Exploring Challenges and Opportunities of Geferssa Mental Health Rehabilitation Center (GMHRC) in its Rehabilitation Program in Oromia Regional State (ORS)

Yitbarek Hizekeal

A Thesis Submitted to

The school of Social Work

Presented in Partial Fulfillment of the Requirements for the

Degree of Masters of Arts (Social Work)

Addis Ababa University

Addis Ababa, Ethiopia

May, 2015

Addis Ababa University

School of Graduate Studies

This is to certify that the thesis prepared by Yitbarek Hizekeal, entitled: Exploring the Challenges and Prospects of GMHRC in Oromia Regional State in partial fulfillment of the requirement for the degree of Masters of Arts (Social Work) complies with the regulation of Universities and meets the accepted standards with respect to originality and quality.

Signed by the Examining Committee

Examiner: - _____ signature: - _____ date: - _____

Examiner: - _____ signature: - _____ date: - _____

Advisor: - _____ signature: - _____ date: - _____

Advisor: - _____signature: - _____ date: - _____

Declaration

I, the undersigned, declare that this thesis is my original work and has not been presented for degree in other university and that all sources of materials used for this have been duly acknowledged

Name of the student: - _____

Signature: -_____

Place: - _____

Date of submission: - _____

Acknowledgement

First of all I would like to thank the almighty God for his innumerable and benevolence up on me through all walks of my life.

My Advisor, Dr. Mengistu Legessie, has contributed a lot to develop this paper. I am really thankful of all the help and advice I have been given by my Advisor. Than you, Doctor for assisting me throughout proposal development and conducting the actual thesis. I can't forget your encouraging and friendly approach.

My deepest gratitude is also goes to Mr. John, who permitted me to conduct my thesis at the rehab center and facilitated my interview with staff members, rehabilitated clients of the center and the family members of out- patients. I would like to thank other staff members of Geferssa Mental Health Rehabilitation Center, (GMHRC) (Mohammed Ibrahim, Shitaye Adinew, Ayelech Bedane and Zemedu Tefera) and to all those who participated in my study and give me the necessary data to complete this study.

I am also very much grateful for my father, mother and my brothers. Dad and Mom, this success is un thinkable, if you did not supported me through your words of encouragement. I do have also special thanks to my love, Hewan Tilahun for your love and psychosocial support throughout my stay in Addis for the last two years. May God bless our love!

Finally I would like to appreciate and thank Oyda Woreda Administration for their financial and material support. Individually I am indebted to acknowledge the special support given by the former Woreda Administrator of Oyda, Mr. Tenkir Tenka, to me to join and complete my study in Addis Ababa University. Dear Tenkir, may God almighty bless you and your family.

Acronyms and Abbreviations

AIDS: Acquired Immune Deficiency Syndrome

DALYs: Disability Adjusted Life Years

FDREMH: Federal Democratic Republic of Ethiopia Ministry of Health

FGD: Focus Group Discussion

GMHRC: Geferssa Mental Health Rehabilitation Center

GNP: Gross National Product

HIV: Human Immune Virus

IGAs: Income Generating Activities

LMICs: Lower and Middle Income Countries

MDGs: Millennium Development Goals

NGO: None Governmental Organization

NIMHE: National Initiative for Mental Health in Ethiopia

ORS: Oromia Regional State

ORSLA: Oromo Region Social and Labor Affair Barrio

SNNPR: Southern Nations Nationality and Peoples Region

TB: Tuberculosis

USA: United State of America

WEF: World Economic Forum

WHO: World Health Organization

Abstract

This thesis had been developed based on searching answer for the basic research question "what are the challenges and opportunities of GMHRC?". To answer this question and other related sub questions the researcher used qualitative research design with special employment of case study strategy of inquiry. A total of 27 participants were selected from staff members, family members and rehabilitated member of the center by using purposive (non-probability) sampling. After conducting interview, focus group discussion, observation and document review different issues were emerged from the empirical data. Based on the analysis of empirical data, prospects and challenges of GMHRC in its rehabilitation program were identified. Accordingly, themes like poverty and related socio economic factors, stigma and discrimination, communication barrier between the management body and most of workers, absence of systems to manage violence and limited attention for psychosocial and spiritual rehabilitation were developed as challenges of the center. Concerning the opportunities of the center, the march of the center towards di-institutionalization, the action of creating, searching and connecting admitted member of the center with income generating activities and political commitment of the current government to promote mental health were identified. The findings have implication for the social work practice and research, policy makers and the center.

Keywords: mental illness, rehabilitation, mental health, opportunities, challenges

Table of content

Topic **page** no

Chapter One

Introduction

Background of the study

Mental illness has great impact on the patients, their families and the larger community. According to world Health Organization (WHO) (2001) report, research conducted on assessing the impact of mental illness estimated that at least one family member suffers from a mental or behavioral disorder at any point in time. Mental health conditions frequently lead individuals and families into poverty and hinder economic development at the national level. A recent analysis estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to US$ 16 000 billion over the next 20 years (World Economic Forum (WEF), 2011).

Mental illness includes common conditions such as depression and anxiety, those due to abuse of alcohol and other substances and also sever and disabling disorders such as schizophrenia and bipolar disorder (WEF, 2011). According to Vic Health (2007), mental illness refers to a range of cogitative, emotional and behavioral disorders that interfere with lives and productivity of individuals. The impact of mental disorder varies based on the level of economic development of countries. The burden is high in developing countries as compared to the developed one. WHO (2003 p.2) report found that "Mental disorder accounts for nearly 12% of the global burden of the disease. By 2020 it will account for nearly 15% of disability adjusted life year lost to illness. The burden of mental disorder is maximal in young adults, the most productive section of the population. Developing countries are likely to see as disproportionately large increase in the burden attributable to mental disorder in coming decades".

Different types of psychiatric services have been developed in order to respond to the burden of mental disorder throughout the world. The development of psychiatric services has diverged markedly in developed and developing countries. During the nineteenth and early twentieth century, in developed countries psychiatric services become strongly centralized through a massive program of building psychiatric hospitals. These hospitals were usually cited outside towns and cities; they are enclosed worlds that isolated from the rest of the society and patients once admitted, were likely to remain for the rest of their life (Burtland, 2001). Twenty first century is a turning point in the history of mental health care centers in developed countries. Currently care of mental illness is radically reformed in many western countries, as institutional care is replaced with the care in the community (Morant, 2007).

The development of mental health services and service provision centers goes in opposite to developed counties for developing countries. As Bertland stated in developing countries few psychiatric hospitals were built by colonial powers, but these were often designated for their own personnel to the exclusion of the local population. With the ending of colonial rule, the psychiatric centers were taken over by the new governments, but they are catered to more than a tiny proportion of the population. According to Wig (1997) as cited in Burtland (2001), in India for example, there are only about 25,000 psychiatric beds for the population exceeding one billion.

As one of the developing country in the world, Ethiopia has very few mental health service provision centers. Geferssa Mental Health Rehabilitation Center (GMHRC) is the only psychiatric facility besides Amanuel Hospital that provides rehabilitation service for individuals with mental illness since its foundation. GMHRC has many interesting unique features that can be a lesson for other psychiatric service delivering hospitals and institution in the country.

Accordingly this research is highly interested in exploring the challenges and opportunities of GMHRC and to recommend ways how to maximize the opportunities and overcome the challenges.

Statement of the problem

Mental health is one of the major public health problems in the world. According to world health organization summit report, about 450 million people suffer from mental and behavioral disorder worldwide one person in four will develop one or more of these disorders during their life time. Neuropsychiatric conditions account for 13% of the total Disability Adjusted Life Years (DALYs) lost due to all disease and injuries in the world and are estimated to increase to 15% by the year 2020 (WHO, 2004).

Mental health care has simply not received the level of visibility, commitment and resource that is warranted by the magnitude of mental health burden. According to Burtland (2001), more than 40% of the countries have no mental health policy and over 30% have no mental health program. It is only after the development of publication of world development report, disability adjusted life year for estimating the global burden of disease and other emerging scientific investigations, the burden of mental disorder come in to great public spear (WHO, 2001a). This shift in global attitude towards mental illness also leads to development of many scientific investigations. Parental mental illness effect on children, economic impact of mental health stigma and the role of families in treating mental illness are some of the major dimensions of mental illness that are currently highly researched.

Studies by Solominski (2010) on the effect of parental mental health disturbance on children, shows that parental mental health problem is a risk factor for range of maladaptive outcome among offspring's. Parental mental health appeared to have significant effects on offspring adult relationships, with offspring sometimes becoming romantically involved with individuals having similar mental health problems. In support of this the researcher also finds as

the lack of information and understanding of parental mental illness may lead to children blaming themselves for their parents' problem.

Scientific investigations (Marie, 2009 & Morrison, 2011) on the economic impact of mental health stigma didn't hide the impact of stigma on the economy of patients and their family as a whole. Mental health stigma has adverse effect on employment income and public allocate resources to mental health care. People had negative attitudes towards patients' mental illness and providing people to view merely passive an anti-stigma video does not have an impact on stigma (Marie, 2009). Stigma and discrimination doesn't stop at the public level it also goes to the professionals. The work of Morrison, on the attitude of nursing students on mentally ill found that students of nursing has initially negative view on the patient before taking psychiatric/mental health courses (Morrison, 2011).

Studies (Mphelane, 2006; Jubb & Shanley, 2002) on the role of family members in the rehabilitation process of the individuals with mental illness come up with different roles played by the family and factors that hinders the role played by family members in the rehabilitation of their family member with mental illness. Mphelane (2006) work on the role of families in treating relative with mental illness came up with four categories of supports. Physical supports which include functions such as ensuring the client had food, building shelter, supervising the client and taking medication and building good hygiene is the first category. The second category of support is psychosocial support. This category includes providing client with love and affection, entertainment and encouraging them to involve in group activities. Financial support is the third category of support. It ranges from providing many to buy tobacco, foods and clothes to paying insurance for them. The last category of support is developmental support which is more of concerning with helping individuals with mental disability to rehabilitate.

Different factors hinder the family from performing these roles. According to Jubb & Shanley (2002), there are three factors that militate against caregivers' contribution to the recovery of their family members. First, the utilization of traditional medical model in patient setting, which focuses on the individual, paying little attention to the family and the person's social environment took the lion share. The second most important factor that impedes the contribution of family members' involvement in treatment programs is failure of professionals to recognize the therapeutic benefits of family member involvement as care giver in treatment programs. Finally number of different health care professionals (with different professional backgrounds and attitudes towards perception of families during patient's hospitalization) result in families to feel isolated in terms of their dealing with professionals who can be separated and disjointed.

Researches on the impact of mental health impact on countries insures that the problem has been getting worth in developing countries like Ethiopia, where very limited psychiatric centers are on process which complicate the cost estimation of mental illness on national economy. The national mental health strategy of Ethiopia (2012/2013), state that in Ethiopia, mental illness is the leading non-communicable disorder in terms of burden. Indeed, in predominantly rural areas of Ethiopia, mental illness comprised 11% of the total burden of disease, with schizophrenia and depression included in the top ten most burdensome conditions, out-ranking HIV/AIDS

In our country very limited researches were conducted in this area. Among those currently two studies were conducted at the communal level and the other two at the institutional level. From the studies which conducted at the community level the work of Ababi (2008), focuses on the economic burden of schizophrenia and bipolar disorder in rural Ethiopia. Based

on the estimation of out of pocket medical expense made by families at the societal level, he found that the total direct cost of Ethiopia because of schizophrenia and bipolar disorder is approximately from $687, 390.69 to $3.23 million and from $39.1million to 113million respectively. Likewise the indirect cost of loss of annual cumulative working days due to care giving was approximately from $1.43million to 6.74million for schizophrenia and from $15million to $25million for bipolar disorder.

In the same study area like that of Ababi (2008), Butagira in rural Ethiopia, Alemayehu (2009), conducted a research on bipolar disorder in Rural Ethiopia. This research found that the burden of bipolar mental illness on caregivers includes economic constraints to emotional reactions to the illness, the stress of coping with disturbed behavior, disruption of household routines and restriction of social activities, in particular at the time of onset relapse.

In addition to research at the community level, researches were also conducted at the institutional level. One of these works was done by Galmessa (2005), on assessment of prevalence, determinants and effects of mental disorder among Haromaya university students. The finding of this research shows that the prevalence of mental illness among the university students is 19.3%.

The general review of literature on mental illness found no empirical research that has been done on identifying the challenges and prospects of mental health rehabilitation center in Ethiopia. Due to this the main aim this planned study is to fill this gap and to produce the first systematic evidence on challenges and prospects of GMHRC.

Objectives of the study

General objective: - the general objective of the study is to explore the challenges and prospects of GMHRC

Specific objective: - the following are the specific objective of the study

1. To explore opportunities for improvement of the GMHRC in service provision
2. To identify the challenges that the GMHRC faces while delivering services to clients
3. To assess the level of participation of family members in the rehab program
4. To assess the major strategies that used by the GMHRC to fight stigma and discrimination on clients

Research question

General research question: - what are the challenges and prospects of GMHRC?

Specific questions: -the specific research questions include the following

1. What are opportunities for GMHRC in order to improve its service delivery for individuals with mental health problem?
2. What are the main challenges that hinder the rehab program?
3. How do GMHRC fight stigma and discrimination on individuals with mental illness and their families?
4. How do GMHRC work in cooperation with family members to facilitate the rehabilitation of individuals with mental health problem?

Significance of the study

Mental illnesses are common in Ethiopia; they are associated with a high burden due to disability and mortality, they constitute important but largely unrecognized barriers to achieving the MDG's (FMOH, 2012). Although the extent of mental illness is increasing in Ethiopia the number of psychiatric centers is very limited. In addition, much remains to be learned about these centers, what problems they face, what opportunities they have for future and others. It is hoped that the findings of the study will

- Give insight into the situation
- Provide information to policy makers and social workers that enable them to work with mental health centers
- Assist authorities in GMHRC and Ministry of Health to intervene in identified challenges and to maximize strengths
- Provide information for future research

Definition of terms

Challenges: - A challenge is call to engage in a contest, fight, or competition: A challenge to a duel. It also refers to an act or statement of defiance; a call to confrontation advancement (The American Heritage Dictionary of English Language, 2009). However, in this investigation , it refers to different situations that hinders the center from achieving its mission of providing high quality and inclusive rehabilitation mental health care for both in and out-patients.

Mental illness: - disturbance of mood or thought that can affect behavior and distress the person or those around them, so the person has trouble functioning normally. They include

anxiety disorder, depression and schizophrenia (National mental health commission, 2012). For the purpose of my study, mental illness incorporates all pathologies that are prevalent in GMHRC. Pathologies which are prevalent in the center are; Schizophrenia, Depression, HIV + Schizophrenia, Epileptics, Mental retardation, Leprosy, Blindness + diabetes, Paralysis, Manic depression, TB, Gastritis, Autism, Behavior problems, Physical disabilities, Chronic schizophrenia, Bipolar disorder + schizophrenia, Mood disorder and Post psychotic depression.

Rehabilitation: - is a set of targeted intervention that is intended to prevent further complication or reduced disability that is associated with mental health problems (NSW Health Department, 2002). In my study, targeted innervations are restricted to only to services provided by the center in its inpatient and community based rehabilitation program. The type services which are delivered in the impatient rehabilitation program are food, shelter, clothing, medical treatment and counseling, vocational training (weaving, tailor, animal husbandry) and recreational service. In the case of community based rehab, there is weekly (every Thursday) home visiting activity by case team to our 24 clients discharged after rehabilitation from Geferssa.

Opportunities: - refers to favorable or advantageous circumstances or combination of circumstances and a chance for progress or advancement (The American Heritage Dictionary of English Language, 2009). In my study, opportunities refer to different circumstances, situations or conditions which are favorable and can be utilized by GMHRC for attainment of its mission in the rehabilitation program.

Chapter Two

Literature review

The literature review sections have categorized under six sections. The first section deals with the historical development of mental health services throughout the world and it followed by the global socio-economic impact of mental illness. The third and fourth section deals with the historical development and socio-economic impact of mental disorder in Ethiopia. The fifth section is about the challenges and opportunities of mental health service and the final section is about review of models and frameworks which used to assess the prospects and challenges of mental health rehabilitation center.

Historical perspective of the development of mental health services

In order to gain an understanding of the origin of the current burden of mental illness and of the trends in care and treatment it is necessary to consider the history of the subject. This reveals both the reason for the failure of previous reform effort and the wide variation in the way services have evolved in developed and developing countries (World Health Organization (WHO), 2003).

According to different authors (Busfield, 1996; jones, 1996; Goodwin, 1997) as cited in WHO, " for centuries, religious or spiritual explanation have determined the way in which people with mental disorder have been treated in many societies. During the middle ages, people in European countries as having supernatural causes associated with demonic or divine possession. The early 17th c saw the rise of secular explanation of madness as a physical state. Increasing number of poor people with mental disorder were confined in public jails,

workhouses, poorhouses, general hospitals and private asylums across Europe and what is now North America between 1600 and 1700" (WHO, 2003, P.17).

The early medical explanation of madness did not encourage compassion or tolerance but implied that this impaired physical state was self-inflicted through an excess of passion, so justifying punishment. During the first part of 18th century the dominant view of mentally disturbed people as incurable sub humans was used to justify the poor living conditions and the use of physical restraints in places of confinement (Jones, 1996). The pressure for reform of these institutions coincided with the rise in humanitarian concerns in the 18th century, and many institutions introduce moral treatment programs (Breakeya, 1996).

The success of moral treatment led to the building of many asylums in European countries and USA. However, most of these large public institutions were unable to replicate the success of the dedicated pioneers of moral treatment. Financial constraints, large number of patients and the lack of cost effective alternative to moral therapy meant that these state mental hospitals quickly become custodial institutions (WHO, 2003).

Twentieth century marked as a turning point in the historical development of mental health rehabilitation center. The report of WHO (2003), found the following:

> After the Second World War the human right movement expanded and focused attention on gross violation of basic human rights, including violation against people with mental disorder. Research showed that mental asylums had little therapeutic impact and that they sometimes exacerbated mental disability. Internationally, there was an increased awareness of the poor living condition and inadequate treatment and care available in many asylums and of the necessity of governments to protect the rights of people with

> mental disorders. The discrediting of mental asylums on humanitarian grounded to the process of reducing the number of chronic patients in state mental hospitals, the downsizing and closing of some hospitals, and the development of community mental health services as alternatives, a process known as deinstitutionalization" (P. 18).

Several countries have witnessed a marked shift from hospital based to community based systems, leading to an important decrease in the number of mental hospital beds and in some cases, to the complete closure of psychiatric hospitals. In Italy the 1978 Mental Health Reform provides an illustration of this trend. Thus in Italy the psychiatric hospitals were closed and replaced by a wealth of community-based services providing medical care, psychosocial rehabilitation and treatment for acute episodes (WHO, 2003).

Protected housing and employment schemes were introduced so that people with mental disorders had greater opportunity for integration into the community. Among other cities around the world which have developed comprehensive mental health in the community are Melbourne in Australia, Santos and Rio Grande do Soul in Brazil, Lille in France, Siauliai in Lithuania, Asturias and Madrid in Spain, and London and Birmingham in the United Kingdom. However, deinstitutionalization is not merely the administrative discharge of patients. It is a complex process in which de institutionalization should led to the implementation of a network of alternatives outside mental hospitals. In many developed countries, unfortunately, deinstitutionalization was not accompanied by the development of appropriate community services (Thornicroft & Tanesella, 1999). It was often mistakenly believed that alternative forms of community treatment would be more cost-effective than the increasingly expensive custodial care of chronic inpatients, or that they would enable governments to spread the cost of treatment

to other role players (Breakey, 1996, c; Sharfstein, 1996; Goodwin, 1997) as cited in WHO (2003).

It has become increasingly clear that if adequate funding and human resources for the establishment of alternative community-based services do not accompany deinstitutionalization, people, with mental illness may have access fewer mental health services and existing services may be stretched beyond capacity. Recent reports from united USA indicate that services provisions is in state of disorganization because of budgetary constraints and confusion among key role players as to who is responsible for the funding and provision of community mental health services (Sharfstein & Freeman, 1996).

In many developing countries, mental health services of the western kind began when the state or colonial powers built mental health hospitals in the late 19th century or early 20th century. In general, mental hospital systems have provided less comprehensive population coverage in developing countries than in developed countries. Some developing countries have been able to upgrade their basic psychiatric hospital services and establish new psychiatric units in district general hospitals (Kilonzo & Simmons, 1998; Somasundaram, 1999; & Sidandi , 1999), or have integrated basic mental health services in to general health care by training primary care workers in mental health (Kilonzo & Simmons, 1998; Somasuandaram; 1999) as cited in WHO (2003). In most developing countries, however, psychiatric services are scarce, they cover a small proportion of the population and they face acute shortages of trained personnel and appropriate institutional facilities.

There are grounds for believing that the 21st century will see a significant improvement in the care of persons with mental disorders. Advances in the social sciences have given new

insights in to the social origins of mental disorder such as depression and anxiety. Developmental research is shedding light on the difficulties that arise from early childhood adversity and adult mental disorder (Brown & Harris, 1993; Kessler et al., 1997; Manughan & McMarthy, 1997) as cited in WHO (2001). Clinicians now have access to more effective psychotropic medication for range of mental disorders. Research has demonstrated the effectiveness of psychological and psychosocial interventions in hastening and sustaining recovery from common mental disorders such as depression and anxiety, as well as from chronic conditions such as schizophrenia (WHO, 2003).

Economic and social burden of mental disorder

According to different authors (Vaughan, 2003; Amanda, 2003; Sean, 2003; Scotuholmess, 2003 & Lawin, 2003) as cited in Ababi (2008), mental and behavioral disorders are the result of interaction of biological, psychological and social factors. "the facts are associated with the prevalence; major physical disease, and the family and the social environment. The development of mental disorder and caring for individuals with such disorder may result in socio-economic burden on individuals, families and communities" (Ababi, 2008, p.3).

The socio-economic burden of mental disorder is wide ranging, long lasting and large (Burtland, 2001). Examining the overall burden of mental disorder on sufferers, family and friends, employers and society is wide ranging (World Bank, 1993). The work of Ababi (2008), on Economic Burden of Schizophrenia and Bipolar Disorder in Ethiopia, states that on suffers, mental disorder has the cost of health care and treatment, reduced poverty as a result of work disability and lost earnings and other costs of anguish suffering, treatment side effects and

suicide. On family and other friends it has the cost of informal care giving, less productivity due to off work, and other costs of anguish, insolation and stigma. On employers it has the cost of contribution to treatment and care and low productivity of a worker with mental disorder. On society, it has the cost of provision of mental health and general medical medicine care, reduced productivity, and other costs of loss of lives, untreated illnesses with un met needs and exclusion (Ababi, 2008).

According to WHO (2003, p. 2) report, the total economic cost of mental disorder are substantial in both developed and developing country. In USA, for example, the annual direct costs were estimated to be US $ 148 billion, accounting for 2.5% of Gross National Product (GNP). The indirect costs attributed to mental disorder out weights the direct costs by two top six times in developed market economies, and are likely to account for even larger portion of the total treatment costs in developing countries, were the direct treatment costs tend to be low.

Measurable causes of economic burden includes health and social service needs lost employment and lost productivity, crime and public safety, pre-mature death and impact on families and care givers (Burtland, 2001). " In most countries families bear a significant portion of the economic costs because of the absence of publically funded comprehensive mental health service networks. Families also incurs social costs such as emotional burden of looking after disabled family member, diminished quality of life for care givers, social exclusion, stigmatization and loss of future opportunities for self-improvement" (WHO, 2003, P.2).

In light of these socio economic costs, mental disorder did not get proper recognition throughout the world. According to the work of Burtland (2001), currently in most nations of the world, mental health budget constitutes less than 1% of the total (public sector) health

expenditure. Especially in developing countries, nearly 28% countries do not have separated budget of mental health of the countries. Of the countries that have such budgets, 37% spend less than 1% of their health budget on mental health. General, expenditure on mental health amounts to under 1% health budget in 62% developing countries and 16% of developed countries (WHO, 2003).

Historical background of mental health service in Ethiopia

Before the opening of psychiatric nursing training in 1987, mental health treatment services were provided by Amanuel specialized psychiatric hospital, the only hospital in the country located at the capital city, Addis Ababa, of Ethiopia. Ethiopian Mental Health Strategy stated that here are very few mental health service, mental health professionals and mental health service providing sectors compared to the general population. The draft has also emphasized the need for developing community mental health care and psychosocial rehabilitation service for chronic mental ill patients (FMOH, 2007).

In fact recently the country has shown some visible improvements in the availability of mental health services. Mesfin (2009) reported that in addition to the only psychiatric hospital, mental health services are being given in five more hospitals in the capital city: St Paul Specialized Hospital, General Hospital, Zewditu Hospital, Yekatit 12 General Hospital, Armed Force General Hospital and Police force Hospital in Addis Ababa. Regional hospital such as Adama, Assela, Harar, Jima and Mekele hospital have also started to provide mental health services.

Under the guidance and sponsorship of the post first lady of Ethiopia, Ms. Azab Mesfin, the National Initiative for Mental Health in Ethiopia (NIMHE) was established in 2005 to guide

the overall development of national mental health in Ethiopia. In addition to providing high level advocacy and awareness regarding stigma of mental illness, NIMHE spearheaded the initiation and construction of the new GMHRC which is the state-of-the art facility (FMOH, 2012).

The mission of GMHRC is To provide a referent high quality and inclusive rehabilitation mental health care; to restore value and human dignity; to install hope and, to enhance quality life; in addition to restore functional, psycho-social and professional skills to people who are wounded in their human capacities because of mental disease; to compete against stigma and discrimination; to advocate in favor of the less privileged specially our clients by offering activities inside the center and getting opportunities through collaboration and partnership with other related social services, the Federal Ministry of Health , the churches for normal integration of clients in the society (unpublished document review of GMHRC).

The aim of rehabilitation mental health care is to promote recovery and to integrate the patients in to the society and to reinstall meaningful life in the community. People with persistent and severe mental problems are the target group of the rehabilitation center.

The Admission criteria of GMHRC includes seven major criterions, the admission should be always approved by the medical authority, Admitted clients should be free from severe acute psychic and somatic symptoms, The admitted patients should have a reasonable chance to go back to the society, Every client should be able to rely on family ties, The family has to commit itself through a written document to visit their relative at least once every two weeks, The maximum stay at GMHRC will not exceed 90 days (3 Months), the GMHRC is not able to admit minors (minors need guidance and care at the specialized centers) and An ID of a family member

is requested at the moment of admission of their relative (unpublished document review of GMHRC).

There are about above 95 workers employed in the rehabilitation center. Eleven of them are health professionals constituting psychiatry nurse, clinical nurses and social workers and they are part of rehabilitation team. Those professionals make decisions about the patients' needs to be admitted based on the admission criteria. There are no professional social workers and psychologist in the center except those who work with other professional background.

In the center total number of the individuals with mental illness are approximately 134 (Female 38 & M 96), in addition these patients, there are 24 out patients. Pathologies which are prevalent in the center are; Schizophrenia, Depression, HIV + Schizophrenia, Epileptics, Mental retardation, Leprosy, Blindness + diabetes, Paralysis, Manic depression, TB, Gastritis, Autism, Behavior problems, Physical disabilities, Chronic schizophrenia, Bipolar disorder + schizophrenia, Mood disorder and Post psychotic depression

In addition, there are clients with double diagnosis like Mental retardation plus autism or with epilepsy or with psychosis, schizophrenia and epilepsy, Bipolar disorder and schizoaffective, schizophrenia and depression disorder. Furthermore, a few clients have triple diagnosis and somatic problems like: HIV and schizophrenia and mood disorder, Psychotic disorder and schizophrenia and HIV, Diabetes and epilepsy and blindness and schizophrenia.

The two main programs of Geferssa rehab center are inpatient rehabilitation program and Community based rehabilitation program. The type services which are delivered in the impatient rehabilitation program are food, shelter, clothing, medical treatment and counseling, vocational training (weaving, tailor, animal husbandry) and recreational service. In the case of community

based rehab, there is weekly (every Thursday) home visiting activity by case team to our 24 clients discharged after rehabilitation from Geferssa.

Burden of Mental illness in Ethiopia

In Ethiopia, mental illness is the leading non-communicable disorder in terms of burden. Indeed in predominantly rural area of Ethiopia, mental illness comprises 11% of the total burden of disease, with schizophrenia and depression included in the top ten most burdensome conditions out-ranking HIV/AIDS. This statistics points out that mental illness have been overlooked as a major health priority in Ethiopia and underscore the need for public health program targeting mental illnesses (FMOH, 2012).

The economic effect of mental health is also tremendous in the country. The work of Ababi (2008, p.4) states that " total direct cost of Ethiopian society because of Schizophrenia and bipolar disorder is approximately between $687,390.69 to $3.23million and from $39.1 million to 113million respectively. Likewise the direct cost of loss annual cumulative working days due to care giving was approximately from $1.43million to 6.74 million for schizophrenia and bipolar disorder to families in Ethiopia ranging approximately between $2.12 million to $9.97million and from $45.5million to 128.5million respectively".

In addition to the direct costs the disability associated with mental illness in Ethiopia is high: where people are already struggling for survival, the catastrophic impact of a chronic and disabling illness on the person and their family can be well-appreciated. The lack of mental health services or any kind of financial support for families who have member with mental illness are the biggest factors causing caregivers burden in Ethiopia. Stigma, discrimination and

human rights abuses a apart of the daily lived experiences of the mentally ill and their families in Ethiopia (FMOH, 2012).

Challenges and opportunities of mental health service

Challenges

Establishing effective mental health systems faces many challenges. A common issue is ensuring the transfer of care from mental hospitals to the community; the many obstacles include political considerations, stigmatization and the absence of community services (WHO, 2005). How to organize and finance mental health services is also an issue for most countries .Because of the significant disruption to social functioning caused by mental illnesses, cooperation is essential between private and public sectors such as education, housing, employment, criminal justice, media, social welfare and women's affairs (WHO, 2001).

Securing an adequate and affordable supply of psychotropic drugs is a major concern for many mental health systems. Similarly, most parts of the world are experiencing a critical shortage of trained professionals. Services are lacking for people with specialized needs, such as children, refugees and older persons, as well as those who have substance use disorders, particularly in rural areas. Services for linguistic and cultural minorities and indigenous people in many societies are often inadequate or inappropriate (WHO, 2001).

Most people who need and could potentially benefit greatly from services are not getting them. Even in developed countries with well-resourced health services, less than half those people who need treatment and care receive it. The following are the discussion on major challenges that universally experienced:

Stigmatization and human right violations*:* - Stigmatization and violations of human rights represent a sizeable, albeit hidden, burden of mental illness. Around the world, many mental health patients still receive outmoded and inhumane care in large psychiatric hospitals or asylums, which are often in poor condition because of stigma (WHO, 2001). The report of WHO on the impact of stigma on mental illness, states that mental illness has often been seen as untreatable, and mentally ill individuals are labeled as violent and dangerous. People with alcohol and substance dependence are considered morally and psychologically weak. The media perpetuate these negative characterizations. Stigmatization often leaves persons suffering from mental illness rejected by friends, relatives, neighbors and employers, leading to aggravated feelings of rejection, loneliness and demoralization (WHO, 2001).

Besides contributing to endemic stigmatization and discrimination of the mentally ill these failings have led to a wide range of human rights violations. According to Baldwin & Marcus (2011), the stigma, myths, misconceptions surrounding mental illness and negative feelings created on individuals with mental disability because of them are the root causes of much of the discrimination and human right violations. People with mental illness often experience human right violations in their daily lives in the community with responsibilities handed to the guardian who make decisions about place of residence, movements, personal and financial affairs and medical treatment (Drew, 2001 & WHO, 2005).

One of human right violations that are universally experienced by people with mental illness is lack of access to proper judicial mechanisms. WHO (2005), found that people with mental disability lack access to proper judicial mechanisms to protect their rights. This means that their fundamental rights such as the right to exercise legal capacity and the right to be free from, inhuman and degrading treatment and punishment continue to be violated arbitrarily and

with impunity. People with mental disability also often experience restriction in the right to work, to obtain an education, to participate in politics, as well as to marry and found family. In Bulgaria, for example, people with mental disability may not adopt or foster children, and in the Russian federation, they may not file for divorce, may lose custody of their children and in Hungary, people under guardianship are also denied the right to vote, that contribute to the political marginalization, disenfranchisement and invisibility of people with disability (Human right watch, 2012).

In majority of countries, particularly in Lower and Middle Income Countries (LMICs), people with mental disability and their family members are not able to actively participate on decision making process on issues affecting them. This is in contrast to issues such as HIV/AIDS and physical disability (Funk, Minoletti, Drew, Taylor & Saraceno, 2006). This failure can in part be explained by the lack organizations of people with mental disability in many parts of the world especially in developing countries. However the assumption that people with disability lack the capacity to make meaning full contribution to society due to their mental illness is also a significant barrier to their participation in decision making process (Michelle, Natalie & Martin, 2012).

Socio-economic factors*:* -Socioeconomic factors influence mental health in powerful and complex ways. Poverty and poverty-related conditions such as unemployment, low educational level, deprivation and homelessness are widespread not only in poor countries, but also affect a sizeable minority of the rich countries. Data from cross-national surveys in Brazil, Chile, India, and Zimbabwe show that common mental disorders are about twice as frequent among the poor as among the rich (Patel et al., 1999) as cited in Alemayehu (2009) . According tom WHO (2003), especially poverty is highly correlated with an increase in

the prevalence of serious disorders such as schizophrenia, major depression, antisocial personality disorders and substance use. Most of mental health disorders are about twice as common among the poorest sections of society as in the richer ones. For example, In the USA, children from the poorest families were reported to be at increased risk of disorders in the ratio of 2:1 for behavioral disorders and 3:1 for comorbid conditions (Costello, 1996).

Concerning the relationship between poverty and psychiatric disorder WHO (2003) found that the relationship between poverty and high prevalence rates of psychiatric disorders can be explained in two ways, which are not mutually exclusive and which appear to be operative for different disorders. First, poor people in most societies, even among the wealthiest countries, are exposed to greater levels (quality and quantity) of environmental and psychological adversity, which produces high levels of stress and psychological distress (p. 19). More over people living in poverty are often unable to access treatment or have to spend high proportion of their income on treatment, exacerbating their already precarious financial position (Saxena, Thornicroft, Knappe & Whiteford, 2007).

The second explanation for the relationship between poverty and high prevalence rates of psychiatric disorders refers to that people with a mental illness incurring much greater risks for homelessness, unemployment and social isolation that can result in poor living condition. While families remain the key providers of care in most parts of the world, the strain of providing care over time can lead to people with severe mental illness being rejected by their families (WHO, 2003). In addition to that family members may also have to set aside time to provide care and support, diminishing caregiver's opportunity to work, in turn affecting their income, pension and insurance entitlements, thus further increasing the risk of poverty. The economic effect there for

extend beyond the individual with mental illness to significantly impact the household income (Maglino, McDaid, Kirkwood, & Berzins, 2007).

According to a study conducted in Uganda, people with mental disorder are exposed to poverty than other people in three ways. First of all if employed, their illness may result in more sick days or reduced productivity, intern reducing income, pension or health insurance coverage. Secondly, someone with the history of untreated mental illness will not had the same opportunities as other peoples to accumulate human capital (i.e general and specific skill) that allow them to be competitive when searching for working and applying for promotion. Finally, discrimination which is particularly strong for mental disorder, may systematically deny people many work opportunities (Ssebunnay, Klgozi, Lund, Kizza & Okello, 2012).

Urbanization is also the socio-economic factor that is associated with an increase in mental disorders. Urbanization increases the risk of homelessness, poverty and exposure to environmental adversities such as pollution. It also disrupts established patterns of family life, leading to reduced social support (Desjarlais, 1995). In developing countries, urbanization has accompanied economic development, the emergence of formal market economies and rapid industrialization. Government policies do not necessarily promote urbanization but governments can intervene through legislation and policies to improve the housing environment and living conditions of urban populations (WHO, 2003).

Homelessness is a risk for and a result of mental disorders. People living in poor housing conditions are more likely to complain of psychological distress and have a higher prevalence of mental disorders than other people (Sullivan , 2000; & Kamieniecki, 2001). Housing-related legislation and national housing policies which reduce homelessness and

raise the quality and availability of housing stock in a country may have a positive effect on the prevalence of mental disorders.

In Ethiopia, according to FMOH, scarcity of budget and other resources, lack of alternative services, stigma and abuse of mentally ill persons, poor implementation and use of available research evidences and lack of evidence base for evaluating health service developments were analyzed as a threat for development of psychiatric services (FMOH, 2012).

Opportunities

Global health reform trends as an opportunity for mental health service*:* - Health sector reforms (decentralization and health finance reforms) provide a number of opportunities for mental health services. Decentralization is the transfer of responsibility for health service provision from central to local government structures (Cassel, 1995) and Health finance reforms have largely been driven by a desire to improve access to health care, advance equity in health service provision and promote the use of cost-effective technologies in order to obtain the best possible health outcomes for populations (WHO, 2003). It includes changes in revenue collection, involving the concept of pooling, and reforms in the purchasing of health services. Accordingly in a rational decision-making process the obvious burden of mental health and the availability of effective interventions should lead to an increased provision of financial and human resources for promotion, prevention, treatment and rehabilitation in the field of mental health. A reforming health system provides the opportunity to redirect available resources towards mental health even in circumstances where the total health resources are constant (WHO, 2003).

Health sector reforms also provide an opportunity to integrate mental health services into general health care, especially at the primary care level. Integration with primary care increases the possibility of universal coverage (including mental health) without a substantial increase in financial and administrative inputs. Integrated care helps to reduce the stigma associated with seeking help from stand-alone mental health services (WHO, 2003).

In low-income countries with acute shortages of mental health professionals the delivery of mental health services through general health care is the most viable strategy for increasing access to mental health care in underserved populations. As noted above, mental disorders and physical health problems are very closely associated. People with common mental disorders such as depression and anxiety often present with somatic symptoms to general primary care services. An integrated service encourages the early identification and treatment of such disorders and thus reduces disability. Among other possible benefits are the provisions of care in the community and opportunities for community involvement in care (WHO, 2003).

In the case of our country specifically, political commitment, improved infrastructure, expanding health sector, and decentralization were taken as an opportunity for the development of psychiatric services (FMOH, 2012).

Review of models of mental disability

There are two broad models which guides the treatment of the individuals with mental illness. These are the medical and the social model:

Medical model

Historically the medical model of disability dominated the western world throughout early 20th c. This model locates virtually all aspects disability within the clinical/medical framework by solely focusing on the individual's body. It especially concentrates attention on what is different about or wrong with the body of the disabled person, and the way that their body functions (IS International, 2012).

Through the medical model disability is understood as an individual problem; it is seen as the condition of the people who have difficulties arising as the result of their impairments. If somebody has impairment, for example, their inability to see, walk or accumulate human capital is understood as their disability (Scotland's National Disability Information Service, 2012).

According to Carson (2009), typical definitions based on this restricted perception of are historically offered by WHO in 1980. Based on this definition, impairment refers to any loss or abnormality of psychological or anatomical structure or function; disability refers to restriction or lack, resulting from an impairment of ability to perform any activity in the range considered "normal" depending on age, sex, social and cultural factors for individuals.

These definitions of health condition were criticized by many authors for focusing only on individual factors and neglecting environmental and social factors. Barnes (2012), found three drawbacks for this definition. First it relays exclusively on individualistic medical definitions and

bio-physical assumptions of normality; but for (Abberly,1993 & Davis, 1995), as cited in Barnes(2012) normality is a continuous concept influenced by various historical, cultural and situational forces. Second impairment is defined as a cause of both disability and handicap. Although handicap, or social disadvantage, is presented as a natural and invisible consequence of either impairments or disability, this is difficult to sustain, many impairments do not inhibit an individual physical or intellectual capability. For example, short stature, hair loss, and skin blemishes has no impact on individual inelegancy. This example assures that what is disability is historically, socially and culturally variable. Finally this approach places people with an acute or accredited impairment in a dependent position. Their condition is individualized and marginalized and therefore assumes that they are reliant up on professional experts and others to provide therapeutic and social support.

Carrison (2009), also points that the medical model of disability, also affect the way disabled people think about themselves. Many disabled people internalize the negative message that all disabled people problem stem from not having normal bodies that lead disabled to believe that their impairments automatically present them from taking part in social activities.

People with disability have generally rejected this mode. They say it has led to their low self -stem, underdeveloped life skill, poor education and high unemployment level. Above all they have recognized that the medical model requires the breaking of natural relationship with their family's communities and the larger society (British Dyslexia Association, 2007). This is the reason why an alternative social model was developed by the initiation of people with disability.

Social model

During 1960's newly formed groups of disabled people started to challenge the way in which they were treated and regarded with in the society. The detain opportunities, the restriction on the choice, self-determination and the lack of control over the support system in their lives lead them to question the assumptions underlying the traditional dominance of medical model (Carson, 2009).

Carson, further points that through the social model, disability is understood as an unequal relationship with in a society which the needs of people with disability are often given little or no consideration. The idea that people with impairments disabled by the fact that they are excluded from participation with in the main stream of society as a result of physical organizational and attitudinal barriers. For Morris (2000 p.3), "the social model of disability gives us the words to describe our inequality. It separates out (disabling barriers) from impairment because the social model separates out disabling barriers and impairments, it enable us to focus on exactly what it is which denies us our human and civil right action to be taken.

Social model definition where first proposed by the Union of the Physically Impaired against Segregation (UPIAS) in 1976. Accordingly impairments refers to lacking part or all of the limbs, or having a defective limb, organ or metabolism of the body & disability refers to the disadvantage or restriction of activities caused by a contemporary social organization which takes little or no accounts of people who have physical impairments and those excludes them from participation in the main stream of social activities.

According to the definitions cited above, social construction of physically impaired people as "disabled" arises in the first instances from the specific ways in which society

organizes its basic material activities (work, transport, leisure, domestic activities and so forth). Impairment is simply a bodily state characterized by malfunctioning of the physical and cognitive activities of the individual as a result of altered physiological or psychology which defines physicality of certain people (Lang, 2009).

Lang (2009), further points that the central tent of social model is that, irrespective of the political, economic and religious characterictis of society in which they live, disabled people are subject to oppression and negative social attitudes, that inevitable undermine their personhood and their status as a full citizen.

Language through social model lens: - Language powerfully shapes the sense of self by influencing how people describe themselves and are described by others (Slade, 2009). Language also shapes possibilities, and promotes positivity and strengths more generally. It also helps people to break with the past, transform the present and usher in the future they wish to see. Social paradigms increasingly advocate the adoption of such "people-first" language description as: "Person who are expert by training" or "people with lived experience" , "people with mental illness" rather than description that focus on deficits or relationship to services such as : "clients", "service users", or "patients" ' this terms may also apply to family members, parents and friends (Deegan, 2003).

Conclusion

It is increasingly evident that mental health problems are a major public health burden. In the last five years, the world has become more aware of this enormous burden and the tremendous potential for mental health gains (European Commission, 2004).

The prior response for mental health problems were result in the building of general psychiatric hospital hospitals and private asylums throughout the world especially in the west based on the medical model of treating mental health disorder. The rise of humanitarian concerns during 18th c and advances in the social sciences have given new insights in to a social model because research has demonstrated the effectiveness of psychosocial and psychological intervention in sustain recovery from common mental disorder such as depression and anxiety and even from chronic mental disorder such as schizophrenia (WHO, 2003).

Ethiopia has long history of mental illness but recent history in building psychiatric centers to treat individuals with mental disorder. According to FMOH (2012), GMHRC is the only rehabilitation center in Ethiopia that works with the community and family members to facilitate the rehabilitation of individuals with mental illness.

Chapter Three

Research Methodology

Research design

Qualitative research design was used to explore the prospects and challenges of GMHRC. Concerning the time dimension of the research, data collection for the study was done from March 2014 to May 2014, which makes the research cross sectional. The rationale behind the selection of qualitative research design rests on three grounds. The first ground is the nature of the research problem. According to Creswell (2008), qualitative research design is a means for exploring and understanding the meaning individuals and groups ascribe to the social or human problem. When detail description is needed to define and analyze human experience, qualitative research would be the right choice for the study (Marvast, 2004). The second rational behind the selection of the design is my personal background. I did not conduct any quantitative or mixed research before but I have experience in inquiring some qualitative projects.

Finally the third most important things that shaped the selection of qualitative research design is my philosophical world view. World views refer to a basic set of beliefs that guide action (Lincoln & Guba, 2000; Mertens, 1998) as cited in Creswell (2008). Although the philosophical ideas remain largely hidden in research, they still influence the practice of the research and need to be identified. My world view that influenced the selection of the qualitative research design is advocacy or participatory world view. Inquirers guided by this philosophy felt that the constructivist stance did not go far enough in advocating for action agenda to help the marginalized people. An advocacy/ participatory world view holds that research inquiry needs to

be intertwined with politics and a political agenda and these assumption holds true more for qualitative research than others (Croswell, 2008).

Description of the study site

GMHRC is geographically located in the Oromiya regional state. It was initially managed by the Social and Labor Bureau of the Oromia Region. In 2005 the National Initiative for Mental Health in Ethiopia (NIMHE), headed by the former first lady Azeb Mesfin, made an agreement with the Social and Labor Bureau to take over the facilities, to build and improve the standards of mental health care in Ethiopia with a vision of making Gefersa a center of Excellence.

In order to provide advocacy and awareness regarding the stigma of mental illness, NIMHE organized with Salini about the construction of the center. In May 2010, after the inauguration of the center, NIMHE decided to hand over the property and its new facilities to the Federal Ministry of Health (FMOH)

At the end, FMOH had asked the Ethiopian Catholic Bishops' Conference to provide professional management for GMHRC. It is in this context that Brothers of Charity as Congregation were contacted and took over the Management of the Center. An operational agreement of this private – public partnership was then signed on 7th December 2011.

Strategy of inquiry

Among qualitative design approaches to inquiry my study employed case study strategy of inquiry. A qualitative case study is an approach to research that facilitates exploration of the phenomenon with in its context using variety of data sources (Baxter & Jack, 2008). The rationales behind I used the case study approach is that, case study helps to uncover the realities

of contemporary complex social phenomena while retaining the holistic and meaningful characterictics of real life events. That is case studies are appropriate if and when the research is concerned with uncovering contextual factors in phenomena and when boundaries are not clearly between the phenomena and the context (Yin, 2003). The concern of this research fits in this description in that it is difficult to look for the case of challenges and prospects of the center without considering the context of the center in which these prospects and challenges were created. Without considering the contexts such as the organization of the staff, building of the center, the political situation, the nature and back ground of family and individuals with mental illness in the center; it is difficult to understand the phenomena of challenges and prospects of the center. This reality makes qualitative case study strategy of enquiry best approach for this research.

Determining the case/ unit of analysis: - Determining the case of a study can be a challenge for both novice and seasoned researchers (Baxter & Jack, 2008). According Miles & Huberman (1994), a case is defined as a phenomenon of some sort occurring in a bounded context. Accordingly my case is GMHRC.

Binding the case/ scope of the case: -"Once you have determined what your case will be; you will have to consider what your case will not be. One of the common pitfalls associated with case study is that there is a tendency for researchers to attempt to answer a question that is too broad or a topic that has too many objectives for one study" (Baxter & Jack, 2008). In order avoid such problems several authors (Yin, 2003, Stake, 1995 & Creswell, 2003) suggested that placing boundaries in case prevents such explosions from occurring. According to Creswell (2003), a case should be bounded by place and time in order to limit the scope of the case and thereby it can be feasible for investigation. My study on challenges and prospects of

GMHRC in its rehabilitation program interested in examining the case from the time 2010, were the center established as a center of excellence up to 2014.

Determining the type of case study*:* - The selection of specific type of case study is guided by the overall purpose of the study. Based on the purpose of the study, the type of case study that used is explanatory case study, this is because, exploratory case studies used to explore situations in which the intervention being evaluated has no clear, single set of out-comes (Yin, 2003). Since the study is done in a unique context of the Geferssa, and data were collected from different units in the center (family members, rehabilitated members and staffs); the case become single case with embedded units.

Sampling: - To achieve the objectives of the research participants were selected in collaboration with GMHRC from staffs, rehabilitated members of the center and individuals with mental illness. The selection of rehabilitated members of the centers was specially recommended by both the medical and social department concerning their current health status. Accordingly in depth interview with 5 staff members (one female and four male), with five family members (tree female and two male) and with six rehabilitated members (two female and four males) was done. Totally in depth was done with 16 individuals. In addition to in-depth interview two consecutive FGD were conducted with rehabilitated clients of the center. The first FGD was with five rehabilitated male clients of the center and the second FGD was with two female and three male totals five members. Finals key informant interview was conducted with two government officials from FMOH. In general all participants involved in the study were 28 in number.

Since the enquiry is qualitative the findings of this investigation cannot be generalized because the sample is not representative. The only thing that determined the size of the sample is the saturation of information that gained from the participants of the study.

Data collection procedure

Before engaging in data collection activity, I made sure that necessary pre-conditions were met. Agreement from the center was gained before interview and focus group discussion, and observation were started. Letter of request from Addis Ababa University was sent to GMHRC and given to delegated manager of the center and after discussion with concerning body the center permitted me to collect the necessary data that I want. The center also provided me with one safe room to interview and discuss with participants.

The first data collection task was observation. First of all I carried out an extensive observation about the situation of the center, patients, caregivers and the staff members to have an overall picture of the status of the rehabilitation program based on the observation checklist. The observation is not one time task due to this I took notes based on what I have observed each day throughout the whole process of data collection and analysis.

Secondly, just after the initial observation, I started to collect data through document review, interview and FGDs. Document reviews of the center does not include the financial documents and files of the individuals with mental illness in the center. This is because I am restricted by the center in order not to access such documents. Even though such limitations are observed the information which I got through review of different reports and broachers of the center provided me with an overview of the center, its intentions and the contextual factors in play. After completion of in-depth interview and FGD with participants; concerning the overall

situation of the center I gathered information through key informant interview with officials from FMOH.

The final stage is closure after the end of data collection and analysis. Like the day I started collection of data in the center, meeting was made after end of data collection with the delegated manager of the center.

Instruments of data collection

To conduct the research, data were collected from both primary and secondary sources trough in-depth interview, key-informant interview, observation, FGD and document review. This is because qualitative case study is an approach to research that facilitates exploration of the phenomenon with in its context using verity of sources (Baxter & Jack, 2008). In order to gather the primary information, interview (in depth interview & key informant interview), Focus Group Desiccation (FGD) and direct observations were used with in the center. Whereas to collect secondary information document review was used.

Interview*:* - In-depth interview was done with staff members, family members and rehabilitated members, whereas, key informant interview was conducted with government officials in FMOH. An interview guide for staff members, rehabilitated individuals, government officials and family members were developed before collecting the data. Interview guides were prepared in English and translated to Amharic and then translated back to English in order to avoid miss of meanings in the process of translation. Checkup of translation also involved professional peoples to improve the accuracy. The interviews employed open ended questions that allowed the researchers to probe further on the responses and get more details on each issue. During the interviews tape recorder was used. I recorded the information of the respondents in

order not lose important information. Note taking of both the responses to the questions and facial/ non-verbal information was also conducted.

FGDs*:* - two consecutive FGDs were conducted with rehabilitated members of the center. Like that of interview questions, open ended questions were prepared as a discussion guideline for rehabilitated member was prepared before the discussion. Two continuative FGDs were conducted in order make possible comparison of data from both discussions.

Observation: - Observation was done after getting consent from the organization. Observation of the services which has been delivered by the rehab center to patients (food, shelter, play grounds, recreational centers and outreach services) was guided by the observation checklist. During the period of direct observation notes were taken on the points in the observation. While in the process of observation, care givers of the patients were not informed about the observation in order to avoid deliberate actions and to be free from biases. According to Krueger and Newman (2006), if those being observed know the true purpose, they would modify their behavior which will make it impossible to learn from the situation.

Document review: - Reviews of secondary sources were useful before conducting the field of study. As a result attempt was made to review some materials related to the rehab center functions such as broachers, publications, books, reports, journals, manuals and guidelines. This helped to have some background on the issue understudy and to strength the primary sources.

Plan of data analysis

According to Marriem (1998) qualitative data analysis is a complex process that involves moving back and forth between concrete bits of data and abstract concepts, between inductive and deductive reasoning and between description and interpretation. In qualitative research

analysis begins while collecting the data (Kreuger & Neuman, 2006). So the analysis was done simultaneously with data gathering.

Since the objective of the study is to explore the prospects and challenges of GMHRC, thematic analysis which according to Cough and Medill (2007) as cited in Temesgen (2010), focuses on the coding of qualitative data, producing cluster of texts with similar meaning often searching for the central theme and capturing the essence of the phenomenon under investigation was used. The collected data transcribed verbatim from in-depth interview, FGD and key informant interview. After the transcription, coding and thematic development procedure was followed which was the most commonly used method of analytic procedure in qualitative research (Croswell, 2007). Therefore in order to develop code labels, I read each transcribed data repeatedly and listing the record session to construct meaning and synthesis and condensed them to themes. This enabled me to search for meanings that can serve as a ground for broader conceptualization. In line with this memo writing was made since it enabled to document thoughts and ideas of the researcher (Yin, 2003). As texts are fractured into meaning units, transcripts will be replaced by the resulting code as a focus of analysis. This was done in relation with and referring to the research question and literature review since it helped for reframing and re contextualizing (Creswell 2007).

Analysis of data that was collected through document also followed the same procedure. The researcher defined codes and began to develop his own themes to put the data into categories to help him analyze and sort and the data. So in order to analyze critically and interpret the findings, case analysis was applied in line with the findings from the direct observation, documents and interviews.

The researcher's role in the investigation

In qualitative research, the role of the researcher as a primary data collection instrument necessitates the identification of personal value, assumptions and biases at the outset of the study. According to Creswell(2008), "good qualitative research contains comments by the researcher about how their interpretation of the finding is shaped by their background such as gender, culture, history, and socio-economic origin" (P. 192). Accordingly my perception and interpretation of GMHRC is shaped by my personal experience. I got BA in sociology from University of Gondar in 2001. After graduation, from 2001-2004 for three consecutive years I used to work in rural Ethiopia (Oyda Woreda of Gamo Goffa Zone which in South Ethiopia Nations Nationality and Peoples (SENNAP)) as manager of the one government sector in which I got my first experience in leadership until I joined Masters of Social Work (MSW) in Addis Ababa University. My admission to health concentration especially what I have learned in the course mental illness as mental health is neglected sector in Ethiopia shaped my interpretation of the findings of my study.

Measures taken to ensure trustworthiness of the research

I took different measures to ensure both the internal and external accuracy of my study. Measures taken to internal trustworthiness or credibility of the study include:

Triangulation of the data: - data collected through in depth interview, key informant interview, FGDs, observations and document analysis were triangulated before interpretively understanding the findings. According to Baxter & Jack (2008), the collection and comparison of data collected from different sources enhances data quality based on the principle of idea convergence and the confirmation of findings.

Member checking: - after themes were developed, in the course of analysis participants of the research allowed to check for the meaning and thereby to make changes if they believe that something is wrong with the theme. Baxter & Jack (2008), as the data are collected and analyzed, researchers should integrate member checking, were participants have the opportunities to discuss and clarify the interpretation and contribute new additional perspective on the issues under study.

Peer examination: - peer review of the procedure that I employed during my study was done by classmates who employed qualitative research design with special employment of case study approach or research strategy.

Clarification of the researcher's bias: - I wrote on the section called the role of the researcher about my background that shaped my interpretation of the study.

Different measures were also taken to ensure external trustworthiness or credibility of the study. These measures include:

Provision of reach, thick, detailed description of the setting*:* -According to Merriam (1988), as described in Creswell (2008) provision of detail description of the setting helps every one interested in transferability with solid framework for comparability. Accordingly based on the information from different sources, I tried to make detail description of the setting as much as I can.

Ethical considerations

Conducting a research is a complex process. According to Hesse-Bieber & Leaver (2006) as mentioned in Creswell (2008), in addition to conceptualizing the writing process, researchers

need to anticipate the ethical issues that may arise during their studies. The work of Israel & Hay (2006) found that during the research conducting process it is expected from the researcher to protect their research participants, develop a trust with them; promote the integrity of the research; guard misconduct and impropriety that might reflect on the organizations or institutions and cop with the new, challenging problems. Due to this in my study different actions were taken in different stages of the research process such as in identifying the research problem, setting objectives and goals, data collection stage, analysis and interpretation and finally in writing and dismantling the research end product.

According to Punch (2005), during the identification of the research problem, it is important to identify the problem that would be benefit individuals being studied. To ensure this, in the process of identifying the research problem, first I went to the field to look for the role of GMHRC in reducing the burden on family members; however after prolonged observation of the study area, it was believed that it would be better and benefit the participants if the study would be conducted in identifying the prospects and challenges of the center rather than exploring the role of the families in the rehabilitation program of the center.

After assurance was reached in identifying the research problem that would benefit the participants, data collection stage is also the most important stage in which ethical issues emerge. As Creswell (2008) mentioned during the data collection researchers need to respect the participants and the sits for research. To overcome ethical dilemmas in this stage different measures have been taken. First of all before going to the field to collect the data, my last draft proposal was given and reviewed by the Addis Ababa University, school of social work and each phase was checked by my Advisor. This is to assess and manage the potential risk that can cause harm to participants. After the approval of my proposal informed consent was taken from all

participants. Participants of the study were briefed about the purpose of the research and were asked about for their informed consent to involve in the study. Participants were assured that all the information they provide remained confidential. Respondents were also informed about that they are free to withdraw, to change their ideas, to edit their recorded or quoted ideas and the records will be destroyed after the study completed. According to Kruger and Neuman (2006), researchers should respect participant's right to privacy and take responsible stapes to ensure that their records are not available to others who are not authorized to have access. To assure that the respondents were participated voluntarily, a written consent which accommodates all the above issue was signed so that they were protected from participating involuntarily.

Special recognition was also provided for the selection of rehabilitated members of the center. Their selection was supported by professionals from both medical and social work department in the center. In addition consent form was taken from both the center and the rehabilitated members. Finally to ensure that the research sites were undisturbed after the completion of study, prolonged observation before collecting data was made in order to understand the nature of the center and interviews and FGDs were also made in secured open class in the site.

The other important stage in research where ethical dilemmas raised is the analyses and interpretation stage. Here the issue of anonymity is the core issue. Accordingly to protect the anonymity of individuals and their position pseudonyms were employed and clearly included in the last secession consent of informed consent form. To came up with accurate data triangulation of data from different sources was made.

Finally in writing and disseminating stage care was taken in order not to use discriminatory words such as mentally disordered people or patients, and subjects of the research, the word individuals with mental illness and participants of the study was used respectively from the social model of disability point of view. In order to minimize the influence of the researcher on the final finding and to reduce the potential of suppressing, falsifying or inventing findings to meet the researchers need as much as possible proactive stance was taken by the researcher. In addition, in order not to miss use the results of the study to the advantage of one group or the researcher only, consensus was reached between the researcher and GMHRC on the point that the center will be offered by the copy of the thesis just after defense.

Limitation of the study

One the major limitation of the study is that available secondary information in the center was not fully reviewed. Especially information related to files of the individual with mental illness and financial documents. This is because the center restricted me through legal letter in order not to access such information. In addition to this, like other findings of qualitative research the findings of this research cannot be generalized for other mental health settings.

Chapter Three

Findings of the study

The following are findings of the center which are grounded in data collected from the different instruments of data collection (observation, FGD, interview and document review). The findings are categorized under the challenges that hinder effective service delivery of the center and the opportunities for future advancement of the center.

Socio-demographic characterics of participants

The socio-demographic characterics of all participants of the research (in depth interview, and FGDs) of the study is summarized in table as follows:

Table-1 socio-demographic characterics of participants

Socio-demographic variables	Category	Number
Sex	Male	19
	Female	9
Marital status	Single	19
	Married	7
	Divorced	2
	Other	-
Religion	Orthodox Christian	24
	Muslim	2
	Protestant	2
	Others	-
Level of education	Illiterate	-
	Primary	12
	Secondary	5
	12 & above	11

According to the table above, majority of the participants of the study are male, 19 of the total 28 participants were male and the reset 9 were female of the whole participants. Since the

sampling strategy employed by the researcher is purposive, no effort was done to make equal representation of both sexes except the care taken to achieve the purpose of the study.

Concerning the marital states of participates, 19 of the total 28 participants were single before and after their admission to the center. 7 participants were married before their entry to the center and the rest 2 were divorced manly because of complications related to mental illness. This finding goes with the finding of Human Right Watch (2006), that in many countries of the world people with mental illness often experience restriction in the right to marry and found family.

As to the educational status of the respondents, nearly half of them (12) of the participants have attended primary school education, while none of them reported to be illiterate. Those who attended secondary education and above are above half of the total participants (15).

Finally the religious affiliation of the participants is dominated by Orthodox Christian and followed by equal proportion of both Muslim and Protestant. Orthodox Christianity followers from the center were 19 of all participants and the rest 8 were belongs to both Muslims and Protestant.

Range of services provided by GMHRC

Since its establishment in 2010, GMHRC, has been providing different services for admitted member of the center and their family members. The rehabilitation services were generally delivered under the umbrella of two broad programs. The first broad program is the in-patient rehabilitation program and the second one is community based rehabilitation program.

Under the in-patient rehabilitation program services like shelter, food, clothing, dormitory, recreational, medication and counseling services were provided to admitted individuals of the center with mental illness. In addition to this training on IGA's such as agriculture, tailoring, weaving and animal husbandry has been provided for in-patients. Some members are also currently involved in production of outputs on what they are trained for.

In community based rehabilitation, services like medication, and psychotherapy for the individual with lived experience of mental illness and psycho education for family members has been provided by the center. Currently there are 24 individuals with lived experience of mental illness with in the community under the control of family members that are supported by GMHRC. The multi-disciplinary team of the center, that composed of professionals from both medical and social department, visits these 24 individuals each two month and provide the services that listed above with field visit that has been conducted once a week.

Challenges of the GMHRC

In these category five themes (stigma and discrimination, poverty, absence of systems to manage violence inside the center, problem of communication between the management and workers and scarcity of social work and psychology professionals), were developed.

Stigma and discrimination: - Stigma and discrimination is one of the most persistent them throughout the study that impedes the activities of the center. Data from four out of five staff interviews, from nine out of ten discussants and from all interviewee of rehabilitated members go in line with this issue. The discrimination patients came from both the wider community and the family members themselves. One of the discussant informed the following when he asked about his relationship with his family members:

> I do have family members in Addis and in abroad (America and England), however, none of them are concerned about my problem; none of them visited me since 1994 (the time I admitted to GMHRC) for twelve consecutive years. I know they have no any economic problem on them to do so; their only problem is their thought as I am useless.

Interview with staff members also put the avoidance and negligence of the family members at the core of challenges that hinders the rehabilitation program of the center. One respondent from staff members noted that:

> The greatest negligence on our clients came from family members of the client. I called for many family members to take their relative in our center back to home after the multi – disciplinary team decided that the member has to be discharged, however except very few family members most of family members are not volunteer even to talk about their relative and sometimes deny their relationship with their relative with mental illness by saying I don't know about the person you are taking about. The center has no system to deal with such cases except allowing the admitted members with mental health problem to continue living in the center.

According to the regulation of the center, when one patient admitted to the center, the family members sign contract with the center for three months with probability of extension up to three months. The existence of familiars follow ups for the rehabilitation of the center are also taken as the criterion for admission. However, most of the family members were failed to do so after admission. Due to this some clients are forced to stay at the center for more than two decades, an action that limits the chance of others patients to get the service from the center.

Because of prolonged stay at the center some clients started to develop a sense of looking the center as a residence rather than rehabilitation center. For instance one informant from the rehabilitated members of the center talked this when he asked about how long he stayed at GMHRC "I had entered the center in 1981Ec. It has been 25 years since I was admitted to the center. I don't know what life looks like out of this center, this place is my everything because my families and all my relatives forgot me and I also did the same; in general this center is my world".

The total number patients who were discharged from the center and treated as an out-patient are the best evidence for the stigma and discrimination on individuals with mental health problem. Currently there are only 24 patients who were re-united with their family and treated as an out-patient by the center; this is a very small number as compared to the total 137 admitted individuals with mental health problem in the center, that can be taken as evidence for the challenge of rehabilitation in the center. One family member of the patient responded like this during an in-depth interview. "I am the sister of patient, I see changes in the life of my brother because of the support from the center through medication and counseling service but I think it would be better if he got the chance to re-join the center once again".

Other three family members also expressed the same wish. Wrong perception about individuals with mental illness by the family members and larger community found to be the core reason behind discrimination and stigmatization. Individuals with mental illness are not seen as the human beings or seen as sub humans by the most community and family members. This attitudinal problem is reflected by the names given by these community members. Accordingly names like "ibdi", "nik" (to mean mad and abnormal) and others were given to patients. One mother of the patient told me that

> Ones an individual got mad what you are going to do except waiting for almighty intervention? My son can't do what other do, does not participate in social relationships and income generating activity. Sometime when he gets better we let him to do activities like baying something from the shop, but owners of the shop do not provide services for him because they take him as incapable to do so. My son, these things make his rehabilitation more complicated.

The findings from in-depth interview with staff members of the center also go in line with what I got from family and individuals with mental disability concerning causes of stigma and discrimination. Once the individuals with mental illness are admitted to the center, except very few most of the family members do not came to visit and provide emotional support to the clients in the center. These trends of the family members end up in making the rehabilitation of patients problematic and complicated. According to the response of staff members, some family members totally ignored their relationship and agreement as family member when they requested by the center to take their relative back to the home after contract for the rehabilitation come to an end. I am highly impressed by the answer given by one staff member who works in multi-disciplinary team concerning the discharge of patients after maximum stay at the center:

> I tried to call many family members to take their relative with mental illness back to home after the end of three month contract. However except few family member most of them tell me that they can't do that. This is the main reason that limits the capacity of the center to serve more individuals with mental illness problem because the center is occupied by many individuals that have to discharged. For your surprise many of the clients that you hear stayed for more than twenty years in GMHRC.

Poverty: - In addition to problems related to wrong perception about individuals with mental illness; the study also found low socio-economic background of the patients as a challenge that hampers the reunification process of the center. Some family members have nothing to pay for medication and other costs of the client if they were ready to take rehabilitated patients back to home. As an interview with members of multi –disciplinary team shows, sometimes discharge become an activity of sending the client back to worst condition that can easily result in relapse of the illness. One staff member from the centers said during an interview that:

> Some family members have nothing to feed the patients after discharge, to pay for medication and in some cases nobody among family members is found to take responsibility given whole day, this is because all members of the family have to work to insure their existence, to pay for what they eat, house rent and other social costs. It is also very difficult for families with in poverty to hire guardian while they go to work station. These conditions some time make rehabilitation of patients very complicated because the center fell in dilemma between serving as a residence for clients versus serving as a rehabilitation center.

The information from in-depth interview with family members shows that the reason behind their reluctance to take their family member is because of fear of high economic cost (both direct and indirect) that they spent on their relative with mental illness and stigma on them and their family member with mental illness by the larger community. For instance, the mother of daughter with mental illness said that:

> My daughter was at good health status when she joined as from the center, however here illness relapsed immediately after she joined us because our home not comfortable to rehabilitate here like that of the center. Due to this now we took her to "tsebel" (a place where spiritual remedy was given for different physical, mental and social problems through the help of holly water). In order to secure here stay at center were spiritual remedy has been given; we spent more than two thousand birr for overall cost (house rent, food and care giver) each month. We are doing this because we have no any other choice. If she did not get well quickly, I'm Sure that we will be forced to take her back to home because of the huge cost" to sustain here stay nearby tsebel.

Absence of system to manage violence inside the center: - As mentioned in the description of the center, one criterion for individuals with mental illness to be admitted to the center is the fact that they are not individuals with acute mental health problems. Due to this most patients in the center are not at the tough level of illness and with the ability to partially control their action if proper medication and counseling is offered. The problem in the center is that when individuals with mental disability participate in violent activity on each other and on others, professionally reviewed method for controlling such actions was not developed in the center. As I observed, some patients usually fight each other in the midday with in the center. In addition to this there is tangible evidence about the existence of the crime of abduction and homosexuality (especially gay) in the center. An in-depth with staffs, and individuals with mental disorder as well as FGD with patients supports this theme. Three of the stuff members among five confirms that girls are abducted by boys, in the center and no preventive as well as corrective measures were taken in the center. One of the participants from the staff members stated that:

> Men usually abduct and rape girls who are unable to protect themselves; it has been also accomplished on girls who are conscious enough by cooperative force of three to four men special in weekend. I reported the case of homosexuality and abduction many times to the center in management discussions; however, corrective measures were not taken yet. Before some years when one participate in violence activities measures like torturing the violent for limited time and other related punishments was used to be taken. Due to this there is respect for workers by the individuals with mental illness and except few with sever problem most patients were with good discipline. However things were change now, because the mechanism what was used is banned because such actions were believed by the management of the center as they are violating human rights of the client. But personally I can't agree with what was done by the center because which is the worst torching or rape? For me the second is more worst and crime than the second.

A result from two consecutive FGDs with rehabilitated member ensures that absence of system to manage violent actions is a big threat for the center. Concerning lawlessness in the center one of the discussant explained that " some years a go there is mutual respect between workers and clients because proper measures were taken on patients but now as you see at this time even over there, fighting among us is common".

Communication problem between the management and the workers: - As I described earlier in the section description of the center, after the control of the center was taken from ORSLAB and given FMOH, the management of the center was given to brothers of charity since 2014. Brothers are an international NGO whose action is guided by the principles of catholic religion, & communicate in English language, however others staffs communicate with Amharic. These created difficulty in communication between the management and other workers. As one

informant the situation “there is a communication gap between the administrative body and workers and everything is boring because we need to communicate through translation”.

Discussion with discussants, in two of the FGDs comes up with the challenge that there is a birch between the workers and the management especially because of communication problem. The problem may not work for few educated workers who are able to communicate in English; however the majority faces such problems.

Limited attention for the psychosocial and spiritual rehabilitation: - There are very few professional in the center when the center was under the umbrella of ORSLAB, but after the control moved to Ministry of Health there is increment in the number of patients. There are currently 97 workers in the center, among them 11 were professionals (3 psychiatric nurses & 8 clinical nurses). As it is evident from the above data there are no professional social workers and psychologists in the center. In addition workers are pointing that there is no within work training for workers until this year which demotivated the workers. One informant from staff members told me that “I have worked in this center for more than six years; I am not working in the place where my profession is required but where my experience is needed. In addition I did not got any training in this position yet; there is no change in position either demotion or promotion what silly is that!”

Generally in addition to the above themes problems related with budgeting is raised as the needs of the center that has to be properly addressed. Up to the last few months there is a department to control only the entry of material including finance but not for performance auditing of both material and human resources. Since I am restricted by the center in order not get documents related to finance and files of the client, I couldn’t succeed in supporting

this information (that I got through primary data collection methods, interview, observation and FGD) with secondary document analysis.

Opportunities of the center

Opportunities were picked up from the entire data collection process through analyzing and giving meaning to the entire information gathered by different instruments of the data collection. Finally the following themes are identified as the opportunities that can be utilized to maximize effectiveness and efficiency in service delivery of the center

Networking clients with IGAs: - Economic rehabilitation is the most important component of holistic rehabilitation that helps to promote and maximize mental rehabilitation of individual with mental illness since poverty is both the cause and effect of mental illness. To facilitate economic rehabilitation; the center strives to network the rehabilitated members with IGAs outside the center. Currently six clients of the center work outside the center with in different fabrics. The workers paid from three to five hundred Ethiopian birr per month. Having access to food and shelter in the center, getting something to save has great advantage for employees since it hits one of the major root causes of their illness.

Due to this activity of the center tangible changes are coming in the life of the clients. Information which I gathered through qualitative instruments go in line with this point. One of the participant in the IGAs outside GMHRC said this when asked to tell about the impact of IGA in his life " after the last two years, I have seeing changes in my life, because of my engagement in daily work of candy fabric for monthly salary of 500 birr. Before this I also participate in tailoring activity in the center, but it has no business like this. I think this is not enough payment for us as you compered the what is needed to live especially at this time but it has a special

meaning for us because we communicate with outsiders, tend to save what we gain and start think about life outside of this center".

The fabrics that agreed with the center in order to hire rehabilitated members of the voluntary corporates to hire individuals with mental illness are three in number. Due to this the numbers of individuals working are small in number (one civil servant and five daily workers). The contract is also with tree months of duration which too short to see that did not result in tremendous change in the life of the employee; however still this activity of the center can be taken as a huge march towards rehabilitation of the clients.

March to di-institutionalization: -Out-patient therapy through organized multi-disciplinary team is an emerging activity that shows the march of the center towards di-institutionalization. Currently twenty four clients of the center joined their family after discharge from the center. An in-depth interview with staff members and key-informant interview with individuals in deferent position and document review confirms that outpatient service is the best way in which the family members and the center works together to facilitate the rehabilitation process.

Political commitment: -There is clear commitment for improving mental health care and increasing coverage at the highest governmental level. For the first time, a mental health strategy that lasts for three years (2012/13-2015/16) was adopted with the goal of addressing the mental health needs of all Ethiopians through quality, culturally competent, evidence based, equitable and cost effective care. The strategy is also acquainted with core principles that are recommended by WHO; such as accessibility, protection of human right, efficiency and sustainability, and community involvement. In addition to this Mental Health Technical Working

Group has been organized under the Health Promotion and Disease Prevention Directorate of the Federal Ministry of Health. Various forums have and will be organized to share this strategy, pulling together key stakeholders such as the Regional Health Bureaus, including policy makers, program managers from relevant areas such as FMOH's Medical Directorate and PFSA, communication experts, and experts from community and health systems. These activities are planned to ensure buy-in and commitment during the implementation phase (FMOH, 2012).

After the incorporation of the center under FMOH, there is tremendous improvement in infrastructure, budgeting and human resource supply. Currently the center has 190 beds, there also additional vacant huge vacant space for future expansion in infrastructure (27 hectare). The annual budget of the center also rose from below five million when it is under ORSLAB to 10 million currently. There is also increment in number of professionals from less than five before for years to 11 now days. These changes in the center can be taken as an opportunity for the future development of the center.

Chapter Four

Discussion

The study was exploratory in nature and it has provided some insights about the current situation of GMHRC and the challenges and opportunities in the activity of rehabilitating patients. This part discusses the major findings obtained during interviews and FGDs, with staff members, family members and rehabilitated members of the center and observations made by the researcher.

Poverty at the root of socio economic problems

Socio-economic problems such as homelessness, low level of education, unemployment and poverty as a whole are the root causes for keeping most rehabilitated members for more than a decade in the center. Poverty in the root of socio-economic factors challenged the rehabilitation and re-unification of the member with mental illness in two ways of the center.

First of all rehabilitated members are reluctant to leave the center because of fear of the harsh living condition out of the center (unemployment, housing problem, and other related problems). Some few have no family members for support, while the majority of individuals with mental illness in the center have family members out of the center; however they are not willing to support the re-unification of the center because of absolute poverty. In addition to this more than 95% of people with intellectual disability in the center have no history of participating in income generating activities that can support them when they start to live out of the center with community and family members. Due to poverty related socio economic factors such as very low or absence of employment opportunities outside the center and even employed low productivity because of illness, low level of education, lack of participation in IGAs with in the

center for many years and fear of discrimination outside center are the driving factors that forces individuals with mental illness in GMHRC to choose living in the center up to death as the only choice. This finding is similar to the finding of studies in Uganda, which states that lack of accumulated human capital; reduced productivity and discrimination which is particularly strong for mental disorder which deny people with mental illness many work opportunities are the tree ways in which people with mental disorder are exposed to poverty than other people (Scebunnya, Klgozi, Lund, Kizza & Okello, 2009).

Secondly family members for the majority of individuals with mental disorder in the center are not willing to accept the reunification program of the center after rehabilitation because of extreme poverty. Most family members of the individual with mental disability have nothing or insufficient income to cover medical cost, house rent, costs of food and other emergency costs. Due to this reason they oppose to accept the rehabilitated patient and even some times to deny the relationship with the individual with mental illness.

Due to this two broad problems created on both individuals with mental disability and their family members because of poverty and related socio-economic factors, the centers program of rehabilitation and re-unification of rehabilitated members of the center with their family members is highly hampered. In the history of the center only 22 rehabilitated members reunified with their family from the total 137 members which is 14.5%. Though the reunification of these individuals can be taken as an eye break and milestone activity towards de-institutionalization, it still needs massive activity in creating IGAs for reunited individuals through networking the reunified individuals with volunteer fabrics. Skill trainings that has been given to individuals with mental illness in tailoring, farming and other activities in the center has to be diversified and maximized in order to meet the need of individuals with mental illness.

Human right violations as a challenge for the center

GMHRC used to take measures of torture as a punishment when individuals with mental illness in the center participate in violence and criminal activities, though; currently the center took measures to stop torture as a punishment for violence and criminal activity that was committed by admitted individuals with mental illness by the center. Admitted individuals when commit crimes were not currently tortured, however appropriate measures were not replaced torture by the center.

There are studies that explain the basic reason behind violation of basic rights of people with intellectual disability. One of the prominent investigation conducted by Beldwin & Marcus (2011) states that the stigma, myths and misconceptions surrounding mental illness are the root causes of much of the discrimination and human right violations experienced by people with mental illness on daily bases. The case of GMHRC is different in that in addition to the violation of human right emanate from outsiders on the individuals with mental illness in the center, human rights are also violated by the admitted members with intellectual disability on themselves. There is no study that explains the violence of individuals with mental illness on individuals with mental illness with in the rehabilitation center.

Some of the violations on individuals with mental disability by individuals with mental disability are forced sex on females by males and homosexuality. The report of WHO (2005), states that people with mental health often experience human right violations in their daily life in the institutions with responsibility handed to caregivers and professionals who make decisions about place of residence, movements, personal and financial affairs and medical treatment concerning individuals with mental health disability. In addition to being violation of human

right what make unique this activities in the center that they are crimes according to the law of the country.

Income generation for rehabilitated members as prospect

Admitted individuals in the center participate in different vocational activities such as weaving, tailor, animal husbandry with in the center. However most of these activities which performed in the center do not create income for the inpatients. Currently the center started to network in patients with good rehabilitation record with volunteer fabrics outside the center and succeed in finding job opportunity for only six members of the center out of 137 admitted individuals with mental illness. From the figure above it is possible to conclude that unemployment is rampant in the center specially among individuals with mental disorder. This finding goes with the work of Harnois & Gabriel (2000) which states that mental illness is associated with high rate of unemployment, leading individuals in to economic poverty and depriving them of social networks & status within the community.

The basic reason behind these small connections between individuals with mental illness and IGAs is that number of corroborations which are volunteer to participate some individuals from GMHRC is very small. Currently there are only 3 institutions were agreed for such agenda of the center. A number of studies (Stuart, 2006; McDaid, 2005; Bigges, 2010 & McDaid, 2008) as cited in Michelk, Natalie & Martin (2012), indicated that there high rate of reluctance of employers to hire people with mental disability.

IGAs for individuals with mental illness are initially signed for maximum of three month with very few possibility of extension. The amount of income which the employees earn from the work is also very small it ranges from 300 for female employees to 500 for males. According

to Michelk, Natalie & Martin (2012), when people with mental disorder are able access employment opportunities, they often earn less than the rest of the population. WHO's survey on mental health shows that respondents with serious mental illness earned on average a third less than median earning, with no significance between country difference. These losses are equivalent to 0.3 to 0.8% of total nation earning.

Given these all realities the movement of the center towards securing economic retaliation of the individuals with mental illness can be taken as a prospect to achieve its goals and objectives.

Chapter Five

Conclusion and Implications

Conclusion

In developing countries like Ethiopia there are limited researches in the area of mental health because of hindering factors related to socio-economic growth level of the country. Given this difficulties however some researches had been conducted at the community and institutional level. This thesis on the prospects and needs of GMHRC is also part of the overall investigations done in the areas of mental health. GMHRC is the only mental health rehabilitation center in the country and psychiatric facility in addition to Amanuel Hospital. Since its establishment as a formal rehabilitation center in the country it has been performing both inpatient and outpatient services for people with mental health problem. In the inpatient service activities like medical treatment, psychosocial therapy and vocational training and others like food, shelter, recreational etc and in outpatient services psycho education for family members, psychotherapy medical treatment for the outpatient has been performed.

This qualitative investigation, amid at exploring the prospects and challenges of the center, based on interviewing and discussing with 26 participates who were selected based on the purpose of the study from staff members, family members and rehabilitated members of the center. The study has three focus areas. These are identifying needs and problems of the center, prospects and strategies used by the centers to deliver services to individuals with mental illness.

Concerning the needs of the center five themes were developed during data analysis. These are stigma and discrimination, poverty and related socio-economic factors like low homelessness, un-employment, and others, violation of human rights inside the center and

absence of organized system to manage such systems, scarcity of professionals from social fields like psychology and social work, and problem of communication between the management body and other staffs because of language barrier.

The second focus area of the center is identifying opportunities for future growth of the center. Accordingly three opportunities were identified. The first one is creating employment opportunities for individuals with mental illness. This activity of the GMHRC can be taken as a milestone towards economic rehabilitation which is in core of eradicating poverty and open a way for holistic rehabilitation of the center. The second opportunity identified is the movement of the center provision of outpatient service which padded the way for de-institutionalization. Providing mental health services in closed world of hospitals is an outdated approach towards treating mental health. Therefore this out-patient service of the center provides an opportunity for individuals with mental health problem not to be far from the community. The final case that identified as an opportunity for the center is the political commitment by current government to wards mental health issues.

The third area of focus for the research is exploring and identifying strategies that are utilized by the center. Here the research identified that the center broadly relies on two strategies in fighting mental health problems. These are rehabilitative strategy for inpatients and community outreach. While the former is restoring mentally ill individual to its normal position where as the second strategy is promoting and sustain normality of the rehabilitated individual with connecting him to IGAs and other services.

Implications

Based on the findings of the research and documents reviewed on the issues, implication of the findings for social work intervention and education, policy implications and implications for GMHRC were identified.

Implication for social work intervention: - there are many areas in which social workers can intervene based on the findings of the research. One of the major roles of social workers is connecting clients with available possible resources within the environment. Accordingly social workers can intervene in searching, identifying and connecting clients with IGAs inside the center and out of the center based on assessing the need and assets each individual client has. There are some activities of providing training on tailoring, dairy and weaving with in center. This activity has to be based on assessment of individual's needs and strengths. Therefore social workers can participate in assessing the needs and assets of each individual and diversifying the training areas based on the finding of each individual assessment.

Social workers can participate in promoting public campaign to fight stigma and discrimination on individuals with mental illness and their families. This is because the participation of the community in designing and implementation of health care services is both cost effective and best means in fighting stigma and discrimination. Stigma can't stop by intervening on only clients and their families. Therefore, social workers can play the role of community outreach worker in the center in order to minimize the stigma and discrimination on patients.

Finally the psychosocial and spiritual rehabilitation of patients has not given proper recognition. This is highly reflected on the fact that there are no professional social workers and

psychologists(clinical and counseling) with in the center, there for through the utilization of bio psychosocial and spiritual model of intervention, social workers can intervene fulfilling the psychosocial and spiritual need of individuals with mental illness with in the center.

Implication for social work education: - currently more research concern is given to the experience of individuals with mental health problems and little has been done in understanding the current situation of mental health rehabilitation centers in Ethiopia. Therefore, social workers need to involve in research and inquiry that help to understand the current situation of mental health rehabilitation center in the country. Strategies of diversifying and utilizing the opportunities of such center and minimizing the challenges have to be integrated to the teaching process of social work courses of health streams.

Implication for GMHRC: - one of the challenges in the finding session is absence of system to control violence like the rape and homosexuality inside the center. To minimize such problems the center can establish independent committee that monitors and take corrective action to cases related to human right violations. In addition active follow up of the situation of the center especially during weekend can also be taken as an alternative way to minimize such violations.

The other challenge that identified by the study is huge amount clients who are rehabilitated as the same time living in the center for more than decades. This is completely different from the aim of the center because the aim of rehabilitation mental health care is to promote recovery and to integrate the individual with mental illness into the society and to reinstall meaningful life in the community rather than serving as a residence for individuals with mental health problem. This challenge imply for the center that, parallel to rehabilitation of new

entries with mental health problem, the activity of searching family ties, and re-integrating specially those who stayed too long with in the center should get proper recognition.

Connecting rehabilitated members with IGA's is a milestone towards economic rehabilitation however it is not enough. Continuous support during the episodes of illness has to be added. People with severe mental illness performs paid work with ongoing support and training resulting in higher employment rates, better wages, more hours of employment per month and better health compared to people who receive only pre-vocational training. There for, in collaboration with concerning bodies including FMOH the center can establish system in which admitted members of the center can get financial support especially during the time of relapse of mental illness.

Building interactive and communicative environment among the workers and between workers and the management is essential to achieve the mission of the center. The cause for the problem of communication especially between the management and most of the workers is language barrier. There for, GMHRC can minimize such problems by taking actions like bringing individuals with good performance and capability of communicating with English at the unit leading position thereby they can serve as a mediator between the worker and the management.

Proper attention for psychosocial and spiritual rehabilitation of the client has to be given by the center. To do so the center need to take measures (planning and hiring) professionals form social fields which deals with the rehabilitation of individuals with mental illness especially social work and psychology. If the first option is not successful, creating an access for short term trainings concerning psychosocial and spiritual rehabilitation of individuals with mental health problem can be the taken as an alternative.

Implications for policy makers: - To provide a financial safety net to employed people with mental illness and their family (particularly during the episode of illness), government should add an article in the national mental health strategy of the country which deals with such issues and strive for its implementation. In addition to that one of the great problems for the reluctance of rehabilitated clients to be integrated with outside community is housing problem. This factor highly contributed for the infancy of di-institutionalization in the center, there for to overcome such problem, the national housing policy of the country should take measures to promote mental health by diving priority for housing for persons with long-standing disorder, particularly housings geared towards their needs.

Reference

Ababi Zergaw. (2008).*Economic burden of schizophrenia and bipolar disorder in rural Ethiopia*. Addis Ababa University. Ethiopia

Alemayehu Glemessa .(2005).*Assessment of prevalence, determinants and effects of mental disorder among Haromaya University students*. Addis Ababa University

Alemayehu Negash. (2009). *Bipolar disorder in rural Ethiopia*. Sweden Umea press

Atalay Alem.(1997). Mentality health in rural Ethiopia: Studies on mental distress, suicidal behavior, and use of khat and alcohol. Umea university medical dissertation. From the department of clinical science. Division of psychiatry. Sweden

Baldwin, M.L., & Marcus, S.C.(2011).Stigma discrimination and employment outcomes among Persons' with mental disability. New York

Barnes, C.(2012).The Rutledge of handbook of disability studies: the social model of disability. London. LGS press

Baxter, P., & Jack, S.(2008).Qualitative case study methods: Study design and implementation for novice researcher. *The qualitative report*.13(4), 544-559. Retrieved from http://www.nova.edu/ssss/QR/QR13-4/baxter.pdf

Brown, G.W., & Harris, T.O.(1993).A etiology of anxiety and depressive disorder in an inner city Population. Psychological medicine, 23(1): 143-54

Burtland, H.G.(2001).*mental health: a call for action by world health ministers*. Geneva Switzerland. Avenue appia 20 press.

Carson, G.(2009).*Social model of disability*. Scotland. TSO publisher

Cassels, A. (1995). Health sector reform: key issues in less developed countries. *Journal of International Development*,7 329-47.

Common Wealth of Australia.(2013). *A national framework for recovery oriented mental health service: policy and theory*. Australia, ISBN press.

Costello, E.J. (1996). The Great Smoky Mountains study of youth: *goals design, methods, and the prevalence and the prevalence of DSM-III-R disorders* *Archives of General Psychiatry* 53: 1129-1136.

Creswell, J.W. (2003). Research design: Qualitative, quantitative and mixed method approaches (2nd ed.). Thousand Oaks. Sage publication

Creswell, J. W. (2007).*Qualitative inquiry and research design (2nd ed.) thousand oaks*. Seg publication Inc.

Deegan, G.(2003).*Discovering recovery, Psychiatric Rehabilitation Journal*, 26(4), 368-376.

Desjarlais. (1995*). World mental health: problems and priorities in low income countries*. New York: Oxford University Press Inc.

Funk, M; Saraceno, B; & Drew, N.(2005).Global perspective on mental health policy

Human Right Watch.(2012). *"I want to be citizens just like any other", barriers to political participation of people in Hungary*. ST press

IS International staff.(2012).Disability in UK. Retrieved from http//: www.internationalstaff.ac.UK

Isreal, M., & Hay, I. (2006).Research ethics for social scientists: Between ethical conduct and regular compliance. London: sage.

Jones, L.(1996). George ill and change views of theses on the effect of mental health education on reducing stigma and increasing positive attitude towards seeking therapy madness: mental health matters. London. Macmillan open University press

Jubb, M., & Shanley, E.(2002).Family involvement: the key to opening locked wards and closed minds. *International Journal of Mental Health Nursing*, 11(59), pp. 47-53.

Kreuger, L.& Neumann, L. (2006). Social Work research Method quantitative and qualitative applications, persons and educated. Inc.

Lang, R.(2009).*The development critique of the social model of disability*. Overseas development groups. University of east Angelia .

Marrison, R. (2011). Thesis on nursing student's attitude towards people with mental illness: Do

they change after institutional and clinical exposure?. Florida University of south Florida press

McLeod, S.A.(2008). The medical model. Retrieved from http://www.simplypsychology.org/medical-model.html

Mesfin Araya, Mamuye Mussie, & Jacobson, L. (2009). Decentralized psychiatric nursing service in Ethiopia-A model for low income countries. Ethiopian medical journal. Ethiopia

Miles, M.B., & Humberman, A.M.(1994).Qualitative data analysis: An expanded source book(2nd ed.). Thousand Oaks, CA: Sage publication

Morant, N. (1995).What is mental illness? Social representations of mental illness among British and French mental health professionals. *Papers on social representations*,4 (1).

Mphelane, L. M. (2006). *Thesis on the role played by the family in support of their mentally ill relative in a rural community in the Limpopo province.* South Africa. Sauth Africa University press

New Zealand Mental Health Commission.(2001). *Recovery competencies for New Zealand mental health workers*. New, Wellington

Rosaland, C & Posy, M.(2009*). Attitudes towards mental disorder (students from collague of William and mary)*. Washington DC

Saxena, S; Thornicrofti, G; Knapp, M & Whiteford, H.(2007).*Resource for mental health : scarcity, inequity, & inefficiency*. Lancet press

Slade, M.(2009). Rethink recovery series, 100 ways to support recovery: A guide for mental health professional, London

Sharfstein, S.S.(1996). The political and social context of modern community psychiatry. integrating mental services. New York: Oxford University Press inc

solominski, J. (2010). The effect of parental mental illness on children. University of Michigan. USA

Ssebunnaya, J., Klgozi, F., Lund, C., Kizza, D., & Okello, E.(2009).Stakeholders perception of mental health stigma and poverty in Uganda. BMC Int Health Human Rights. Kampala

Victorian Department of Health. (2011*). Recovery-oriented practice: literature review*. State government of Victoria. Melbourne press

Queensland Mental Health Association.(2009).*The road to recovery-a history of mental health services in Queensland 1859-2009*.

pp. 41-52. Retrieved from http://www.psr.jku.at/PSR1995/4_1995Moran.pdf

Punch, K.F. (2005). Introduction to social research : qualitative and quantitative approachs (2nd ed). London. Sage

World Bank.(1993). *World development report: investing in health*. New York: Oxford University press inc

World Health Organization.(2001a).*Mental health resource in the world*. Geneva Swaziland

World Health Organization.(2004).Summit report on mental health. Geneva Swaziland

World Health Organization.(2005).*World health organization resource book on mental health, human right and legislations. Stop exclusion and, dare to care*. Geneva.

World Health Organization. (2001b).*Mental health: A call for action by world health ministries*. Geneva.

World Health Organization.(2003).*Mental health policy and service guidance package: mental health context*. Geneva, Switzerland. Ch-1211 press

World Economic Forum.(2011).*The global economic burden of non-communicable diseases*. Geneva

Yin, K.R.(2003).*Case study Research: Design and Methods*. Sage publication. California

Annexes

Annex -1

Informed consent form

Dear respondent: - My name is Yitebarek Hizekeal. I am from the Graduate School of Social Work at Addis Ababa University. I am currently collecting data for my Thesis project entitled "challenges and opportunities of GMHRC in its Rehab program". The aim of this research is to explore the challenges and prospects of GMHRC and to indicate implication for different stockholders based on the findings of the study.

The participants of the study will be staff members who work in the center, rehabilitated clients and family members of the clients. The respondents should be 18 years, communicate with either Amharic or English and have some willing to participate in the study.

I will do one to one interview. During this process, I would like to assure you that your identity will not disclosed to anyone. This is to protect your privacy and confidentiality of the information you provide. I will use tape recorder to avoid wastage of information and to correctly handle the conversation we did and finally after completion of research the notes and records will be destroyed.

Respondents have the right to not respond to some questions that they are note clear with or quitting participation at all if they are not comfortable with. However, in other cases the respondents honest and right answers to questions are very essential to achieve the objective of the research.

By signing this form, I agree to participate in this research, under the provided conditions

Name of the respondent (pseudonym) ----------

Date----------

Signature----------

If you have any doubt or questions in the process of inquiry you can use the following address to contact me

Mobile Number: - +251 936 993 306

Email: - yitbarekhizekeal@yahoo.com

Thank you for your time!

Annex -2

Focus group discussion guide for rehabilitated beneficiaries of GMHRC

1. ***Socio-demographic feature of the discussants***

   Name_____

   Age_____

   religion_____

   Ethnicity_____

   Marital status_____

   Educational level_____

2. ***Would you tell me the reason why you interred to this center?***

   Proving question

   - When did you join the center?
   - Did you checked in any other institution before you joined the center?

3. ***What are the services provided for you in the center?***

   Proving question

   - Is the support is cash or kind?
   - Is there psychotherapy?
   - Do you have any recreational centers in the campus of GMHRC?
   - Did you participate in income generating activity?

4. ***Tell me about your relationship with your family members***

   Proving question

   - How often your family members visit you?

- Do you think that the support that you got from your family members is enough? If your answer is yes or no why?

5. ***What do you think are the improvements/ strength of the center?***

   Proving question

   - What are the positive changes you observed in nutrition, treatment, recreation and income generating activities?
   - What do you think should be done to sustain the community such strengths?

6. ***What are the challenges for you in this center?***

   Proving question

   - What do you think are the remedies for such challenges?

7. ***Is there anything else that you can add?***

   Thank you!

Annex-3

Amharic version of in-depth interview guideline for rehabilitated patients in GMHRC

በገፈርሳ አዕምሮ ጤና ማገገም ማዕከል ካገገሙ ህሙማን ጋር ቃለ-መጠይቅ ለማድረግ የተዘጋጁ ነጥቦች

1. ***የታካሚዉ ጠቅላላ ገጽታ***

ስም ----------

ዕድሜ ----------

ፆታ ----------

የጋብቻ ሁኔታ ----------

የትምህርት ሁኔታ ----------

ብሄር ----------

ሐይማኖት ----------

2. ***እዚህ ማዕ በምን ምክንያት እንደገባችሁ ትነግሩኛላችሁ?***

የማረጋገጫ ጥያቄ

- መች ነዉ ይህን ማዕከል የተቀላቀላችሁት ?
- ይህን ማዕከል ከመቀላቀላችሁ በፊት ለላ ሆሰፒታል ታክማችሁ ነበር ?

3. ***በዚህ ማዕከል ዉሰጥ ምን ምን አገልግሎቶችን ታገኛላችሁ ?***

የማረጋገጫ ጥያቄ

- የሚደረግላችሁ ድጋፍ በገንዘብ ነዉ ወይስ በአይነት ነዉ?
- የምክር አገልግሎት ይሰጣችኃል ?
- ምን ምን መዝናኛ ቦታዎች አለላችሁ ?
- ገቢ በምያስገኙ ስራዎች ተሳትፋችሁ ታወቃላችሁ ?

4. ***እስቲ ከቤተሰብ አባላት ጋር ስላላችሁ ግንኙነት ንገሩኝ?***

የማረጋገጫ ጥያቄ

- ቤተሰብ መች መች ነዉ የምጠይቋችሁ ?
- ከቤተሰብ የምታገኙት ድጋፍና እንክብካቤ በቅ ነዉ ብላችሁ ታስባላችሁ? መልሶ አዎ ወይም አይደለም ከሆነ ለምን?

5. ***የማዕከሉ ጥንካሬ የምትሏቸዉ ምንድናቸዉ ?***
   - በምግብ፤ በመዝናኛና እንዲሁም ገቢ ማስገኛ ስራዎችን ከመፍጠር አኳያ ጥሩ የሚባሉ ለዉጦች ካሉ ?
   - እነዚህን ለዉጦች አጠናክሮ ለመቀጠል ምን ቢደረግ ይሻላል ትላላችሁ ?
6. ***የማዕከሉ ጥንካሬ የምትሏቸዉ ምንድናቸዉ ?***

   የማረጋገጫ ጥያቄ
   - እነዚህን ችግሮች ለመፍታት ምን ቢደረግ ይሻላል ትላላችሁ ?
7. ***እስከአሁን በተነጋገርንባቸዉ ነገሮች ላይ የምትጨምሩት ነገሮች ካሉ*** ?

   አመሰግናለሁ!

Annex-4

In-depth interview guide for rehabilitated members of GMHRC

1. ***Socio-demographic feature of the discussants***

   Name_____

   Age_____

   religion_____

   Ethnicity_____

   Marital status_____

   Educational level_____

2**. Would you tell me the reason why you interred to this center?**

   Proving question

   - When did you join the center and how long did you stayed in this center?
   - Did you checked in any other institution before you joined the center?

3. **What are the services provided for you in the center?**

   Proving question

   - What services are given to support you economically?
   - What services are given to improve your social life with I the center and out of the center with the larger community?

4. ***Tell me about your relationship with your family members***

   Proving question

   - How often your family members visit you?

- Does your family members co-operate with the center in order to facilitate your rehabilitation?
- Do you think that the support that you got from your family members is enough? If your answer is yes or no why?

5. ***What do you think are the improvements/ strength of the center?***

   Proving question

   - What are the positive changes you observed in nutrition, treatment, recreation and income generating activities?
   - What do you think should be done to sustain the community such strengths?

6. ***What are the challenges for you in this center?***

   Proving question

   - What do you think are the remedies for such challenges?

7. ***Is there anything else that you can add?***

   Thank you!

Annex-5

Amharic version of FGD guideline for rehabilitated patients in GMHRC

በገፈርሳ አዕምሮ ጤና ማገገም ማዕከል ካገገሙ ህሙማናን ጋር ቃለ-መጠይቅ ለማድረግ የተዘጋጁ ነጥቦች

1. የታካሚዉ ጠቅላላ ገጽታ

ስም ----------

ዕድሜ ----------

ያታ ----------

የጋብቻ ሁኔታ ----------

የትምህርት ሁኔታ ----------

ብሄር ----------

ሐይማኖት ----------

2. እዝህ ግቢ በምን ምክንያት እንደገባህ/ሽ ትነግርኛለሽ/ህ?

የማረጋገጫ ጥያቄ

- መች ነዉ ይህን ማዕከል የተቀላቀልከዉ/ሽዉ ? ገብተህስ/ሽ ምን ያህል ግዜ ሆነህ/ሽ ?
- ይህን ማዕከል ከመቀላቀልህ/ሽ በፊት ሌላ ሆሰፒታል ታክማችህ/ሽ ነበር ?

3. በዚህ ማዕከል ዉስጥ ምን ምን አገልግሎቶችን ታገኛለህ/ሽ ?

የማረጋገጫ ጥያቄ

- የኢኮኖሚ አቅምህን/ሽን ለማሳደግ የሚሰጡ አገልግሎቶች ምን ምን ናቸዉ ?
- የማህበራዊ ግንኙነታችሁን በማዕከለ ዉሰጥ ሆነ ከማዕከለ ዉጪ ለማሻሻል ምን ምን ድጋፎች ይደረጋሉ ?

4. ***እስቲ ከቤተሰብ አባላት ጋር ስላለሽ/ህ ግንኙነት ንገርኝ/ረኝ?***

የማረጋገጫ ጥያቄ

- ቤተሰብ መች መች ነዉ ምጠይቀህ/ሽ ?
- ቤተሰቦቻችሁ አንተ/ቺ ቶሎ እንድታገግም/ሚ በአገልግሎት አሰጣጥ ላይ ከማዕከለ ጋር ይተባበራሉ ?
- ከቤተሰብ የምታገኙት ድጋፍና እንክብካቤ በቂ ነዉ ብለሽ/ህ ታስብያለሽ/ህ ? መልሶ አዎ ወይም አይደለም ከሆነ ለምን?

5. ***የማዕከሉ ጥንካሬ የ ምትይዉ/ለዉ ምንድናቸዉ ?***

- በምግብ፣ በመዝናኛና እንዲሁም ገቢ ማስገኛ ስራዎችን ከመፍጠር አኳያ ጥሩ የምባሉ ለዉጦች ካሉ ?
- መልሶ አዎ ከሆነ እነዚህን ለዉጦች አጠናክሮ ለመቀጠል ምን ቢደረግ ይሻላል ትላለህ/ትያለሽ ?

6. ***የማዕከሉ ችግሮች የምትይዉ/ለዉ ምንድናቸዉ ?***

የማረጋገጫ ጥያቄ

- እነዚህን ችግሮች ለመፍታት ምን ቢደረግ ይሻላል ትያለሽ/ላለህ ?

7. ***እስከአሁን በተነጋገርናቸዉ ነገሮች ላይ የምትጨምሪዉ/ረዉ ነገሮች ካሉ ?***

አመሰግናለሁ!

Annex-6

Checklist for in-depth interview with family members

1. ***Demographic feature of the family member***

   Name_____

   Age_____

   religion_____

   Ethnicity_____

   Marital status_____

   Educational level_____

   Your kin relationship with the patient_____

2. ***Why your relative does joined GMHRC?***

   Proving question

   - When your relative did join GMHRC?
   - Did your relative took any treatment before GMHRC? If your answer is yes where?

3. ***What kind of services does GMHRC provide to rehabilitate your relative with mental illness?***

   Proving questions

   - Is there any economic support either in cash or kind for your relative?
   - What do the center doing to reduce stigma and discrimination on you and your relative with mental disorder?

4. ***Did you participate in the rehab of your relative***

   Proving question

   - How often did you visit your relative in the center?
   - What are the supports you provide for your relative with mental illness there by to facilitate his rehabilitation

5. ***Have you observed any improvement in the health of your relative after he admitted to the center?***
6. ***What do you think are the strength of GMHRC in the process of service provision?***

   Proving question

   - What do you think should be done to ensure the sustainability of strengths of the rehab center?

7. ***What do you think the limitations/ weakness/ in service provision?***

   Proving question

   - What do you think should be done to overcome its weakness?

8. ***Is there anything that you would like to tell me?***

   Thank you for your co-operation

Annex-6

Amharic version of in-depth interview guideline for family members

በገፈርሳ አዕምሮ ጤና ማገገም ማዕከል (ገአጠማማ) ከታካሚ በተሰብ አባላት ጋር ቃለ-መጠይቅ ለማድረግ የተዘጋጁ ነጥቦች

1. የቤተሰብ አባሉ ጠቅላላ ገጽታ

ስም ----------

ዕድሜ ----------

ያታ ----------

የጋብቻ ሁኔታ ----------

የትምህርት ሁኔታ ----------

ብሄር ----------

ሐይማኖት ----------

ከታካሚዉ ጋር ያሎት ዝምድና----------

2. የቤተሰብ አባሎ ገአጠማማ በምን ምክንያት እንደገባ ትነግርኛለሽ/ህ?

የማረጋገጫ ጥያቄ

- **መች ነዉ ማዕከሉን የተቀላቀለዉ/ችሁ ? ገብቶስ/ታ ምን ያህል ግዜ ሆነዉ/ናት ?**
- **ይህን ማዕከል ከመቀላቀሉ/ሏ በፍት ለላ ሆሰፒታል ታክሞ/ማ ነበር ?**

3. በማዕከል ዉሰጥ ምን ምን አገልግሎቶችን ይሰጡታል ?

የማረጋገጫ ጥያቄ

- የኢኮኖሚ አቅማቸዉን ለማሳደግ የሚሰጡ አገልግሎቶች ምን ምን ናቸዉ ?
- የማህበራዊ ግኑኝነታችዉን በማዕከለ ዉሰጥ ሆነ ከማዕከለ ዉጭ ለማሻሻል ምን ምን ድጋፎች ይደረጋሉ ?

4. *እስቲ ለታካሚዉ የምታደርጉትን ድጋፍ ይንገሩኝ ?*

የማረጋገጫ ጥያቄ

- መች መች ነዉ ታካሚዉን/ዋን የምትጠይቁት ?
- ከማዕከለ ጋር እንዴት ተባብረዉ እንደሚሰሩ ያጫዉቱኝ ?
- ለታካሚዉ የምታደርጉት ድጋፍ በቂ ነዉ ብላችሁ ታስባላችሁ? መልሶ አይደለም ከሆነ ለምን ?

5. *የማዕከሉ ጥንካሬ የምትይዉ/ለዉ ምንድናቸዉ ?*

- በምግብ፤ በመዝናኛና እንዲሁም የገቢ ማስገኛ ስራዎችን ከመፍጠር አኳያ ጥሩ የሚባሉ ለዉጦች ካሉ ?
- እነዝህን ለዉጦች አጠናክሮ ለመቀጠል ምን ብደረግ ይሻላል ትላለህ/ትያለሽ ?

6. *የማዕከሉ ጉድለቶች የምትይዉ/ለዉ ምንድናቸዉ ?*

የማረጋገጫ ጥያቄ

- እነዚህን ችግሮች ለመፍታት ምን ብደረግ ይሻላል ትያለሽ/ላለህ ?

7. *እስከ አሁን በተነጋገርናቸዉ ነገሮች ላይ የምትጨምርዉ/ረዉ ነገሮች ካሉ ?*

አመሰግናለሁ!

Annex -7

Interview questions for staff members

1. Socio demographic charactericts of the participants

   Age----------

   Sex----------

   Religion----------

   Ethnicity----------

   Marital status----------

   Position in the center----------

2. Roles strengths and needs of the center

   2.1 What services your department provide in GMHRC in meeting the social and economic need of individuals with mental disability and their family?

   2.2 How do you perform the roles and provide services?

   2.3 What strategies and procedures are employed?

   2.4 What do you think are opportunities for the rehab program from the perspective of your department?

   2.5 What do you think are the challenges of your department?

   2.6 How do these challenges can be addressed?

   2.7 Is there anything that you can add?

   Thank you

Annex- 8

Amharic version of interview with staff members

በገፈርሳ አዕምሮ ጤና ማገገም ማዕከል (ገአጠማማ) ከቢሮ ሰራተኞች ጋር ቃለ-መጠይቅ ለማድረግ የተዘጋጁ ነጥቦች

1. ***የሰራተኛዉ ጠቅላላ ገጽታ***

ስም ----------

ዕድሜ ----------

ያታ ----------

የጋብቻ ሁኔታ ----------

የትምህርት ሁኔታ ----------

ብሄር ----------

ሐይማኖት ----------

በስራ ሂደቱ ዉሰጥ ያሎት ኃላፊነት----------

2. **የማዕከሉ ሚና ፣ ጥንካሬ እና ድክመት**

2.1ለታካሚዎችና ለታካሚ ቤተሰቦች የርሶ ስራ ሂደት ምን ምን አገልግሎቶችን ይሰጣል ?

2.2እንዴት ነዉ አገልግሎቶችን የምትሰጡት?

2.3ምን ምን ስትራተጂና ታክቲክ ትጠቀማላችሁ?

2.4በማዕከሉ ምን ምን ዕድሎች አሉ ይላሉ?

2.5በማዕከሉ ምን ምን ተግዳሮቶች አሉ ብለህ ታስባለህ/ሽ?

2.6እነዝህን ተግዳሮቶችን ለማሸነፍ ምን ቢደረግ ይሻላል ትያለሽ?

2.7እስካሁን በተነጋገርንባቸዉ ነገሮች ላይ ምትጨምረዉ/ሪዉ ካለ ?

አመሰግናለሁ

Annex-9

Key informant interview guideline

1. Socio demographic charactericts of the government official

   Age----------

   Sex----------

   Religion----------

   Ethnicity----------

   Marital status----------

   Position in the center----------

2. Roles strengths and needs of the center

   2.1 Would you tell me what do you know about GMHRC?

   2.2 How do you perform the roles and provide services?

   2.3 What strategies and procedures are employed by the center to perform its activities?

   2.4 What do you think are opportunities for the rehab program from the perspective of your department?

   2.5 What do you think are the challenges of your department?

   2.6 How do these challenges can be addressed?

   2.7 Is there anything that you can add?

   Thank you

Annex-10

Amharic version of interview with key informants

በገፈርሳ አዕምሮ ጤና ማገገምያ ማዕከል (ገአጠማማ) ከመንግስት ባለስላጣናት ጋር ቃለ-መጠይቅ ለማድረግ የተዘጋጁ ነጥቦች

1. ***የባለስልጣኑ ጠቅላላ ገጽታ***

ስም ----------

ዕድሜ ----------

ያታ ----------

የጋብቻ ሁኔታ ----------

የትምህርት ሁኔታ ----------

ብሄር ----------

ሐይማኖት ----------

በቢሮ ዉስጥ ያሎት ኃላፊነት----------

2. **የማዕከሉ ምና ፣ ጥንካሬ እና ድክመት**

2.1እስቲ ስለ ገአጠማማ ማዕከል የምያዉቁትን ንገሩኝ ?

2.2እንዴት ነዉ ማዕከሉ አገልግሎቶችን የምሰጠዉ?

2.3ምን ምን ስትራተጂና ታክቲክ ይጠቀማል?

2.4በማዕከሉ ምን ምን ዕድሎች አሉ ይላሉ?

2.5በማዕከሉ ምን ምን ተግዳሮቶች አሉ ብለህ ታስባለህ/ሽ?

2.6 እነዚህን ተግዳሮቶችን ለማሸነፍ ምን ብደረግ ይሻላል ትላለህ/ሽ?

2.7 እስካሁን በተነጋገርንባቸዉ ነገሮች ላይ ምትጨምርዉ ካለ/ሽ ?

አመሰግናለሁ

Annex-7

Observation checklist

1. ***The situation of staff members***
   A. Staff construction and sanitation
   B. Multi-dispel nary team relationship
   C. Client professional relationship
2. ***The situation of clients***
   A. Dining hall and food composition
   B. Dormitory sanitation
   C. Recreational centers
   D. IGA centers
3. ***The situation of family members***
   A. Multi dispel nary team and family relationship
   B. Family and client relationship
   C. Family and wider community interaction