how feasible it is to integrate mental health in the activities of HSAs.

Progress and Interim results

So far 271 community health workers were trained in June of 2010 and these included; 3 cluster managers, 4 AEHOs and 264 HSAs. The group was composed of 68% females and 32% males.

On Pre-course knowledge, the HSAs showed gaps in their knowledge on mental health care – especially on 'different mental health problems', 'how to respond' (including to people threatening suicide) and on the treatment and monitoring of people with mental health problems. On Pre-course confidence; the HSAs expressed confidence in their abilities around mental health care.

Phase one program evaluation results shows that 98.1% of participants felt that "The course addressed things that are relevant to my work as an HSA" and 83% of participants felt that "The level of difficulty of the course content was right for me" and lastly 98.5% of participants felt that "I believe that I can now work better in the area of mental health care". Therefore, whatever their knowledge and confidence, after day 2, HSAs felt better equipped to care for people with mental health problems in their communities.

Discussion of interim results

The interim results show that the program has been well received by the HSAs and it is of interest to see how this translates into practice taking into consideration the concerns from some quarters that HSAs are already overburdened with work. For the program to succeed, it is important that the implementers who in this case are the HSAs not only accept the program but also feel that it is relevant to their work. The fact that 98.1% of participants felt that the course addressed things that are relevant to their work is significant. Results of the Client Intervention form and the Mental Health Promotion Activity Report will give us a good indication whether HSAs have been putting into practice what they have learnt. Successful implementation of what is covered in the course will go a long way in early detection, management and improving access to services for people with mental health problems and epilepsy. The project finishes in January of 2012 and we hope then to share these important results in scaling up services for people with mental health problems in Malawi by building the capacity of Health Surveillance Assistants to respond effectively to the mental health needs in their communities.

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