EFFECTS OF MENTAL HEALTH CLINIC SERVICESE IN KHARTOUM SUDAN.

BY

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DECLARATION

I **Fadul Ishag Issa Tagil** declare that this research report is an original work and that where other authorities or texts have been used, it has been clearly acknowledged. To the best of my knowledge, this research has not been submitted for any award of Degree or Diploma in any institution or university.

Signature…… Date……

Fadul Ishag Issa Tagil

APPROVAL

I clarify that I have supervised and read this research report and that in my opinion; it conforms to acceptable standards of scholarly presentation and is fully adequate in scope and quality as a dissertation for partial fulfillment for the award of Master's Degree in Public Health of Kampala University.

Signature…… Date……

DR. MOHAMED YUSUF

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OPERATIONAL DEFINITIONS OF TERMS

Clinic

A facility, often associated with a hospital or medical school that is devoted to the diagnosis and care of outpatients.

Mental illness

It is clinically significant behavioral problems associated with distress and causes disability, WHO (2020).

Delirium

A clinical syndrome of confusion, variable degree of clouding of consciousness, illusions, visual hallucinations, liability of affect and disorientation, (David, S. etal (2018).

Delusion

A belief that is held with utter conviction despite evidence to the contrary, and cannot be explained by the educational, social or cultural background of the person who holds the belief (Rockville Pike, Bethesd 2023).

Neurosis

It is a mental disorder whereby the patient recognizes his/her states as abnormal but does not Suffer hallucinations and delusions. (David, S. et al (2020).

Psychosis

It is a mental disorder characterized by delusions hallucinations and disorganized behavior. (David, S. et al (2020).

Schizophrenia

Schizophrenia (literally, split mind,) is a disintegrative psychosis, characterized by splitting of normal links between perception, mood, thinking, behavior and contact with reality, (David, S. et al (2017).

Depression

This is a mood disorder characterized by five of the following according to DSM -IV: Depressed mood for most of the day nearly every day, weight loss of at least 5%, diminished interest in pleasure, fatigue or loss of energy, feeling of worthlessness, inability to concentrate or think recurrent thoughts of suicide, insomnia almost every night,(David, S. etal (2017).

Hallucination

This is perception in the absence of an external stimulus, (David, S. etal (2017). Mental disorder A mental disorder is a clinically significant behavior or psychological pattern that occurs in an individual and is associated with a significant increased risk of suffering, death pain and disability (David, S. eta! (2021). Mental health WHO (2021) defines mental health as a 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, is able to make a contribution to his or her community, and harmonious functioning of the whole personality (physically, socially and morally).

ABSTRACT

The study factors affecting mental health clinic services in Sudan:

Methodology: A health facility based descriptive cross sectional study design was used for this research. A total of 208 mental patients in remission phase were enrolled from four purposively selected health facilities in Sudan. Additionally eight key informants were interviewed.

Data was generated using a questionnaire about social demographic factors, socioeconomic and health facility factors that influenced mental health clinic attendance, and key informant interviews provided in depth information on factors influencing regular clinic attendance.

Results: Results indicated that majority 41.8% of the respondents were aged between 25-34 years, and more than half (53.4%) were females. Factors affecting regular clinic attendance included, having a care taker, (P-value 0.05) having someone in charge of treatment costs (p-value

0.002) and having a relative with mental disorder (p-value 0.01) and incurring no cost on transport,(p-value 0.03) Health facility factors affecting clinic attendance included distance to facility, drug availability, health facility accessibility and awareness of service, (p-value 0.005).

Conclusion: The study recommends need to develop and promote interventions to economically empower families and people affected by mental illness so that they can sustain themselves an visit mental health clinic regularly to ensure continued stability.

Additionally medications should be regularly stocked at the health centers to enable patients be able to access them whenever they visit the clinics for review.

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

1. 1.1. Historical Background

Various studies have demonstrated that one's decision to engage with a particular medical channel is influenced by a variety of social-economic variables such as: sex, age, social status of women, type of illness, access to services and perceived quality of the service. Depending on the area a person lives in, some treatment might be available but other than other forms of treatments. Therefore, a patient is limited to what is accessible and available to them when seeking treatment for a disease.

A mental disorder is characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour. It is usually associated with distress or impairment in important areas of functioning. There are many different types of mental disorders. Mental disorders may also be referred to as mental health conditions. The latter is a broader term covering mental disorders, psychosocial disabilities and (other) mental states associated with significant distress, impairment in functioning, or risk of self-harm. This fact sheet focuses on mental disorders as described by the International Classification of Diseases 11th Revision (ICD-11).

In 2019, 1 in every 8 people, or 970 million people around the world were living with a mental disorder, with anxiety and depressive disorders the most common (1). In 2020, the number of people living with anxiety and depressive disorders rose significantly because of the COVID-19 pandemic. Initial estimates show a 26% and 28% increase respectively for anxiety and major depressive disorders in just one year (2). While effective prevention and treatment options exist, most people with mental disorders do not have access to effective care. Many people also experience stigma, discrimination and violations of human rights.

In 2019, the World Health Organization argued that "the distribution of money, power and resources at global, national and local levels" creates these conditions. Socio-economic status (SES), gender, race, and education are factors of health-seeking behaviour that are influenced by the social determinants of health. This study will intend to study socio-economic, demographic and health facility factors affecting mental health clinic Services in Sudan.

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2015). This raised the expenditure on mental health to approximately 4% of health care expenditure. Of all the mental health expenditures, 55% was directed towards the National Mental Hospital (SUPR, 2011). About 1% of expenditure by the government health department was directed towards mental health in primary care. However, as part of the integrated health service delivery, other aspects of mental health were funded within the general health budget as well. Furthermore, under donor support to the government, the health sector's financing was at the time supplemented by funding from the African Development Bank (ADB), with nearly 45% of the support going to mental health. This raised the expenditure on mental health to approximately 4% of health care 2 expenditure. Of all the mental health expenditures, 55% was directed towards the National Mental Hospital (SUPR, 2011). Mental health problems are increasing, with depression at 12- 68%, anxiety disorders at 20-62% and alcohol dependency at 14% in the general population (Mental Health Policy, 2007). Sudan Hospital is the only national referral psychiatric hospital in Sudan, caring for hundreds of patients from all over the country, with numbers as high as 1200 on some occasions. 60% of the patients at the hospital suffer from acute conditions. However Mental illness affects many health related outcomes for an HIV positive individual and the prevalence of anxiety, depression and substance abuse is higher among people living with HIV/AIDS than in the general population (Mellins&Malee, 2013). The HIV virus also directly affects the central nervous system, giving rise to mental illnesses such as manias (UNAIDS, 2015). A mental disorder is a clinically significant behavior or psychological pattern that occurs in an individual and is associated with a significant increased risk of suffering, pain, disability or death (David,S. eta! 2005). Mental health or mental ill health is still little understood as we try to battle the causes and the devastating consequences of mental disorders in the 21st century. Between the 17th and the 18th century, mental disorders were more identified with the devil and evil spirits and mental disorders were seen as a social problem hence patients were put in prisons with the poor and those practicing homosexuality (Alaki, 2005).

It was perceived that patients with mental illness were not fit to belong to human society and exposed to violence and left to roam in the community and were commonly chained and treatment was by shock therapy with no doctors involved (Alaki, 2005).

Additionally, in the 21" century over 50% of the resource limited countries did not have policies specifically dedicated to mental health (WHO, 2019). Contributed to various human rights violations and abuses towards people suffering from mental ill-health.

Despite limited research about the prevalence of mental illness in resource limited settings a few studies indicate that the prevalence of mental illness continues to increase (WHO, 2022). A previous study done in Uganda in 2004 revealed that at least 35% of Ugandans had mental health problems and of these 15% required treatment from mental health unit (Byaruhanga et al 2018).

Mental health services were started in Uganda in 1920 in Lubaga Hospital initiated by the then District commissioner (Alaki, 2016). As the number of patients continued to increase a national mental hospital was constructed in 1954 to meets the needs of the patients. This was later followed by construction of 13 regional referral hospitals with mental health units to bring services near the people.

Unfortunately the amount dedicated to mental health services in the country has remained inadequate (Kigozi et al, 2018). Mental health clinic services is irregular and it is estimated that over 65% of the mentally ill persons do not receive treatment and are being mismanaged in the community by traditional healers and are brought to mental health clinics when other treatment modalities have failed out, (Okello, 2017).

1.1.2 Theoretical back ground

There is no exact definition to the word mentally illness, although researchers and publications have tried to define it. Mental illness is any disturbance of emotional equilibrium, as manifested in maladaptive behavior and impaired functioning, caused by genetic, physical, chemical, biological, psychological and social and cultural factors. It's also known as mental disorders/emotional illness/psychiatric disorders. (Health psychology – Shelley E. Taylor 2nd Edition 1999). When resources at a person's disposal are requirement it results into stress. Stress is one of the predisposing factor if it cannot be managed well. Stress is harmful to an individual because it disrupts emotional and psychological functioning and can cause medical problems over especially with prolonged exposure to stressors. The community perception about mentally

ill patients is different, and coping with the challenges is different. Some of the challenges include death of such patients, financial constraints, young female are raped and end up with unwanted pregnancy, and leads to end of school life etc. The mental ill patient also due to psychological or physiological vulnerability compounded with exposure to situations resulting into “ware and tare” f the body systems, the community, thins that such fellows are bewitched, others tend to isolate such fellows, and others take their relatives who have the same mental problem to mental hospital for treatment. But most people have negative attitude towards mental ill patients. But most of these can be overcome by appropriate measure put in place to reduce or eliminate them, and health educate the community to have positive attitude towards mentally ill patients (Geddes and Grosse 2022)

Health belief model (HBM) will be adopted for this study. In this model, 'Health seeking' is a conditioned behavior, so any attempt to encourage people to seek care requires an understanding of their motivation for such behavior. The model is based on the idea that people are more likely to change their behavior and adhere to treatments they perceive that they are at risk of relapsing if they don't attend to the clinic regularly or they perceive the disease might have an unfavorable outcome or if they perceive the proposed health behavior to be both effective and practical. The model also indicates that the respondents can adhere to health seeking behavior if they perceive the barriers to adopting the behavior to be minimal and if they have the ability of applying and practicing the specific behavior proposed. The model further explains about perceptions where the patients have the cues for motivating their actions such as internal cues (, past experiences or relapses following treatment default) or external cues (advice from friends, relatives and mass media campaigns). The specificity of the HBM components are considered in this study to be 2 useful in assessing risk perceptions with respect to mental disorders and mental health clinic attendance as well as in explaining the individual decision-making processes as regards the health-seeking behavior for these condition. When the benefits of attending the mental health clinic are perceived to outweigh the perceived barriers also influences the decision to attend the clinic. Moreover people are normally hesitant to attempt new behaviour unless they believe they can do it. As such a person may opt to undertake health-seeking behaviour for mental disorders and continue with care or not.

1.1.3 Conceptual background

Mental health is state of wellbeing in which the individual realizes his/ her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can make contribution to his/her community. A mental disorder is a clinically significant behavior or psychological pattern that occurs in an individual and is associated with a significant increased risk of suffering, death pain and disability (David,S. et al 2017).The factors affecting mental health clinic attendance can be explained by multiple factors interacting with one another. The factors in this study included type of mental disorder, social economic factors, factors related to the health facilities factors and regularity of clinic-attendance. Regularity of attendance meant that a respondent had come within appointment date or within two to three months from the previous visit. Social economic factors are those related to the differences between groups of people caused mainly by their financial situation .This study looked at social support system at home , amount of income one earns, one's marital status, one's education and the cost of care along with the distance to the facility. Healthy facility factors were those at facility, where patients received care and these included, drug availability, facility accessibility, facility personnel. Mental health clinics are special clines with specialized personnel to assess, diagnose, and offer treatment to those with mental disorders.

1.1.4 Contextual back ground

Mental health disorders are steadily approaching the second highest cause of disability in the world of the global burden of disease, 14% is attributed to neuropsychiatric disorders, indicating a 2% growth since the year 2000. It is believed that the figure will have increased by 2023 (Fournier, O.A. 2021). Mental disorders account for nearly 12% of the global burden of disease and by 2023, mental disorders will account for nearly 15% of disability-adjusted life years lost to illness, (Marcia, 2017).

The burden of mental disorders is higher in young adults, who make up the most productive section of the population (Marcia, 2018). The Government of Uganda estimates that common mental disorders account for 20% to 30% of all outpatient clinic. The findings from this research will indicate that people suffering from mental health problems very often delay seeking professional help, or avoid it altogether, which in turn significantly compromises appropriate care and treatment. (Okello, 2017).

Factors like fear of being diagnosed as suffering from mental illness, distrust towards the system, and lack of confidence in health professionals have been documented to make people hesitant to seek professional help (Howerton, 2017). Seeking help also appears to be related to the individual's perception of the severity of the illness, with individuals who perceive the illness to be severe feeling more compelled to seek help (Okello, 2017).

Furthermore, the choice of where to seek help is said to depend on what is believed to be the causal factor of the illness (Okello, 2017). Because mental illness is believed to be due to super natural causes, a significant number of people with mental health problems tend to initially seek and to continue seeking traditional healers' services after western medical help. In Sudan mental health services have been decentralized from referral hospitals to 13 regional referral, general hospitals, health centres and village health teams (Mental health policy, 2005). Sudan has four facilities that offer mental health services and for the years (2011-2019) there has been a 21% increase in number of patients seeking for mental health services. However, the attendance of these patients is always irregular with patients coming in following a relapse. (Sudan annual report, 2021).

1.2 Problem statement

There is growing recognition of mental health as an important public health and development issue in Sudan. Statistics show that close to 20% (9.8 million) out of the 47 million people in Sudan have some degree of mental illness, ranging from anxiety and depression to severe mental illness and mental disorders have been recognized to be not only a clinical problem but also a serious public health problem in the country,(Kavuma,2017).

Human resource development has been undertaken through training of psychologists, psychiatrists, social workers, psychiatric clinical officers and psychiatric nurses along with renovations and infrastructure development of regional referral hospitals. Community sensitizations through media; radio talk shows, print media and health education talks, religious and political heads along with traditional healers has also been done. The government of Sudan has decentralized mental health services from one national mental referral hospital 1 to 13 regional referral hospitals and mental health services have been decentralized further to HCIVs. (Ssebunnya,et al 2017).

Despite the above developments mental health clinic services is irregular and it is estimated that over 65% of the mentally ill persons do not receive treatment and are being mismanaged in the community by traditional healers and are brought to mental health clinics when other treatment modalities have failed out, (Okello, 2017). And, this has led to; high relapse rates and prolonged stay on wards before patients can get better again, reduction in economic growth and this has posed a serious social and economic threat to the country.

This has further lead to low productivity and high dependence rates among the mentally ill. Other mentally ill persons end up murdering people and destroying valuable property. The poor, social disadvantaged and those with low social support are commonly affected. In order to contribute to the reduction in treatment failure and relapses thus improving the lives of the mental patients. Hence the findings of this study are hoped to improve on community sensitization and to improve on regularity of clinic services.

1.3 Objective of the study.

1.3.1. General objective

To identify the factors affecting mental health in clinic Services in Sudan.

1.3.2. Specific objectives

i) To assess the regularity of mental health clinic patients in Sudan.

ii) To identify social and economic factors affecting mental health clinic services in Sudan.

iii) To determine health facility factors associated with regular mental health clinic attendance in Sudan.

1.4 Research Questions

i) What is the regularity of mental health clinic attendance in Sudan?

ii) Which social- economic factors are affecting mental health clinic services in Sudan?

iii) Which Health facility factors are affecting mental health clinic services in Sudan?

1.5 Justification

Although there mental health services in almost all district hospitals and health centre in Sudan most patients with mental illness do not attend mental health clinics regularly for review and medication refills. The factors affecting mental health clinic services in Sudan are not well documented.

The study findings are hoped to contribute to literature concerning factors affecting mental health clinic services in Sudan. The study findings may further help to improve patient care and management in these health facilities and ensure compliance to medications among these patients to ensure stability. The findings of this study are hoped to enable community members to understand the factors affecting mental health service delivery.

1.6.0 Scope of the study

Scope of study included; geographical scope, theoretical scope, content scope and time scope.

1.6.1 Content scope

This study will base health facility. The study will document factors affecting mental health clinic services in Sudan in selected health facilities Sundan. The study also will assess how different factors including social, economic, and environmental and health facility factors interacted with one another to affect mental health clinic services. These variables were sought to contribute to either regular or irregular mental health clinic services or affect compliance to medications among patients with mental illness.

1.6.2 Geographical scope

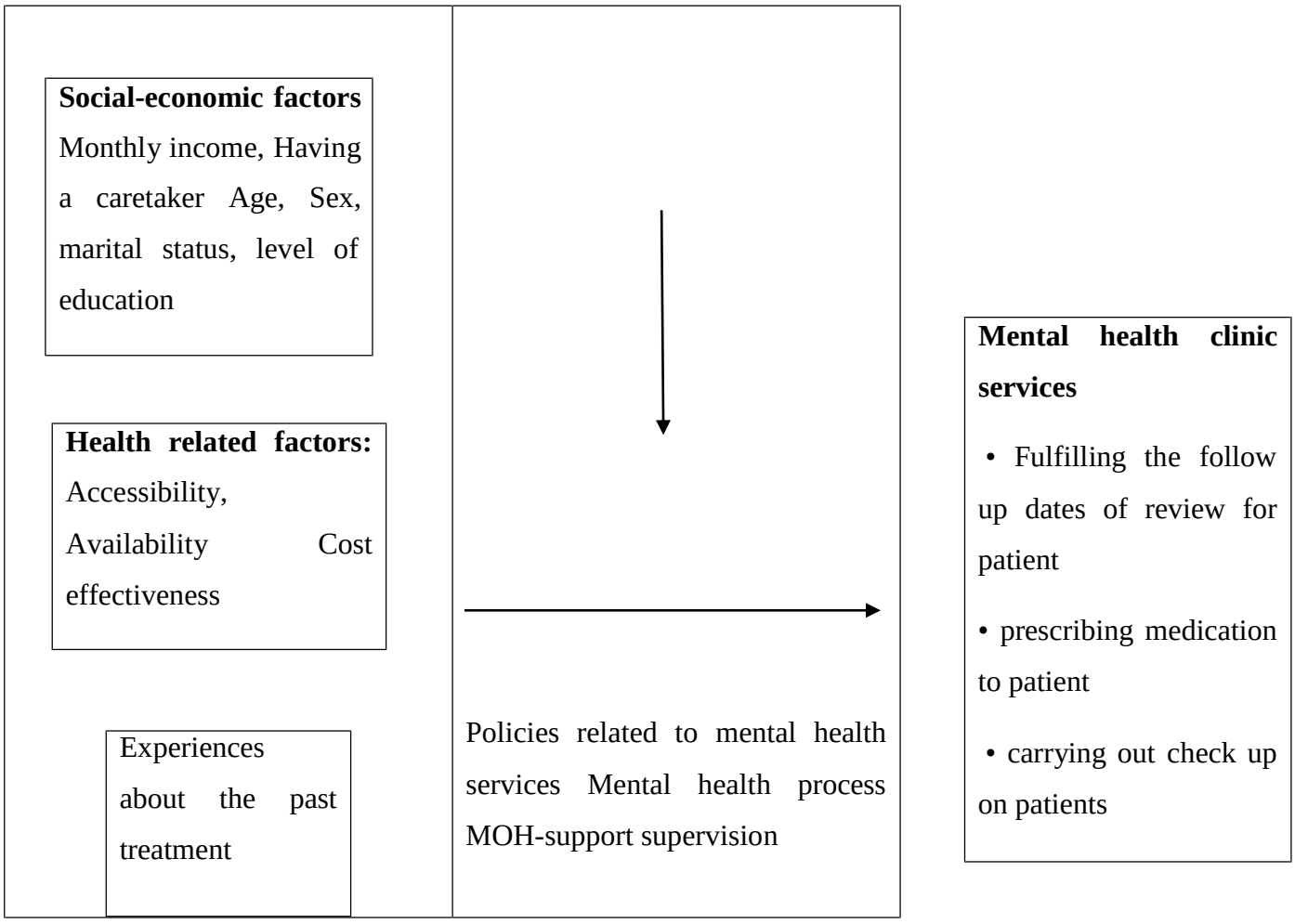
This study will be conducted in Sudan. The researcher sampled Khartoum Sudan one of the health facilitate offering mental health services to patients from districts of such as Khartoum that offers general patient care, in-patient care, obstetrics and gynecology services as well as mental health services.

1.6.3 Time Scope

This study considered data from 2016 to 2019 as it's from this time that health facilities had been provided with mental health workers.

1.7 Conceptual Framework

Independent Variable **Intervening variable** **Dependent variable**



1.8 Explanation of the conceptual frame work

The factors responsible for mental health clinic services cannot be explained by a single factor but rather multiple factors interacting with one another. This study aimed to establish how social -economic, health facility factors, past experiences interact with one another to affect mental health clinic services by patients with mental illness. A number of factors at the health facility are likely to influence patients' getting services. If drugs are available at the facility, the health workers are welcoming, the facility is within reach and there adequate professional health staff, and the patients are more likely to attend to the clinic regularly and vice versa. Such factors include availability of drugs when patients visit the clinic, how the health workers communicate to the patients, arrangement at the health facility to enable privacy time management by the health workers, qualified health workers at the health facility. Other factors include economic status of the family or the patients, if the family 1 patient have some income, offer social support and have employment, have some level of education and knowledge about the benefits of attending the mental health clinic then they will attend more regularly.

Perceptions of the patient also increase the likelihood of mental health clinic services. These included perceived benefits, community sensitization/public awareness. The clues of health action include actual attendance at the health facilities which is motivated by the availability of skilled personnel, availability of enough and quality medicines, accessibility which includes distance to health facility. Policies related mental health services provision such as staffing, medicine supplies and supervision all impact positively on regularity of services.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of literature pertaining to the study objective, and of the existing literature on factors affecting mental health clinic services among patients with mental illness. Help-seeking behavior among patients with mental illness was noted to depend on a number of factors including beliefs and perceptions about the causes of mental illness, the nature of service delivery, social and economic factors, and severity of the condition, stigma, testimonies from those who have benefited from the services and awareness of the availability of services.

According to parker and Rurid (2019) states that too much of drinking, smoking stress and drug abuse are the pre disposing factors to mental illness. They also observed that alcohol drinking is a disease that cannot be cured or treated by any physiotherapist. It instate develops and becomes a habit and at the end it's either abused or combined with other drug abuse that at the end of everything it pre exposes the person concerned to mental illness. (Parker 2016)

Mental illness is a common problem in the community due to many factors, and it has several effects to the community, among the effects that are pronounced and seen in the community includes; unstable families or break p of families, people who are mentally ill are exposed to dangers like infection of dangerous diseases, death, loss of respect and dignity and affects the income of the caretakers and guardians (Benjamin 1999).

Most mental ill patients have their brain damaged. Hence they have no ability to judgment and decision making. Most of the crime and antisocial actions are committed by mental ill patients. Most of them appear to be normal and even the community thinks that they are normal until they undergo mental checkup or until the problem is severe that attracts the attention of people around the person.

A mental disorder is characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour. It is usually associated with distress or impairment in important areas of functioning. There are many different types of mental disorders. Mental disorders may also be referred to as mental health conditions. The latter is a broader term covering mental disorders, psychosocial disabilities and (other) mental states associated with significant distress, impairment in functioning, or risk of self-harm. This fact sheet focuses on mental disorders as described by the International Classification of Diseases 11th Revision (ICD-11).

In 2019, 1 in every 8 people, or 970 million people around the world were living with a mental disorder, with anxiety and depressive disorders the most common (1). In 2020, the number of people living with anxiety and depressive disorders rose significantly because of the COVID-19 pandemic. Initial estimates show a 26% and 28% increase respectively for anxiety and major depressive disorders in just one year (2). While effective prevention and treatment options exist, most people with mental disorders do not have access to effective care. Many people also experience stigma, discrimination and violations of human rights.

Anxiety Disorders

In 2019, 301 million people were living with an anxiety disorder including 58 million children and adolescents (1). Anxiety disorders are characterised by excessive fear and worry and related behavioural disturbances. Symptoms are severe enough to result in significant distress or significant impairment in functioning. There are several different kinds of anxiety disorders, such as: generalised anxiety disorder (characterised by excessive worry), panic disorder (characterised by panic attacks), social anxiety disorder (characterised by excessive fear and worry in social situations), separation anxiety disorder (characterised by excessive fear or anxiety about separation from those individuals to whom the person has a deep emotional bond), and others. Effective psychological treatment exists, and depending on the age and severity, medication may also be considered.

Depression

In 2019, 280 million people were living with depression, including 23 million children and adolescents (1). Depression is different from usual mood fluctuations and short-lived emotional responses to challenges in everyday life. During a depressive episode, the person experiences depressed mood (feeling sad, irritable, and empty) or a loss of pleasure or interest in activities, for most of the day, nearly every day, for at least two weeks. Several other symptoms are also present, which may include poor concentration, feelings of excessive guilt or low self-worth, hopelessness about the future, thoughts about dying or suicide, disrupted sleep, changes in appetite or weight, and feeling especially tired or low in energy. People with depression are at an increased risk of suicide. Yet, effective psychological treatment exists, and depending on the age and severity, medication may also be considered.

Bipolar Disorder

In 2019, 40 million people experienced bipolar disorder (1). People with bipolar disorder experience alternating depressive episodes with periods of manic symptoms. During a depressive episode, the person experiences depressed mood (feeling sad, irritable, and empty) or a loss of pleasure or interest in activities, for most of the day, nearly every day. Manic symptoms may include euphoria or irritability, increased activity or energy, and other symptoms such as increased talkativeness, racing thoughts,

increased self-esteem, and decreased need for sleep, distractibility, and impulsive reckless behaviour. People with bipolar disorder are at an increased risk of suicide. Yet effective treatment options exist including psychoeducation, reduction of stress and strengthening of social functioning, and medication.

Post-Traumatic Stress Disorder (PTSD)

The prevalence of PTSD and other mental disorders is high in conflict-affected settings (3). PTSD may develop following exposure to an extremely threatening or horrific event or series of events. It is characterised by all of the following: 1) re-experiencing the traumatic event or events in the present (intrusive memories, flashbacks, or nightmares); 2) avoidance of thoughts and memories of the event(s), or avoidance of activities, situations, or people reminiscent of the event(s); and 3) persistent perceptions of heightened current threat. These symptoms persist for at least several weeks and cause significant impairment in functioning. Effective psychological treatment exists.

Schizophrenia

Schizophrenia affects approximately 24 million people or 1 in 300 people worldwide (1). People with schizophrenia have a life expectancy 10-20 years below that of the general population (4). Schizophrenia is characterised by significant impairments in perception and changes in behaviour. Symptoms may include persistent delusions, hallucinations, disorganised thinking, highly disorganised behaviour, or extreme agitation. People with schizophrenia may experience persistent difficulties with their cognitive functioning. Yet, a range of effective treatment options exist, including medication, psychoeducation, family interventions, and psychosocial rehabilitation.

Eating Disorders

In 2019, 14 million people experienced eating disorders including almost 3 million children and adolescents (1). Eating disorders, such as anorexia nervosa and bulimia nervosa, involve abnormal eating and preoccupation with food as well as prominent body weight and shape concerns. The symptoms or behaviours result in significant risk or damage to health, significant distress, or significant impairment of functioning. Anorexia nervosa often has its onset during adolescence or early adulthood and is associated with premature death due to medical complications or suicide. Individuals with bulimia nervosa are at a significantly increased risk for substance use, suicidality, and health complications. Effective treatment options exist, including family-based treatment and cognitive-based therapy.

Disruptive behaviour and dissocial disorders

40 million people, including children and adolescents, were living with conduct-dissocial disorder in 2019 (1). This disorder, also known as conduct disorder, is one of two disruptive behaviour and dissocial

disorders, the other is oppositional defiant disorder. Disruptive behaviour and dissocial disorders are characterised by persistent behaviour problems such as persistently defiant or disobedient to behaviours that persistently violate the basic rights of others or major age-appropriate societal norms, rules, or laws. Onset of disruptive and dissocial disorders, is commonly, though not always, during childhood. Effective psychological treatments exist, often involving parents, caregivers, and teachers, cognitive problem-solving or social skills training.

Neurodevelopmental disorders

Neurodevelopmental disorders are behavioural and cognitive disorders, that? Arise during the developmental period, and involve significant difficulties in the acquisition and execution of specific intellectual, motor, language, or social functions.

Neurodevelopmental disorders include disorders of intellectual development, autism spectrum disorder, and attention deficit hyperactivity disorder (ADHD) amongst others. ADHD is characterised by a persistent pattern of inattention and/or hyperactivity-impulsivity that has a direct negative impact on academic, occupational, or social functioning. Disorders of intellectual development are characterised by significant limitations in intellectual functioning and adaptive behaviour, which refers to difficulties with everyday conceptual, *social*, and *practical* skills that are performed in daily life. Autism spectrum disorder (ASD) constitutes a diverse group of conditions characterised by some degree of difficulty with social communication and reciprocal social interaction, as well as persistent restricted, repetitive, and inflexible patterns of behaviour, interests, or activities.

Effective treatment options exist including psychosocial interventions, behavioural interventions, occupational and speech therapy. For certain diagnoses and age groups, medication may also be considered.

Who is at risk from developing a mental disorder?

At any one time, a diverse set of individual, family, community, and structural factors may combine to protect or undermine mental health. Although most people are resilient, people who are exposed to adverse circumstances – including poverty, violence, disability, and inequality – are at higher risk. Protective and risk factors include individual psychological and biological factors, such as emotional skills as well as genetics. Many of the risk and protective factors are influenced through changes in brain structure and/or function.

Health systems and social support

Health systems have not yet adequately responded to the needs of people with mental disorders and are significantly under resourced. The gap between the need for treatment and its provision is wide all over

the world; and is often poor in quality when delivered. For example, only 29% of people with psychosis (5) and only one third of people with depression receive formal mental health care (6).

People with mental disorders also require social support, including support in developing and maintaining personal, family, and social relationships. People with mental disorders may also need support for educational programmes, employment, housing, and participation in other meaningful activities.

WHO response

WHO's Comprehensive Mental Health Action Plan 2013-2030 recognizes the essential role of mental health in achieving health for all people. The plan includes 4 major objectives:

- To strengthen effective leadership and governance for mental health;
- To provide comprehensive, integrated and responsive mental health and social care services in community-based settings;
- To implement of strategies for promotion and prevention in mental health; and
- To strengthen information systems, evidence, and research for mental health.

WHO's Mental Health Gap Action Programme (mhGAP) uses evidence-based technical guidance, tools and training packages to expand services in countries, especially in resource-poor settings. It focuses on a prioritized set of conditions, directing capacity building towards non-specialized health-care providers in an integrated approach that promotes mental health at all levels of care. The WHO mhGAP Intervention Guide 2.0 is part of this Programme, and provides guidance for doctors, nurses, and other health workers in non-specialist health settings on assessment and management of mental disorders.

2.2 Socio-demographic factors influencing mental disorders among

PLWHA Socio-demographics are personal characteristics used to evaluate and collect data on people in a given population (Bhandari, Taneja, Mazumder&Bahl, 2017).Socio-demographic factors are important because if we believe that health is genetically, biologically, ecologically, culturally and socially determined, then gender must be recognized as being one of these determinants as it is interconnected with biology and the socio-cultural factors that affect health (Ahmed, Adams, Chowdhury &Bhuiya, 2012).

Once it is established that gender does play a role in health, the focus can be taken away from gender‟ perse and turned toward the social divisions of the sexes, so called „gender relations‟ (World Health Organization, 1998). It has been found that women are more likely to delay health-seeking and treatment, particularly for health conditions that are more prone to carry

social stigma, such as tuberculosis (Fienrich&Jellema, 2019).

HIV infected individuals often have difficulties telling others about their status. For disclosure to happen, it depends on several factors which include age, socio-economic status, level of

education, marital status, social relations, knowledge, cultural factors and acquaintance on the importance of HIV disclosure. In a study that was conducted in Guru TegBahadur Hospital and University College of Medical Sciences, Delhi. One hundred and sixty patients were interviewed using a questionnaire containing factors that affect depression. CES-D (Center for Epidemiologic Studies – Depression) scale was used to measure depression. The prevalence of depression 11 increased with the severity of symptoms (Ntseane, 2016). The unemployed, uneducated, unmarried, belonging to joint families, having no or low family income, migrants, having indifferent or poor relationship with spouse, poor social support and had visited commercial sex workers had a greater prevalence of depression.

The rate of depression in patients with HIV/AIDS is very high. Detecting depression early and treating it goes a long way in improving the compliance to treatment as well as quality of life .Demographic characteristics assessed include age, sex, ethnicity, marital status, education, job, monthly income, and sexual orientation. Demographics is measured using the following attributes;

Age

Age is a factor associated with health (Chung, Zenilman & Hanh, 2018). Age can be considered a factor of greater vulnerability, as with children under five years or the elderly, or greater robustness, or because the age group 18 to 25 years is more likely to been gaging in higher risk behaviours such as sexual activity, and alcohol, tobacco and other drug use. The effects of age can be due to differences in socio-economic status as defined by employment, education and as well as greater economic dependency, poor housing, loneliness and lowered self-esteem (Ntseane, 2017). The elderly are often unable to access adequate health care which can contribute to their poor health status. This can be a concern in developed countries and the less developed

Gender

Gender has often been used interchangeably with sex.

Gender is a social construct that refers not only to the biological sex differences between men and women, but to the different roles and expectations, behaviours and constraints that are placed upon an individual by culture and society, by virtue of their sex (Chung, Zenilman&Hanh, 2017).

Many health indicators for adults exhibit considerable gender differences according to an individual's social position and role (Borrell, Benach&Rohlfs, 2017).

As these issues are being addressed in industrialized countries, there is recognition of the specific health needs of women and the complex nature of the determinants of health for both women and men (Ntseane, 2018).

Marital status

It has been reported that women with long standing relations are more likely to disclose their status than those of shorter duration or who had multiple sexual partners. Similarly, other studies asserted that clients who are not married and those who have fewer sexual partners, less than two in a year, are more likely to disclose their HIV positive status than those who have many sexual partners. Additionally, women with more than one sexual partner are more likely to have disclosed their HIV status than those with only one sexual partner (Ahmed, Tomson, Petzold & Kabir, 2018).

Level of Education

A key socio-cultural determinant of health is education (Ahmed, Adams, Chowdhury &Bhuiya, 2018). Again it is difficult to separate education from literacy and other indicators that are regularly used as convenient markers of socio-economic status. Available data in all countries points to the relationship between the risk of disease and lower levels of education (Dressler, Balieiro& dos Santos, 2018).

Occurrence of illness is significantly lower in groups with higher education, especially among men, but there was no difference between occupational and economic groups in Vietnam (Ntseane, 2019). The World Bank views the two as interlinked and regard the "economic and social benefits of education for girls and women as a form of human capital investment" (cited in Waweru et al., (2016), p. 650) as well as poverty reduction, specifically in Africa (Ntseane, 2014).

Economic status

Many studies identify economic status as the most significant predictor of service use (Fienrich&Jellema, 2013) and how income affects the level to which health care facilities are

sought and used (Buor, 2003, p. 296). While often the decision to seek health care is based upon the cost as compared to the perceived benefit (Chung, Zenilman&Hanh, 2014). According to Buor (2003) the ability to pay determines the use of health services. A lack of finance seriously affect health care seeking (Dressler, Balieiro& dos Santos, 2011), so although the willingness to pay for services may be there (Ntseane, 2014), the means to do so, may not. Not surprisingly low income has been found to be a barrier to health seeking and can create an overwhelming financial burden for some (Fienrich&Jellema, 2013).

2.3. Institutional Factors influencing mental disorders among.

PLWHA the people living with HIV Stigma Index was used to measure stigma and discrimination, and a short version of general health questionnaire (GHQ-12) was used to measure mental disorders. Multivariate logistic regression analysis was conducted. The reported experiences of discrimination in communities in the past 12 months ranged from 0.8% for reports of being denied health services to 42.3% for being aware of being gossiped about. Internal stigma was also common ranging from 2.8% for avoiding going to a local clinic and/or hospital for deciding not to have (more) children.

The proportions of PLWHIV who reported fear of stigma and discrimination for fear of being physically assaulted for fear of being gossiped about. AIDS-related stigma and discrimination among PLWHIV in Cambodia are common and may have potential impacts on their mental health conditions (Siyan et al., 2016). These findings indicate a need for community-based interventions to reduce stigma and discrimination in the general public and to help PLHIV to cope with this situation. Institutional factors are measured using the following attributes.

Presence of drugs

The presence of antiretroviral therapy (ART) has greatly improved the morbidity, and decreased the mortality associated with HIV infection. The benefits of ART, however, are typically contingent upon excellent ART adherence and persistence in order to achieve suppression of HIV-1 RNA levels and an increase in CD4 T cell lymphocytes. Suboptimal adherence to antiretroviral therapy is strongly related to viral proliferation drug resistance, disease progression and death. Factors that can impair adherence to ART include drug addiction, alcohol use disorders, low socioeconomic status, social stigma, neurocognitive disorders, and mental

disorders. Waiting time the waiting time the patient takes while waiting for the health services determines how often he/she receives the service.

In absence/insufficiency of the drugs, the patients ends ups losing the patience, becomes depressed hence mental illness of PLWHA. Therefore there is need to respect the patient's time and provide at most attention in the health facilities. This encourages the patients to have a positive attitude on the epidemic.

Counseling and Testing

Counselling provides the patient with information on the technical aspects of testing and the possible personal, medical, social, psychological, legal and ethical implications of being diagnosed as either HIV positive or HIV negative. The purpose of pre-test counselling is further to find out why you want to be tested, the nature and extent of your previous and present highrisk behaviour, and the steps that need to be taken to prevent you from becoming infected or from transmitting HIV infection. The questions asked during counselling provide the counsellor with an opportunity to ascertain your perceptions of your own high-risk behaviour, and allows you to assess whether you intend to be tested and whether your fears are realistic or if you are unnecessary concerns.

Training

If mental health is to be effectively integrated into primary health care in low income countries like India then grass-roots workers need to acquire relevant knowledge and skills to be able to recognise, refer and support people experiencing mental disorders in their own communities. There is an influence of institutional factors on mental illness in health care settings because institutional factors affect discrimination toward persons with HIV/AIDS.

A representative sample of 1101 Chinese service providers was recruited in 2012, including doctors, nurses, and laboratory technicians. Multivariate analyses revealed that respondents" general view of persons living with HIV/AIDS and their perceived levels of support from their institutions regarding protection procedures were both important predictors for discrimination intent (Siyan, Pheak, Suong, Kouland, Brody and Tuot, 2017).

Perceived institutional support varied according to age, gender, ethnicity, and training background. A better understanding of HIV-related discrimination in health care settings requires consideration of both individual and institutional factors (Zunyou et al., 2010).Recent studies have confirmed these findings and includes other mental health outcomes such as anxiety, stress, or post-traumatic stress disorders (PTSD) in different populations of PLWHIV in different countries around the world including mainland China, India, South Africa, the United States, and several other countries (Siyan et al., 2016).

2.4 Regularity and Patterns of mental Clinic services.

Demographic variables (demographics) such as age, gender, ethnicity, annual income, marital status, and education level are frequently reported as factors affecting mental health clinic services in studies that address adherence to treatment among chronic illnesses including mental health problems (Guerrero, E. Get al., 2018). Busby and Sajatovic (2016) found that men had lower psychotherapy appointment attendance compared to women while Alonzo et al. (2021) found that individuals with severe depression were more likely to miss appointments than those with less severe depression.

Other studies (Basco & Smith, 2009; Fenton, Blyler, & Heinssen, 20017) revealed that people who were diagnosed with bipolar disorder and psychotic disorders were less likely to show up for treatment if they had no insight into their symptoms. Murphy et al. (2017) reported that individuals who attempted suicide were more likely to miss appointments and less likely to follow through with treatment than those who did not engage in self-harm.

According to the study done by Abbo, (2019) results revealed that in Africa, traditional healers are usually the first source of care people seek when faced with mental health problems, and frequently the only source of care sought.

2.5 Social and economic factors affecting mental health clinic services.

In 2022, the World Health Organization estimated that up to 80% of mental health patients who reported to the health centre had visited the traditional healers first in common developing countries.

The traditional belief system and cultural explanatory models of mental illness were noted to be very influential in the choice of where to seek help. Passino et al, (2022) highlighted that mental illness is mostly perceived to be due to witchcraft, curses and evil or ancestral spirits.

In addition accessibility of health facilities and financial costs associated with seeking care also influence help-seeking behavior among patients with mental illness. Transport costs and other financial implications including procuring medication when they are not available at the health facility were reported to frustrate patients and their caretakers, making them resort to the readily available and affordable traditional healers within their communities,

The house hold resources, educational level, economic status of patient /care takers, marital status, occupation of patient and caretakers, the age and sex of patient, all have an impact on number of patients seeking health care (Mazzotti, E., & Barbaranelli, C. (2019).

The educated, those with source of income, employed and the married have better health seeking behavior compared to their counterparts. The cost of care also affects the number of patients seeking health services. Due to limited sources of income among most families in rural areas most of the patients are not able to access care, (Alonso-Escolano, D. (2016).

Other factors affecting patient's regularity of attendance and medication compliance were: social isolation, social neglect, discrimination and unemployment, (Kwintner, M. (2018). Further, Health seeking behavior studies demonstrate that the decision to engage with a particular medical channel is influenced by a variety of socio-economic variables, sex, age, the social status of women, the type of illness, access to services, perceived quality of the service and awareness of service availability

Environmental factors including living conditions, work stresses, employment status along with family and community support networks also affect an individual's ability to seek health services, (Muntaner etal, 2018). Other social factors include a dysfunctional home environment, poor relationships, living in poverty and social isolation unemployment or a stressful work environment highly stressed in your work can all put pressure on an individual's mental health seeking behavior (Muntaner et al, 2018). In Uganda no such study has come out with social economic factor affecting mental health clinic services.

2.6 Health Facility factors affecting Mental Health Clinic services.

Health seeking behavior studies demonstrate that the decision to engage with a particular medical channel is influenced by a variety of health facility factors including the type of illness, access to services, perceived quality of the service and awareness of service availability (Mark et al, 2016).

Other health facility factors associated with engagement in care among patients with chronic conditions including mental illness include policies, perceived quality of health serve at particular health facility, standard of equipment available, competence of staff, attitudes of staff and interpersonal communication (Henzen etal., 2016).

According to O'Brien, Fahmy, and Singh (2019), commonly cited reasons for treatment dropout include dissatisfaction with services, unsympathetic providers and poor communication. Additionally it has been stated from previous research that providing knowledge about causes of ill health and choices available to patients will go a long way towards promoting a change in individual behavior and promoting beneficial health seeking behavior (Mackian, 2022). Distance to the health facility has also been documented to affect health seeking behavior of the patients. When the facility is within reach and easily accessible it will encourage patients to seek services from that particular health facility.

This why with the decentralization of health services to regional hospitals and health centers the number of patients seeking services at these centers has increased since patients can easily access the health facilities (Kigozi & Ssebunya, 2009).

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter included the study design, study area, study population, sampling procedure, sample size determination ,data collection technique, ethical considerations, data processing and analysis, inclusion and exclusion criteria and study limitations .

3.1 Study design

A health facility based cross-sectional study design was used to study patients with mental illness who were in remission phase and a qualitative study of key informants(health workers) providing mental health services in Sudan.

The researcher used both quantitative and qualitative methods to explore factors that affect the ability of patients with mental health regularly attend the mental health clinics for review and medication refills to ensure compliance to medications and getting proper services at the hospital.

3.2 Study area

The study was conducted in selected health facilities Khartoum Sudan. In a similar way the researcher selected health workers from this hospital selecting two participants per department. This hospital offers mental health services to the people of Sudan.

3.3 Study population

Data was collected from patients with mental illness who were in remission phase and on continued care and were able to understand and respond to questions appropriately. The researher also

interviewed 8 health workers offering mental health services working in the mental health clinics within Khartoum Sudan.

The number of patients attending mental health clinics is four hundred eighty (480) patients according to HMIS (2022) annual report for Lubaga Hospital health office 56. Respondents aged between 18-65years were only interviewed and an interval often was used.

3.4 Sampling Method

The Lubaga health facility was purposively selected as it was among the main hospital offering mental health services according to RIMS 2023 for Kampala district.

Simple random sampling method was used to select study participants. The study participants were selected from each health department by use of rotary method were by pieces of paper equivalent to the number of patients were written on yes and others no, put in a box and after shaking the box they picked one after the other whoever picked yes was to participate in the study. Proportionate random sampling method was used to distribute the study participants that had been attending the mental health clinics. The total of all respondents was 214 to be considered in the study.

3.5 Sample size determination

Morgan tables were used to determine Sample size, where by **N** is the study population=480 and

S is the sample size =214

3.6 .0 Study Variables

3.6. 1 Dependent Variables.

Regular mental health clinic attendance.

3.6.2 Independent Variables.

Social and economic factors including monthly income, marital status, occupation of the patient, having a care taker, having another family member with mental disorder. Other factors included health facility factors which included accessibility of the health facility and availability of the health services, distance to the health facility, the quality and distribution of the technical staff in the mental clinic and Policies related mental health services Mental health process.

3. 7 Data collection technique.

Data was collected by using a standardized questionnaire, key informant interview guide and record review. The questionnaire was locally generated and pretested prior to use to make sure it was appropriate for the population of interest. A questionnaire was used and this was preferred because of its ability to enable a researcher collect a lot of data over a short period of time. Eight (8) key informant interviews were also conducted to collect more information that could not be directly observed but we also wanted to get the views of health workers on the factors affecting the mental health clinic services in Lubaga Hospital in Kampala. The key informants were mental health workers, who were Psychiatric nursing officers and psychiatric clinical officers.

3.8 Inclusion and exclusion criteria

3.8.1. Inclusion criteria

Only people who had suffered from mental illness that were in remission phase and consented were accessing mental health care in Lubaga Hospital. The researcher enrolled adults aged between 18-65 years.

3.8.2 Exclusion criteria

The study excluded patients with mental illness who had active symptoms and were not in position to consent were excluded from the study. Additionally the researcher excluded patients who were receiving mental health services from other health centers that were not the focus of the study. Participants below 18 years were also excluded.

3.9 Data quality control

In this study, data quality issues were addressed through pre-testing the questionnaire a process that helped the researcher to make changes and improve clarity of the questions. Proper filling of the questionnaires was also ensured by checking for completeness and accuracy of completed data collection forms at the end of each day of data collection to ensure that all required data was filled in the questionnaires.

3.10 Data analysis and presentation

Data cleaning was done manually to ensure completeness, consistency and accuracy of the data collected. Data was analyzed and processed by use of computer Statistical Programme for Social Scientists (SPSS) Version 16 and Microsoft excel.

At univariate level, the socio-demographic variables of the respondents such as age, sex, level of education, occupation etc. was analyzed independently. At bivariate level, binary logistic regression was used to determine the significance association between dependent and independent variables. Multivariate level, logistic regression was used to study the significance of different independent variables. Different variables were compared in analysis. The results were presented in form of tables. Qualitative data was audio recorded and transcribed and then coded to identify relevant themes.

3.11 Study limitations/ delimitations

The researcher anticipates encountering the following limitations

(i) **Sensitivity of information**: Some respondents were reluctant to respond to some of the questions. The researcher however assured them of maximum confidentiality so they can provide all the required information.

(ii) **Information bias**: The study presumed challenges may arise from information bias when the respondents prefer not to supply correct information example when administering questionnaire to the respondents, this was overcome by emphasizing on the confidentiality of the information verbally and inclusion in the questionnaire.

Some of the respondents may have under reported or given incorrect information. This was prevented by ensuring that the respondents were properly talked to prior to questionnaire administration. The researcher ensured that the questionnaire was brief so that the respondents didn't feel delayed.

3.12 Ethical considerations

The researcher received clearance from the ethical committee of the school of post graduate studies and research of Kampala University and then received Ethical approval for the study. Permission was also obtained from the office of the health office of Lubaga hospital before proceeding to the respective health centers for data collection.

3.12.1. Informed Consent

All participants provided written informed consent before data collection procedure. The researcher introduced himself to the participants and all the procedures involved in the study were explained to participants. The purpose of the study, the information about the criteria for

selecting study participants, procedures to be followed and any risks and benefits of the study were explained to the respondents. The participants were also informed that their participation was voluntary, and they were free to terminate their participation at their own will at any point during the study and they were guided on whom to contact in case of any inquiry, the respondents who understood and consented were made to sign the consent form.

CHAPTER FOUR: PRESENTATION AND INTEPRETATION

OF RESULTS.

4.0 Introduction

This chapter covers the major findings from the study. The study described the factors associated with mental health clinic attendance in Lubaga hospital. The findings were illustrated in form of tables. The study had initially considered 218 mental patients. But due to the fact that some of them never consented, a total of 208 participants were included in the study. They generated mainly quantitative data using 208 questionnaires and that were administered by the researcher.

To obtain qualitative data, eight key informants were interviewed by the researcher using an interview guide. These Key informants were health workers working in mental health clinics in the hospital.

4.1 Demographic characteristics of the respondents

Table 1: Social demographic characteristics of individual attending mental health clinic in Lubaga Hospital (N=208)

CHARACTERISTICS	**FREQUENCY**	**PERCENTAGE**
Sex		
Male	97	46.6
Female	111	53.4
Age group		
15-24	28	13.5
35-44	87	41.8

45-54	59	28.4
55-64	27	13.0
Marital Status		
Never married	40	19.2
Married	77	37.0
Separated	86	41.
Widow/ widower	5	2.4
Occupation		
Employed	86	5.0
Unemployed	112	53.8
Civil servant	17	3.2
Business	30	14.4
Peasant farmer	31	14.9
Others	18	8.1
Religion		
Catholic	66	21.7
Protestant	91	40.8
Moslem	26	12.5
Others	40	13.0
Education level		
No formal education	25	10.0
Primary	115	50.3

Secondary	43	20.7
Tertiary	25	12.0
University	12	7.0

Over half ill (53%) of the participants were female, majority 87 (42%) were aged between 25-34 and almost half 91 (44%) were unemployed while more than half 115 (55%) had attained primary level of education.

4.2 Regularity of attendance

The regularity was measured by the number of times the patient missed appointments. We considered that clinic attendance was not regular when the patient missed 3 or more appointments, by checking on the treatment notes and clinic attendance registers. Majority 133 (74%) did not attend the clinic regularly compared to 75 (36%) who attended the clinic regularly.

On regularity of attendance, majority 6/8 (75%) of the key informants reported that patients do not attend the clinic regularly as indicated by the fluctuations of the numbers attending the clinic every month. They attributed this to seasonal changes and farming activities by some of the patients who miss clinics to plant their seeds during the rainy season. One of the participants had this to say; "We usually get low clinic attendance during times of planting seeds as patients are busy with farming activities" (Lubaga hospital)

Another participant added "our patients attend more regularly during times of coffee harvest as they have some money and attend irregularly during times of hunger and starvation in the community" Lubaga hospital)

CHARACTERISTICS	IRREGULAR ATTENDANCE	REGULAR ATTENDANCE	P-VALUE
Type Of Mental Disorders			
Schizophrenia	40	27	0.00
Manic depressive	15	12	0.005
Depression	08		0.415
HIV induced psychosis	22		0.78
Substance induced	03		0.66
Psychosis	05		0.002
Sex of the Respondents			
Male	34		
Female	41		0.08
Occupation			
Unemployed	17		0.12
Civil servant	23		0.83
Business	22		0.8
Casual labour	10		0.70
Others	21		0.41
Level of Education			
No formal education	20		0.01
Primary	30		0.02

Secondary	22		0.08
Tertiary	21		0.91
University	14		0.04

Respondents with schizophrenia had highest regular attendance (36%), Males were majority (54.7%), those involved in business (30.7%) and those who had attained primary level of education (54.7%).

Table 3: Health facility factors affecting respondents' Regularity of mental health clinic attendance.

Variables	**Regular attendance**	**Irregular attendance**	**P-Value**
Distance to Facility			
1-5KM	70	54	0.0001
6-10KM	5	46	0.99
11& above km	0	33	0.99
Accessibility to facility			
Easily accessed	67	8	0.0001
Difficult to access	28	105	-
Factors promoting attendance			
Drug availability	62	13	0.0001
Good communication	12	70	0.001
Got better on treatment	1	50	0.042

Majority of respondents who attendant more regularly were from a distance within 5kms, 70 (93%), easily accessed the facility (89.3%), and reported drug availability as the biggest motivating factor (82%).

4.3 Social economic factors affecting regular mental health clinic attendance

Different factors were related to the regularity of mental health clinic attendance as summarized in the table 5 below. We found that availability of care taker OR 25.173, 95% CI (8.868-72.99) and P-value< 0.0001, Level of income OR 3.389, 95% CI (2.402-4.781) and P-value <0.0001 and access to service OR 24.96,95% CI (4.19-148.65) P-value< 0.0001 were significantly associated with regular mental health clinic attendance.

According to key informants, majority 7/8 (88 %) of the KI reported that poverty impacted on the ability of the patients to attend the clinic on a regular basis. They reported that due to poverty patients cannot afford transport fair to the clinic every month for review and to get their medication refills.

"Majority of our clients are un employed hence unable to afford funds for transport and drug purchases since they need to come on a monthly basis year after year"(Lubaga Hospital)

Another factor that prevented the patients from attending the clinics regularly was lack of family support. The participants reported that patients who do not have responsible caregivers commonly miss the clinic compared to those who are well supported. They reported that those who are cared for by the parents attended the clinic regularly. "When a patient has responsible care takers especially those who are cared for by parents, they rarely miss appointments"(Lubaga hospital).

Majority of key informants also reported that traditional beliefs about the cause of the mental illness also affected regularity of clinic attendance.

One of the Respondents said "patients that attribute their mental disorder to witchcraft often attend irregularly than those who don't attribute it to other causes ". (Lubaga hospital)

Majority (6/8) of respondents reported that those who are informed about their mental disorder and have insight were more likely to attend regularly compared to those with no insight.

Poverty coupled with unemployment was also reported to be affecting regular clinic attendance

Majority of respondents 5/8 reported that marital conflicts, separation or divorce impaired the patient's ability to attend the clinic.

Following divorce/ separation especially the woman who has been getting support from the husband it has often been difficult for such a person to keep appointments as their second homes may be far away from the facility or in even another district. (Lubaga hospital).

Another factor that was reported by informants to affect regularity of mental health clinic attendance by patients with mental illness was alcohol and drug abuse. "Often when these patients that have a problem of alcohol and they are tired of telling lies about their drinking

habits they often decide not to come back (to the clinic), not until they are readmitted in acute states following withdrawal/ intoxication syndrome "(Lubaga Hospital).

Patients with insight rarely missed their clinic appointments compared to those who lacked insight or who believed that the cause of their mental illness was ingrained in family traditions that they were not sick.

4.4 Health Facility factors affecting mental clinic attendance.

In this study, the distance to the health facility, accessibility and motivating factors such as drug availability and having no cost on transport to the facility were factors influencing regular clinic attendance.

Accessibility to clinic), P-value 0.007, having no cost on transport to facility, OR 0.002, 95% CI (0.000-0.187), P-value 0.008.

These are summarized in table 5 above. According to the key informants the following health facility factors were reported to be affecting regular clinic attendance: All key informants mentioned inadequate staffing at the health facility as a major factor affecting regular mental health clinic attendance.

*"*The long waiting hours at our clinics often put patients off They hence end up going to buy medicines from drug shops" (Lubaga hospital).

Majority 6/8 of key informants mentioned that drug shortage at the health facility has always had an effect on regularity of attendance "Whenever a patient comes on more than two occasions finding no medicines their regularity pattern will be affected"

Majority 6/8 of key informants reported that patients are not given enough time at the clinic and are often not explained to the cause for their mental disorder which does not encourage them to come back for review. "Patients often expect to get better on a single month medication hence when they don't recover they resort to other sources of treatment"

"Another key informant reported "that the side effects of medications have often lead to irregular attendance as drug side effects are seen to worsen the diseases picture than improve it". "Majority of our patients expect to see change within a short period of time, so when this doesn't

happen they believe that the mental problem is due to other causes. Hence find no need of coming hack hut instead come hack when conditions have worsened. (Lubaga hospital)

Another key informant reported" due to abnormal behavior exhibited by the mentally ill, majority of the patients are thought to have been cursed/ bewitched hence they go for prayers Traditional healers and move from church to church and from tradition healer to the other before they can come back to a health facility" (Lubaga hospital)

CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This study focused on assessment of factors influencing mental health clinic attendance in selected health facilities of Lugaba hospital, Kampala Uganda. The discussion reflects 208 participants that had been stable on treatment at the time of enrollment in the study. It also reflects the views of 8 mental health care workers who were key informants and provided their views on the factors affecting mental health clinic attendance. The study findings show that majority of the patients did not attend the clinic regularly a situation they attributed to social, economic and health facility factors. Distance from the health centre, availability of medications at the health centre, type of the metal disorder, having a stable caretaker and employment status were significantly associated with regular clinic attendance. Other factors significantly associated with regular clinical attendance included availability of transport to the clinic and having another relative with mental illness.

5.1 Patterns of mental health Clinic attendance

Few (36%) of the respondents attended the clinic regularly. No such study has been done in Uganda previously to compare with. Patients with manic depressive illness attended more regularly compared to other mental disorder type. These findings are in disagreement with findings of Basco & Smith, (2009);

Fenton, Blyler, & Heinssen, (2007) that showed that people who were diagnosed with bipolar disorder were less likely to show up for treatment if they had no insight into their symptoms and hence did not adhere to their medication regimen.

5.1.2. Socio-Economic Factors influencing mental health attendance

According to the study findings, having a care taker was a significant factor that determined regular clinic attendance. Patients who had care takers that would meet the cost of care and other social needs attended more regularly. The study findings are in agreement with the study of Kavuma 2010 where by accessibility of health facilities and financial costs associated with care influence health-seeking behavior.

This study revealed that transport cost was an important factor determining regular attendance. Those who incurred no cost on transport and came from within a distance of 5 km from the facility attended more regularly compared to those that incurred transport and came from a distance above 5km. The study findings are similar to the study by Alonso, Escolan (2018) whereby high transport costs, cost of treatment, time of travel along with the economic status of the patient or care taker all had an impact on patient attendance to a particular health needs.

The study also revealed that lower education level was associated with regular clinic attendance compared to those with higher education levels. These study findings differed from one done by Mazzotti, E., & Barbaranelli, C. (2016) where those with high education had a better health seeking behavior.

The study findings that those with lower education attended more regular could be attributed to the majority of Ugandans having attained primary level of education, according to the national census report of 2022.

This study also revealed that having a person responsible for medical treatment, was also another significant factor that influenced regular clinic attendance. This study also revealed that those who had relatives responsible for their medical care attended more regularly compared to those without relatives in charge of their care. One who stayed with parents had more chances to attend regularly compared, to any other relative. The study findings were also in agreement with the study of (Kwinter,M ,2016) whereby neglect, social isolation, loneliness or discrimination , social disadvantage, poverty and, unemployment has an effect in clinic attendance.

5.1.3 Health facility factors affecting mental health clinic attendance

Drug availability at the facility was another significant factor along with communication between health worker and patient care taker as well as previous response to the medication that was prescribed even from the key informant interview it was revealed that when drugs are available there is more clinic attendance and drug stock out was responsible for irregular attendance, as patients would resort to buying from drug shops or even abscond from treatment. Inadequate health staffs for the mentally ill patients with delays at health facility along with insufficient information on when and why they need to come back were also echoed as barriers to regular

attendance of mental health clinic attendance. The results agree with findings by Hasvold and Wooton (2018) who found that missed appointments resulted in clinicians and support staff being less efficient in their work due to increased paperwork, which gave them less time for their job requirements.

Another significant factor according to this study that affected regular clinic attendance was awareness of service. Patients were more likely to attend regularly when they are aware of the availability of services most especially when informed by those who had recovered from the same facility or someone they have known before with a mental disorder gets improved.

5.2. CONCLUSION

5.2.1 Regularity of attendance

Patients attended mental health clinic irregularly. Less than half of the total number of patients was able to attend following their appointment dates. Irregular clinic attendance was more likely to be associated with poor adherence to medications. This would lead to high relapse rates, multiple admissions and reduced productivity hence leading to reduced economic growth in the country.

5.2.2 Social economic factor affecting clinic attendance

Significant factors that influenced regular attendance according to this study were; having a care taker, incurring no cost on transport and having someone in charge of treatment cost. Those who had care takers and most especially parents and siblings attended more regularly compared to those that did not have. Those who incurred no transport cost coming from within 5km from home also attended more regularly. Patients that had someone in charge for medical care costs also attended more regularly compared to those that didn't have someone in charge.

5.2.3 Health facility factors affecting clinic attendance

Significant factors that affected attendance of regular attendance at the facility were awareness of service and drug availability. Those who were aware of the availability of health services and clinic lays attended more regularly compared to those that didn't. Drug availability i.e. having drugs available at the facility and being able to purchase drugs, was linked to attending more regularly.

5.3 RECOMMENDATIONS

5.3.1 Regularity of attendance

There is a need to sensitize the patients/ caretakers on the importance of complying with medications and keeping appointment dates, so as to improve on regularity of mental health clinic attendance.

5.3.2 Social economic factors affecting attendance of mental health clinic

Patients during recovery should be encouraged to participate in occupational therapy that includes handcrafts making skills so as to boost their ability to generate income that will enable them to attend mental health clinics more regularly.

Also Patients' care takers should be asked to start some projects /small scale businesses that will enable the patients to have income for transport/ drug purchases so as to provide the much needed support to their patients both social and economic.

5.3.3 Health facility factors affecting mental health clinic attendance

There is need for government to increase on number of health workers specialized to handle patients with mental disorders and have adequate supplies and medicines for mentally ill patients. There is need to establish outreach clinics so as to reduce on distance travelled by patients to health facilities. Health workers in mental health clinics should improve on communication and should allocate more time to answer patient's issues affecting their attendance. Health facility in charges should be asked to promptly order more drugs for mental patients and health workers should give more information concerning drug doses, side effect, and duration of treatment and how to notice relapse symptoms. Patients/caretakers should be asked to form support groups which can help them solicit funds from both governmental and nongovernmental organizations.

5.4 Areas for further research

There is need to do further research on determinants of choice of where patients with mental illness would prefer to be taken for treatment.

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APPENDIX A: QUESTIONNAIRE

Your participation is voluntary and the information you give is confidential. You may also stop the interview at any time you wish Hoping that this information will be used in improving the welfare of our children.

NB: Tick the correct answer and answer where necessary.

SECTION:

SOCIAL DEMOGRAPHIC CHARACTERISTICS.

1. Age of the respondent.

10 – 20 ☐

21-30 ☐

31 -40 ☐

41 -50 ☐

51-60 ☐

61 and above ☐

2. Marital status of the respondent

(a) Single ☐

(b) Married ☐

(c) Widowed ☐

(d) Separated/divorced ☐

3. Educational level of the respondent.

(a) None ☐

(b) Primary ☐

(c) Secondary ☐

(d) Tertiary/University ☐

4. Occupation of the respondent ☐

(a) House wife ☐

(b) Civil servant ☐

(c) Self employed ☐

(d) Peasant/farmers ☐

5. Main occupation of the respondent.

(a) Farmer ☐

(b) Civil servant ☐

(c) Businessman ☐

(d) Unemployed ☐

(e) Others ☐

6. Religion of the respondent.

(a) Catholic ☐

(b) Protestant ☐

(c) Muslim ☐

(d) Others ☐

7. Do you know anybody that has mental problem?

A). Yes ☐

b) No ☐

SECTION B,

Knowledge on causes of mental illness

1. Have you ever heard about mental illness?

(a) Yes ☐

(b) No ☐

2. What is mental illness?

……

… ……

3. Do you think that mental illness have any effect in the community/family?

(a) Yes ☐

(b) No ☐

If no give reasons?

……

… ……

SECTIONC;

DETERMINING ATTITUDE OF MENTAL ILLNESS IN THE COMMUNITY

1. What are the causes of mental illness?

   ……

   …… ……

2. Can the mental illness prevented or cured?

   …….

…….

……..

3. What is the effect of mental illness in the community?

……

……..……

……..……

……

4. What do you do if you're culture does not allow the mental ill patient to be taken to hospital?

……

… …….

SECTION D.

PREVENTIVE MEASURES.

1. How do you prevent the mental illness from occurring in the society after knowing the causes?

   ……

   ……

   ……

   ……..……

   ……..……

   ……

2. How do you protect those who have not affected from the effects of mental illness/exposure to mental illness?

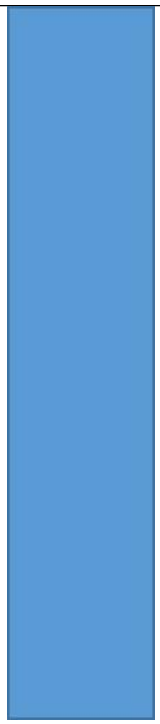
   ……

   …… ……

THANKS.

APPENDIX B: WORK PLAN.

Objectives	Activities	Time frame 2022 to 2023						
		July to September	October to November	December	January to February	March to April	May to June	Indicators
Administrative requirements	Choosing & Presentation of the research topic for approval							Supervisor researcher
proposal writing	• Writing a proposal and preparing research tools • Typing and binding the proposal Handing the proposal to the supervisor							Supervisor Researcher
Gathering data	Distribution of research tools and collection							Researcher

Data analysis	• Making sense of the collected information • Compilin g the analyzed information Discussing, finalizing, the findings.							Data analyst and Researcher
Dissemination of information	Copies of the dissertation presented to DEAN, KU library and conferences							Researcher

APPENDIX C: ESTIMATED BUDGET FOR THE PROJECT.

NO:	ACTIVITY	QUANTITY	AMOUNT PER QUANTITY	TOTAL AMOUNT
1	Stationery	1 ream	15,000	15,0000
2	Printing & Binding		80,000	80,000
3	Communication		50,0000	50,000
4	Transport		100,000	100,000
5	Lunch	10 days	10,000	100,000
6	Research Assistants	2	100,000	200,000
7	Miscellaneous		200,000	200,000
TOTAL				**745,000**