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Status of adoption and Implementation Level of Integrated Mental Health Service at Primary Health Care Units In Addis Ababa, Ethiopia,2017

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APPROVED BY THE BOARD OF EXAMINERS

This thesis, by Roman Mehari is accepted in its present form by the board of examiners as fulfilling for the degree of masters of public health in health system management.

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Table of Contents

ABBREVIATIONS vi

LIST OF TABLES vii

LIST OF FIGURES viii

ABSTRACT 1

1. INTRODUCTION 3

1.1 Background 3

1.2 Statement of the problem 5

1.3 Significance of the study 6

2. LITERATURE REVIEW 7

2.1 Conceptual framework 12

3 OBJECTIVES 13

4. METHODOLOGY 14

4.1 Study area 14

4.2 Study design 14

4.3 Source population 14

4.4 Study population 14

4.5 Study variables 14

4.6 Sample size 15

4.7 Sampling procedures 16

4.8 Data collection procedure 19

4.9 Data collection tool 19

4.10 Operational definitions 19

4.11 Data quality management 21

4.12 Data Analysis Procedure 21

4.13 Ethical considerations 22

4.14 Dissemination of results 22

5. RESULT 23

5.1 General characteristics of study participants 23

5.2 Knowledge and attitude of primary health care providers towards mental health 26

5.3 Knowledge and attitude towards mental health service integration 27

5.4 Self-perceived competency among health professionals in providing mental health care 28

5.6 Adoption status of integrated mental health service in primary health care units 28

5.7 Implementation of integrated mental health service in primary health care units 29
5.7.1 Mental health training 29
5.7.2 Health care provider's roles and responsibilities regarding mental health care 29
5.7.3 Availability of ongoing support from mental health professionals and regular supervision..... 30
5.7.4 Availability of psychotropic medication in primary health units 30
5.7.5 Availability and utilization of guideline related to mental health 31
5.7.6 Formal discussion about mental disorder and recording system 31
5.7.7 Referral practice among health care providers 31
5.7.8 Implementation of integrated mental health service in primary health care units 32
5.8 Multivariate logistic regression analysis 32
6. DISCUSSION 36
7. LIMITATIONS AND STRENGTH OF THE STUDY 40
8. CONCLUSIONS 41
9. RECOMMENDATION 42
10, REFERENCES 43
11, ANNEXS 46
ANNEX 1: Informed Consent (English version) 46
ANNEX 2: Questionnaires in English version on adoption status and implementation level of integrated mental health in primary health care units. 48
ANNEX 3: Informed consent in Amharic 57
ANNEX 4: Questionnaires in Amharic version on adoption status and implementation level of integrated mental health in primary health care unit. 58

ABBREVIATIONS

ART-Antiretroviral Therapy

AOR-Adjusted Odds Ratio

CI-Confidence Interval

COR -Crude Odds Ratio

HSDP IV -Health Sector Development Plan IV

MH GAP-Mental Health Global Action Program

MNS-Mental, Neurological and Substance use disorders

PRIME-Program for Improvement of Mental Health Care

PHC-Primary Health Care

WHO-World Health Organization

WONCA-World Organization of National Colleges Academies

LIST OF TABLES

Table1-General characteristics of the respondents in primary health care units, Addis Ababa 2017……………………………………………………………………………………..21

Table 2-Resposes of primary health care providers regarding mental health care integration in PHC units, Addis Ababa Ethiopia 2017……………………………………………….24

Table3-Adoption status of integrated mental health service among primary health care providers in primary health care units, Addis Ababa Ethiopia……………………………………..25

Table4-Summery description of type of mental health training received by respondents in primary health care units, Addis Ababa Ethiopia 2017……………………………………26

Table5-Primary health provider's role and responsibility in providing mental health care in primary health care units, Addis Ababa, Ethiopia………………………………………27

Table6-Reported availability of psychotropic medication by health care providers in Addis Ababa, Ethiopia ………………………………………………………………….

Table 7-Implementation of mental health integration in primary health care units, in Addis Ababa Ethiopia.……………………………………………………………………………..28

Table8-General characteristics of respondents, health care provider's factors and adoption status of integrated mental health service in PHC units, in Addis Ababa Ethiopia 2017 ……..31

LIST OF FIGURES

Figure 1: Conceptual framework from different literature and modified by a researcher which shows determinates of successful integration of mental health service integration…………11

Figure2: Diagrammatic presentation sampling procedure…………………………………..17

ABSTRACT

Background: -In middle and low income countries it is believed that three in four persons with mental disorder do not receive appropriate treatment. To address this extensive unmet mental health need in low-income countries. World Health Organization (WHO) recommends integration of mental health service into primary health care level that is providing mental health services which involve diagnosing and treating people with common mental disorders within the general framework of available health services. Ethiopia implemented this program based on World Health Organization (WHO) scale up program called mental health gap action program (MH-GAP).

Objective: - The objective of this study was to assess integrated mental health service adoption status and extent of implementation in primary health care units in Addis Ababa, Ethiopia in 2017.

Methods:-Facility based cross-sectional study was conducted and subjects were selected randomly using proportional size allocation among health care workers in selected health centers in 2017. The total sample size for the study was estimated by single proportion population formula and total sample size was estimated to be 422.Data was collected from selected participants using self-administered questionnaires. Epi data 3.1 was used to enter and clean the data. Stata 14.1 was employed for data analysis. Descriptive analysis percentage and summary measures were conducted for adoption status and implementation level of integrated mental health service. Bivariate and multivariate logistic regression was calculated to examine association between general characteristics of respondents, health care provider's factors and adoption status of primary health care providers.

Result:-More than half of respondents (61.69%) 238 of health care providers were found to be under mean score or having poor status of adoption. Majority of respondents 236 (58, 7%) had stated that there were poor implementation level of mental health integration in their facility. Work experience more than 11 years [AOR: 12.34.95% CI :(3.76- 40.56)], pre -service training[AOR: 2.1.95%CI: (1.249 -3.533)], Presence of discussion with colleagues or higher supervisor [AOR: 1.82. 95%CI :(1.066- 3.068)], having role or responsibility to diagnosis and assessment of mental disorder cases. [AOR: 1.93.95%CI :(1.021 -3.683)]have found to be influencing factor for adoption status of integrated mental health service.

Conclusion and Recommendation: -Status of adoption towards mental health integration among majority of primary health care providers is poor. The influencing factors for adoption status of integrated mental health service in primary health care units are work experience, pre-service training, having a role or responsibility to diagnosis and assessment of mental illness, presence of discussion with colleagues and supervisors in the facility. Majority of primary health care providers are indicated that there is poor level of implementation in the primary health care units.

Ministry of health and health science colleges should consider pre-service training to several field of study. Mental health global action implementers should facilitate consistent support and supervision after in-service training. In addition several interferences should be used to change awareness and attitude of health workers towards mental health service integration.

1. INTRODUCTION

1.1 Background

Prevalence of mental health disorders has been reported to be increasing in recent years. In the year 2013 it was estimated that 14% of global burden of disease attributable to mental, neurological and substance use disorders [1].Mental disorders including neuropsychiatric disorders make the second highest global contributors of years lived with disability [2].Almost three quarter of this burden occur in low and middle income countries [3].It is believed that in this countries three in four persons with mental disorders do not receive appropriate treatment. The treatment gap can exceed 90% in the case of sub-Saharan Africa [4].

To address the extensive unmet mental health need in low-income countries World Health Organization (WHO) recommends integration of mental health service into primary health care level[5].Integration of mental health service in primary health care is about providing mental health services which involves diagnosing and treating people with common mental disorders within the general framework of available health services, putting in place strategies to prevent mental disorders, ensuring that primary healthcare workers are able to apply key psychosocial and behavioral science skills, as well as ensuring an efficient referral system for those who require more specialized care[6].

In Ethiopia prevalence rate of mental disorders is high with the prevalence rate of 12-17 %. Despite the fact that number of patients are being treated in different health care settings, majority of them go unrecognized and exposed to unnecessary diagnosis which lead to financial loss[6].In order to overcome problems of low coverage, Ethiopian Ministry of Health has implemented integration of treatment of mental disorders in primary health care (PHC) after adapting policy and plan titled national mental health strategy [7].This program is guided by mh GAP-IG (mental health Global action program intervention guideline) manual for helping non specialists to provide the service which is contextualized based on our country setting [8].

While integration and adaption of such program embraces guarantee for low income countries, the success of the programme relies on the primary healthcare providers. To ensure the successful adaptation and implementation of the policy it is essential to know the current extent

of adoption status and implementation level by primary health care providers in primary health care facilities [9].

1.2 Statement of the problem

As recommended by WHO, Ethiopia has integrated mental health program to the primary health care level after a successful piloting of the programme for three years (2010-2013) in different regions [10]. The Health Sector Development Plan IV (HSDP IV) planned to integrate mental health into 50% of primary health care settings through providing care for common mental disorders [11].

Several studies have been conducted prior to the integration of the mental health programme in the PHC to identify the challenges and opportunities in particular country settings. In 2013, District level situation analyses done from five countries where Ethiopia, Sodo district was included, the study identified, among other challenges, that there is inadequate mental health professionals to support the service [13].

Other study conducted on 2014to show the perceived challenges and opportunities of integrating the care in Jimma, Ethiopia demonstrated that the integration is acceptable and feasible in primary health care and professionals fully support the idea of the integration which is of paramount to the successful scale up of the mental health programme in the PHC [14].Study done in 2014,carried out in the country showed a promising result that non specialized professionals could carry out the delivery of the basic intervention package. It also revealed that the post test scores in the knowledge of health care providers were improved after training [15].

So far the studies have shown the scenario before the implementation of the integrated program as it is important to show evidence prior to implementation. After the program is integrated studies are meager in showing the adoption and extent of implementation of the integrated mental health service; in view of the fact that policy adaption could be a success or a failure, examining factors associated with the success or the failure will have a paramount importance.

This study examined the progress of adoption and implementation of integrated mental health service in primary health care level in low income countries like Ethiopia.

1.3 Significance of the study

Since health providers are crucially important for provision of integrated mental health care understanding their adopting status of this new role and investigating their level of implementation is important for the next planning on how this new strategy will proceed for reaching the goal of involving 50% of primary health care facilities in the integration.

Knowing the real experience on the ground will help the policy makers in further enhancing, modifying and contextualizing in accordance to the settings. More over this study will help in pointing out whether or not there should be supplementary trainings given to the professionals, additional resources required for the integration and other challenges faced by the primary health care unit. Generally enhancing health professional's competency and developing mental health system structure will contribute to improvement mental health care provision at the community level.

2. LITERATURE REVIEW

This section of the thesis includes important information that deals about integration of mental health, adoption of integrated mental health service regarding knowledge and attitude of health professionals towards mental health, self-perceived competency level for provision of care. And about implementation of mental health service in primary health care level. It also includes challenges and effectiveness of integrating mental health approach at primary health care level.

Integration of mental health

The integration of mental health care into primary care has been the commonest approach advocated to narrow the treatment gap in low income countries since the 1970's.This approach adapted for country context through mh-GAP-IG package which used for health facility level intervention. And this package is limited to common MNS (mental, neurological and substance use disorders) selected for each country. These prioritized mental disorders in PRIME (program for improvement of mental health) countries are psychosis, depression, alcohol use and maternal mental disorder. Epilepsy has also included in some countries like Ethiopia [16].

Effectiveness and challenges of mental health integration

Globally several low and middle income countries have served as a model for successful integration of mental health service into primary health care. According to the World Health Organization (WHO) and World Organization of Family Doctors (Wonca) there are principles included for successful integration of mental health service such as [17]:-

- Mental health for primary care must be included in policies and planning
- Support for attitude and behavior change in addressing mental health issues is essential to protection of human rights
- Training about integration of primary health service for primary health care workers should be appropriate and feasible.
- Primary care workers must have access to mental health professionals for referrals and support
- Integration of mental health service is a continual process which need development, agreement and acceptance among health professionals and community
- Mental health service coordinator is also essential for deriving the service forward.

- Mental health integration requires the involvement of various stakeholders including community health workers, nongovernmental organizations, and volunteers.
- A sustainable system requires financial and human resources

Integration of mental health service is feasible and successful for those in need for example in Argentina primary health care physicians provide the first step to diagnosis and provide treatment for psychiatric disorder. Integration of mental health service in primary health care helps patient to keep from stigmatization or isolation from the community so demand for service increased [12].Countries that could successfully integrate mental health care shows shifting of responsibility for providing treatment. Approximately 56%of primary care workers prescribe without restriction, 40% of them with some restriction in some countries [18].

Studies done in Ethiopia on integration of mental health service shows there is promising result on the feasibly of the intervention and the improvement of primary health care workers capacity for providing the service. But there are concerns or challenges to overcome for successful integration of services, such as integrated mental health service requires investment on continues training beside within that context also primary health care worker could be uncomfortable with this new role. And also health professionals raise their concerns about availability of time and overburdened by other tasks. In addition, in adequate supervision, absence of good referral system, shortage of primary health care staff and lack of adequate working conditions such as payment are the main barriers that could severely affect the effectiveness of mental health care delivery in primary health care [19].

Study conducted for participatory planning of primary health care service to people with severe mental disorder in rural Ethiopia, using focus group discussion and in-depth interview with stake-holders (health care administrators and providers, caregivers, service-users and community leaders) showed that though acceptance of new service was qualified there are concerns by community about knowledge and skill of primary health care staff to provide counseling and advice. Additionally, they were unsure about getting effective management and follow up. Healthcare professionals also accept some of concerns about their ability and impact of their capability on their patients. To overcome this concerns training and refreshing training was indicated as a key intervention. [20]

Adoption and implementation of integrated mental health at facility level

Study done in southern India, to assess primary health care doctors knowledge and attitude regarding mental health care provision reported that majority of participants (69.6%) felt competent in providing mental health service to their patients. One third of these doctors had not received any in-service training related to mental health care and only few were able to name three signs and symptoms of depression and psychosis [22].

Study conducted in South Africa, on integrating mental health service in primary health care, a survey of primary health care knowledge, attitude and beliefs showed that primary health care nurse's attitude and belief were positive. but the concern found on this study were primary health care nurses have inadequate knowledge to manage psychiatric patients and also most of them do not have the opportunity to be exposed to refresher courses related to mental health.

A study done in Nigeria to assess knowledge and attitude towards mental health among primary health care workers reported that knowledge of PHC workers about psychopharmacological was low for antidepressant medication, and only 30% could mention specific type of mental health program that cloud be introduced at PHC level. Most of them reported negative attitude towards mental illness [21].

Study conducted in Uganda on challenges to and opportunists for integration of mental health, using semi structured interview and focus group discussion on selected stakeholder demonstrated that integration was noted as a policy recommendation but has not been entirely institutionalized in guided manner at all level of care. Even though there were reports shows there has been improved system of supply for medicine and enabling provision of psychotropic medicines for general health worker to prescribe and administer, this study also shows that some health manger believe that integration of mental health occur automatically and without intentional effort for its operationalization. Concerning knowledge and skill of health workers in mental health most are ill equipped and with very few having training in mental health care and health workers also admitted that knowing mental illness only in severe form [24].

Mixed type of study conducted in Jimma, Ethiopia on perceived challenge and opportunity arising from integration of mental health service in primary health care showed that almost all respondents expressed positive attitude towards mental health and idea of integration in to primary health care. Similarly respondents also support the idea of providing mental health

service in their health facility but from those respondents 66.9% were expressed their interest to deliver the service. Assessment towards their knowledge about mental illness showed that majority couldn't identify anti-psychotic or anti-depressant medications in addition half of respondents reported that they would faces shortage of room for examination and equal percentage also reported they would not obtain enough time for delivering mental health service [14].

Another Study conducted In Ethiopia to assess efficacy of MH Gap intervention package through statically analysis of pre-test and post test score showed that the knowledge of health care providers was improved in the post test phase and there was promising result that this non specialized professionals could deliver basic MH Gap intervention package. But the study also mentioned as a limitation that there is no information about their practice on delivery of intervention package after training. During field visit observation done after training insight that health workers congested with additional tasks and forced to give limited time for each visit. This situation forced them to treat mental disorder with pharmacological treatment with few notation of psycho-education assessment [15].

Integrating mental health into routine health care platforms require proven methods of care management ,supervision support and evaluation that provide a strong starting point and known framework for implementation of integrated mental health care. Ethiopia was one of the countries included in the programme for Improving Mental health care (PRIME) that aim to reduce evidence gap during implementation to integrate mental health care and developed locally relevant plan [23].

Study conducted in all region of Ethiopia in the expectations of trying to assess the experiences, strengths and challenges of integration of mental health into primary care have shown promising findings in the experience of mental health integration. Facility based supervisions in health centers was done using a semi structured and standardized questioner from the WHO mental health global action program support and supervision questionnaires was used to collect the information. In general the study findings have demonstrated that there are certain achievements in number of trained professionals, health care centers involved, availability of drugs and cases identified and treated by trained professionals. But the study also marked on the biggest challenges faced when and during the integration of this course. Staff turnover, lack of

attentions, awareness and understanding of the program by regional health bureaus, inadequate promotion and follow-up of the MH Gap scale up by the stake holders, delayed and inadequate supportive supervisions for trainees, shortage of budget for supportive supervision and mentoring, interrupted supply of drugs, inadequate demand for the service[11].

Study conducted in Ethiopia, Deberemarkos town on integration level of mental health service in primary health care units with the aim of determining level of integration based on recommended principle of successful integration by WHO. Cross-sectional study was done using literature review of mental health policy, document review in primary health units and secondary care unit for MNS cases seen and referred cases from primary care unit respectively. The study findings shows that the health center didn't have separate policy for referral and feedback, training limited to HIV/AIDS clinic staff, no medication in health post and limited medication in health center, limited involvement in mental health disorder and funding for mental health service is not available. Generally this study concluded that mental health integration in primary health care is poor and it appears to be integrated through documentation but the capacity for intervention, diagnosis and referral is very limited [12].

Almost all studies done on integration of mental health in Ethiopia are conducted for the purpose of evidence for to adapting policy or to show some what the effectiveness of integration process. In addition most studies in other countries aim to show acceptability, feasibility and challenges that possibly will be faced through the process. Even though some studies done in other countries that evaluate knowledge and attitude of health professionals towards mental health the main aim was pre-assessment of health professionals before implementation. This proposed study will examine health professionals after actual experience of integrated mental health, so it will assess not only the knowledge and attitude about mental health but also its integrated approach and implementation level.

2.1Conceptual framework

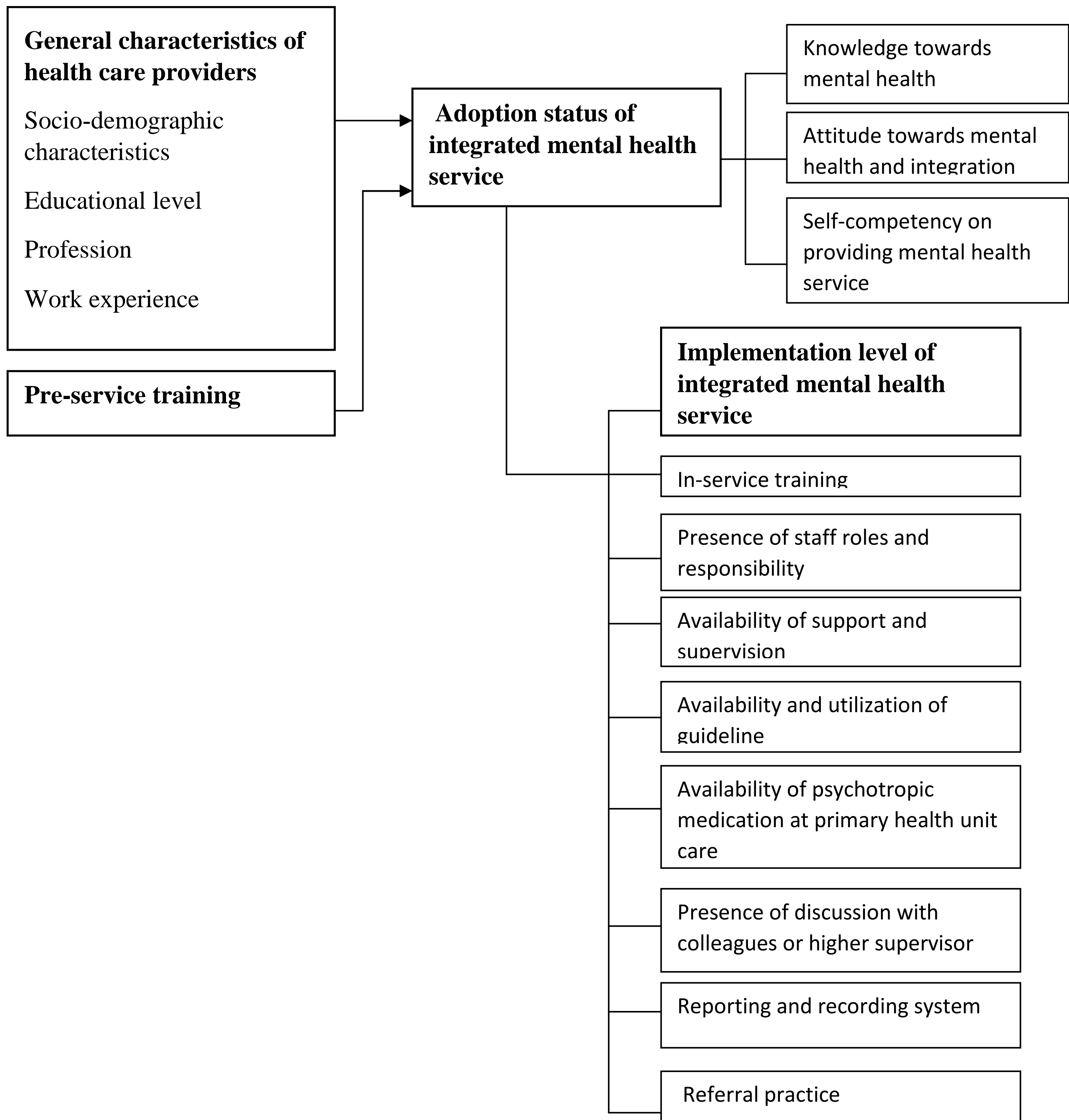

Figure 1: conceptual framework from different literature and modified by a researcher which shows determinates of successful integration of mental health service integration.

3 OBJECTIVES

- **General objective**

  To assess adoption, implementation level and factor influencing adoption status of integrated mental health service in primary health care units, in Addis Ababa, Ethiopia in 2017.

- **Specific objective**

  1) To determine the adoption status of integrated mental health service in primary health care units in Addis Ababa, Ethiopia in 2017.

  2) To assess the implementation level of integrated mental health service in primary health care units in Addis Ababa, Ethiopia in 2017.

  3) Identify factor influencing adoption status of integrated mental health service in primary health care units in Addis Ababa, Ethiopia in 2017.

4. METHODOLOGY

4.1 Study area

The study was conducted in Addis Ababa, capital city of Ethiopia. The city had a total of 608 health facilities (which include hospitals, health centers and private clinics). Addis Ababa is divided into 10 sub cities and 116 woreda administrations. According to the 2010 population Census, the total population of Addis Ababa was about 3,384,569.Addis Ababa had 111 functional health centers and 56 health centers were implementing integrated mental health care in their facilities [30].

4.2 Study design

Facility based cross sectional study was conducted in health centers.

4.3 Source population

All primary health care providers that were working in those 56 health center which were implementing mental health integration in there facility in Addis Ababa.

4.4Study population

Randomly selected health professional who works in the selected health centers found in Addis Ababa.

4.5Study variables

Dependent variable

- Status of adoption of integrated mental health service in health center
- implementation level of integrated mental health care in health center

Independent variable

- General characteristics of health care providers
- Perceived competency of providing mental health service
- Knowledge towards mental health and integrated mental health service
- Attitude towards mental health service and integrated mental health approach
- Mental health training

Inclusion criteria

All physicians, health officers, nurse (diploma, degree), midwifery (degree, diploma), pharmacist (degree, diploma) who were working in selected health center were included in the study.

Exclusion criteria

All laboratory technicians that were working in selected health centers and health care and health professionals how have work experience less than 6 month in that health facility**.**

4.6 Sample size

For the first and second objective

For the first objective sample size was calculated taking assumed prevalence 50%.Because previous studies done on knowledge and attitude towards mental illness or attitude towards mental health integration was not comparable with adoption status of integrated mental health care .which tried to assess knowledge, attitude and competency of primary health care providers towards mental health care.

Similarly for the second objective 50% prevalence was taken for sample size calculation of integrated mental health service implementation because there was no study done on integration of mental health service in health care provider's perspective.

Single proportion formula was used to calculate sample size

n= $\underline{Z(\ /2)2P(1-P)}/d^2$

Z standard normal distribution of with CI of 95%	P(assumed prevalence on status of adoption and implementation level)	d(tolerable marginal error	Non response rate	n(sample size)
1.96	0.5	0.05	10%	422

For the third objective

Sample size was calculated using double population proportion formula because third objective was identifying factor that influence status of adoption, for two determents of adoption status

(level of education and clinical attachment during pre-service training) among primary health care providers.

Influencing factors for positive attitude to deliver mental health care was considered as determinates for adoption status of primary health care providers.

$$n = \frac{[z\ \ /2\ \ \ (1+1/r) + z\beta\ \ p1\ (1-p1) + p2\ (1-p2)/r]^{2}}{(p1 - p2)^{2}}$$

- For the first factor

High Educational status was taken as an exposure

P1(proportion of positive attitude to deliver mental health with degree level of educational status)	P2(proportion of positive attitude to deliver mental health with diploma level educational status)	P(pooled proportion)	r	ß		Non Response rate	N
83.7%	60.2%	(0.719)71.95	1	20%	0.05	10%	132

- For the second factor

Clinical attachments during pre-service training was taken as an exposure

P1(proportion of positive attitude to deliver mental health care with who experienced clinical attachment during in service training)	P2(proportion of positive attitude to deliver mental health care without experienced clinical attachment during pre-service training)	P(pooled proportion)	r	ß		Non Response rate	N
93%	56.4%	(0.747)74.7	1	20%	0.05	10%	172

- Taking the largest sample size and finally the sample size was delineated to be 422.

4.7Sampling procedures

Out of 56health centers in Addis Ababa which have implementing integrated mental health service in their facility. 20 health centers were randomly selected by taking 35% of total sampling health centers, using lottery method from total health centers that had implemented mental health service. Following that number of primary health care providers was selected from each selected health center based on proportional allocation in total number of health

professionals in selected health center. Study participant, drawn from each selected health center using list of health professionals based on the number of health professional allocated for each health centers then they selected by lottery method. Those primary health care providers worked on data collection day were eligible.

➢ Sampling procedure for primary health care providers selection

Total number of health facilities = 56 HC

Total number of health professionals IHC =2659

Selected health centers =20

Total number of health professionalsSHC=1217

BO	AK	AM	GO	GR	ME	GT	FR	HI	L2	L1	KE	L3	KA	EF	Y8	Y4	A	FI	K 8
N= 72	N= 64	N= 59	N= 57	N= 59	N= 68	N= 62	N= 64	N= 71	N= 72	N= 52	N= 61	N= 76	N= 54	N= 76	N= 54	N= 62	N= 71	N= 68	N= 56
n= 24	n= 21	n= 19	n= 18	n= 19	n= 23	n= 21	n= 24	n= 24	n= 17	n= 20	n= 25	n= 17	n= 25	n= 17	n= 25	n= 20	n= 23	n= 22	n= 18

HP= number of health professionals IHC=number of health center that had integrated mental health service

HC= health center n=Number of selected health professionals in each Health center

BO-Bole 17 HC	ME-Mesholekiya HC	L2-Lafto wereda 2 HC	Y8-Yeka wereda 8 HC
AK-Akaki HC	GT-Gotera HC	KA-Kality HC	Y4-Yeka wereda 4HC
AM-Amoraw HC	FR-Feres meda HC	L3-Lafto werda 3HC	A-Arada HC
GO-Goro HC	HI-Hiwet amba HC	KE-Kebena HC	K8-kality wereda 8 HC
GR-Gergi HC	L1-Lafto wereda 1 HC	EF-Efoyeta HC	FI-ferehiwot HC

Fig 2 Diagrammatic presentation of sampling procedure

4.8Data collection procedure

Health care providers were randomly selected based on health professionals list that were found from human resource department. Then self-administered questionnaire was distributed for the selected health professionals while they work at their work station. The self-administered questionnaire were completed during their free time and collected on that day. The data was collected between March and April 2017. Two data collectors were assigned for distributing self-administered questionnaire and guiding participants if any problems happened. One Health officers were assigned as supervisors throughout the study period to check completeness of the questionnaires.

4.9Data collection tool

Data collection was in the form of structured questionnaire that was adapted from pervious literature and checklist that had been used for supervision of integrated mental health service. In addition some modification was done by the researcher. The questionnaires were included four section 1) Socio-demographic characteristics of respondents.2) Knowledge about mental disorder and awareness about integrated mental health approach. This section include ‘yes’ or ‘no’ question in order to assess health care providers awareness about mental health and integration 3)Self-perceived competency in providing mental health care, this section included general and clinical competency such as assessment, diagnosis and provision of care for different mental disorders and each items were on the statement form with likert-scale responses which were labeled by health care providers to evaluate their competency for each items.4) Attitude towards mental health and integrated mental health , in this section the questioners were designed in likert-scale responses which assess the attitude of health care providers in each item. 5) Implementation of integrated mental health service, this section included questions that assess extent of implementation in view of staff perception. This section included likert- scale responses with a range of never to frequently which had a value of 1 to 4 and also include ” yes” or “no” questions in order to assess their practice regarding mental health care .

4.10Operational definitions

Primary health care providers: A person who provides health care service in primary health care units after qualified and certified for the training and education he/she receives.

Primary health care unit: A health facility that often offers the first point of entry into the health care system which usually provide the initial assessment and treatment for common health conditions and refer those requiring more specialized diagnosis and treatment to facilities with staff with a higher level of training.

Adoption of integrated mental health care –extent of health professional's approval in order to practice mental health care and their stage of acceptance to take on the new role. Status of adoption was categorized as good and poor based on average or mean derived from score on each independent variable (indexes) such as perceived competency of health professionals, knowledge towards mental health and attitude towards mental health and integration.

Adequate knowledge towards mental health- if the sum of respondents score above 70% of questions for already defined answers (If score greater than 70% of knowledge questions).

Inadequate knowledge towards mental health-if the sum of respondents score below 70% of questions for already defined answers (If score less than 70% of knowledge questions).

Favorable attitude towards mental health-if the sum of respondents answers for statements with attitude questions is on positive side of responses for above 11 out 15 or 70% of questions. .

Unfavorable attitude towards mental health- if the sum of respondents answer for statements with attitude questions is on positive side of response for below 11 out 15 or 70% of questions.

Good status of adoption -primary health care providers who scored the sum of each indexes (knowledge towards mental health, perceived-competency, attitude towards mental health and its integration) above mean score.

Poor status of adoption- primary health care providers who scored the sum of each indexes (knowledge towards mental health, perceived-competency, attitude towards mental health and its integration) under mean score.

Implementation of mental health integration –level of practicing scale up mental health care approach based on some included principles of integration by WHO and implementation check list of MH GAP-IG/.Level of implementation was determined for all primary health units that had started implementation of integration in , Addis Ababa. It was categorized as poor and good implementation level for primary health care units depending on the average score of health care

providers. Determinates used for implementation level score are presence of staff role and responsibility regarding mental health care, availability of support from mental health professionals from psychiatric institution, availability of regular supervision, availability of guideline ,utilization of guideline ,availability of psychotropic medication, internal referral practice ,external referral practice in the facility, presence of formal discussion with colleagues and higher supervisors ,reporting or tracking mental case with specified period.

Good implementation level –the sum of each items scored by health care providers for determinate variables of implementation is above mean score.

Poor implementation level – the sum of each items scored by health care providers for determinate variables of implementation was under mean sore

4.11Data quality management

Data collection was done after pretest conducted by taking 5% sample from total sample size and health care providers were taken from two health centers (Lafto werda 5 health center and saris health center) other than health centers which was included in the study. The questioner was developed in English language then transferred to Amharic. The data collection tool was reviewed by Amanueal Psychiatric hospital, research department in order to check and correct translation of Amharic from English version, and also to check appropriateness of questionnaires. One day training was given for the data collectors about data collection and the aim of the study. Data collectors were communicating with selected health professionals at their work setting through giving brief orientation about the study, procedures to complete the questioners and how to request help if they got problem to response for the questioners .On the spot checking and review of completed questionnaires to ensure completeness and consistency of the information was done and immediate action were taken. Data entry was done by the principal investigator using Epi data 3.1software.

4.12Data Analysis Procedure

Descriptive data was summarized using simple percentages, range and measures of central tendency (mean and median). Data analysis was done using stata version 14.1. Descriptive analysis percentage and summary measures was conducted for perceived competency, knowledge and attitude towards mental health, status of adoption and implementation of

integrated mental health care. Bivariate and multivariate analysis was conducted to examine any association between adoption status of respondent's and general characteristics of respondent (work experience, profession, status of education (degree, diploma). And also to investigate association between mental health training and health care providers practice with health care provider's status of adoption.

The responses for knowledge towards mental health were with a value range of '0' for incorrect answer and '1'for correct answer. The responses for self -perceived competency of primary health care providers scaled from five point, with value range from 1 (strongly disagree) to 5 (strongly agree).And merged into two representing value poor as'0 '(if they were scored under midpoint) and "1" if they were scored on the above midpoint). The responses for attitude towards mental health and mental health integration also with a value range from (1-5) and categorized into two representing as negative attitude or'0' (if they were scored on the negative side of the midpoint and positive or '1' (if they were scored on the positive side of the midpoint).The Responses for implementation level were scaled with a value range '0' and '1' for 'yes' or 'no' questions. And also from four point scale within a range value of (1-4) and merged in two representing value '0' if below half point and '1' if above half point.

4.13Ethical considerations

Ethical approval was obtained from the School of Public Health, Addis Ababa University, Research Ethical Committee and Addis Ababa Health Bureau. After the ethical approval written consent was submitted to the respective sub city and written consent was also requested to all the participants during data collection. Questionnaire completed by health professionals remain anonymous. The right to withdraw from the research process at any point in time was respected.

4.14 Dissemination of results

The study conducted for the partial fulfillment for the dissertation of degree of Masters in Addis Ababa University, college of health science, school of public health and the result of the study will be submitted to the institute. The study findings will also be given to relevant bodies such as Federal Ministry of Health, Addis Ababa regional health bureau and stakeholders related to mental health integration.

5. RESULT

5.1 General characteristics of study participants

Out of 422 primary health workers who were eligible for the study, 402 respondents had participated with non-response rate of 4.73%. From total participates, 257(63.9%) were females. Median age of the study participants were 27 year with maximum 58 and minimum 20. Regarding marital status, 234(58.2%) were unmarried, 164 (40.8%) were married. Most of study participants 300(74.63%) were orthodox in religion followed by protestant 59(14.7%), and 34(8.5%) were Muslims.

Among total respondents most of health care providers were nurses 181(45.02%), followed by 107(26.62%) health officers, 60(14.9%) were midwives and 49 (12.19%) pharmacist. Concerning their status of education 149 (37.06%) of health professionals were diploma holders. Mean work experience of health care providers were 5.27 with (SD= 0.27).As shown in table 1

Table1-General characteristics of the respondents in primary health care units, Addis Ababa .2017

Variables	Frequency(N=402)	Percent(%)
Gender		
Female	257	63.9
Male	145	36.1
Age (N=366)		
20-24	73	19.95
25-29	391	45.6
30-34	72	19.7
35-39	33	9.02
40-45	9	2.5
Above 45	12	3.3
Religion		
Orthodox Christian	300	74.6
Muslim	34	8.5
Protestant	59	14.7
Catholic	4	1.0
Others	5	1.24
Marital status		
Unmarried	234	58.2
Married	164	40.8
Divorced	3	0.75
Widowed	1	0.25
Level of education		
Diploma	149	37.1
First Degree	243	60.45

Second degree	10	2.49
Profession		
Physicians	3	0.75
Health officer	107	26.6
Nurse	181	45.0
Psychiatry nurse	2	0.5
Midwifery	60	14.9
Pharmacist	49	12.2
Year of work experience		
1-3	119	29.6
3-5	177	44.03
5-10	59	14.7
>11	47	11.7

5.2 Knowledge and attitude of primary health care providers towards mental health

Among the total respondents half of health care providers 203 (50.5%) had received pre- service training related to mental health. Out of those health care providers that had received mental health training 69 (34%) of health care providers had received type of training that include clinical attachment or practical session.

Regarding knowledge towards the cause for mental illness greater than one quarter 116 (28.86%) of health care providers considered supernatural cause (evil-spirit) as important or risk factor for mental health problem. Among health care providers who considered supernatural cause as risk factor for mental illness 68 (58.62%) had not received pre-service training.

General level of knowledge towards mental health among health care providers were scored adequate for more than half 222(55.2%) of the participants. Mean score for knowledge towards mental health were found to be 7.56 (SD=1.89) within a range of (2- 10). Health care provides scored inadequate knowledge were 180(44.78%).Among those health care providers who scored inadequate knowledge towards mental health majority 135(67.84%) had not received pre-service training.

Majority 227 (56.47%) of the respondents were found to be having unfavorable attitude towards mental health. Mean score were 8.84 (SD=2.82) within a range of (1-15).Negative statements were presented to evaluate attitude of health care providers towards mental health and the findings shows there were several endorsement of negative attitude among health care providers for each items. Almost half of health care providers 205(51%) were indicated that it is hard to talk to people with mental disorder. Majority 248(61.69%) of participants were agreed with sedation would guarantee the safety of other patients in the facility. Most respondents 256(63.68%) agreed with detention in solitary place should be consider for people with mental illness. And 117(29.1%) of health care providers reported that they would be doubtful to be around people with mental disorder even after treatment.

5.3 Knowledge and attitude towards mental health service integration

Questions were asked to assess health care provider's awareness about integration of mental health service. Most (83.83%) 337 of respondents had awareness about the integration of mental health service in primary health care level. However more than half (56.22 %) n=226 of the respondents had no awareness about mental health global action program (MHGAP).

Participants were presented with a number of statements and asked to express their reaction to assess attitude of primary health care providers towards mental health care integration. Most respondents 382(95.02%) expressed the importance of mental health service integration. More than one third of heath care providers 152 (37.8%) indicated they were uncomfortable to provide mental health care or treating mentally ill person generally. Furthermore as shown in table 2, more than half of the participants 232(57.1%) expressed that primary health care providers have little to offer in provision mental health care .Also nearly half of respondents195(48.1%) expressed negative attitude towards providing mental health care in the same facility with other patients. More than two third 292(72.64%) of the respondents expressed their notion about exposing other patient for an accident during provision of mental health care in their health centers.

Table 2-Responses of primary health care providers regarding mental health care integration in PHC units, Addis Ababa Ethiopia 2017

Variables	Agree n(%)	Disagree n(%)	Uncertain n (%)
Mental health care integration is important	382(95.02)	20 (4.98)	0
Feeling comfortable to provide mental health care	240(59.7)	152 (37.81)	10(2.49)
PHC providers has little to offer in providing mental health care	232(57.71)	137(34.08)	33 (8.21)
Providing mental health care in the same facility will expose others for danger	292 (72.64)	66 (16.42)	44 (10.95)
People with mental illness shouldn't treat in the same facility	195(48.51)	163(40.55)	44(10.95)
Traditional healers are more effective than medical treatment	139 (34.58)	173(43.03)	90 (22.39)

5.4 Self-perceived competency among health professionals in providing mental health care

Most respondents felt confident in recognizing signs and symptoms of depression 372 (92.54 %) and psychosis 384 (95.52 %).In contrast less than half (44.37%) n=178of respondents reported that they were not felt confident to provide mental health care .And in the same way nearly half of participants expressed that they were not comfortable or confident to provide intervention or medication for psychosis 215(53.48%) and 187(46.52%) for depression respectively. Since treatment of epilepsy was started before integration of mental health service, only one hundred forty two (35.32%) reported that they were not confident to intervene or initiate medication for epilepsy.

5.6 Adoption status of integrated mental health service in primary health care units

The purpose of the present study was to evaluate mental health service integration in PHC units in view of primary health workers. This study used indexes to evaluate status of adoption in primary health care unit. Such as knowledge towards mental health, self-perceived competency of health care providers and attitude towards mental health and its integration. Status of adoption categorized having poor and good adoption status of mental health service integration among PHC providers. Based on summation score of indexes and operational definition mentioned above.

Majority 248 (61.69%) of primary health care providers in this sample were found to be having poor status of adoption of integrated mental health service. Mean score of status of adoption were 29.87(SD=5. 33) with range of (16-42).

Table 3- Adoption status of integrated mental health service among primary health care providers in primary health care units, Addis Ababa Ethiopia 2017

Status of adoption among primary health care providers	Frequency n=402	Percent(%)
Good status of adoption	154	38.31
Poor status of adoption	248	61.69

5.7 Implementation of integrated mental health service in primary health care units

The purpose this objective was to describe implementation of mental health service integration in primary health care unit from primary health care providers view.

5.7.1 Mental health training

From total participant of this study nearly one fifth 77 (19.15%) of healthcare providers had received in-service training related to mental health. Among health care providers who had received training only one fourth 21(27.27%) reported that they had refresher training. From total respondents who had in-service mental health training less than half of respondents 33(42.86%) were found to be having mental health action program (MH GAP) based training. And from those respondents who had mental health gap training nearly one third 14 (35.9%) of health professionals had supervision after training.

Table4-Summary description of type mental health training received by respondents in primary health care units, Addis Ababa Ethiopia 2017

Type of training	Frequency N=77	Percent(%)
Short term training	31	40.26
Long term training	3	3.90
MHGAP training	33	42.86
Mental health training related to ART medication	8	10.39
Diploma in psychiatry	2	2.60

5.7.2 Health care provider's roles and responsibilities regarding mental health care

Among total respondents of health care provider's (62.06%) n=247ofparticipantsreported that they had defined roles with regard to mental health care in their facility. As indicated in table 5, from total participant only fifty five (13.68) % were responsible for treatment and prescription of medication related to mental illness. Majority of respondents (58.3%) n=144reported that they had role for internal referral to focal person in the facility or external referral to mental health institution.

Table 5-Primary health provider's roles and responsibilities in providing mental health care

Variables	Frequency n=247	Percent(%)
Diagnosis and assessment of patients for mental illness	93	23.13
Treatment and prescription of medication for mental health problems	55	13.68
Treating emergency psychosis	34	8.46

5.7.3 Availability of ongoing support from mental health professionals and regular supervision

Among health care providers who had received in-service training, below half 30(38.96%) of respondents had support from mental health professionals (psychiatric professional).And thirty six (46.75%) were reported that they had regular supervision related to mental health. From total participants nearly one fourth 110 (27.3%) of health care providers expressed that they had regular supervision in their institution. Similarly 113 (28.11%) of respondents reported that they had continuous support from mental health professionals in their facility.

5.7.4 Availability of psychotropic medication in primary health units

Questions were asked to primary health care providers about availability of psychotropic medication for the previous month. Such as anti-psychotic drugs (haloperidol, chlorpromazine), anti-depressant drugs (amitriptyline, fluoxetine) and anti-epileptic drugs (Phenobarbital, carbamazepine, diazepam, phenytoin).Among 402 participants ,164 didn't know about the availability of anti-depressant and anti-psychotic medication .For the remaining (238) health professionals anti-depressant and anti-psychotic medication were reported as available by 76.63% and 73.03% of health care providers .Similarly among 402 participants ,136 health professionals didn't know about the availability of anti-epileptic medication. For the remaining n=226 health professionals 89.46% reported that anti-epileptic drug were available for the last month. As shown in table 6.

Table 6-Availability of psychotropic medication reported by health care providers in primary health care units in Addis Ababa, Ethiopia,2017.

Variables	Frequency	Percent(%)
Availability of anti-depressant drug	180	76.63%
Availability of anti-psychosis drug	173	73.03%
Availability of anti-epileptic drug	235	89.46%

5.7.5 Availability and utilization of guideline related to mental health

From total participants of health care providers 153(38.83%) reported that guideline related to mental health were not available in their institution. Out of the remaining respondents only seventy six (19.29) %reported that easily or very easily available and below half of respondents 165(41.8%) reported that guideline were barely available in their facility. Among total participants lower than half 172 (42.79%) of respondents had utilize mental health related guideline.

5.7.6 Formal discussion about mental disorder and recording system

Half of the respondents 203(50.5%) expressed that they had no formal discussion about mental disorder cases during their teaching sessions with their supervisor or colleagues. And more than half of respondents 218(54.23%) were reported that there was no tracking and recording system with in some specified time in their facility.

5.7.7 Referral practice among health care providers

From total respondents 109(27.11%) of health care providers had reported that they don't know about any referral link that had connection with their facility. From total participants forty two(10.45%) of health care providers reported that generally there was low referral practice from the health center to psychiatric institution in their facility .In addition slightly above one fourth 110(27.36%) of health care providers reported that there was no internal referral practice within health professionals in their facility.

5.7.8 Implementation of integrated mental health service in primary health care units

Over all, Implementation level of integrated mental healthcare was evaluated based on determents of successful integration. Mean score of implementation were 6.58 (SD=3.32) within a range of (1-15).Based on the score by primary health care providers majority 236 (58.71%) of health care providers scored under mean or indicated poor implementation of mental health service integration in their institution.

Table 7-Implementation of mental health integration in primary health care units, in Addis Ababa Ethiopia

Variables	Frequency n=402	Percent(%)
Good implementation level	166	41.29
Poor implementation level	236	58.71

5.8 Multivariate logistic regression analysis

Variables with P-value < 0.25 on the bivariate regression analysis were entered to the multivariate model. From this analysis adjusted odds ratio shows statistically significant association for work experience, pre-service training, having diagnosis and assessment role or responsibility in their institution and presence of formal discussion with higher supervisor or colleagues.

Concerning work experience of health care providers, those health care providers with work experience of more than 11 years have 12.3 times higher status of adoption towards mental health service integration than those health care providers with work experience less than three years, AOR (95% CI) = 12.3(3.76- 40.56)p-value 0.000

In addition after controlling other factors, odds of having good status of adoption among health care providers who took pre-service training was found to be 2.1times higher than those health care providers who hadn't received pre-service training. AOR (95% CI) =2.1(1.249 -3.533) p-value 0.005.

Presence of discussion with colleagues and supervisor had significant association with status of adoption. Odds of having good status adoption among those health care providers who reported

they had discussion with their collogues and supervisor was found to be 1.82 times higher than primary health care providers who had reported that they hadn't discussion with their colleagues or supervisor. AOR (95%CI) 1.82 = (1.066- 3.068) P-value= 0.028.

Those primary health care providers who had reported that having role or responsibility to diagnosis and assessment of mental illness were found to have 1.93 times better status of adoption of mental health care integration than those who had no role on diagnosis or assessment of mental disorders.AOR (95% CI) =1.93 (1.021 -3.683) p-value 0.043.

Table 8-General characteristics, health care provider's factors of the respondents and status of adoption toward integrated mental health service in PHC units, Addis Ababa Ethiopia 2017

Variables	Status of adoption		COR(95%CI)	AOR(95%CI)
	Good (%)	Poor(%)		
Gender				
Female	90(35.02)	167(64.98)	0.68{.449 -1.034}	.76{.466 -1.243}
Male	64 (44.14)	81(55.86)	1.0	1.0
Age				
19-24	26(35.62)	47(64.38)	1.0	1.0
25-29	56(33.53)	111(66.47)	0.91{.512-1.623}	.547{.259-1.157}
30-34	29(40.28)	43(59.72)	1.22{.623-2.386}	.323{.119-.872}
35-39	14(42.42)	19(57.58)	1.33{.574-3.086}	.195{.056-.676}
Above 40	29(50.88)	28(49.12)	1.87{.923-3.793}	.308{ .098- .966}
Profession				
Health officer	57(53.27)	50(46.73)	1.0	1.0
Nurse	58(32.04)	123(67.96)	0.42{.253 -.677}**	.534 {.280- 1.018}
Midwifery	17(28.33)	43(71.67)	0.35{.176 -.684}*	.583 {.243- 1.402}
Pharmacist	20(40.82)	29(59.18)	0.61{.305- 1.199}	1.37 {.575- 3.265}
Level of education				
Diploma	141(55.73)	107 (71.81)	0.49{.334 - .772}*	.849{.510 - 1.412}
Degree	112(44.27)	42(28.19)	1.0	1.0
Work experience				
1-2	31(26.05)	88(73.95)	1.0	1.0
3-5	63(35.59)	114(64.41)	1.57{.940 - 2.618}	1.65 {.853- 3.209}
5-10	31(52.54)	28(47.46)	3.51{1.633- 6.048}*	3.8 {1.458- 10.09}
>11	29(61.7)	18(38.30)	4.57{2.234- 9.364}**	12.3{ 3.76- 40.56}**
Pre service training				

Yes	99(48.77)	104(51.23)	2.49{1.646-3.774}**	2.1{1.249 -3.533}*
No	55(27.67)	144(72.36)	1.0	1.0
In-service training				
Yes	41(53.25)	36(46.75)	2.15{1.304 - 3.564}*	1.2{ .6293- 2.343}
No	112(34.57)	212(65.43)		1.0
Utilization of guideline				
Yes	75(44.12)	95(55.88)	1.6{1.057-2.425}*	1.12{.6511 1.891}
No	71(33.02)	144(66.98)	1.0	1.0
Presence formal of discussion with colleagues and higher supervisor				
Yes	90(46.39)	104(53.61)	2.06{1.3572-3.123}*	1.82{ 1.066- 3.068}*
No	58(29.59)	138(70.41)	1.0	1.0
Diagnosis and assessment role in mental health care				
Yes	54(58.06)	39(41.94)	2.89{1.789-4.657}**	1.94{1.021 -3.683}*
No	100(32.36)	209(67.64)		1.0
Prescribing and treatment role of mental health care				
Yes	37(67.27)	18(32.73)	4.04{2.02-7.40}**	1.76{.790- 3.929}
No	117(33.72)	230(66.28)	1.0	1.0

*P-value <0.05, **p-value<0.001

6. DISCUSSION

Since integration of mental health service is a new task shifting strategy to primary health care providers, examining their status of adoption and implementation would have an input for comparing with the past and upcoming experience. In addition would be preliminary for knowing the gap for successful integration.

In this study the main index used for evaluation of adoption status were perceived competency in providing mental health care, knowledge and attitude towards mental health, and integration of mental health. Findings in this study show 55.2% of health care providers had adequate knowledge towards mental health. Study conducted in rural district of Iran, on evaluation of mental health integration shows knowledge score towards mental health among health worker was 64.4 %(26).This difference might be because of training level towards mental health and health workers difference on their profession and also difference on the arrangement of primary health care units. On the other hand, study done in Addis Ababa Ethiopia on 2014 to assess knowledge towards mental illness among nurses in public hospital shows 50% of them had adequate knowledge (7). This had very slight difference compared to the present study. The possible reason might be similarity of study participants in their professions on study done in Addis Ababa public hospitals.

Regarding perceived competency in providing mental health care, in this study shows (55.63%) felt confident in providing mental health care for their patients. And more than half of respondents reported that they were not confident to provide interventions for patient with psychosis. Study conducted in southern India, among primary health care physicians shows majority of (69.6%) of them felt confident to provide mental health care (22).This might be the difference in profession or educational status. In other way, in this study most primary health care providers had high perception of competency in recognizing signs and symptoms of psychosis and depression compared to study conducted in southern India .The possible reasoning for higher perception in the present study might be most healthcare providers (81.59%) in this sample believed that mental illness could recognized easily by the characteristics of the patients.

In the other hand study conducted on primary health care providers in Jimma on 2011, Ethiopia shows majority 60.35% of health care providers reported that they were dissatisfied with their level of mental health knowledge. Moreover qualitative result of these study also described about

primary health care provider's competency level was very low to treat and diagnose a person with mental illness (14).

Concerning attitude towards mental health the finding on this study shows majority of (56.47%) of health care providers had unfavorable attitude towards mental health. In contrast study conducted in Iran, shows majority 92% health workers scored favorable or positive attitude towards mental health (26). Which has high discrepancy compared to our study, the possible reason might be mental health training was given for one quarters of health care providers in Iran before the study. And similarly the findings on the present study shows endorsement of negative attitude towards mental health was slightly higher compared to study done among nurses to assess attitude towards mental illness in Addis Ababa, Ethiopia(7).

Furthermore compared to cross sectional study conducted in Zambia on 2011, endorsement of negative attitude towards mental illness among health care providers were higher in the present study. (44.1%) of respondent in Zambia indicated they find it hard to talk to people with mental illness which was founded to be 51% of health care providers in our study. Similarly42.3% agreed with dentition in a solitary place should consider for mentally ill person, which (63.68%) on the present study (27).

Regarding, attitude towards mental health care integration in primary health care units more than half (57.71%) health care providers expressed negative attitude towards providing mental health care .Which was somehow higher compared to study conducted among primary health care physicians in southern India. The possible reason might be difference in educational status of primary health care providers.

Some studies show that there are different factors that could influence knowledge and attitude towards mental health care. Regarding profession of primary health care providers, in this study the wide discrepancies on adoption status of mental health care integration among professionals presented. This might be because of difference in input of training during.

Concerning level of education, diploma level health professionals had lesser adoption status to mental health care integration than degree level .In similar way, study conducted on perceived challenge and opportunity of mental health integration in Ethiopia, shows diploma level health care workers are more likely to endorse on supernatural cause as a risk factor for mental illness.

In addition, there were differences on favoring the health center for delivery of mental health care among degree level compared to diploma nurse. The possible reasons might be diploma level health professionals had low pre-service training regarding mental health training

On this study work experience shows major influence on health care provider's adoption status of mental health care. Similarly a study conducted in Kenya on 2011to assess knowledge, attitude and practice towards mental illness reported that senior physicians were more knowledgeable about mental disorders and they also appeared having positive attitude towards mental health. The possible reason might be seniority in their careers made use their experience, clinical exposure and awareness in the course of their practice (28).

In the present study pre-service training had significant influence on adoption status of mental health service integration among primary health care providers. Primary health care providers that had received training were found to have better adoption status of integrated mental health service than compared to those who were not received any pre-service training. With this regard, study conducted among primary health care physicians in rural district of southern India shows negative attitude towards mental health care were endorsed by those primary health care providers who had not acquired pre-service training (22).In addition, study done among nurses in Ethiopia Addis Ababa on 2011, shows that nurses who took training are two times more likely knowledgeable towards mental illness than from those who had not took training (7).

In this study findings show, presence of discussion with colleagues or higher supervisor had significance on health care providers adoption status of mental health care .This might be health care providers with good adoption status which implied as good level of knowledge and attitude towards mental health care probably having active participation on discussion regarding mental cases .On the other way, presence of discussion in the PHC units improved the health care providers level of knowledge and attitude towards mental health care .

Those having role on diagnosis and assessment of mental illness had better adoption status towards mental health care .This might be those having role in providing mental health care had good level of knowledge and skill and in addition those who expressed as having mental health care responsibility had training and clinical exposure in their institution .

Regarding implementation of integrated mental health service, determinates of successful integration were assessed in primary health care provider's perspectives. In present study out of primary health care providers who receive in service training, almost half of health care providers were not supervised after training. Similarly, study conducted in Ethiopia to assess experience ,strength, and challenge of integrated mental health service reported that low level of support and supervision after training as challenge for integration of mental health service .(11)

Concerning role and responsibility of mental health care provision among total respondents (62.1%) of participants had reported as they had known roles in regarding mental health care .And only (13.68%) of health care providers were responsible for treatment and prescription of psychotropic medication. On the other hand, Review done by WHO, on integrating mental health care in primary health settings reported primary health care physicians in Argentina, approximately 56% of primary care workers can prescribe without restriction, 40% with some restriction .The possible reason might be socioeconomic factors and setup differences between the countries. In addition different competencies level of healthcare workers and greater experience of integration in their country(17).Furthermore WHO review on integration of mental health service in Uganda reported that their ministry of health allow general health workers to prescribe and administer psychotropic medicines for chronic patients, after the treatment has been initiated by a mental health professional .According to WHO report increasing primary care responsibility for treatment is indicator for a task shifting in mental health care(17).

Regarding availability of psychotropic medication majority of health care providers reported that availability of anti-psychosis, anti–depressant and anti-conversant medication (76.63%, 73.03%, 89.46%) respectively. Similarly study conducted in all region of Ethiopia, using supervision of primary health care units that were implementing the scale up program shows good availability of psychotropic medications in primary health care units and also mentioned as strength for mental health service integration (11).

Concerning mental health guideline majority (60%) of health care providers reported that guideline were available in different amount or distribution in their institution .In contrast study conducted in Jimma, Ethiopia among health care providers shows there were no available guideline in health centers .The possible reason might be implementation of integrated mental health service was not started during the study period (14). With this regard utilization of

guideline among total participants were reported only among half of the respondents. The possible reason might be low availability and distribution of guideline in the primary health care units.

In this study, nearly half (199) 49.87% healthcare providers reported they had formal discussion about mental disorder with higher supervision or colleague. Unlike a research conducted in Jimma, Ethiopia almost all 96.7% of primary health care providers expressed there was no discussion in their institution regarding mental disorder (14).This discrepancy might be also because of implementing mental health integration was not started at that study period of time.

In this study more than half of respondents reported that there was no tracking or reporting systems related to mental disorder cases. However depending on the report of WHO one factor for successful mental health integration is integration of mental health data in to general health information and reporting system at primary health care level (17).

7. LIMITATIONS AND STRENGTH OF THE STUDY

Limitation of study

- Since the study only include health care providers other important stakeholders such as community, patients with mental health problem and their families, policy makers and health managers are excluded on evaluating the status or level of the scale up program.
- Score towards implementation of mental health service integration might be biased by health care provider’s knowledge or awareness on the situation.

Strength of the study

- Even if few studies done on knowledge and attitude before implementing process have started, this study has tried to evaluate overall status of health care providers and units towards integration of mental health service after implementation by adding some value on the previous information. This study also clearly shows important factors that could use as input to improve mental health care in primary health care level.

8. CONCLUSIONS

Status of adoption towards mental health integration among majority of primary health care providers is poor. As well as majority of Primary health care providers also have negative attitude towards mental health and mental health service integration. This shows though acceptability of integrated mental health among health care providers was good, readiness to deliver mental health care in their settings is low.

The influencing factors for adoption status of integrated mental health service in primary health care units are work experience, pre-service training, having a role or responsibility to diagnosis and assessment of mental illness, presence of discussion with colleagues and supervisors in the facility. Primary health care providers who had higher work experience have great level of influence on good status of adoption of integrated mental health service.

Majority of primary health care providers were indicated that there is poor level of implementation in the primary health care units. With this regard, low level of support and supervision, low availability of guideline, lack of tracking and reporting system for mental health data and absence of formal discussion regarding mental health in their institution are most important weakness.

9. RECOMMENDATION

Ministry of health and health science colleges should consider pre service training to several field of study in order to improve acceptance regarding mental health care and to advance integration of mental health care from the source.

Mental health global action implementers should facilitate consistent support and supervision after in-service training. In addition several interferences should be used to change awareness or attitude of health workers towards mental health service integration. Such as providing orientation for all primary health care providers about the service and increasing availability of flow chart and guideline in all departments.

Further research could be done to evaluate implementation of integrated mental health service from the entire perspective that includes community and client with mental health problem or families.

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11, ANNEXS

ANNEX 1: Informed Consent (English version)

Addis Ababa University, School of public health

Subject Information Sheet

Hello,

My name is ———————————————— I am here on behalf of Roman mehari, a student of Addis Ababa University School of public health service management unit. She is conducting a research on “status of adoption and implementation level of integrated mental health in primary health unit. She received permission from Addis Ababa university school of public health and medical director of the health center to conduct this study.

You are selected by simple random sampling technique to participate in this study because you are currently working in this health facility. One of those selected health center for the study purpose. Your participation on this study will only be on based on your willingness .You have the right to choose not to take part in this study. If you choose to take part, you have the right to stop at any time. If you are willing to participate or refuse or decide to withdraw later, you will not be subjected to any ill-treatment.

If you agree to participate in the study, you will take the questioner that will be answered by you. The questioners is about your knowledge, attitude towards integrated mental health care and extent of implementation on your facility

The study could provide information that would be useful in the formulation of better training, for management and service delivery on mental health issues in primary health care level and better implementation of integration of mental health service. It could also give insight on the current knowledge and attitude status that could be addressed during training and supervision and factors that could effect of adoption and implementation of mental health service. The information that you provide will be kept confidential by using only code numbers and locking the data. Your name will not be written on the questionnaire. No one will have access to the non-coded data except the principal investigator and the data will not be used for purposes other than the study. Your willingness and active participation is very important for the success of this study.

Informed Consent

Based on the understanding of the above information, are you willing to participate in this study?

A) Yes

B) No

If yes, you will continue to respond for the following questioners.

Respondent

Signature ______________________Date__________________

Result of response

A) Completed

B) Not completed

C) Partially completed

D) Refused

Checked by Supervisor: Name ________________________Signature_____________

For further explanation use the Principal Investigator's Address;

Name: Roman MehariTesgaw

Email: romanmehari11@gmail.com

Cell phone: +251 911928721

: +251913828582

ANNEX 2: Questionnaires in English version on adoption status and implementation level of integrated mental health in primary health care units.

Section 1: General characteristics of the participants.

NO	Question	Answer
101	Gender	1.Female 2.Male
102	Age	----------------------year
103	Religious affiliation	1.Orthodox 2.musulim 3.protestant 4.chatholic 5.Other (specify)------------
104	Marital status	1.Single 2.Married 3.Divorced 4.Widowed 5.Other (specify)------------
105	Educational level	1.diploma 2.degree 3.masters
106	Field of study (profession)	1. physicians 2.nurse 3.Health officer 4.Midwife 5.pscahtric nurse 6.Other (specify)--------
107	Work experience	------------in years

Section 2.Assesment of knowledge towards mental health and integrated mental health service

2.1. Assessment of knowledge towards mental health

201	Have you received pre service training (basic) course on mental illness?	1,yes 2,No
202	If yes for question no203, what type of training have you received?	1.Theory only 2.Theory& clinical practical
203	Is it enough to manage mentally ill the training you take?	1.yes 2,No
204	Strange or altered behavior seen in mental illness which can be the result of neuro-chemical abnormalities in the brain	1.yes2. No
205	A diagnosis of mental illness is made based on history of the	1.yes 2. No

	patient and mental status examination at the time of interview	
206	Did you think Mental disorders are inherited?	1,yes 2,No
207	Strange or altered behavior seen in mental illness can improve by administering of medication, which alter the neuro- chemicals abnormalities in the brain	1.Yes 2.No
208	Generally Very effective and safe drugs are available to treat mental illness	1.Yes 2.No
209	The risk of occurrence and relapse of mental illness is high in patients who abuse drugs like cannabis or amphetamine like substance such as khat.	1.Yes 2..No
210	Did you believe that Mental illness Caused due to evil spirit?	1,yes 2,No
211	Mentally ill individual can have strange experience like hallucinations& false firm beliefs like delusions	1,yes 2,No

2.2 **Assessment knowledge towards integration of mental health service**

216	Do you know about integration of mental health service in primary health care	1.yes 2.no
217	Have you heard about GAP (mental health global action program)?	1.yes 2.no
218	How much do you know about (mental health global action program)?	1.Nothing 2.Little 3.Some 4.A great deal

Section 3.Assesemnt of self- perceived competency on providing mental health service in the facility

Evaluate your perceived competency towards assessment of mental illness		Agree or disagree with the statement
301	I asses and recognize signs and symptoms of psychosis (schizophrenia).	Strongly disagree…1 disagree …………..2 Neutral……………3 agree……………...4 strongly agree……..5
302	I can recognize signs and symptoms of Depression.	Strongly disagree…1 disagree …………..2 Neutral……………3 agree……………...4 strongly agree……..5
303	I recognize behaviors that indicate a patient may have alcohol or drug abuse Problems.	Strongly disagree…1 disagree …………..2 Neutral……………3 agree……………...4

		strongly agree……..5
304	I am able to assess patients for risk of Suicide (suicidal attempt).	Strongly disagree…1 disagree …………..2 Neutral……………3 agree……………...4 strongly agree……..5
305	I am able to assess and recognize patient's behavior with alcohol and substance abuse.	Strongly disagree…1 disagree …………..2 Neutral……………3 agree……………...4 strongly agree……..5
Evaluate your self -perceived competency regarding intervention and practice of mental illness		Agree or disagree with the statement
306	I feel confident in providing mental health service to patients	Strongly disagree…1 disagree …………..2 Neutral……………3 agree……………...4 strongly agree……..5
307	I am confident that I can initiate antipsychotic medication for cases present with psychosis.	Strongly disagree…1 disagree …………..2 Neutral……………3 agree……………...4 strongly agree……..5
308	I am confident that I can initiate anti-depressant medication for cases present with depression	Strongly disagree…1 disagree …………..2 Neutral……………3 agree……………...4 strongly agree……..5
309	I am confident that I can initiate anti consultative medication for cases with epilepsy	Strongly disagree…1 disagree …………..2 Neutral……………3 agree……………...4 strongly agree……..5
310	I am confident that I can provide counseling section for patients with depressive disorder.	Strongly disagree…1 disagree …………..2 Neutral……………3 agree……………...4 strongly agree……..5

Section 4 Assessment of attitude towards mental health and integration mental health service

4.1Assessment of attitude towards mental health

NO	Statement to assess attitude towards mental health	agree and disagree with the statement
401	Mental health problems are signs of personal weakness	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1
402	People with mental illness have unpredictable behavior	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1
403	If people become mentally ill once, they easily become ill again	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1
404	People with mental illness are dangerous	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1
405	It's easy to identify who has a mental illness by the characteristics of their behavior	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1
406	All people with mental illness have some strange behavior	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1
407	Find it hard to talk to someone with mental health problems	Strongly disagree…5 disagree …………..4 Neutral……………3

		agree……………....2 strongly agree……..1
408	Even after treatment, I would be doubtful to be around people who has been treated for mental illness	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1
409	People with mental illness should not be allowed to work	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1
410	Political and individual rights of mentally ill persons should be suspended while they are on treatment.	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1
411	Those with mental illness should not have children	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1
412	Psychiatric hospitals is the only place for people with mental illness	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1
413	Violent mental patients should be handcuffed	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1
414	Detention in a solitary place should be considered for people with mental illness	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1
415	Sedation of mental patients would guarantee safety for other people in all cases	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1

4.2 Assessment of attitude towards mental health care integration

NO	QUESTION	**agree and disagree with the statement**
416	What do you think about importance of providing mental health service in primary health care level	Extremely unimportant…1 Unimportant…………2 Important……………3 Extremely important…4
417	Do you feel comfortable to diagnosis or assess patients with mental disorder	extremely uncomfortable 1 comfortable…….2 undecided……….3 uncomfortable……..4 extremely uncomfortable.5
418	PHC providers have little to offer patients with mental health problems	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1
419	Some health workers believe that health centers can't play any role in intervening for mental Illness? What about you?	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1
420	Some health workers believe that delivering mental health services in the health centers will put other patient in danger? What about you?	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1
421	Some health workers believe that mentally ill patient should not be treated in the same health centre with the general patient. What about you?	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1
422	Some health workers believe that traditional healers are better in effectiveness than our medical Care? What about you?	Strongly disagree…5 disagree …………..4 Neutral……………3 agree……………....2 strongly agree……..1

Section 5- Assessment of integrated mental health service implementation in primary health care units in health facility

NO	Question	Answer	Skip
501	Have you received any in service training related to mental health	1.yes 2.no	Skip to 505 if no
502	If yes for the question 401, what type of training have you taken?	1.short course training 2.long term (6 month to 1 year) 3.mental health related to ART 4.MH GAP training 5.diploma in psychiatry 6. advanced diploma in psychiatry 7.other specify	
503	If yes for 501, Were this training followed by supervision?	1,yes 2,no	
504	Did you take refreshing training after you receive the first training	1,yes 2,no	
505	Have staffs had defined roles in identification, management and referral of mental disorders?	1,yes 2,no 3, I don't know	Skip to 507 if no
506	What is the scope of role in mental health service that you are delivering in your facility? (tick to all apply)	1.assessing /screening for mental problems 2.perscrabing for psychotic and depression 3.provide counseling for MNS cases 4.referral 5.treat patient with psychotic emergency 6.no role till now	
508	Regularity of supervision visit related to mental health	4.Frequently 3.Sometimes 2.Rarely 1.Never	

509	Availability clinical ongoing support from mental health professionals(psychiatric specialist)	4.Frequently 3.Sometimes 2.Rarely 1.Never	
510	Did you know any referral option for mental health specialist, psychiatric clinic or hospital that had a link with this facility?	1.yes 2.no	
511	Generally, mental illness cases referrals occurs from your facility to mental health specialty clinic or hospital	4.Frequently 3.Sometimes 2.Rarely 1.Never	
512	Generally, mental illness cases referral occurs internally from one health professionals or to the other health professionals (unit).	4.Frequently 3.Sometimes 2.Rarely 1.Never	
513	Generally, Referral from Community health workers to PHC units	4,Frequently 3,Sometimes 2,Rarely 1,Never	
514	What do you think the Availability of generic anti-depressant Eg (amitriptyline, fluoxetine) for the previous one month	5.always 4.usually 3.sometimes 2.rarely 1.never	
515	What do you think Availability of generic anti-psychotic medication eg (haloperidol, chlorpromazine, fluphenazine) for the previous month	5.always 4.usually 3.sometimes 2.rarely 1.never	
516	What do think about the Availability Generic anti-epileptic Medication e.g (phenobarbital carbamazepine, diazepam inj,phenytoin, valproic acid) for the previous month	5.always 4.usually 3.sometimes 2.rarely 1.never	
517	How often you used psychiatric medication in practice	5.always 4.usually 3.sometimes 2.rarely 1.never	
518	What do think about Availability of mental health related guideline	1.Poor/inadequate 2.barely/adequate 3.good 4.very good 5.excellent	

519	Utilization of guideline to assess and manage person with mental disorders	5.always 4.usually 3.sometimes 2.rarely 1.never	
520	Dose discussion with supervisor or colleagues about mental health cases take place in regular meeting?	1.yes 2 no	
521	If mental illnesses are identified at the PHC level, it is documented in clinical charts?	1.yes 2.no	Skip 522 if no
522	If yes, these are collected from charts and tracked in weekly or monthly data collection?	1.yes 2, no	

ANNEX 3: Informed consent in Amharic

አዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ፋካልቲ የህብረተሰብ ጤና አጠባበቅ ትምህርት ክፍል

የመላሾች የመረጃ ቅጽ

ጤና ይስጥልኝ እንደምንነዎት?

የመጣሁት በአዲስ አበባ ዩኒቨርስቲ የህብረተሰብ ጤና አጠባበቅ የጤና አገልግሎት አስተዳደር (health service management) ክፍል ተማሪ የሆነችውን ሮማን መሀሪ ወክዬ ነው።

የጤና ባለሞያዎችስለአእምሮጤናእናአገልግሎትመዋሀድ እና መካተት ያሎትንጠቅላላ የአቀባበልሁኔታእናየአፈፃፀምደረጃ በተመለከተ ለማወቅ ይህ ፕሮግራም ተግባራዊ የተደረገባቸው የአዲስ አበባ ጤና ጣቢያዎች ላይ ጥናት እያደረገች ሲሆን ከአዲስ አበባ ዩኒቨርስቲ፣ ከአዲስ አበባ ጤና ቢሮ እና ከተመረጡት ጤና ጣቢያዎች ፍቃድ አግኝታለች ። እርስዎ በዚህ ጥናት ላይ እንዲሳተፉ የተመረጡት በተደረገ የአጋጣሚ የናሙና አወሳሰድ ስልት መሰረት ነው።እንዲሁም ለዚህ ጥናት አላማ ከተመረጡ ጤና ጣቢያዎች በአንዱ ውስጥ ስለሚሰሩ ነው።

በጥናቱ ላይ ያለመሳተፍ ሙሉ መብት አለዎት። የእርስዎ ተሳትፎ ሙሉ በሙሉ በፍቃደኝነት ላይ የተመሰረተ ነው። ለመሳተፍ ፈቃደኛ ከሆኑ በኂላ በፈለጉት ጊዜ ማቆም ወይም ማቋረጥ ይችላሉ። በጥናቱ ባለመሳተፎ የሚደርስቦት ችግር አይኖርም።

በጥናቱ ለመሳተፍ ከተስማሙ በራሶ የሚሞላ ወይም የሚመለስ ጥያቄዎችን ይመልሳሉ። ጥያቄዎቹ የአእምሮ ጤናን እንዲሁም የአእምሮ ጤናን አገልግሎት መካተትን በተመለከተ ያላችሁን እውቀት፣ አመለካከት ፣ አገልግሎትን የመስጠት ብቃት እንዲሁም በጤና ጣቢያዎ ያለውን የአፈጻጸም ደረጃ የተመለከተ ነው።

ይህ ጥናት የተሻለ ስልጠናን ለማዘጋጀት፣ የአእምሮ ጤናን እና የአእምሮ ጤና አገልግሎትን አሰጣጥ አስተዳደርና አፈጻጸም በተሻለ ሁኔታ ለመተግበር ፣ከዚህም በተጨማሪ በአሁኑ ጊዜ የጤና ባለሞያዎች ያላቸውን የእውቀትና የአመለካከት ደረጃ እንዲሁም ተያያዥ ሁኔታ ለማወቅ ነው። ይህም ደግሞ በስልጠና ወይም በድጋፍ ቁጥጥርጊዜ የተሻሉ መንገዶችን ለመቅረጽና ለመተግበር ተጨማሪ ግብዓት ሊሆን እንደሚችል ጽኑ እምነት አለን።

በመጨረሻም ከእርሱዎ የምንሰበስበው መረጃ ከስምዎ ጋር አይያያዝም ስምዎት እንደማይጠቀስ እና ለማንም አካል ተላልፎ እንደማይሰጥ ልናረጋግጥልዎት እንወዳለን። የዚህ ጥናት ውጤት ግን ተጠርዞ እና ተዘጋጅቶ ጉዳዩ ለሚመለከታቸው የጤና ድርጅቶች ወይም ለሌሎች አካላት ሊሰጥ ይችላል።

የስምምነት መጠየቂያ /ማረጋገጫ ቅጽ

ከላይ በተሰጠዎት መረጃ መሰረት በጥናት ላይ ለመሳተፍ ፍቃደኛ ነዎት

1.አዎ 2.አይደለሁም

መልስዎ አዎ ከሆነ ጥያቄዎችን መሙላት የቀጥሉ ፍቃደኛ ካልሆኑ ምክንያትዎን ጠቅሰው ጥያቄዎችን ይመልሱ።

ANNEX 4: Questionnaires in Amharic version on adoption status and implementation level of integrated mental health in primary health care unit.

ክፍል 1 መሰረታዊ የጤና ባለሙያዎች መረጃ

ተ.ቁ	ጥያቄዎች	መልስ/ኮድ
101	ጾታ	ሴት………1 ወንድ…….2
102	እድሜ	-------
103	ሀይማኖት	1.ኦርቶዶክስ 2.ሙስሊም 3.ፕሮቴስታንት 4.ካቶሊክ 5.ሌሎችም
104	የጋብቻ ሁኔታ	1.ያላገባ/ች 2.ያገባ/ች 3.የፈታ/ች 4.የሞተበት/ባት
105	የትምህርት ደረጃ	1.የመጀመሪያዲግሪ 2.ዲፕሎማ
106	ያጠኑት የሞያ ዘርፍ	1.ሃኪም 2.ነርስ 3.የጤና መኮንን 4.አዋላጅ ነርስ 5.የአእምሮ ጤና ነርስ
107	የስራ ልምድ	---------በአመት

ክፍል 2፡-ስለአእምሮ ጤና እና የአይምሮ ጤና አገልግሎት መዋሀድን ወይም መካተትን በተመለከተ ያሎዎትን እውቀትለመቃኘትየሚሰጥ መረጃ

2.1 <u>የአእምሮ ጤናን በተመለከተ ያሎትን ዕውቀት ለመቃኘት የሚሰጥ መረጃ</u>

ተ/ቁ	ጥያቄዎች	መልስ
201	አገልግሎት መስጠት ከመጀመር በፊት የአእምሮ ጤና እና ህክምና ጋር በተያያዘ መሰረታዊ ሥልጠና ወስደዋል?	1,አዎን 2,አልወሰድኩም
202	በተራ ቁጥር 203 አዎ ከነበረ መልስዎ የትኛውን የስልጠና አይነት ነው ወስደው የነበረው?	1.በፅንስ ሀሳብ ላይ ብቻ የተመሰረተ 2.ፅንስ ሀሳብ እና ተግባራዊ የህክምና ምርመራ ላይ የተመሰረተ
203	የወሰዱት ሥልጠና የአእምሮ ህመምን ለማከም በቂ ነው ብለው ያስባሉ ?	1,አዎ 2,አይደለም
204	ያልተለመደ ወይም የተረበሸ ፀባይ በአእምሮ ህሙማን ላይ ይታያሉ የዚህ ምክንያት በአይምሮ ውስጥ የሚገኙ ኬሚካሎች አለመስተካከል ሊሆን ይችላል::	1,አዎ 2,አይደለም

205	የአእምሮ ህመም ህክምና እና ምርመራ በህመምተኛው ታሪክ(patient history) እናየአይምሮ ሁኔታ ምርመራ (physical examination)ላይ መሰረትየሚያደርግነው	1,አዎ 2,አይደለም
206	የአእምሮ ህመም በዘር ይመጣል ብለው ያስባሉ?	1,አዎ 2,አላስብም
207	በአጠቃላይ የአይምሮ ህመምን ለማከም በጣም ውጤታማ እና የማይጎዱ መድሀኒቶች አሉ	1,አዎ 2,የለም
208	የአይምሮ ህመም በርኩስ መንፈስ ምክንያት ይከሰታል ብለው ያስባሉ	1,አዎ 2,አላስብም
209	ታካሚው በአደንዛዥ ዕፅ ማለትም እንደ ካናቢስ ወይም ጫት የመሳሰሉት አይነት ሱስ ውስጥ ከገቡ ወይም ካሉ የአይምሮ ህመም ሊከሰት ወይም እንደገና ሊነሳ የሚችልበት መጠን ይጨመራል፡፡	1,አዎ 2,አይደለም
211	የአይምሮ ህመም ያለባቸው ሰዎች ያልተለመዱ ነገሮች ያጋጥማቸዋል ለምሳሌ ያልተከሰተ ነገሮች ማየት (hallucination) እና ከእውነታ የራቀ ነገር ማመን (delusion) ናቸው	1,አዎ 2,አይደለም

2.2 የአእምሮ ጤና አገልግሎት በመጀመሪያ ደረጃ የጤና የአገልግሎት ተቋም (ጤና ጣቢያ) ውስጥ መዋሀድን ወይም መካተት በተመለከተ ያሎትን እውቀት የሚሰጥ መረጃ

ተ.ቁ	ጥያቄዋች	መልስ
213	የአእምሮ ጤና አገልግሎት በመጀመሪያ ደረጃ የጤና የአገልግሎት (ጤና ጣቢያ) ስለመዋሀዱ ወይም ስለመካተቱ ያውቃሉ ?	1.አዎ 2.አላውቅም
215	ስለ MHGAP (metal health global action program) ምን ያህል ያውቃሉ	1.አላውቅም 2.በጣም ትንሽ አውቃለሁ 3.ትንሽ አውቃለሁ 4.በደንብ አውቃለሁ

3.2 የአእምሮ ጤና አገልገሎትን ለመስጠት የእርስዎንየብቃት መጠን በተመለከተ የሚሰጥመረጃ

ተ/ቁ	ዓረፍተ ነገሮች/አባበሎች	ከዓረፍተ ነገሮቹ ጋር ይስማማሉ /አይስማሙም
301	የአእምሮ መቃወስ (schizophrenia) ምልክቶችን መለየትና ማወቅ እችላለሁ፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
302	የድባቴ (Depression)ህመም ምልክቶች ለይቼ ማወቅ እችላለሁ፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም

303	ታካሚዎች በአልኮል ወይም በአደንዛዥ እፅ ሱሰኝነት ምክንያት ሊያሳዩ የሚችሉትን ፀባዮች ለይቼ ማወቅ እችላለሁ፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
304	የታካሚዎችን እራስን ለማጥፋት ተገላጭነት ያላቸውን ታካሚዎች መመርመር እና መለየት እችልለው፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
305	የአእምሮ ጤና አገልግሎት ለመስጠት ብቃት እዳለኝ እተማመናለሁ	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
306	የአእምሮ ጤና እክል ጋር ለሚኖሩ እንዲሁም ከዚህ ጋር ለተገናኘ ህክምና ተገቢውን መድሀኒቶች ለማስጀመርና ለመከታተል ብቃት እንዳለኝ አምናለሁ	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
307	ለአእምሮ መቃወስ (schizophrenia) ህመም መድሀኒት ማስጀመር እንደምችል እተማመናለሁ፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁምአልስማማም
308	ለድባቴ (Depression) ህሙማን መድሀኒት ማስጀመር እንደምችል እተማመናለሁ	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
309	ለሚጥል ህመም (epilepsy) ላለባቸው ህሙማን መድሀኒት ማስጀመር እንደምችል እተማመናለሁ፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም

310	ለድባቴ (Depression) ህሙማን የማማከር አገልግሎት (non pharmacological management) መስጠት እንደምችል እተማመናለሁ	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁምአልስማማም

ክፍል4. ስለአእምሮ ጤና እንዲሁም የአእምሮ ጤና አገልግሎት መዋሀድን ወይም መካተትን በተመለከተ ያሉትን አመለካከት ለመዳሰስ የሚሰጥ መረጃ

4.1 ስለአእምሮ ጤና በተመለከተ ያሉትን አመለካከት ለመዳሰስ/ለመቃኘት የሚሰጥ መረጃ

ተ.ቁ	ዓረፍተ ነገሮች/አባበሎች	ከዓረፍተ ነገሮቹ ጋር ይስማማሉ /አይስማሙም
401	የአእምሮ ህመም የግለሰቡ የድክመት ምልክትነዉ፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
402	ከአእምሮ ህመም ጋር ያሉ ሰዎች ያልተጠበቀ ፀባይ ያሳያሉ፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
403	ሰዎች አንዴ በአእምሮ ህመም ከታመሙ በቀላሉ እንደገና ሊታመሙ ይችላሉ፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
404	ከአይምሮ ህመም ጋር ያሉ ሰዎች አደገኞች ናቸው፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
405	ታካሚዎች በሚያሳዩት ፀባይ በቀላሉ የአእምሮ ህመምን መለየት ይቻላል፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም

406	የአእምሮ ህመም ጋር ያሉ ሰዎች ሁሉ ያልተለመዱ ፀባዮችን ያሳያሉ፡፡	5.በጣም እስማማለው 4.እስማማለም 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
407	ከአእምሮ ህመም ጋር ያሉ ሰዎችን ማውራት ከባድ ሆኖ አግኝቸዋለሁ፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
408	ከህክምና በኃላም ቢሆን ከአእምሮ ህመም ታካሚዎች አካባቢ ለመሆን ጥርጣሬ ያሳድርብኛል፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
409	ከአእምሮ ጋር የሚኖሩ ሰዎች እንዲሰሩ ሊፈቀድላቸው አይገባም፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
410	የአእምሮ ህመም ታካሚዎች ህክምና ላይ እያሉ ፖለቲካዊ እና ግለሰባዊ መብቷቻቸው ለጊዜው ሊታገድ ይገባል፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
411	ከአእምሮ ህመም ጋር ያሉ ሰዎች ልጆች ሊኖራቸው አይገባም፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
412	ከአእምሮ ህመም ጋር ላሉሰዎች የአእምሮ ህክምና ተቋም ብቸኛ ቦታቸው ነው፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
413	ሀይለኛ እና ረባሽ የአእምሮ ህመም ታካሚዎች እጃቸውን መታሰር አለባቸው፡፡	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም

414	የአእምሮ ህመም ታካሚዎችን ማረጋጋትና ማደንዘዝ የሌሎችን ታካሚዎች ደህንነት ሊያረጋግጥ ይችላል።	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
415	በአእምሮ ህመም ለሚመጡ ታካሚዎች ለብቻ ለይቶ ማቆያ ሊዘጋጅ ወይም ሊኖር ይገባል።	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም

4.2 የአእምሮ ጤና አገልግሎት መካተትን ወይም መዋሀድን በተመለከተ ያሎትን አመለካከት ለመዳሰስ የሚሰጥ መረጃ

ተ.ቁ	ጥያቄዎች	ይስማማሉ /አይስማሙም
417	ለአእምሮ ጤና እክል የሚሰጡ የምክር አገልግሎቶች በዘርፍ ለሚሰሩየጤና ባለሙያዎች መተው ወይም መሰጠትአለበት።	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
418	በጤና ጣቢያ ውስጥ የሚሰሩ ባለሞያዎች ከአእምሮ ጤና እክል ጋር በተያያዘ የሚያበረክቱት አስተዋፅዎ በጣም ትንሽ ነው።	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
420	አንዳንድ የጤና ባለሙያዎች የአእምሮ ጤና አገልግሎት በጤና ጣቢያመስጠቱ ሌሎች ታካሚዎችን አደጋ ላይ ይጥላል ብለው ያምናሉ።እርሶስ?	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
421	አንዳንድ የጤና ባለሙያዎች የአእምሮ ጤና ህሙማኖች ለሌላህክምና ከመጡ ታካሚዎች ጋር በተመሳሳይ ቦታ አገልግሎት ሊሠጥ ይገባም ብለው ያስባሉ።እርሶስ?	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም
422	አንዳንድ የጤና ባለሙያዎች ባህላዊ እና ሀይማኖታዊ ህክምናዎችን የተሻለጥሩ ውጤት ያመጣሉ ብለው ያስባሉ።እርሶስ?	5.በጣም እስማማለው 4.እስማማለው 3.አስተያየት የለኝም 2.አልስማማም 1.በፍፁም አልስማማም

ክፍል5 የአእምሮ ጤና አገልግሎት መዋሀድ ወይም መጣመር በተመለከተ የአፈፃፀም ደረጃውን ለመዳሰስ የሚሠጥ መረጃ

ተ.ቁ	ጥያቄዎች	መልስ/ኮድ
501	የጤና አገልግሎት መሰጠት ከጀመሩ በኃላ ከአእምሮ ጤና ጋር በተያያዘ ሥልጠና ወስደው ያውቃሉ?	1.አዎ 2.አልወስድኩም
502	ለጥያቄ 501 መልስ አዎ ከሆነ የትኛውን አይነት ስልጠና ነው የወሰዱት	1.የአጭር ጊዜሥልጠና 2.የረጅም ጊዜሥልጠና 3.MHGAP ላይየተመሰረተሥልጠና 4.ከፀረ HIV መድሀኒት ጋር በተያያዘ የሚመጣየአእምሮጤናእክልየሚሰ ጥ ሥልጠና 5.በስነ አይምሮ ጤናዲፒሎማ
503	ለጥያቄ 501 መልስ አዎ ከሆነ ከስልጠናው በኃላ ክትትል ወይም ቁጥጥር(supervision) ነበርዎት?	አዎ………..1 አልነበረም….2
504	ከመጀመሪው ስልጠና በኋላ ማነቃቂያ ወይም ተጨማሪ ስልጠና ወስደዋል?	አዎ……..1 አልወሰድኩም….2
505	በዚህ የጤን ጣቢያ ላይ የምትሰሩ የጤና ባለሞያዎች ከአእምሮ ጤና አገልግሎት ጋር በተያያዘበመለየት፣በማከምና እንዲሁም ወደ ተሻለ ህክምና ማዘዋወር ወይም መላክ ላይየታወቀ ሚና አላችሁ?	አዎ……..1 የለንም…2
506	የአንተ ወይም የአንቺ ሚና በአእምሮ ጤና አገልግሎት ውስጥ የትኛውን ያጠቃልላል (የሚመለከቶትን በሙሉ ያክብቡ)	1.ታካሚውን ለአእምሮ ጤና እክል መለየትና መመርመር 2.መድሃኒቶችን ማዘዝ እና ማከም 3.የምክር አገልግሎት (counseling) መስጠት 4. ወደ አእምሮ የህክምና መስጫ መላክ 5.በድንገተኛ የአእምሮ ቀውስ ለሚመጡ ህክምና መስጠት 6.ምንም ሚና የለኝም
507	የአእምሮ ጤናን በተመለከተ በምን ያህል ጊዜ በየጊዜው የሚደረግ(regular) ቁጥጥር ወይም ክትትል ይደረግላችኃል::	4.በተከታታይ 3.አንዳንዴ 2.በጣም አልፎ አልፎ 1.በፍፁም
508	በምን ያህል ጊዜ ከአእምሮ ጤና ባለሙያዎች (mental health professionals)ህክምናውን በተመለከተ ድጋፍ ያገኛሉ?	4.በተከታታይ 3.አንዳንዴ 2.በጣም አልፎ አልፎ 1.በፍፁም

509	ወደ አእምሮ ህክምና ተቋም ለመላክ ቢፈልጉ ከዚህ ጤና ጣቢያ ጋር ግንኙነት ያለው የመላኪያ ተቋም ያውቃሉ ?	አዎ…………1 አላውቅም……2
510	በአጠቃላይ የአእምሮ ጤና ህሙማን ዝውውር ከጤና ጣቢያው ወደ አእምሮ ህክምናተቋም ይደረጋሉ::	4.በተከታታይ 3.አንዳንዴ 2.በጣም አልፎ አልፎ 1.በፍፁም
511	በአጠቃላይ የአእምሮ ጤና ህሙማን ዝውውር ከጤና ጣቢያው ወደ አእምሮ ህክምናተቋም ይደረጋሉ::	4.በተከታታይ 3.አንዳንዴ 2.በጣም አልፎ አልፎ 1.በፍፁም
512	በአጠቃላይ የአእምሮ ጤና ህሙማን ዝውውር በጤና ጣቢያው ውስጥ ከአንዱ የጤና ባለሙያ ወደ ሌላ የጤና ባለሞያ ይደረጋሉ::	4.በተከታታይ 3.አንዳንዴ 2.በጣም አልፎ አልፎ 1.በፍፁም
513	ላለፈው አንድ ወር የድባቴ መድሀኒቶች ለምሳሌ (amitriptyline,fluoxetine) ምን ያህል ይገኛሉ	5.ሁልጊዜ 4.አብዛኛውን ጊዜ 3.አንዳንዴ 2.ከብዙጊዜ አንዴ 1.በፍፁም
514	ላለፈው አንድ ወር Anti psychotic መድሀኒቶች እንደ (haloperidol,chlorpromazole,fluphenazine) ምን ያህል ይገኛል ?	5.ሁል ጊዜ 4.አብዛኛውንጊዜ 3.አንዳንዴ 2.ከብዙጊዜአንዴ 1.በፍፁም
515	ላለፈው አንድ ወር Anti-epileptic መድሀኒቶች እንደ (phenobarbital,carbamazepine,diazepam,phenytoin,valporic acid) ለምን ያህልያገኛሉ?	5.ሁል ጊዜ 4.አብዛኛውንጊዜ 3.አንዳንዴ 2.ከብዙጊዜአንዴ 1.በፍፁም
516	የአእምሮ ህመም መድሀኒቶችን በተግባር ምን ያህል ጊዜ ይጠቀሙበታል::	5.ሁል ጊዜ 4.አብዛኛውንጊዜ 3.አንዳንዴ 2.ከብዙጊዜአንዴ 1.በፍፁም
517	ከአእምሮ ጤና ጋር በተያያዘ Guideline በሚሰሩበት ጤና ጣቢያ ዉስጥምን ያህል ይገኛል?	1.በቂ አይደለም 2.በትንሹ ይገኛል 3.በቀላሉ እናገኘዋለን 4.በጣምበቀላሉ ይገኛል

519	በአእምሮ ጤና እክል ውስጥ ያለን ሰው ሲመረምሩ ወይም ሲያክሙ መመሪያ መፀሃፍ (Guideline)ይጠቀማሉ?	1.አዎ 2.አልጠቀምም
520	የአእምሮ ጤናን በተመለከተ ከሥራ ባልደረባዎ ጋር ወይም ከተቆጣጣሪ(supervisior) ጋር ውይይቶችን ያደርጋሉ?	1. አዎ 2. አናደርግም
521	በጤና ጣቢያችሁ የአእምሮ ህሙማን ከለያችሁ በኃላ በህሙማንየማከሚያ ካርድ መመዝገቢያ ላይ ይመዘግቡታል፡፡	1. አዎ 2. አይመዘገብም
522	ለጥያቄ 521 መልስ አዎ ከሆነ የታካሚውን ካርድ ተሰብስቦ በወር ወይም በሳምንት በአእምሮህክምና ውስጥ ያሉት ታካሚዎች ለብቻ ይመዘገባሉ?	1. አዎ 2.የለም