FACTORS AFFECTING MENTAL HEALTH PRACTICE IN DAR ES SALAAM AND DODOMA, TANZANIA: THE NURSING PERSPECTIVE

Paul Magesa Mashauri

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FACTORS AFFECTING MENTAL HEALTH PRACTICE IN DAR ES SALAAM AND DODOMA, TANZANIA; THE NURSING PERSPECTIVE

By

Paul Magesa Mashauri

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CERTIFICATION

The undersigned certifies that she has read and hereby recommends for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled, ***Factors Affecting Mental Health Practice in Dar es Salaam and Dodoma, Tanzania; The Nursing Perspective,*** in (partial) fulfillment of the requirements for the degree of Master of Science Nursing (Mental Health) of Muhimbili University of Health and Allied Sciences.

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Khadija I. Y. Malima, PhD
(Supervisor)

Date: _____

DECLARATION AND COPYRIGHT

I, **Paul Magesa Mashauri**, declare that this **dissertation** is my own original work and that it has not been presented and will not be presented to any other university for similar or any other degree award.

Signature …….. Date …….

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ABBREVIATIONS

FGD	-	Focused Group Discussion
GHAWA	-	Global HealthAlliance Western Australia
ID	–	Identification number
IDI	–	In Depth Interview
MEHATA	-	Mental Health Association of Tanzania
MNH	–	Muhimbili National Hospital
MOHSW	–	Ministry of Health and Social Welfare
MPH	-	Masters of Public Health
MUHAS	–	Muhimbili University of Health and Allied Sciences
NSW	–	New South Wales
SHDC	-	Senate Higher Degrees Committee
WHA	-	World Health Assembly
WHO	-	World Health Organization

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SUMMARY

Introduction

Recently, hospital management teams have experienced and received reports that are highly suggestive of elements of inadequate mental health care. Adverse events such as patient killing one another in the psychiatric wards are one among incidences that indicate the degree or severity of deterioration of the quality of mental health practice. Limited infrastructure makes patients cared for in a non therapeutic milieu; non-conducive working environment for nurses, including high workload, creating more demands from patients and their significant others. These factors compromise the quality of care provided and this affects the motivational factors for nurses working in mental health care. Understanding factors affecting mental health practice will be vital in correcting this anomaly.

Objective: The study aimed at determining factors affecting mental health nursing practice in Tanzania.

Methodology: The study deployed a descriptive qualitative design at Mirembe National Hospital for Mental Health and Muhimbili National Hospital. A total of 27 nurses participated in providing information through focused group discussions and in depth interviews were by 16 nurses were Muhimbili and 11 nurses from Mirembe National Hospital. Also a total of 10 nurses in charges and managers were involved in filling up the institutional quality assessment tool. Sessions were audio recorded, transcribed, analyzed and translated.

Findings: Un-conducive working environment was the main factors affecting mental health nursing practice in which there was low motivation to nursing staffs, lack of on job training for long time, limited infrastructure in mental health facilities, high workload, unguaranteed safety at work place, and nursing leadership in mental health units affected performance. Other factors included shortage of qualified nurses trained in mental health, limited treatment modalities, poor environments for hospitalized patients, inadequate funding of mental health services and absence of community

mental health nursing. It was found that both facilities performed well in Case management for severe psychiatric disorders and length of treatment for substance – related disorders, specifically MNH also performed well in writing the patients' daily progress report while Mirembe Hospital had few hospital readmissions for psychiatric patients. Generally both institutions performed below standard in most areas assessed hence there is a need to employ some measures to improve the quality of care.

Conclusion and recommendations

There is a need for the government to provide adequate budget for financing mental health services which could enable to hospital managements improve the working environment and motivate nurses and increase their engagement in their work also to have effective community mental health nursing and training to nurses working in mental health settings. Mental health nursing needs to be provided by well trained and competent nurses in this area. Future research should investigate whether these findings remain consistent in other mental health facilities also there is a need to undergo study to find the impact of patients being enclosed in the wards for most of their hospitalized period.

BACKGROUND

Mental disorders are prevalent in all societies and create a substantial burden for the affected individuals and their families, and they produce significant economic and social hardships that affect society as a whole (WHO, 2008). Mental health disorders affect hundreds of millions of people worldwide and if left untreated, create an enormous toll of suffering, disability and economic loss, yet despite the potential to successfully treat mental disorders only a small minority of those in need receive even the most basic treatment (WHO, 2008). According to the World Health Organization (WHO), mental health services provided are still either inadequate or of low quality. WHO estimates that 154 millions suffer from depression, 25 millions suffer from schizophrenia, 91 millions suffer from alcohol use disorder, 15 millions suffer from drug use disorder, 50 millions suffer from epilepsy, 24 millions suffer from Alzheimer and other dementia, and 877,000 die by suicide every year. Within countries the overall one-year prevalence of mental disorders ranges from 4% to 26%, (WHO, 2008). To date, comprehensive published documents that confirm the prevalence of mental health disorders in Tanzania remains to be found. What is available as evidence of mental health problems in Tanzania mental disorders and were limited in types of disorders and also not representative of the general population of Tanzania (Mbatia et al, 2010), these studies provided some insight to the magnitude of the problem.

The phasing out of community outreach has decreased community awareness on mental health, and limits adequate follow up and all of this information is not published and only some have been documented. Limited infrastructure makes patients cared for in a non therapeutic milieu; non-conducive working environment for nurses, including high workload, creating more demands from patients and their significant others, disproportionate nurse/patient ratio that makes one nurse to care for more patients than is recommended. Internationally one nurse is supposed to take care of one patient in the general ward and two nurses for a single patient in an acute ward, at MNH one nurse takes care of about 12 patients or more in the general ward while at Mirembe one nurse takes care of more than 150 patients in the general ward. Psychiatrists and nurses are concentrated in the major urban centers, and a high proportion of the psychiatric nurses have been redeployed to

medical or surgical clinics, so the specialist service for nearly all regions and districts is largely delivered by extremely overstretched psychiatric nurses (Mbatia and Jenkins, 2010).

One of the key factors that limit strengthening of mental health services is the lack of a separate mental health policy in Tanzania. The existing mental health policy is embedded in the Health Policy which contributes to limitation of resources but, since there is limited health budget, competition of resources with other ever-changing health priorities ultimately, neglects allocation of adequate mental health budget (Mbatia and Jenkins, 2010). Limited resources makes the adoption of new and better drugs an impossible application and lead clinicians to prescribe old and traditional drugs for patients, very often have higher likelihood of causing extra pyramidal side effects that are complex and troublesome to patients and their families to cope. In addition to that, the chances of monitoring drug concentration levels by therapeutic monitoring of blood is also not feasible, hence potent drugs that require this monitoring cannot be used. This situation contributes to poor adherence and compliance to these drugs and relapses.

I have worked in both Mirembe and Muhimbili National hospital in mental health units for some time, also I worked for five weeks at Saint John of God, mental health hospital in Malawi where I experienced patients under high quality of care and the outcome of care, it was really very good, this experience influenced me to find out what is the realization of the quality of mental health practice in my country. In Tanzania the quality of care is questionable as I have experienced improper handling of aggressive patients has been observed because of absence of safe restraints gears. Also mental illness is still a stigma in Tanzania and likewise, nurses or health personnel working in mental health facilities are also experiencing stigma. In essence, ignorance on mental illness is still a problem that may need intervention at a public level. All these conditions widen the gap between required standards and the actual care provided. It is highly plausible that this gap contributes to the worsening of quality care and a healthy working environment for both the consumer and mental health nurses. Suffice to say that this is a concern that to date, there lacks a single credible report, and this underscores the importance of studying this phenomena using a structured approach that will confirms the existence of problems. Among the few studies done, includes Mbatia, & Jenkins in 2010, and they found that there were limited funds allocated for mental health services, and this study will explore other factors if any.

In 2008 WHO reported that mental health practice has been neglected worldwide especially in developing countries. Tanzania is one among the developing countries where the reported problem is still evident despite of the government's effort in promoting mental health in the country. Mental health care in Tanzania is predominantly government funded but remains limited in scope. The scant resources that are dedicated to mental health are often disproportionately deployed: most of mental health resources are spent on expensive care in psychiatric hospitals rather than in primary care (Jacob, 2007). To date in the country, there is one mental health national hospital called Mirembe Mental Hospital) and ten regions with psychiatric units. Hospitals which have a better established mental health care program than the rest of the government and private hospitals include; Mirembe National hospital of Mental Health with an average of 700 in-patients cared by about 23 nurses. The other two are Muhimbili National Hospital with an average of 50 patients cared by a total of 52 nurses and Mbeya referral hospital with an average of 56 inpatients cared by 6 nurses.

The Ministry of Health and Social Welfare (MOHSW) in collaboration with Mental Health Association of Tanzania (MEHATA), have integrated mental health into primary care in most regions in mainland Tanzania; funded by the MOHSW and various donors and non-governmental organizations (NGOs). Training of general health workers in primary care in identification and management of common mental disorders is followed by supervision, monitoring, and evaluation by district mental health coordinators (Mbatia & Jenkins, 2010).

Mental disorders particularly unipolar depressive disorder has been projected to be the second in contributing to global disease burden by the year 2030 where HIV/AIDS will be leading, (WHO, 2008). Given that the prevalence of HIV/AIDS in Tanzania is relatively high, this is potentially an impending health crisis if stringent control or improvement measures are not taken to slow the progression of both diseases.

In Tanzania, the quality of mental health practice remains to be improved in various levels and scope, given that the overall health care system is overburdened, and the corresponding potential increase of mental health problems as a response to the increase in other chronic diseases, the negatively changing socio-economic pressures to name a few factors. There are many adverse consequences of inadequate treatment for psychiatric patients leading to homelessness, frequent

relapses and readmissions eventually becoming a vicious cycle (WHO, 2008). Thus understanding factors affecting mental health practice will be the primary step in closing this gap. However, before we improve the quality, it is imperative we look into what are the set standards for mental health and psychiatric care where nurses are concerned as they spend most their working hours directly in contact with these patients than any other personnel in the mental health care team.

Globally, nurses represent the most prevalent professional group working in the mental health sector; the median rate of nurses in this sector is 5.8 nurses per 100,000 populations which are greater than the rate of all other human resources groups combined (WHO, MHA, 2011). This may not hold true when looking at specific countries like Tanzania given the limited facilities for promoting mental health. For proper interventions aiming at achieving improvements in this area there is a need of exploring the factors which affect mental health especially in a nursing perspective. The above background underscores the importance of doing this study that is long overdue in Tanzania.

It is expected that this study will come up with factors that affect mental health nursing practice in Tanzania and provide suggestions that may potentially lead to strengthening of mental health policy and practice and where research is concerned, the generated hypotheses will aim at seeking evidence to delineate causal associations through rigorous research methods. The evidence delineated from such studies will guide the implementation of evidence based mental health practice resulting in improved staff engagement, provision of quality mental health practice and improve performance and patient experiences and outcomes.

PROBLEM STATEMENT

In a health care system, the magnitude of a disease is a basic indicator used to measure the progress of mental health care interventions or may provide information on the quality of care given; hence it can be used as a performance indicator that can be used to gauge improvement and allocate resources. Tanzania is still among countries with worsening health indices such as maternal mortality ratio of 578/100,000 live births, under fives mortality rate of 112/1,000 live births. But

indices on mental health disorders are still based on proxy indicators that may likely mask the true magnitude of the problem, leading to either under-estimation or over-estimation of mental health problems in the country. To date there are no published documents that report on the prevalence of mental health disorders in Tanzania and the uncertainty of how well is the health care systems performs its functions increases.

The changing socio-economic and cultural predisposition is expected to increase the incidence of mental disorders and thus worsen the degree of suffering, disability and economic loss. Despite the potential to treat mental disorders to a functional level, only a small minority of those in need receive even the most basic treatment, while the allocation of health care resources is also competing with other diseases of public health importance (WHO, 2008). The misallocation of nursing specialties further compounds the quality of mental health practice. If the situation will remain unresolved it is not only patients who may be affected but also mental health care providers' especially mental health nurses will be affected in one way or another as their work load increases and the risk of being injured psychologically and physically increases as well. Thus understanding factors affecting mental health practice will be the primary step in closing this gap.

Exploring factors which affect mental health practice will guide to interventions that are evidence based and lead to improved staff engagement, mental health practice performance and patient experiences and outcomes. If these factors are not explored there may be no or inadequate or unguided interventions through the strategic framework plan which will lead to increased burden of mental disorders to respective individual, family, society and national at large.

STATEMENT OF PURPOSE

The purpose of this research was to explore factors affecting mental health practice in Tanzania focusing on the nursing perspective. Thus, nurses who were directly involved in mental health practice from institutions which are providing such services, were studied. Currently there about 500 mental health nurses but only less than 150 are directly involved in mental health practice, among these 52 are at MNH in Dar es Salaam and 20 are working at Mirembe National Mental Health Hospital in Dodoma. 6 nurses at Mbeya referral hospital

JUSTIFICATION OF THE STUDY

This study was expected to provide structured information on the factors that affect the provision of quality mental health practice provide a base for intervention using evidence. So far there was no study which has been done to explore such factors. The recommendations brought forward by this study are providing a base for evidence based mental health practice challenges in Tanzania, and provide evidence based conclusions to the governing bodies to the factors that need to be improved and those that need strengthening.

Globally, nurses represent the most prevalent professional group working in the mental health sector (WHO, WHA, 2011), so understanding what nurses are going through in mental health practice is vital as quality of care mostly vested their practice. In Tanzania observation shows that generally nurses have limited chances in developing their career from general nursing practice to specialized nursing practice due to various reasons including worries of administrators to exacerbate shortage in the wards, lack of sponsors for nurses, stigma in the society played part for Mental health nurses. Because of the broad prevalence of mental disorders, primary care becomes a logical and convenient source of potential access to treatment (Druss et al, 2003), but limited funding of mental health services may be among many factors affecting mental health practice. This study is one among the few researches done in mental health nursing to provide frameworks in improving practice

Among indicators that can be used to indicate the quality of care are indicators that target the overall workplace, patient and nurse outcomes that cuts across the health care team and the patient

is the frequency of adverse events in a psychiatry unit. The frequency of adverse events or even the nature of the adverse event serves the purpose. Adverse events such as killing of one patient by another were among incidences that indicate the degree or severity of deterioration of the quality of mental health practice. Unfortunately, such an event happened at MNH in 2008. Other adverse incidences have increased likelihood of occurring due to observations that patients are kept in a non therapeutic milieu that likely cause personal harm among patients in all domains (physical and psychological) and these are also common in the above mentioned setting. Moreover, other indicators on the health workers perspective are also important. The nature of the workplace was a confirmed predicator of the quality of mental health practice. These included unfavorable working environment to nurses; (poor infrastructure-small rooms for a high number of patients, lack of differentiation of units at the various stages of therapeutic process for patients, lack of amenities for the nursing staff who have to be with the patients at all times); appalling nurse/patient ratios; 1: 12 translating into heavy workload. Internationally one nurse is supposed to take care of one patient in the general ward and two nurses for a single patient in an acute ward, at MNH one nurse takes care of about 12 patients in the general ward while at Mirembe one nurse takes care of more than 150 patients in the general ward. In general it is recommended by WHO for 24.8 mental health nurses per 100,000 populations in Tanzania it is less than one mental health nurse for the same population. Mental health specialist care is delivered in district, regional, and zonal (average .5, 1.5, and 6.0 million catchment populations, respectively) outpatient clinics and regional and zonal inpatient units of approximately 20 beds each (Mbatia & Jankins 2010). Care is also available at the national referral hospitals at Dodoma (Mirembe, the former asylum, and Isanga, the forensic unit), Dar es Salaam (Muhimbili University Hospital), and Mbeya. The total number of hospital beds for a population of over 38 million is less than 900 (less than one bed per 35,000 population), in practice, when the national hospitals are excluded, in most regions there are only 20 beds per 1.5 million (Mbatia & Jankins 2010).

RESEARCH QUESTIONS

How can mental health nurses help improve mental health care in Tanzania?

What are the factors that affect mental health nursing practice in Tanzania?

OBJECTIVES

Broad objective

The broad objective of this study was to determine factors affecting mental health nursing practice in Tanzania.

Specific objectives:

1. To describe the working environment of mental health nurse in a tertiary hospital.
2. To explore factors affecting provision of quality care to mental health patients.
3. To explore nurses' motivation in provision of quality mental health services.

CONCEPTUAL FRAMEWORK

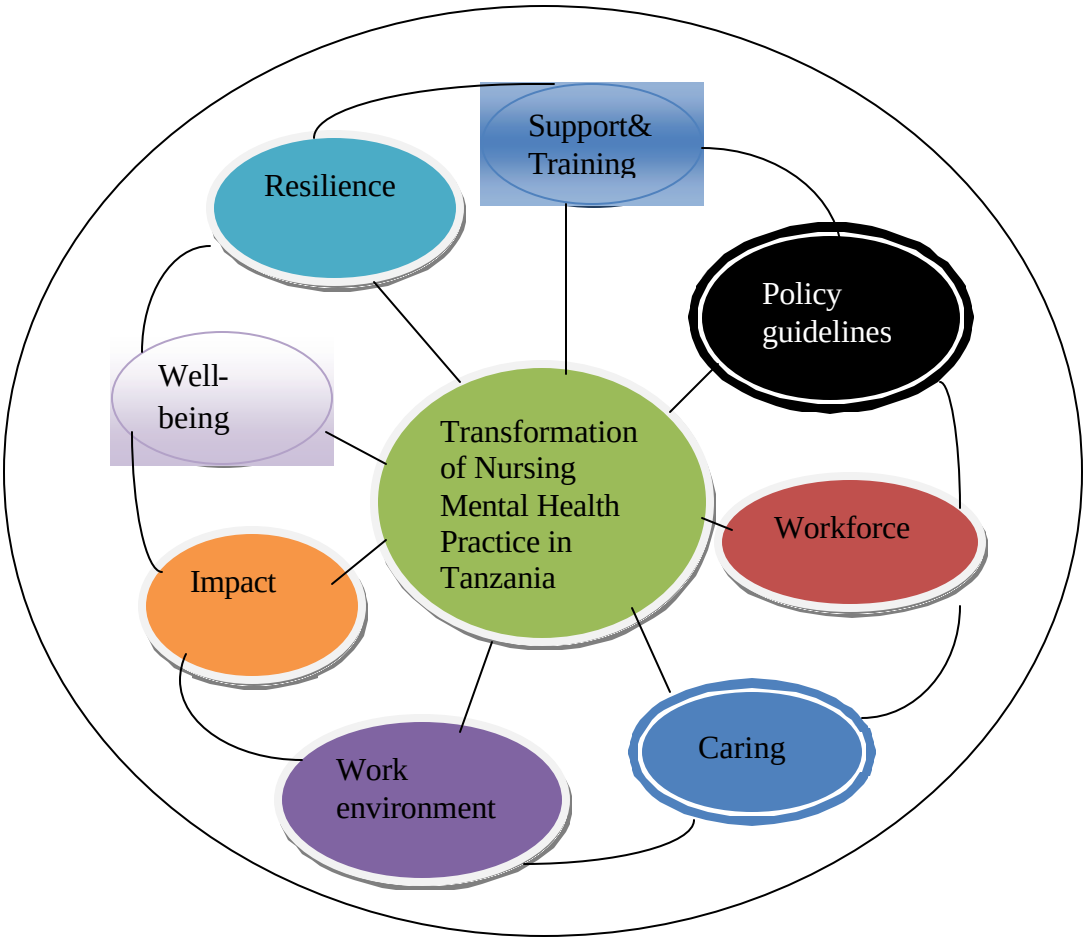


Figure 1: Conceptual framework as adapted from Discussions between Deans of Schools of Nursing Forum of Tanzanian Universities of Health and the Global Health Alliance of Western Australia (GHAWA).

This framework was adopted from concepts developed during a collaborative discussion between Deans of Schools of Nursing Forum of Tanzanian Universities of Health and Global Health Alliance of Western Australia (GHAWA) and some modifications were made to meet nature of this study in Tanzanian environment. All the components of this framework if they are well standardized can transform Nursing Mental Health Practice which we are experiencing now into a high quality mental health nursing service through highly motivated mental health nurses. Improvement of mental health services was thought to depend on the existent of standardization of

the factors outlined in the framework as they has a direct relationship with the quality of mental health services.

Definition of concepts

Caring is a human trait, a moral imperative, an affect, an interpersonal relationship and therapeutic intervention, (Morse et al 1990).

Impact is a marked effect of the nature of the actual mental health practice to nurses and clients.

Mental health – successful performance of metal functions, resulting in the ability to engage in productive activities, enjoy fulfilling relationships, and change or cope with adversity, (Varcarolis,E.M., Carson, V.B., Shoemarker, N.C.,2006)

Mental illness – clinically significant behavioral or psychological syndrome experienced by a person and marked by distress, disability, or the risk of suffering disability or loss of freedom (American Psychiatry Association [APA], 2000).

Mental health practice – an art aiming at helping an individual, family or community to be mentally health through various professional ways integrated in mental health promotion, prevention and alleviation of mental illness.

Mental health nurse – means a nurse who undergone mental health nursing training for period of at least one year

Mental health team – this is a group of mental health professionals working together having different tasks with a common goal to achieve in a specified period of time.

Multidisciplinary Mental Health Team – this is a mental health team consisting of mental health professionals from different disciplines. Such team may consist of Psychiatrist, clinical mental health nurse, community mental health nurse, counselor, psychologist, occupational therapist, depending on a case a social worker may also be part of the team.

Policy guidelines are principles proposed by the MOHSW to be adopted by various mental health institutions for the purpose of providing quality mental health care.

Quality care – refers to mental health care services which meets at least 70% of the benchmark international standards set and would result into early recovery of the patient.

Resilience - being able to withstand or recover quickly from difficult conditions, (Concise Oxford Dictionary).

Supporting and training – Offering assistance, encouragement, and imparting knowledge and skills to mental health nurses

Well being – the state of being comfortable, healthy and happy, (Concise Oxford Dictionary).

Work environment – therapeutic environment in which mental health nurses are practicing.

Workforce – mental health nurses engaged in mental health practice.

LITERATURE REVIEW

Introduction

Mental health and mental illnesses are determined by multiple and interacting social, psychological and biological factors, just like health and illness. In developed and developing world is associated with indicators of poverty, including low levels of education, and in some studies with poor housing and low income, (WHO, 2005).

Mental illness is a significant international health issue. According to WHO (2001), 20 – 25% of all people are affected by mental illness at some stage during their lives. Mental health problems are more common among people undergoing treatment for a health problem (Andrews et al., 2002) as people with a mental illness have more physical health problems than the general population (Harris and Barraclough, 1998).

Despite the potential to successfully treat mental disorders only a small minority of those in need receive even the most basic treatment, (WHO, 2008). Mental health services provided are still either inadequate or of low quality. Despite this, mental health problems often go unrecognized and untreated in non-psychiatric health settings (Andrews and Garrity, 2000). Questionably this situation has worsened both consumers' outcome and the work – place experiences of mental health nurses.

This section, the researcher presents the relevant information about mental health practice in nursing perspective citing different research studies that have been conducted elsewhere in and outside Tanzania. It will be divided in sub- categories which include, Workforce, Caring, Support and Training, Work environment, well being, Policy guidelines, Impact, and Resilience.

Health workforce

Globally human resource for health is a problem of great concern, the problem has been increasing in the developing countries due to various factors including emigration and low motivation. The World Health Organization Regional Director when addressing the *Intercountry Workshop 2006* South-East Asia Region) Dr Samlee *referred* to the crisis in health workforce globally and in the South-East Asia Region in particular. In the same workshop, it was revealed that Nurses and Midwives at the regional and global levels were facing many challenges including shortages, migration, inadequate competency and low motivation that prevented them from providing effective services. To tackle the problems, it was suggested that a proper workforce strategic plan and workforce management, good governance and leadership, strong professional organization and good education were needed.

Inadequate financial and human resource also contribute to lack of inadequate mental health care and the large gap between the number of people who need and those that who receive care, and this is especially true in low and middle income countries, where most of the countries devote less than one per cent of their health expenditure to mental health (WHA 2005). It was recommended that for standard mental health provision 24.8 nurses are needed for 100,000 populations, the ratio is far to be attained in low and middle income countries of which Tanzania is one; the ratio is < 1 nurse per 100,000 populations.

Recruitment problems were compounded by inadequate practices of successive governments and management teams. The cumulative effect of these was further impacted by the allied health workers subsuming mental health nursing roles. There is a range of factors responsible for the acute shortage of adequately trained staff, which is also reported by Hegney (1996), Clinton and Hazelton (2000), and the Commonwealth of Australia (2002). Reasons cited for the shortage of mental health nurses in New South Wales (NSW) include the closure of the mental health nursing register, a shift

to comprehensive/generalist nurse education models, perceived lack of nurses' professional standing, and natural attrition through retirement without suitably qualified replacements.

All these factors affect nursing practice especially the mental health practice in which there is intra profession attrition as it has been evidenced in Tanzania that out of 500 mental health nurses only about 150 nurses are working in mental health settings, this is one of the key pressing problem. In Tanzania observation shows that the number of mental health nurses in practice is steadily declining and many replacements lack mental health nursing specialist education this situation creates acute shortage of adequately trained staff, which was also reported by Hegney (1996), as a result the quality of mental health care goes down.

Misuse of the available human resource is also an issue which affects mental health practice. For example Mtwara, Newala district has four mental health nurses; two are administrators, one is a store keeper and the other is a tutor at the nursing school. In many other districts there is no psychiatric nurse.

Mental health workforce like other health work forces needs to be considered critically for improving the mental health practice in each particular area. World Health Assembly resolution WHA 59.27 (2006) on strengthening nursing and midwifery development urged Member States, among other things to; Establish comprehensive programs for the development of human resources for health which support recruitment and retention, while ensuring equitable geographical distribution, in sufficient numbers of a balanced skill mix, and a skilled and motivated nursing and midwifery workforce within their health services

Caring

Mental health nurse are the key resource for caring those who seek mental health services globally. Nurses have been particularly effective in addressing some of the mental health problems of those two ends of the developmental spectrum, (McBride, 2007). Mental health nurses faces many challenges when providing care, as it was revealed in the study done by Crowther and Ragusa, (2007) that, "We have a lot more social problems, complex diagnoses, mixed diagnoses, dual diagnoses, and limited services, and also . . . a lot of personality issues".

Other problematic areas which have been identified include diagnostic and formulation errors, communication problems, system-based problems, and class and culture misunderstandings were not mutually exclusive; problems occurred in different combinations with varying emphasis, (Goldman, Demaso, Kelmer, 2009). Identifying these areas led the department to take corrective actions that positively and significantly impacted patient care

Support and training

Mental health education is an important component of the Mental Health Practice. Therefore, in the initial stage of strengthening mental health, the focus should be on to mental health education. Meanwhile, urgent issues in relation to mental health services, workforce, research, professional organization and leadership and management also need to be tackled.

It is believed that quality education would produce qualified practitioners who can make a difference in nursing and midwifery care and contribute greatly to the health care system and the health of the people. (WHO, 2006)

Mental health nurses may need on job training so as to update themselves about complicated and new imaging conditions of mental illness, social and medical issues associated with mental illness such as Wars, economic hardship, termination of sexual relationships, HIV, TB, Hypertension etc. as well as technological advancement in health sector.

Work environment

High demands and lack of rewards at work may cause persistent fatigue in mental health nurses. Reduction of demands, adequate feedback, and mental stimulation in the form of support and positive challenges may facilitate recovery in those who have persistent fatigue (Eriksen, 2006). Akin to the workplace stresses acknowledged by Edwards et al. (2000), the acuity of client presentation, the levels of bullying and assault of nurses, and the demands being placed on mental health nurses were felt by participants to be significant to their practice as nurses.

Therapeutic relationship among health care providers is also very important in mental health practice. Lack of such relationship may de-motivate some mental health workers in provision of service to their clients. Crowther , and Ragusa (2007) found that policies of zero tolerance of any aggression towards health staff were seen as political window dressing that merely bred contempt in

the minds of consumers and carers and there were similar concerns about the behavior of psychiatrists, who were accused of bullying and intimidating nursing staff. In the same study some participants (nurses) noted that psychiatrists acted as if they "owned" the patient and could therefore control the entire hospitalization, including what was written in the medical record about events they had not witnessed.

Lack of supplies and equipments are common problems which makes the working environment for mental health nurses to be more difficult.

Well being

Work related injuries have been reported frequently by mental health nurses. At Muhimbili National Hospital – psychiatric unit nurses have been reporting being attacked by patients though it has not been published. Also at Mirembe hospital nurses have been reporting the same and it happened that one nurse was amputated the finger by patients. Sometime mental health nurses have been stigmatized and undervalued due to nature of their work. Respondents stated they felt undervalued in comparison with and by non-mental health colleagues in Australia, Crowther and Ragusa, (2007). Mental health nurses' economical, social, physical and psychological well being may be significantly affected as a result of working as mental health nurse.

Policy guideline

The National Health Policy of Tanzania is aimed at providing direction towards improvement and sustainability of the health status of all the people, by reducing disability, morbidity and mortality, improving nutritional status and raising life expectancy.

The policy recognizes that, good health is a major resource essential for poverty eradication and economic development. Unfortunately the Tanzania health policy does not provide guidelines for mental health practice nor mention anything about mental health. Being authentically engaged in the situation allows the mental health nurse to see what is possible for the patient and understand how to achieve it. When the work of mental health nursing is understood as a practice, the nurse executive's sense of her rightful place in the organization is affected as well. "Understanding what is really going on between the mental health nurse and the patient and being able to put public language to the nurse's practice captures the moral imagination of those organizations genuinely

interested in taking care of sick people. The ethical mandate of the practice is to ensure that vulnerable persons who have entrusted their lives to the mental health nurse are cared for in a way that achieves; healing, restores dignity, and makes complex medical treatments safe and effective, (Cathcart, 2008)".

In the Tanzania national policy on disability of 2004 developed by the Ministry of Labor, Youth development and Sports which does not deal with health issues, there are statements about mental health as follows;

*Mental Health Services***:** Various social and economic hardships are known to have caused mental health problems to a sizeable number of people. Apparently the life situation of the sufferers is dangerous to themselves and to those around them. Besides no agency seems to be responsible for their identification, treatment and care, (Ministry of Labor, Youth Development and Sports, 2004).

*Vision and policy direction***;** Despite their impairment, people with disabilities are a resource which if and when appropriately developed could be of greater benefit to themselves and the community at large. There is therefore a grave need to identify their capabilities and talents and devise strategies to develop them (Tanzania national policy on disability, 2004). It is unfortunate that this ministry has no direct influence on mental health nursing practice in Tanzania. While the lack of policy has been linked to lack of treatment (as cited in Zolnierek, C.D. 2008) , the assumption that countries with mental health policies perform better than those without does not consistently hold true (as cited in Zolnierek, C.D. 2008). This calls the need of looking for other factors which affect mental health practice. Despite of the finding by Lurie, 2005, yet policy is believed to be a fundamental element for program development which enables the provision of services and protection of rights of persons with mental disorders (as cited Zolnierek, C.D. 2008).

Impacts

Significant issues that impact on practicing as a mental health nurse include staff shortages (Gibb, 2000; Hegney & McCarthy, 2000; Hegney et al., 2001), deinstitutionalization

(Allan, 2001; Sands, 2004), generational issues that affect how mental health nurses view their work (Crowther&Kemp, 2009), changes to undergraduate nurse education (Allan, 2001; Brown, 1988), consumer stigma (Allan, 2001; McColl, 2007), the lack of opportunity for promotion, and violence and bullying (Allan, 2001).

Health care professionals working as part of community mental health teams are experiencing increasing levels of stress and burnout as a result of increasing workloads, increasing administration demands, lack of resources, increases in workload, difficulty with time management, inappropriate referrals, safety issues, role conflict, role ambiguity, and a lack of supervision (Edwards et al., 2000). Drury, Francis, and Dulhunty (2005) suggest that isolation, autonomy, and high caseloads further impact on the mental nurses' work experience.

Persistence of work related stress and burnout may lead to chronic fatigue syndrome and depression.

Resilience

Resources and initiatives which have been pulled away from mental health services need to be pulled back so as to improve the mental health practice. The World Health Organization - Regional Director (2006) when addressing the Inter country Workshop South-East Asia Region suggested that to tackle the problems, a proper workforce strategic plan and workforce management, good governance and leadership, strong professional organization and good education were needed.

METHODOLOGY

Design

This study used a descriptive qualitative design in which dialogue interviews and observation of lived events acted as sources of data. The design was selected as it was powerful in collecting nurses' experience and perception in their real world on factors affecting mental health practice in Tanzania. On top to information gathered in a qualitative scheme, the quality assessment tool was also used to determine the quality of care in each facility so as validate the information provided during the interview. In the quality Assessment Tool, 9 indicators out of 12 were extracted from the Quality indicators for international benchmarking of mental health care that assess clinically important processes and outcome of care (Hermann, et al 2006). The measures were selected by an international expert panel using a structured process, represented progress toward the goal of identifying consensus-based measures for international benchmarking of mental health care, (Hermann at el, 2006).

The measures evaluate several domains of quality, including treatment, continuity, coordination, and outcome, (Hermann at el, 2006). Indicators which could fit Tanzanian setting were adopted, as the assessment were in terms of per cent then numerator and denominator were constructed to gather information which could be converted into per cent for evaluation. In the tool there were two sections, one for gathering the statistic of nurses working in mental health in the facility and the second part was about indicators used to measure the quality of care which based on three domains of quality, including *treatment, continuity and coordination of mental health services*. Participants included nurses who are directly involved in mental health practice.

Study settings

The study took place in United Republic of Tanzania found in East Africa, the country has a population of about 43 million (NBS, 2010). The country has 30 regions (State gazette new regions, 2012). In the country there is only one mental health national hospital called Mirembe Mental Hospital) and ten regions with psychiatric units including Muhimbili National Hospital (MNH). Specifically the study took place in two national hospitals which are Mirembe National Hospital for Mental Health and Muhimbili National Hospital with Psychiatry and mental health department; these hospitals are situated in Dodoma and Dar es Salaam region respectively.

MNH is a national referral hospital and a University teaching hospital situated in Ilala Municipal, it has 1500 bed capacity attending 1,000 to 1,200 outpatients weekly. It has 2700 employees of which 1070 are registered and enrolled nurses, 300 are doctors and the rest are supporting operations employees. The psychiatry and mental health department at MNH provides services for patients mostly coming from Dar es Salaam and some from other parts of the country. Services offered include; inpatient and outpatient services, child and adolescent services (children less than 13 years are admitted in medical wards, adolescents are admitted at acute ward of psychiatry department), community services and Methadone Assisted Therapy (MAT) services. Also rehabilitation, occupational therapy and home visiting services are provided. Other services include Provider Initiated testing and Counseling, Voluntary Counseling and Testing, Couple counseling and Training. The inpatients services consists of acute ward which is divided for female and male acutely ill patients, general wards for stabilized male and female patients, and private wards. The department has a capacity of 51 beds currently there are 61 beds, 11 beds in acute, 25 in each male and female general wards, 10 beds in private wards. The unit has 52 nurses, 16 psychiatrists, 4 social workers, 1 community nurse, 4 occupational therapists and 3 clinical psychologists. The unit admits 5 patients on average daily.

Mirembe National Mental Health hospital is situated in Dodoma municipal, it has two compounds Mirembe compound and Isanga Forensic Institute. Both compounds are further divided into sub compounds of male and female compounds. At Mirembe compound each sub compound has acute ward, general wards, and wards for psychiatric patients with physical conditions. Isanga provides services for forensic psychiatric patients while other patients are attended at Mirembe compound. It

receives patients from all over the country. On average have about 700 in patients and it admits 15 patients daily. There is no inpatients service for children and adolescents. Services offered at Mirembe hospital include, Inpatient and outpatient, rehabilitation, physiotherapy, occupation therapy, Ultra sound, X-ray, Dental services, Voluntary Counseling and Testing (VCT), Tuberculosis (TB) services.

The hospital has 20 wards and it has a 350 and 250 bed capacity at Mirembe and Isanga respectively. There are a total of 256 staffs of which 68 were nurses, 1 was a psychiatrist, 2 dental surgeons, 2 medical doctors and 1 MPH doctor. In both hospitals nurses do not come at work all together, they are divided to at least three groups, administrators, morning, evening and night shifts, and some must be in their day off rest, hence this situation limits the number of nurses available in each shift.

Population under study

The population under this study included all nurses working in clinical mental health settings. Countrywide there were about 150 mental health nurses who are working in mental health institutions.

Sample size

The sample size based on saturation principle, data collection stopped when saturation of the collected information was reached. A total of 37 nurses participated in this study, the qualitative part involved 27 nurses among these 11 nurses participated in IDI and 16 nurse participated in FGD and 10 nurses including in charges and managers were involved in filling up the facility quality assessment tool.

Sampling procedure

Both convenience and purposeful sampling methods were employed in accessing the participants so as to a get a sample which provided a rich set of information. Sampling procedure started with convenience which then progressed to purposive sampling. Mental health nurses who were present at the time of data collection who met the criteria were interviewed based on their experiences though mixed level of experiences was considered.

Sampling of the participants took place at Muhimbili and Mirembe hospital. The later has a forensic institute named Isanga from which five nurses participated in the study. The hospital managements were informed about the purpose of the study and the procedure to be used they were happy to hear about it and they assisted in getting the right participants.

Inclusion criteria

Nurses working in mental health setting with at least six months of experience in mental health practice were recruited in study for FDG; participants for IDI were selected purposefully from those meeting the criteria for FGD. Participants were a mix of mental health nurses with different working experiences in mental health settings. In charges and unit managers were involved in filling up the facility quality assessment tool.

Exclusion criteria

Nurses with working experience of less than six months in mental health practice at the time of data collection were not enrolled in the study. These were considered to have less experience on many issues regarding quality of mental health care to patients. Also nurses trained in mental health who were not involved in mental health practice directly were not enrolled in the study.

Data collection instruments

A semi structured guide questions were used for helping the interviewer to guide the interview focusing on the topic of the study see appendix A and C. The guide questions were in Kiswahili language to remove the language barrier so as to get more useful information from the participants. Digital audio recorder was another key instrument which was used to record the voices during the discussion as it could not be possible to write everything in the participants' words during interview, participant were well informed about audio recording prior interview. Furthermore notebooks and pen were used to note down some clues which would not be identified in the digital audio recorder and documenting the field notes. Furthermore facility tool for assessing the quality of care was used, see appendix D. In this case some few quality indicators which were feasible and could be easily being assessed in these setting were considered. The assessment was done at the ward and facility levels.

Data collection and management

Data collection

Data and method triangulation was employed during data collection. Data were collected through Focused Group Discussion (FGD), In Depth Interview (IDI), observations and Questionnaires for assessing the quality of care. The researcher spent most of his time from morning to evening and weekend days in the facilities whose nurses were being studied to observe the characteristic or aspects of situations which were relevant to the study, observation was done in such a way that nurses did not take it more seriously that apart from the interviews the research still was collecting data through observation, nurses were not informed about observation which was going on as it could affect the results in one way or another. Methods of data collection employed synergy each other and helped at minimizing biased information, hence the information collected reflected the actual mental health practice experiences. As Linoln and Guba (1985) noted, "If prolonged engagement provides scope, persistent observation provides depth" (p.304).

In each facility FGD started followed by IDI as more rich information was collected from FGD as participants had a room to think and challenge each other, then IDI followed to capture more detailed information which could not been captured in the FGD sessions, also IDI could provide narrative personal experience and information which could be difficult to be provided during FGD. There were a total of 3 FDGs with five to six participants and 11 IDIs. Both FGD and IDI sessions followed a semi-structured group/individual interview format in which the content of the discussion/ interview were guided by a schedule of key topics. All sessions were audio recorded, transcribed, analyzed for analysis of common themes and finally translated. Participants were asked about a range of topics related to working environment of the mental health nurse in tertiary hospital and explore factors affecting provision of quality care to mental health patients. During interview participants were given enough time to reflect it and respond congruently, sometimes other questions were rephrased or asked twice to insure that the participant understood the concept asked.

At MNH there was a total of 2 FGDs and 5 IDIs while at Mirembe National Mental Hospital there will 1 FGD and 6 IDI. Both FGD and IDI took place in a private and possible quite place to

maximize privacy to participants as well as recording a clear voice to maximize efficiency during transcription. It took 103 to 135 minutes for FGD and 33 to 67 minutes for IDI. All interviews were done in Kiswahili which is daily used by nurses so as to enable them express their lived experiences and perceptions about the study topic.

To get at least minimum participants for group discussion, convenient sampling was used and all FGDs were conducted in the morning between 7.00 am to 9.20 am so as to involve some nurses who were in their night shifts and some who were in the morning shift, this strategy helped much as there was no disruption of needed services in the material time of data collection as during the said time is when night report was being given and cleanness was going on. Convenient sample of five to six nurses mixed up in their biographic data such as in terms of age, working experience, level of education, sex and working shift formed a group. At MNH interviews were conducted at one place which was at least quite in the setting while at Mirembe with exception of FGD and IDI with nurses working in acute wards, all IDIs were done in the nursing stations of each respondent due to shortage which was revealed it was not possible for a nurse to move away from his/her working station, purposive sampling was used to obtain participants for IDI.

The focused group discussion were anonymous and participants were identified by using numbers which was written on a paper and put in front of the participant for easy referencing by group members. Demographic data was confidential and participants were provided with a special form to fill in their particulars, see appendix B. None of the institution was identified by name instead letters was used to maximize confidentiality.

During interview sessions member checking was being done for the concept with ambiguous or contradicting meaning throughout the data collection process so as to get good representation of the of participants' realities. Validation was done through deliberate probing to insure understanding of the participants' meaning. This process was done in such a way that there was very minimal chance of the participants to just agree with the interviewer's interpretation. Also in some few issues which were note clearly understood during the transcription the particular participants (two in number) were called back through phone and they provided what they meant. Member checking confirm the

true value or accuracy of the investigator's interpretations as they emerged, (DePoy &Gitling, 2005).

Ward or compound in charges and manager were involved providing data about the requested information in the Quality Assessment tool. Clear instructions were provided to participants before filling the questionnaire. Out of 10 questionnaires of the Quality Assessment tool distributed, 4 at Mirembe hospital and 6 at MNH, only 7 questionnaires was collected back among these 4 were from Mirembe Hospital and 3 from MNH. It took 5 to 20 days to return the questionnaires. One questionnaire which had more than 80% of the data filled was selected from each facility for analysis of for the quality indicators. Computation of the per cent in each indicator was done by the aid of calculator.

Data management and analysis

Data was managed at high level of confidentiality as nobody who was not directly involved in this study had an access to the collected data. Digital audio voice recorders, demographic and debriefing forms were accessed only by the principal investigator. Data was transcribed and analyzed with contextual content analysis aided by QSR6 NVivo software (computer assisted qualitative data analysis software). Each transcribed was proofread at least twice for accuracy of what was really provided by the participants, within the QSR6 NVivo the tree node was made based on themes and sub themes which emerged after reading thoroughly the first script, other nodes were emerging as coding was going on and then data was coded to specific node in this software. During coding meaning units were generated and each sub tree node formed its own file containing information on the same issue. During coding annotations were generated which were used to during analysis. At the end of coding, key transcript passages exemplifying common themes were generated in form of files whose content was detailed examined/analyzed in the context of surrounding speech to determine the extent to which particular interpretations could be shared among group members.

TRUSTWORTHINESS

In this study rigor was achieved by addressing credibility, confirm-ability, dependability and transferability. With regard to credibility and confirm-ability, member checking was conducted.

Also convenient to purposive sampling procedure of participants cemented with data and method triangulation assisted in making the study credible.

Dependability refers to the stability (reliability) of data over time and over conditions. This was enhanced by having interview guide which was used to insure consistency of questions to all participants. Researcher's pre - understanding of the situation under study was highly observed not to affect the actual experience of participants.

Transferability of the results was enhanced by recruiting the sample with variety of working experiences and education from two different tertiary hospitals. Also thick descriptions of rich vivid quotes of the participants were included in the study findings to increase the transferability of the findings. The extent of transferability will depend on readers' interests.

Ethical consideration

Before undergoing the project, ethical clearance was sought and permission from the MUHAS. After being granted ethical clearance, institutional permission was also sought before starting data collection. Participants were consented and given information about the study individually and they were provided with a two copies written consent which they signed where as one copy remained with the principle investigator while the other copy remained with the participant. (See appendix E informed consent form). Participation was in voluntary bases. Participants who agreed to participate in the study were recruited, fortunately only one nurses refused after being informed about the study as she said that she was busy. There was no harm which was reported due to participation in this study. The study was anonymous; participants were identified using number to maximize confidentiality. Furthermore the study was conducted without interfering services significantly.

MONITORING AND EVALUATION

The research used the implementation work plan which contained activities to be implemented as well as processes and monitoring indicators. After collection of the data, the audio scripts were listened to at least twice by the researcher to get clearly the expression of nurses' words in their real world and to enable the researcher to create category scheme; the transcripts were checked for

matching with the audio records in order to check for any disparity which may lead to wrong interpretation of the data. In the whole process data were handled carefully so that there could be no breach of confidentiality.

DISSEMINATION

Research results will be disseminated to stakeholders including staff and students at MUHAS, Mental health nurses, Policy makers, Tanzania National Nurses' Association (TANNA), MOHSW and MEHATA. Also the results will be disseminated at nursing conferences and published in national or international journal.

RESULTS

Sample characteristics

Of the 37 nurses who participated in this study gender and working experience was observed, the qualitative part involved 27 nurses where 16 were from MNH and 11 were working at Mirembe Hospital. In terms of their sex among these 14 were male nurses and 13 nurses were female; and 10 nurses including in charges and managers were involved in filling up the facility quality assessment tool 5 nurses were male and the rest 5 nurses were female. Working experience varied from one (1) to twenty (20) years with the age range of 25 to 60 years. Among these 11 were enrolled nurses or midwives who had never been trained in mental health practice and 26 were registered nurses who got mental health training during their nursing training. Table no. 1 contains more information for nurses who participated in the qualitative interviews.

Table 1:Demographic data of participants participated in Qualitative study at Mirembe & MNH Hospital.

Id No	Date of Birth	Sex	Pre-Educ.	Prof. Educ.	M.H Train	Post Prof Ed	Design	Years of Exp.
H1F	1978	M	Form IV	Diploma	Yes	Pitc Ipc 2012 - 2010	ANO	6
H2F	1956	F	IV	Certificate	No	Pitc 2010	SNE	15
H3F	1956	F	Form II	Certificate	Yes	Diploma	ANO	8
H4F	1970	M	IV	Diploma	Yes	Certificate	SANO	3
H5F	1968	M	IV	Diploma	Yes	Certificate	SAN0	12
H1F2	1967	M	IV	Certificate	Yes	Diploma	ANO	3
H2F2	1984	F	IV	Diploma	Yes	None	ANO	6
H3F2	1967	M	Secondary	Certificate	Yes	Diploma	ANO	6
H4F2	1966	M	IV	Diploma	Yes	None	ANO	4
H5F2	1956	M	IV	Diploma	Yes	None	ANO	3
H6F2	1982	F	VI	Diploma	Yes	None	ANO	6
H1I	1967	M	IV	Diploma	Yes	Course Ling	ANO	3
H2I	1978	M	IV	Diploma	Yes	None	ANO	1 1/2
H3I	1978	F	IV	Certificate	Yes	Diploma	ANO	7
H4I	1959	F	IV	Certificate	No	None	SNE	12
H5I	1980	M	IV	Diploma	Yes	Bscn	NO	7
R1F	1967	F	STD 7	Certificate	Yes	Diploma	PN	20
R2F	1960	F	IV	Certificate	No	Dip 2008 Midwife	PN	32
R3F	1978	M	IV	Diploma	Yes	On Studies	ANO	3
R4F	1963	M	IV	Certificate	No	None	PEN	24
R5F	1983	F	IV	Certificate	No	Dip -Midwife	ANO	1
R1M	1977	F	IV	Certificate	No	None	EN	4
R2M	1952	M	STD 7	Certificate	Yes	Certificate(Mh)	EN	20
R3M	1961	F	STD 7	Certificate	No	None	EN	16
R1I	1968	F	STD 7	Certificate	No	None	EN	3
R2I	1987	F	IV	Certificate	No	None	EN	1 1/2
R3I	1960	M	IV	Diploma	Yes	Forensic Law	PANO	18

Factors affecting provision of quality mental health services

This study came up with various factors which affect the provision of mental health services and its quality. Some factors resemble to what was found in other studies like high work load, lack of professional development exposures, inadequate community mental health services, some factors were not even expected by the researcher and were unique on their own. This included the following themes which emerged;

1. **Inconsideration of professional skills and competencies in provision of mental health services**

As it was admitted by some participant that working environment also rely on number, qualification or skills and knowledge, at X2 it was found that some nurses who were not trained and they had never been trained in mental health are the mostly workforce who provide services, they do so by looking what others do as they do have knowledge about mental health, this is one of the factor contributing low quality mental health nursing services,

> "...it can affect me (not having training in mental health) because there are some issues I tend to observe how others are doing, I'm using my experience from what others are doing but it is different if you could have been trained" R5F

Another nurse added,

> "... we get skills from long time working experience, from different types of patients, the way we see them, hence we learn in situ that what should we do that how we are continuing to get (experience) but as my fellow former speaker has said, it could be much better to get that training (mental health training) at least twice a year especially for those new employees..." R2F.

Provision of mental health services requires nurses to be trained, but due to the existed situation, patients were also helping nurses to in some situations especially controlling other patients. Communication matters in such case patients had not been trained; this situation gives the picture of quality of care and can predict the future. Shortage of nurses has made them to improvise and try to use patients who have improved as their assistant with underlying purpose of strengthening nurses security, thus life in the mental health units is slowly coping that in prisons with exception of medication for mental illness and absence of hard works, patient acting as chief commander;

"... anyway we are trying our level best using our nature, in the ward there are some patients who have improved we use a technique of giving them administrative positions ' you will be chief commander take care of them' because you are aware that you are alone so if you think yourself that you are a specialist of mental illness, you will be injured..." R3I.

Psychological skills have been reported several times by nurses to be helpful for them in mental health practice, it helps them even when there is misunderstanding among patients or there are some patients who are aggressive also due to shortage nurses coaches health attendants to help them in case. One nurse revealed

"...it is very difficult you just involve them (health attendants) we used to apply techniques, come to help me; you know sometimes you just apply psychology"

2. Nurses working a police

Due to the shortage existing nurses failed to provide quality care and consider a patient as a whole sometime nurses felt like to be working as watchmen in the wards instead of providing the necessary needed care professionally, as many nurses revealed, to quote one,

"...therefore even the services we provide won't be complete we call it as a whole, meaning it will not be good, sometime we *act like watchmen, like soldiers*, preventing the patient not to abscond may be, patient not to run away, patient not to fight others; therefore there will be no quality care, therefore sometimes we provide just care, even when you try to provide quality nursing care to patients may be providing medications to patients but sometimes *we change and act as watchmen..." R3F.*

3. Gender

Female nurses working alone can be bad; more men are needed to work in psychiatric and mental health hospitals. At X2 the issue of gender consideration had security potentials as men found to be protectors to female nurses and other patients, hence settings with few men was thought to be not good working environment. This argument embeds the security matter as presence of male nurses increase security in the mental health working place. As one nurse shared,

" ... sincerely there is shortage of staff especially when you consider this hospital, it needs many male staffs but in this hospital females are more than males,...in most cases mentally ill patients tend to afraid males (male staff) when he sees a male nurse, he afraid as compared to a woman" R1I.

Shortage of nurses' especially male nurses and employment of young ladies of about 23 years was criticized in the mental health setting where there is shortage as it is no safe to them. This is one of the reasons to why male workforce was more preferred for hospitalized mentally ill patients as they masculine and energetic enough to control and care these patients.

4. **Fear of uncertainty**

Nurses felt to be in danger of being injured by the patients as they are fragile sometime be stable sometimes unstable and they assault or even pose injury to nurses hence making the environment to be so un conducive,

"Working environment at our working place is very difficult because in consideration of our patients we are taking care of, sometime you find him stable and sometime un stable,… sometime you may sign in while you are physically fit and sign out with injuries or you may sign in and be assaulted as usual and be treated abnormally" R6I

Working environment at X3 Institute is perceived to be dangerous in relation to the nature of patients who have forensic cases and some are drug abusers. One nurse shared,

"...our patients are dangerous a bit especially here in X3 we are informed that we are receiving patients who have murder cases and they are dangerous cases, we have drug abusers therefore we are taking care while working … "R2I

Working in psychiatry needs someone to be well prepared in mind set. Fear for student nurses to work in mental health institution is also contributed with the exposure to aggressive patients during their acute phase especially during admission when the patient is cuffed, dangerous to other people and some have history of murder. One nurse shared,

"...just the act of escorting the patient while s/he is tied, talking irrelevant, biting people, some have committed murder example those in X3, … therefore *students when are here in*

their field practice some tend to fear as they observe oooh, 'of that type s/he will kill me'..." R1F.

Fear extends to family members when their relative is actually or potential to work in mental health settings, they get worried about safety of their relatives. One nurse revealed,

> "You know mental health section most of people are not interested with it but for me I do not know what I can say because I was interested to the extent that my family members were wondering that ' you are going to provide service to *mentally ill patients they will kill you..." H2I.*

Nurses has been experiencing that the doses prescribed to patients does not sustain for the expected time that it is low dose and the patients currently requires high dose to have the intended effect.

This is an issue which requires more study as drug side effects needs to be considered

Note: as the person who posed it has not been trained in mental health but it requires more investigation.

When resolving patients conflicts sometimes nurses subjected themselves into risky of being attacked, some tended to help them but also there are some who turns against nurses and some uses that chance to escape, patients become aggressive against nurses thinking that nurses are the ones who keeps them in the ward like prisons and prevents them to leave. One nurse shared,

> " sometimes when you are few and when you are resolving the conflict, there are different patients with different thinking from you, after resolving the conflict there are some who are aiming to escape or they intend to attack you that you are the one who prevent them going home, such situation keeps us in danger." H1I

Adverse events like patient killing each other, nurses being injured in various ways happened, some nurses have scars and deformities, nurses get pain when they talk about it. It increases fear among nurses. One senior nurse revealed bitterly showing his scars,

> "You know I have been injured in this hospital several times, do you see here there is a scar, I was injured with a stone by a patient, I bleed the whole body but I did not react to any extent… (He took deep breath then continued) its many staffs have been injured our leaders themselves other staffs got fracture of their arms, some legs and when you go to claim I have heard that it has small compensation, the amount is outdated it has not been reviewed" R2M

Patients with cannabis use history and very aggressive they were perceived to be dangerous to nurses as they ready to fight anytime, it made nurses to provide care with worries. One nurse shared,

> "Currently about 80% of admitted patients are cannabis users, psychotic, they are dangerous, first of all they are confident and they are ready to fight anytime, they can fight you any time, for that reason when you move into the ward some fear feelings also persist a bit, or you become more keen..." H1F

Some patients in mental health institution also play significant role in safety of health workers as they help staffs when nurses'/other patients' security was jeopardized by aggressive patients as there was no enough workforce hence patients acted as experts.

> "... When it happens that there is an aggressive patient in a certain ward, if you look for males there is no one (no male nurse) ok! What happens is that our mentally ill patients who have improved status they help a certain woman (nurse) from being beaten, but sometime in the whole compound you may find no male staff in a shift..." R4F

Another female nurse shared her experience in the male ward,

> "...he tells you that " I do not want (to stay in the ward) I need to go (home)" put into consideration you are a woman in male ward, " I want to go home now" you can reply wait please for me to call a doctor, he says again that " I do not need a doctor or anything else, open the door for me to go home!" while you are in conversation you are slapped already..."R1F

Working alone in the ward or unit was considered to be dangerous and impaired nurses' confidence of providing care to patients, when nurses were subject into such situations they started thinking of their safety. A females nurses who was not trained in mental health yet providing mental health services in a forensic unit revealed,

> "...they are (patients) used to be under control of prison police who have weapons (guns)they can handle them, for example someone is brought while in handcuff from the prison they escort him with their weapons once they handle him to us we do not have weapons and we are not trained in such matters therefore we are more at risk,...there are some who have been trained in psychiatry and there are some who have been employed without being trained in psychiatry like me, I'm a nurse midwife… difficult issues for

example when I enter into the ward there are patients who have been here for years there are some who are aggressive, with my age (she was below 28 years of age) it becomes difficult for me to go and open the ward getting inside because these are men they can do anything" R2I.

Nurses' preferred to stay in group for security purpose rather than being alone, hence some aspects which could have been observed by a nurse were missing as nurses left their wards to seek places within the facility where they will be secured. One nurse said,

"to avoid staying in this room alone or if I'm alone I can move to another ward like RC (acute ward) there are men (male staffs), I close the office because you cannot close it while you are inside as it becomes dark it is different from other offices..." R2I.

Nurses especially those who are working in acute wards are worried of their lives as they are not sure of signing off alive when are on duty the situation which has been reported to contribute problem of retention for new employees. One nurse said,

"... In this hospital it is like we have sacrificed to work for the government because its environment you can sign in and go out as a dead body or with deformities" R3I

Lack of power for sometime makes nurses fear about safety for patients and themselves, they cannot try getting in the ward while there is no light,

" for us here we do not have a generator like in other areas, once the power is off we do not have a lamp which can function for an hour, when we have no electricity for three hours then you can understand psychiatric is off light, you cannot get in psychiatric unit while it is off light..." H1F.

4.2. Patients not responding to prescribed doses of medicine.

Nurses considered recovery and relapse as the measure of impact of services they provide to patients. Pharmaceutical-effects of was thought that patients needed more doses than what they used to. One nurse shared,

"Current if you inject him this haloperidol 5mg start then another dose continues half hourly for two hours, *it is nothing*, that 20mg seems to be small, since year 2000 it was the same 20mg, the patients we are receiving currently are very aggressive, 20mg is like nothing, if

you inject him now the time we have come here he is awake already and has started his riots as usual, they do not fall asleep (do not get sedated)." H4I

The effect of prescribed medicines was challenged by nurses. Patients were not responding to medications to the expectation of nurses. As this nurses shared,

"S/he is discharged today, tomorrow s/he comes back, s/he is discharged in this week the next one s/he is back therefore readmission in the year we have the same patients I mean in the whole year you are providing care to a patient s/he stays just two days s/he is back, now we do not know yet, medicines are not effective to them or they (medicine) decreased in efficiency or what is happening is what we want to find out, what is it why patients become like this?" H1I

5. Cared of like being in prison

The environment in which patients are treated affects the patient to the extent that they become aggressive toward nurses whom they think they are responsible for them being enclosed like in prison, also it is perceived to prolong the hospitalization period, environment which allows the patient to move around and relaxing is suggested to be conducive, the environment was also considered to affect the patients decision in accepting medication;

"...the environment (in the ward) is like a prison, it is not good for the patient to feel relaxed, because they human being too, s/he need to feel relaxed; putting him/her in such room like a 'sero' (small retaining rooms at polices stations) for two weeks until s/he gets improvement, ooh it makes him/her getting angry due to environment, patient pushing away (do not want) injection! It was supposed to have conducive environment s/he gets out in sunrise, looking at the garden..." "H1I.

6. Low financing of mental health services

Financing of mental health services was found to be inadequate and led to inadequate supplies, medicines as a result patients and their relatives blamed nurses to why there was no medicines thinking that they are responsible for that matter. Also there was a difference between nurses who were trained and those who are not trained in mental health about the issue of adequate supplies, those who are trained most of them had complained about it and tried to mention what missed such

as BP machines, sterilizer, cleaning fluids especially Lysol, food utensils and bed sheets but those who are not trained they are reporting to have adequate supplies. Untrained nurse commonly shared,

> "Supplies are available; honestly they are (supplies) adequate" R5I

Trained nurses in mental health had various statements about supplies in their work place,

> "trays are lit, at least we could have this large spoon, we are using a cup to share stiff porridge and meat to patients, …you will be using the same tray for investigations as well as injection procedures…there is no sputum cups, patients cough carelessly" H4I

Video tapes and brochures were also needed for giving mental health education to maximize understanding of the lesson planned but nurses shared that at least there is something patients are getting from their health education,

> "… sometime it is like you are singing when you are teaching, you do not have brochure, you do not have at least video tape to show them, you are talking with him you do not have brochure they are passing by, it becomes like a routine but sometime they get very small of it". H1I

Absence of supplies such as restrain belts sometimes led nurses to improvise which resulted into tearing of bed sheets. One nurse revealed,

> "...in physical restraining we do not have the required tools (belts) hence we are using normal ropes which is not good sometime it reaches a time when we destroy bed sheets, we tear linens so as we can fasten such patient" H5I

At X the issue of availability of medicine was considered in different way. One nurse shared an experience,

> "…but he had (patient) been prescribed with some medicines but they are not available then he comes back to you (nurse) asking, 'why your medicines are not available? 'You find the working environment becoming difficult because what we intended to provide them is missed" H1I

Another nurse added that there are times they buy medicines for their patients,

"…for example some psychiatric medicines, there are some which are missing, sometime *we buy medicines for our patients* ... because I understand that this patient needs this medicine which can help him, but that medicine is totally unavailable thus even the social worker cannot help him because that medicine is absolutely not available in the hospital therefore you are obliged to continue providing him with other medicine as a placement, due to such situation you may find a patient staying longer without getting improvement, it is psychologically disturbing to you because you see the patient becoming more aggressive, he does not sleep, disturbing other patients, it is difficult to you, it creates difficulties in your job performance," H1I

7. Nurse working beyond nursing perspective

Despite of shortage and low knowledge in mental health practice, nurses used their experience to prescribe and admit patients. It was also observed most of the services were provided by nurses during the time of data collection. It reflects the significant contribution of nurses in mental health services. One nurse said,

" you can imagine since morning you have arrived, you have evidenced the way we were busy with our patients, we were receiving, treating and carrying them to the rooms and proceed with documentation, honestly staffs are trying their level best" R2M

Nurse could not provide a holistic care to their patients as the working environment was not friendly. Mentally ill patients need to be taken care of other health problem which they are going through. Sometime nurses applied their creativity to avoid risky situation to them and their patients such as being injured by aggressive patients. This nurse shared,

"...one day I was in male ward, there was a patient who was very muscular I think he is a boxing man, he went to the toilet and bathed the stool and handled it this way and said 'I want to leave home' we were two of us, me a lady and one youth, health attendant, he told me that mom I don't want to splash this stool to you but what I want is, I'm requesting you to open the door for me to go home, if you do not open I know myself what I will do'. Spontaneously he had painted the, he poured the stool, by that moment at male ward the files, the table was terrible undesirable. I told him; 'listen I'm opening but let us agree each other, do you have a relative here? He replied, yes I have' I called her when she came and

saw her patient with stool the whole body you don't see eyes and clothes, she wanted to run away and I discouraged her to run 'do not run come here to help us' then I told her that your patient wants to leave but according to our laws you have to sign in his file, he went away like that with his stool that's when we felt at easy, without being creative and confident if I could have had ran how that ward could have been?" H2F2

Nurses tried their level best to make sure that their patients got the right medications. Week end days pharmacy at **X** was being closed so availability of medicine for psychiatric patients' became difficult and it was a challenge when the prescribed medicine was not available to other patients. One nurses revealed,

"Another issue is that in the week end you find that our pharmacies are closed therefore you have extra duty once you get a new admission and you have to ask from other patients' medicines sometime those who are in the ward they do not use the prescribed medicines" H1I

8. Teamwork

In psychiatry the term team work was found sometimes to be mostly practiced among intra professionally and nurses expressed to work more as a team especially handling aggressive patients. Doctors don't help especially in managing aggressive patients, they are running away,

"...we have vivid examples that there may be alarm call you find that nurses respond quickly, they are frontline you know that, for example acute ward there is a patient who is attacking another patient in the ward you may ring the alarm as you go there you find doctors from their round sitting down and writing while there is emergency there, you will rescue the situation but they (doctors) do not participate or he (doctor) will disappear and come back later ooh ' how that patient, I do not know where I ended up?'. One day I was on night duty and patient came from home the same example he was handling his chips and a stick, the doctor was just coming it was about at 9 or 10pm s/he was still in the office and called me 'aah sorry there is a patient I think you may help him' while he exactly see the patient handling a stick ehn then he went back in the office and close the door they were two of them every one locked up himself in his office" H2F2

Another nurse shared,

> "...there was a sister, she wrote a prescription and told her fellow doctor to escape 'leave to nurses' (handling aggressive patients) to show that we as a team (nurses) but they (doctors) are secede from us as they are of different cadre "let us leave it to them (nurses) because they are the workforce" H2F2

Nurses were also surprised by statements of senior doctors to their juniors. One nurse sadly quoted,

> "... they are saying (senior doctors telling junior doctors) that if the nurse is not there you should not clerk the patient; Are we (nurses) existing to safeguard that doctor?" H3I

Nurses reported that collaboration among themselves motivates them to work hard as they are sure of getting assistance and support from each other. One nurse revealed,

> "In this unit nurses have their unity themselves a nurse cannot hear the alarm or refuse to respond to the request of assistance from the other nurse, that one (system or unity) has contributed a lot, nurse feels like there is no reason to why s/he should not work hard while s/he is getting support from fellow nurses!" H1F2

Unfulfilled task of other workers in the health system was found to affect nurses' implementation of their care plan,

> "every patient's information is supposed to be computerized but due to someone's irresponsibility or due to infrastructure there may be no electrical power hence the patient may come (for admission) having computerized information as a result once he inquires services then he is told that … he has not gone through this process..." H5I

Teamwork was thought that it may extended by involving family members in care especially supporting the patient to use of medicines at home for the person with mental health problems was explained to be significant and helpful to the patient as it accelerates the recovery process. Support from family members is helpful. One nurse shared,

> "...the relationship between the nurse and the patient's relative for sure will make the patient's treatment effective and the patient will recover...our mental ill patients sometimes they do not like to take their medications, it is taken for long time, there is a time where they

become discouraged but if we have a supervisor who advises him/her,...if they refuse to take their medications, all of them in domicile having no assistants, we will have congested the hospital!..." H4F2

9. Leadership

Nurses were not satisfied by the way their leaders responded to their request as they claimed to have poor collaboration with their leaders,

> "... even you write them today that the door or window is broken patients are escaping at night, they do not understand the management is very uncooperative at X2..." R5F

Nurses required assistance aiming at encouraging and uplifting their competences and skills in provision of care to mentally ill patients. The needed support explored was mainly access to information especially research findings through internet and doing their research, supportive supervision and psychological support.

To feel recognized and valued after being injured psychological support was the foremost expected by nurses from their leaders or supervisors. They felt upset when they missed it as it was shared by one nurse who got fracture of the finger after being attacked by patients in the acute ward,

> "… I got treatment (after being injured) and my fellows inside they called the doctor and I got help, there is no even appreciation, I'm telling you there is no appreciation from the leaders, and I'm telling you I can tell her/him physically even more bitterly, because I'm talking with painful feeling, I have experienced it, do you see my finger, I was injured here (in the ward), what have I been compensated? To the extent of getting contraction! Do you see how it is?" R2M

Acute wards were considered as most dangerous wards as even murder case can happen any time, example at Mirembe as mostly there are one nurse and a health attendant in each shift and there is no alarm and nurses were discouraged to work hard as there was no recognition from administrators for them working in such situation which they marked to be very risky as murder case can happen anytime, it increased worries among health care providers, a more experienced nurse who had scars due to workplace injures revealed,

" …for example ward … (acute ward) if you sign in alone you are answerable for murder case yet your leaders scorn you once you face them for at least to be considered for what is called extra duty allowance " R2M

Despite of nature of patients, nurse faced challenges of having many patients to take care of, working long time (for more hours in a shift) due to shortage of staff; overtime work is not recognized by the management or the society,

"... what challenge do we get there, at X2 and X3 there are few staffs compared to number of patients we have, there are so many issues which we are facing including the issue of time, … you may have worked more hours than the usual time like other workers, but it is difficult to be recognized as a worker that your time is not considered in the society or by management..." R3I.

10. Maintaining professional standards

10.1 Need for continuous professional development

Nurses are enthusiastic in their professional development, they needed supportive working environment. At X there was a computer which was used only for issues about patient services, there was no other software installed for accessing other useful information. Nurses needed to have access to information close to their working environment. One nurse shared,

"...even that computer it is just for booking specimens there are some minor issues you may search and access materials even to realize ok there is something and search, okay this patient is having these signs let me revise what is this s/he may access even in the internet and s/he may know and adds knowledge and next time when s/he meets the same signs to the patient s/he will know it, in that the environment is assisting also the environment is motivating to work, there is nothing like that..." H5F2

Another nurse shared on how they could improve care and their competences through evidence based practice and working jointly with Universities,

"… We need matters which can put us together and are able to do something which will uplift us, you know our fellow have one thing, they have access to internet, research findings, and they are doing research on many issues through university, isn't it? Therefore once the university finds out, it is disseminated throughout, I think that is how they are being informed …" H4F

This study revealed wide gap in terms of nurses' training in mental health during their nursing course education at X and X2**.** Hospital X had more highly trained nurses, (RN) which includes diploma, bachelor and holders of Masters of Science in Mental Health compared to X2 where EN where the majority of the workforce who had no mental health education or training. Nurses who were not trained and they had never been trained in mental health provided through various techniques including looking what others do. Nurses working in mental health settings but are not trained in mental health sometime provided services without clear understanding of what they were doing. One nurse shared,

> "...I did not go through mental health in my training I'm using experience what doctor writes (orders) that is it, … I think if I could have gone through I could have more understanding about it more than I do, because sometime you may be working and you may not notice some of the issues because I do not know them, I will be aware of issues I'm used to everyday, so if something new emerges I will not be able to understand them because I was not trained." R1I

The current training system of mental health was also doubted as mental health is not trained in details as compared to previous years. One nurse said,

> "For the previous psychiatric training we were very competent graduates but currently psychiatry is being taught together with how many subjects, I do not know! Psychiatry is being taught may be in one month..." R3I

Induction courses in hospital settings were valued by workers as it made them aware of the surroundings and get prepared for the actual services provision, they wondered with the current system at X2 where by new employee are allocated in acute ward directly without induction course. One nurse revealed,

> "…for us who were employed some years ago, once you are employed we get into class for of all for orientation for two weeks just reading then we were being taken into the wards and it was not so directly but we rotated in all wards then you were officially allocated, currently there is no such a thing, after someone being employed, s/he is told that 'welcome go in ward number six (acute ward)'…" R2F

10.2. Working as a routine without adhering to guideline.

Enforcing adherence to the guidelines to maintain standards of care was seem to be vital as nurses who stay in one station for long time said that they sometime work in routine bases without considering the right way of going through,

> "If you are working here for quiet long time you will start working routinely without considering that this is the protocol, isn't it? If there is something you are doing routinely you may find yourselves continuing with it" H5I

Most of nurses who participated in the study were not sure of presence or absence of mental health practice guidelines in their work places. One nurse honestly said,

> "...to be sincere may be they are reading it themselves, I have never seen it. I think it is available but I have never read it" R1I

Nurse complained on evaluation system of their performance using the guideline which was not compatible with their nature of work, this communicates inadequate of appropriate means of evaluation of mental health nursing services. One nurse shared sadly,

> "... the problem is for example currently we have the infection prevention program the is a guideline which is used but in the mental health department, ...you will find there are some issues in the guideline for sure you cannot implement ...in such environment it can happen they come to evaluate you for something which for your working environment and patients you cannot implement but they rank you that to have zero... eeh, that can take you back (demoralize) that with all my efforts I'm ranked zero?..." H5F2

11. Working conditions

11.1 Nurses' perception about their working environment

Working environment has been perceived in different ways by nurses, some nurses perceived that working environment involves availability of adequate workforce and their quality, working space inside and outside the ward, safety, presence of motivation such as allowances; generally it involves all necessary rights of a health provider to be able to provide services to the extent of client satisfaction as it was shared by one nurse,

> "…when we are discussing about working environment, it is about how is the work is; how is the nature of work; the available workforce: Are they adequate? What is the specialization

and qualification? You see! Third is about working tools, and are they available? Is there security I mean their protections in their job? It involves management in place, is there good relationship between staffs and administrators and does it allow the staff to work freely? Is s/he (staff) earning enough money? Are the leaders having good management of their staffs and not frustrating them? Can they (staff) get basic services when they are sick, have problems, when they have lost their beloved do they get such services? Ok, let me say for example do they (staffs) have working tools such as adequate protective gears and working gears…" H5F

Other nurses commented that working environment also involves the relationship among staffs of different level within and between disciplines,

"…on top to what has been discussed, working environment should consider the relationship among staffs because they are from different disciplines, there are those at officer level, doctors …" H5I.

General comment was also given pertaining perception of nurses that working environment is all conditions which leads a nurse to provide either good or poor care to the patients,

"... Let me say for interest and how I provide care to my patients or what makes me not to take care of my patients badly or well, I consider them to be equal ". H2I.

The working environment was also perceived to be one which considers the care consumers' preferences and dignity. Nurses voiced that to provide quality care their patients needed conducive millue therapy and referred the patients' environment especially in acute wards it was non-conducive ,unhealthy and unsafe due to congestion and. One nurse revealed,

"Sincerely the working environment we have is not conducive in relation to difficulty work and its nature, ...especially today it has revealed itself that one room in which was aimed for a single person use, currently there are twelve patients to the extent that some are sleeping on floor, there are inadequate mattress or beds, the room is too small which is dangerous either to themselves by trampling on, killing and strangling each other or it is even not sufficient to offer security as they can escape; they do not have uniforms hence by mixing

up with relatives who come to visit them, provide food or anything they can escape! It happens several times..." H1F2.

Another nurse added regarding cognition state of the patients that is makes the working environment to be a bit risky,

"It is difficult compared to other settings because our patients are dangerous as they don't have normal cognition as other patients thus our environment is bit difficult..." R1I

While other nurses were commenting to work in un conducive environment one nurse gave an opposing idea that the working environment was good though she agreed to face some challenges which makes the provision of care not to meet standards,

"Generally the working environment is good on my point of view except that there are some few challenges which lead to provision of services below standard; generally the working environment is good to a large extent"

Another nurse added that the working environment at X2 was neutral, not so bad or so good, but nurses agreed to experience some challenges which demoralize staffs and subject them to be demoralized in doing their job,

"At this institute, what I can say is that the working environment is not so good nor so bad but there are challenges which demoralize staffs and results into lack of working motivation"

Means of communication among staffs in mental health facilities was also found to be one element as indicator of good working environment. Presence of alarm in the mental health unit helps nurses to communicate in state of insecurity or aggressive patient and it becomes easier to manage the patients,

"…once the hospital provides means of communication for example if there is alarm system which you can put on when you are attending the patient who in - dangers the safety of other patients, other staffs will rush to that ward" R2I.

Working environment for mental health nurses is perceived to be frustrating for nurses, others claimed that absence of basic services near nurses working areas such as toilets to minimize

consumption of much time seeking that service as they may be two or one nurse in a shift, they need to use much of their time to interact with the patients.

Non conducive working environment lead retention for nurses to be difficult in those stations, as it was aired out by one nurse,

"Interviewer: why they do not stay?

" The real situation which they find it here". R2F

11.2 Workforce

On observation it was revealed that, there was shortage of mental health nurses in all facilities but the situation was more critical at X2 and X3 as at X3 there was a total of 13 nurses, who had to work in two shifts to take care of about 200 patients, among these nurses some had administrative and management roles hence they rarely be involved in direct patient care. One nurse revealed that when they are few or alone the workload increases due to many demands from patients and impair its quality hence makes the work to be difficult,

"We are providing care to patients as I have told you, currently we are few of us with many patients, performance becomes poor, this one (client) demands service, you may be alone it is a problem" R2M.

Furthermore on the day of interview it was observed that night shift was done by one nurse who is a male and was aided by three female health attendants to provide care to 240 patients. Furthermore health attendants sometime were allocated alone in the shift for providing mental health nursing services.

Some of the safety precautions are no longer observed as in the acute ward with 30 patients it was under care of one nurse of 60 years old with assistance of one health attendant such situation may compromise the safety of patients and staffs as well as he said sadly,

"Here! We have 30 patients"

About shortage of nurses one nurse shared bitterly as she was the only registered nurse (trained in mental health) in the ward of about 80 patients the situation which makes it difficult in provision of care,

> "...we are very few you may find may be 80 patients in one ward, the available nurses in that ward you may be a total of seven nurses meaning that there are few nurses, you find that we are a total of seven nurses, I'm the only RN registered Nurse, there are two EN the rest are health attendants, thus in a shift you will be with a health attendant, sometime in the afternoon you are alone, in such situation it is not possible in the job roster, therefore service provision becomes difficulty..." R5F

Institutions providing mental health services have critical shortage of mental health nurses the situation which led the management to arrange for two nursing shifts instead of three shifts

Working extremely makes nurse become tired especially when they are not motivated with adequate allowance especially at X2 and it influenced them to work for more hours inefficiently. One nurse shared,

> "... because of staff shortage we are obliged to continue working up to evening (twelve hours for a shift) we are doing just like that though with difficulties really the environment (working) is so difficult" H1I

11.2.1 Factors contributing to shortage of mental health nursing staff.

In this study some factors which contributed to such shortage were explored which included, extended or additional work to senior nurses, lack of motivation to work in mental health settings, late payment of salaries to new employees, misallocation of nurses, stigma from the community and inadequate replacement; Mental health program has been integrated in the nursing curriculum so all nursing students are being trained at least introduction to mental health. This situation has increased workload to experienced and senior nurses to have added task of teaching students, one nurse shared,

> "...we are learning and getting experience and we become teachers to students who are coming because the subjects we learnt are the same with what they are learning because as the go to symptom logy that is the same psychiatry" R2I

Shortage of mental health nurses who provide care in psychiatric settings is contributed by misallocation of the said cadre,

> "... because you find some who had been trained in psychiatry but s/he is allocated where does not tally with what s/he was trained" R3M**.**

Inadequate replacement of nurses who get retired, diseased and transfer was also found to contribute to the existing shortage and makes it difficult for the remained nurses to perform well, one nurse said,

> "...due to decrease in number of service providers by retiring, death, and transfer yet we don't have others for replacement, it becomes difficult for us who remain..." R3I

Shortage of nurses in X2 hospital among other factors was contributed by the situation of new staffs staying for more than a year to get their salary and negative balance created by higher rate of retirement than new employee. One nurse revealed sadly,

> "...they don't stay after being employed, few days ago some decided to leave after analyzing the environment there was no salary they asked themselves why they should remain at X2 and not to report to other place, … the retirement rate is very high it is more than 10 to 15 each year but there is no employment..." R3F.

Most of the new employees do not like to work in mental health (psychiatric) units or hospitals when they are posted there some tend to report observe and disappear or arrange for transfer to other wards, this is a danger sign for future mental health nursing practices in terms of qualified nurses as the existing ones are aging and some are retiring. One nurse shared,

> "...X usually employs health workers in the nursing cadre but when they are employed if get posted to psychiatry if they were twenty they can come two of them they just peek at the unit, off they go, because they know it is a dangerous place that is why they (management) are tightening us who are available to continue as we have experienced the environment we know how patients are,..." H2I.

11.2.2 Workload

Workload to nurses working in mental health settings is depending on the severity of the patients, nurses at X felt that they could be 4 nurses for a single acute patient but they are 2 nurses for 13 patients instead,

> "... we have 13 patients, one patient is supposed to be taken care of by three to four nurses, as I'm here inside there are 13 patients cared with one nurse.." R2I.

Low number of nurses (workforce) contributed a lot on the quality of mental health services provided, it had made the working environment to be perceived difficult due to workload upon the available nurses as only 4 nurses (one ANO and 3 EN) are supposed to be scheduled in three or two shifts day, night and off, such situation ensures only one nurse to be available for patients care. Furthermore most of these nurses have never been trained in mental health nursing, this includes all EN and some of the ANOs.

High workload that is having many mentally ill patients 90 to 100 cared by one nurse assisted with a health attendant makes the working environment to be difficult with low safety not only to nurses but also to patients themselves like at X2 they sleep two patients in one bed while others sleep on the floor, smartness of buildings also had an impact to health care workers in service provision. One nurse said

> "...to be sincere they have improved it (working environment) may be in my ward may be I have 27 beds but sometimes I have 90 to 100 patients, patients sleeps on floor, wards are worn out,..." R5F.

Workload to nurses was also risky as on observation it was found that night shift on that day of study was being served by one nurse who is a male and was aided by three female health attendants to provide care to 240 patients, two female nurses are taking care of 133 male patients in a forensic institute, In the female wards at X3 in one shift there was one nurse who was being aided with one health attendants to take care of 66 patients.

Knowledge acquired in schools is really used when nurses are overworked with high number of patients, nurses applies more experience than their knowledge. One nurse revealed,

"if you find that you are two or only one (in the shift) and you have fifty patients in such situation it is just experience which plays part, " R3I.

Being too busy in mental health practice sometimes could lead some patients to get wrong treatments as nurses become tired to the extent that they could mix up surnames of patients on the file. One nurse revealed,

"… if you have ten fifteen files all of them you want to document you forget the surname you can write Fred, the name of Magesa you may write Suleiman, you see! that happens sometimes when you are tired" R3I**.**

In this study it was also found that some patients added workload to nurses due to overstaying in the hospital/wards, this situation is caused by relatives disagreement of taking their family members who have been discharged despite of nurses efforts of calling them though their phones. Furthermore stigma at home places influenced some patient to seek admission in the hospital the situation which results in increasing the workload to nurses and other staffs.

11.3 Milieu Therapy

Different aspects including working space, ward space, ward structure, space for recreation and stigma emerged regarding the environments in which patients are hospitalized. One nurse revealed to be discouraged in trying to improve their services due to limitations of the environment,

"You know you can say that you want to improve the provision of care if the environment generally is unfavorable." H5F2

Nurses use more force in treating the patient especially in restraining as the later do not have much trust to nurses since they perceive to be cared in prison, nurses also have less trust to their patients hence much energy was used in restraining. One nurse revealed,

"Let us say for example a patient has reacted against restraining; force has to be applied because s/he is energetic already and hatred in his/her conscious that s/he is being bullied"

Sometimes patients were subjected into risky as waste management becomes a challenge to control at the end they are placed behind patients' wards to the extent that they are smelling and risky to patients. One nurse revealed,

"...the patient is sleeping in the ward there, behind the ward near to the window there are waste drums which are smelling, waste bags are placed there do you expect that we are going to improve services, we can plan all strategies but the environment does not allow to go ahead" H2F.

11.3.1. Working space

It was observed that at X the space was very limited hence minimized comfort-ability for nurses to work more efficiently and some services were compromised. At X2 hospital there were large space and they are using the space for various treatment modalities example having Alcoholic anonymous and Occupational therapy sessions.

Wide chances for assessment of mentally ill patients is needed and they need to have some daily living practices example shopping with special supervision, all these were being practiced previously but currently they are no longer practiced and it minimized chances for nurses to assess their patients. One nurse shared,

> "The way that outing was planned previously there were places for operation, social shop and OT (Occupational therapy) there," H5I.

Patients' confidentiality need to be given its considerable weight. As the space becomes limited nurses activities are being also deployed from specific areas where they could discuss patients' issues and maintain confidentiality, nurses perceive the situation as undermining of the nursing profession. In X currently there was no room to serve such purposes including giving and receiving report and patient review they are being done in the open space which was aimed for recreation as a result patients remain more confined in the wards as there is no space where they can stay outside the wards they are also complaining of being treated as prisoners.

> " for example we had a complex place for major ward round which was good, you could not hear people passing by like that, you will be settled with your patient when you are clerking him you have a relative as an advocate but the room had been taken may be we are not valued" H4I.

Nurses expressed the importance of adequate space in the mental health institution as it matters for the quality of performance of a nurse. At X space in the wards had very limited space for a nurse to provide services freely. Nurses complained,

> "Ward is very small and there are a number of patients to the extent that provision of care becomes not so good. According to the actual situation of our patients, the wards are congested". H4I.

Limited space had influenced admission of acute patient direct in general wards at the psychiatric unit. That situation happened as there was no special room for admitting patients who could not stay with other patients in one room (dangerous patients), he occupied acute male ward and other patients were shifted in the female ward where by acute female patients were shifted into the general ward and all admissions were done the same. Although it was safety insurance decision but other patients are subjected into consequences. One nurse acknowledged,

> " …it has led us not to admit patients in that ward for example acute female ward which may cause annoyance in the general female ward as they will be admitting them directly, also all patients are placed in one room which has six bed, as the other space is occupied by one person". H5I.

Mixing up acute patients and other patients who had improved posed some challenges to nurses in providing care especially to the acute ill ones who need other physical care such as checking BP and Blood sugar level due to fear of carrying working tools in the ward were there may be aggressive patients who would grasp them and use them as a weapon. It is an issue if acute patient requires intravenous fluids or has a catheter it is difficult to control other patients as they tend to remove them. One nurse shared

> "...it is possible that sometime they do not have mental illness only they have some more health needs like checking BP, blood sugar and you have to move in with your tools and there are other patients who have improved it becomes very difficult if there is a serious patient who needs a drip it is difficult, another one may come with the catheter they pool it". R1F

Patients are restrained sometimes because of space accompanied with their alarming condition of being destructive or fear of nurses that the patient may harm others in relation to small space of

which similar action could not have been done to the patient if enough space could available. One nurse revealed,

> "…the one you observe to be dangerous to others while the room is small you provide him with medication if possible you fasten him right away …we are doing so because we are observing his and security others". H3I.

Nurses admitted that restraining hinders nurse to assess the patient clearly to get the picture the patient is displaying especially when the patient is having bizarre behavior, restraining is done because of safety of patients associated to small space available.

11.3.2. Patients' vulnerability of acquiring other diseases as they cannot protect themselves for example from mosquito bite, HIV

Mentally ill patients were vulnerable group for nosocomial infection including malaria due to nature of treatment they get such as being sedated, since they exceed the bed capacity of the ward they have to sleep on flow which increases the chance of being infected. One patient revealed,

> "If you are having case flows, for mentally ill patient when they are sedated, the patient becomes at high chance of acquiring other diseases such as malaria because he has no ability to protect himself from mosquito bite, which is a challenge". H1I.

Ward structure for some wards at X are in such a way that it is difficult for a nurse to have a direct view to the patient so as to see what a patient is doing they may act adversely. Also in this section there is no partition for males and females hence patients can mix up anytime as sometime they do move from one room to another nurses are worried of even patients falling in love to each other which is also risky for acquiring HIV. One nurse revealed,

> "...this ward has no partitions, for example you will find female and men in one place, the ground is the same there is no partition this is very dangerous for female patients to have sex with male within this environment because there is no separation. Also the structure of this ward if you consider the working environment itself it affects us because it is in such a way that patient may be in the rooms and do what you cannot see..." H1I.

11.3.3. Ward structure

Nurses at X wished to have their patients having time to get out of the wards, relaxing and talk to them instead they are enclosed in the wards and become stressed more than when they are at home. One nurse shared in a calm manner,

> "it is supposed to get them out of the wards, talking with them, getting light walk, in that way if you leave the door open they do not go out (escape) as they know they are in hospital, if he feels to be in sunrise then he gets out, but the way the environment is, the patients themselves becomes more stressed once they are admitted than when they are at home" H5I**.**

Nurses expressed that the existed ward structures were not covering the needs of nurses working in mental health units as they do not have basic services such as tea room and toilets close to their ward as they had to travel some distance for such purpose or use the changing room as tea room. One nurse shared this knowledge,

> " stress in our most areas of our wards is not low because I understand that every ward is supposed to have a staff toilet, changing room and nursing station, in most cases in our wards, there is merely changing room which is also used as store for supplies and tea"H2F

Structure of the wards were not conducive for security of the nurses considering the existing shortage, nurses feared to get close to patients most of the time and especially when s/he is alone, they fail to perform rounds well and they had minimal interaction just to maximize their security. Such situation impairs the quality of assessment and hence provision of the required care.

Nurses felt not to be involved in the decision making which could help to improve the working environment in terms of ward structure. One nurse revealed,

> "key decision makers in our mental health department are the administrators, leaders in general from the block manager (nurse), head of department, administrators are the decision makers but they don't involve key stake holders whom we are the ones who are the implementers, we are the principle implementers who know that this room has this and this, you can build it this way, for a vivid example there is recreation hall we call it burudani (entertainment) there is a plan of building other things there, they want to build something like round rooms, ECG, EEG, isn't it?..." H4F

11.3.4. Stigma

Nurses admitted to be marked as affected ones in their course of providing care to mentally ill patients, but themselves feel to be ok unaffected and to have had good relationship in the community. One nurse revealed,

> "the community is pointing toward us commenting that 'aah do not bother with this one he is taking care of mentally ill patients, he is surely affected' but I thank God I feel I'm ok and have good relationship with the community" H2F

Some patients were delayed to get services they required as their relatives were avoiding to escort them in day time because they afraid of being stigmatized so they feel shy. One nurse revealed,

> "Some fail to bring the patient in the day time as they feel ashamed to have such patient sometimes they say that the patient ran away from home hence they cannot stay with him the whole night, hence they bring the patient in that night" H1I

Some patients stayed longer in the ward because of being discriminated by their families, hence increasing the workload to nurse. One participant revealed,

> "... You find that they leave wrong numbers, once they leave if you call them they are unreachable and that is a major problem to our patients, they are congested in the wards and if you fail then you take it to socio-worker to work on it..." H1I

11.4. Premature discharge of patients

Some patients had to be discharged prematurely due to insecurity alert because of congestion in the wards, thus they missed care they deserved and this may contribute to early relapse, the discharge based on the SOP as it was revealed by one nurse,

> "...there are our SOPs for selecting, that at least this one can stay at home but at home they are afraid of him, isn't it? But we have no way out he has to go back home but we are not sure of the environment he will take medications or not but he must go, because they are six and occupied sometimes they go up to nine where will we admit him? Therefore it necessitates the patient to go home because the place is small and staffing is very low, if you visit male ward there are patients sometimes they are twenty five, we mark alert, high alert,

because we cannot manage, hence we have to call each other doctor there are many patients, reduce your patients, hence we have to reduce them for security purpose" H1F2

11.5. Duration of work

Shortage of nurses in the mental health settings had led the nursing team to have two shifts thus nurses have to work for 12 hours, this situation makes nurses to become so tired and fail to provide care to patients whom they are obliged to. Nurses aired out,

> "We are obliged to have two shifts due to shortage we have to work for twelve hours that is you do not sign out after signing in the morning, you are staying with mentally ill patient for twelve hours! We had to discuss with the management" "...for example you will take much time to feed a catatonic patient because you are already tired you cannot continue with provision of other services and time is passing out with no one who is signing you out..." R3F.

Nurses shared that working for long time resulted into low quality performance for them, in the late hours nurses shift their minds from patients to transport on how s/he is going to travel,

> "due to the fact that you will be two in the shift from morning to 6.00pm, it is obvious that your performance from 7.0am, 8.00am to 11am will be different from 3pm to 6pm because physically you are tired yet you are thinking about next morning you are needed again, and there are some transport issues once it is 5pm to 6pm, the mind is no longer in providing services to our clients..." H1F.

Nurses explained the way prolonged work affects their social life and therapeutic relationship into family or social relationship with their patients,

> "it affects us on the other side of life and social aspects as we do not socialize, you cannot attend burials,… issues which separates you with the community, it is stressful, hence it is just going at work then back home tired already, it affects mostly you are not close to your children and your neighbors" R1I
>
> "...as you stay with the patient for many hours it happens the patient changes his/her behavior that s/he fails to understand that you are a nurse s/he considers you as part of the relatives..." H2F

Nurses experienced burnout to the extent of they get tired and getting asleep in working hours. One nurse shared,

> "We experience burn out to a large extent, that is why sometime you may change in the office , may be someone is there you think s/he is drowsy like, but s/he is tired" H1F2

11.6 Nurses Living far away from working premises

Absence of nursing staff houses near work places and lack of transport from their home to work places posed a challenge to nurses. Low salaries also contributed as it was shared by one participant,

> "...nurses earn little economically and unfortunately we do not have staff houses which are close (to working place) especially for nurses, but it is also a challenge to the Ministry because the houses which have been built are meant for doctors only." H3I

11.7 Nurses' unpredictable future after retiring.

This study came up with some issues which may affect nurses' commitment to their work as a result of psychological dynamics as they do not see their future after retiring. Life experiences from retired nurses in the community triggered worried of nurses about their future as it was revealed from their experiences that nurses' low economic status imposed them into early death after retiring. As it was shared by this nurse,

> " … due to his/her poverty (nurse) for all that time s/he worked if s/he could get what s/he was getting I mean after retiring,...s/he is no longer capable of living life which could take him five or ten years ahead." H5F2

11.8. Allowances

There was some differences pertaining some allowances extra duty and night allowance between the two mental health facilities. X had some improvement as there was night allowance 10,000/= (6.4USD) per night while Mirembe had nothing, Extra duty allowance ranged from 15,000/= to 30,000/= depending on level of professional education while at Mirembe it was 5,000/= per day for 10 days only extra days were not considered.

At X2 and X3 nurses had contradicting views about the extra duty allowance some were not satisfied with the 5,000/= which they were paid for a single day shift extra hours and they were curious to why they are paid only 10 days while they may work for more than ten days. One nurse shared,

> "...aah, it is very little, nurses we are paid 5,000/= for a single day extra hours but you may have worked 15 days because there is no staffs but you will be paid for 10 days only, the rest become volunteer work, ...at least you should be motivated even with little one I think you can prolong working for extra hours but if you are not provided with motivation even if you are working it will not be at the required standard...," R2F

It was also criticized that the extra duty allowance which was being paid to nurses was not a motivation as it was a payment for the job they did. One nurse shared,

> "...to me that is not a motivation (extra duty allowance) because motivation is something which someone gives you as an incentive for what you are doing s/he is appreciating the job you are doing and he is thinking that, okay let me continue encouraging him to continue working example there are something called risk allowance...in this department there is no risk allowance, no mental health service allowance and more worse it is like we are in the island" R3F.

For some nurses the tendency of getting medical care through their health insurance after being injured by patients at workplace was not considered as motivation as they used their own money. They thought provision of medical capitation by the hospital could have more meaning,

> "...I have been injured … for example if I have gone to seek medical services I'm using my health insurance, it is not like it is ok, I could have been given money for treatment, It is fine if I'm given some money I understand that at least the hospital has recognized my presence, it has helped me in treatment..." R3F

Nurses commented that motivation to nurses was not necessarily money but appreciation of what good they were doing matters a lot in motivating them in their work. Other nurses were not happy with their leaders due to absence of motivation. He shared,

"…the relationship between us and our employer is not so good because there is no appreciation to each other, I mean in sense of motivation, it is broad, isn't it? It is not necessarily to provide money to someone, even a word, 'you have done it well, your work is good', that one encourages the staff," R4F

Another nurse shared,

"...no motivation why should someone stay at X2, why should he stay at X3 while there are some places where you can be easily employed and they have better pay, there is staff motivation, why should he continue to stay at Mirembe where staff is beaten, he is beaten then there is a commission I do not know, that compensation, I know if beaten you cannot compensate him ... there is a state of being recognized if beaten by being offered off day for medical services". R1F

These statements revealed that health workers would be attracted working in places with motivations rather than where there is no motivation.

Some nurses preferred to get payment of their allowances instantly so as they could use it for their family needs. This nurse painfully shared,

"I'm being affected, I have spend the whole day here fasting, I could have served my kids with that small money if I could have got it but I have not received it in the right time though I will get it later … it could have helped me now" R2M

11.9. Recognition

Nursing professional advancement of nurses was perceived as not recognized by the employers as they were not promoted to the right level of salary after completion of their studies. Sadly, this nurse shared was discouraged,

"As I start working if the patients gets attack like this patients you have seen (patient with epileptic attack) I will not recall that state (being unrecognized), I do work, later I reflect saying that, dear I can be retired without getting that one (what she disserved after advancement of the education from health attendant to EN she is recognized as HA up the time of wring this report) or *I would have disagreed to go to school and remain continue working..." R2I*

Nurses doubted if their efforts were recognized to the extent that they were regretting to pursue in mental health and they perceive that they are working like slaves and they are not ready to disclose the type of work they are doing.

> "...their fingers have been bitten, some have been beaten, so many issues, they have been burnt by hot food splashes, so many issue are happening here, but there is nothing a nurse has been compensated, it is being forced to work like a slave that you have to *do it to the extent that sometime you regret why did I opted for this specialty of mental illness, better I could have been opted for other courses*, more ever you do not want your family to know what you are doing, first of all you are fasting the whole day, you are tired you do not have money for food. You go back home tired but there is no one who cares, no meetings for discussing our problems..." R2I

Another nurse painfully said regarding their profession,

> "...it is not nurses only, you see! Many issues could have stacked, there is a mentality here, just stay here for a month in our combat (uniform) *you can see a certain picture for nurses, it is just a certain profession which is hanging...* though it is the machinery" R4F

Indicating that nurses were not recognized one revealed that,

> "In short there is no value (for nurses) because motivation is very poor, we are not motivated to the extent that up to now we do not have tea room, can you say that we have some value, real? We are taking tea upright (standing up), I do not think if there is someone who has a place to sit down and have tea, no one. If I take you there and show you that here is where we used to take tea you will laugh Magesa, from acute where there is congestion, female, male and here nothing." H1I

Working for more hours especially having frequent night shifts without being paid their night allowances was considered as being valued. Some nurses said that their value kept going down,

> "Discussing quickly if you look at the working environment including the influence of work that 'you have worked for certain hours and you will be paid equivalently to sustain your life, at least that is to recognize, further more we are working at night frequently, we don't

have day off hence our value still seem to be low, no day off, for a person who is working in official hours is supposed at least to have 8 resting days per month, but I don't get the two days per week, *you see my value keeps decreasing meaning that my presence at workplace takes more of my resting time.* when I'm working for three days (night shift) I get one or two resting days because of the shortage ok, if you decide to inform our leader they reply that 'that is the job you applied for' thus my value seems to be nothing..." R3F

Some nurses turned against the Ministry of Health and Social Welfare for poor financing of the mental health institutions. As one nurse shared,

"...but the Ministry (of Health and social Welfare) does not recognize us because it is the one which produces poor (inadequate) budget, unfortunately our hospital has no cost sharing, it depends on the Ministry's budget to a large extent to provide some money at least for workers to get some motivation (allowances)...". R3F

Protection from the employer emerged to be profound; thinking about their employer one nurse painfully felt that it does not value them to any extent,

"There is no value, I'm saying there is no value this is a problem directly from the Ministry because the first person to value the employee is the Ministry (the employer), to what extent does the Ministry protects you as its employee?" R5F

Some nurses felt unrecognized and not motivated by some stakeholders' not recognizing nurses' efforts and work to the recovery of patients, instead doctors were acknowledged. This nurse shared,

"Sincerely to a certain extent no respect to nurses to the expected level, you may meet someone may be, after recognizing that you are a nurse then perceive that your work is just to stay there like watchman, and more or less giving medicines to patients without knowing what is it for and how much is needed other than depending on the doctor's prescription, that is why when relatives visits their patients the first thing is to consult the patient's doctor instead of the nurse who stays with the patient..." H5F

Some nurses were rewarded by their clients and it made them and motivated in service provision. This nurse shared,

" ...therefore as I treat the patient and gets well, I become rewarded because one day he comes 'thank you nurse I'm somewhere doing well', he comes being very joyful, what have you come for? ' I have come for my medication and I'm going back'; we get reward that we are working" R1F

11.10 Working in two shifts makes nurses miss their families

Nurses were affected by having two shifts and their shortage as they spent most of their time at work places. One nurse worried of missing their families as they do not have time to spend together. She shared,

> "It (two shifts) affects us and our family as you arrive home when children are already in sleep and leave early they do not see you, it is hectic … It affects as we are missing love from our children, our husbands, even the society around us in the community some in the community they do not know you, once they see you they just call 'doctor' after two days you have night shift, then they doubt 'or she is a guard! (Others laughed), is this a doctor or a watchman?' everyday you are leaving your partner alone!" H3I

For some nurses who were tired and could not afford to have lunch and they were staying with the patients the whole day taking care of the patients at one point they failed to adhere to ethical issues. As one nurse revealed,

> " … you are fasting the whole day, honestly when the patient calls mom come, you will respond for the first time and the second time but for the third time you become depressed (feeling bad/annoyed) aah, 'I'm tired too' but in real sense you are hungry" H4I

Another nurses shared,

> "two days ago, the patient insulted me but when it reached around 4.30pm I was really very tired and I was hungry with no money also I had to insult her you see ...also she has become a patient..." H4I

Suggestions from participants

Nurses suggested the government should finance mental health services adequately so as to create conducive working environment. As it was shared by this nurse,

> "To improve mental health services in the country, the government need to consider it and approve the budget through the parliament to increase the allowances to nurses providing

mental health services to mentally ill patients because there are nurses who afraid to specialize in this cadre" R3F

Nurses suggested having doctors in place all the time could help in providing services quickly especially those which required attention of the doctor. One nurse shared,

"Doctor like an intern it is just four weeks only, s/he fails to stay there when s/he on duty or to stay there at acute ward, s/he will be talking with her/his age-met, there (nurses), if the patient comes we can work easily or if there is serious one here won't s/he get services more easily?" H4I

It was suggested to have transport for staffs to and from their work places; availability of staff transport could make them motivated. As it was shared,

"…transport is very important …we could have been provided even coaster which could be going around and pick staffs in special areas and take you back, staffs will feel that they are living in their country, they will feel happy and that they happy to be employed." R3I

There was absence of specialized nurses in specific areas for mental health care for example there was only one nurse for child and adolescent who was about to retire in this year of data collection yet there was no replacement. One nurse shared,

"... there are few professionals for child services, at X2 I think there is only one and she is about to retire," H6F2

QUALITY ASSESSMENT

Summary of the results

In this assessment 10 questionnaires were distributed to nurse managers for filling information regarding their specific area of supervision and then data was compiled manually to have one questionnaire for each institution for determination of quality of care. It was found that both

facilities performed well in Case management for severe psychiatric disorders and length of treatment for substance – related disorders, specifically MNH also performed well in writing the patients' daily progress report while Mirembe Hospital had few hospital readmissions for psychiatric patients.

Both facilities had absolutely poor performance in different treatment modalities provided and Milleu therapy while MNH was absolutely poor in number of visits during acute phase treatment of depression while Mirembe Hospital were poor in this area.

The shortage of nurses in both facilities was two folds of the number of available nurses. In terms of nurses who had been trained in mental health the shortage was almost three folds of those who were available

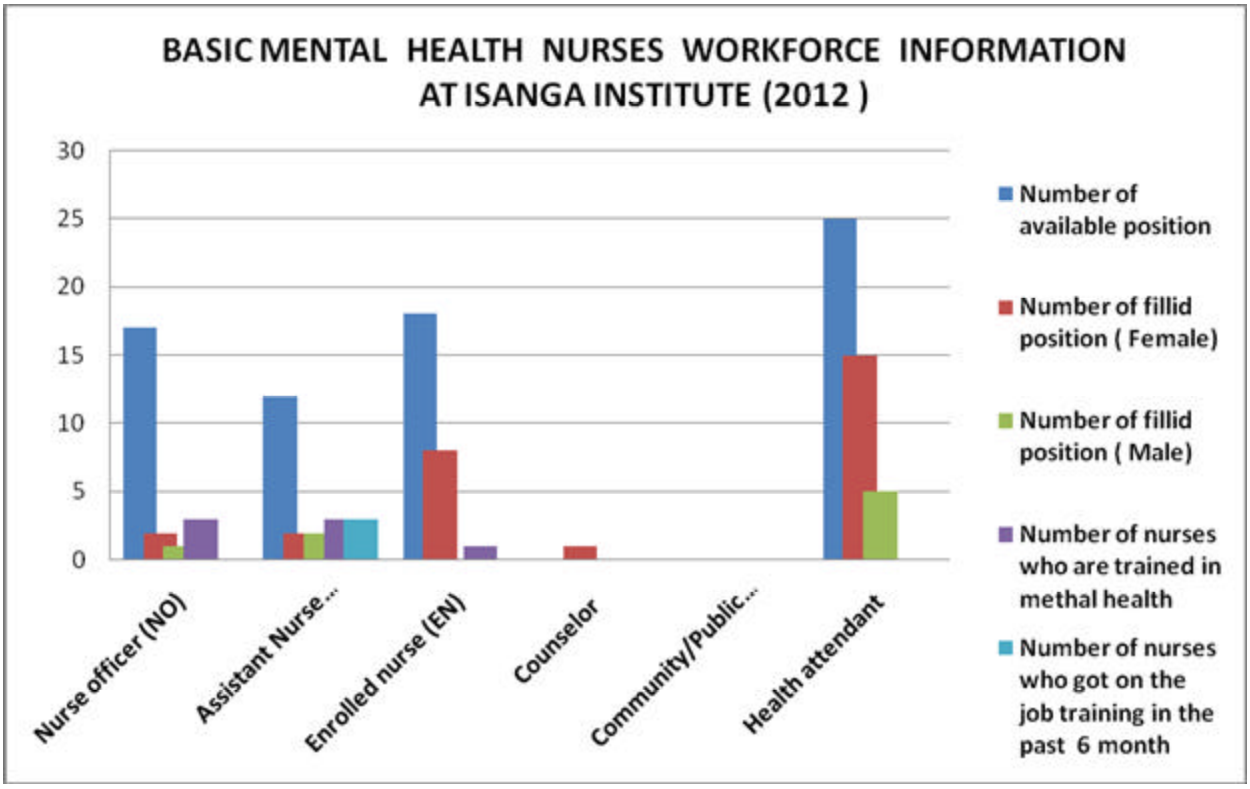
Generally both institutions performed below standard in most areas assessed hence there is a need to employ some measures to improve the quality of care.

Statistic of nurses working in mental health units

The number of available and the filled positions and the available gap were explored. Also the number of nurses who have been trained in mental health during their nursing education programs was explored.

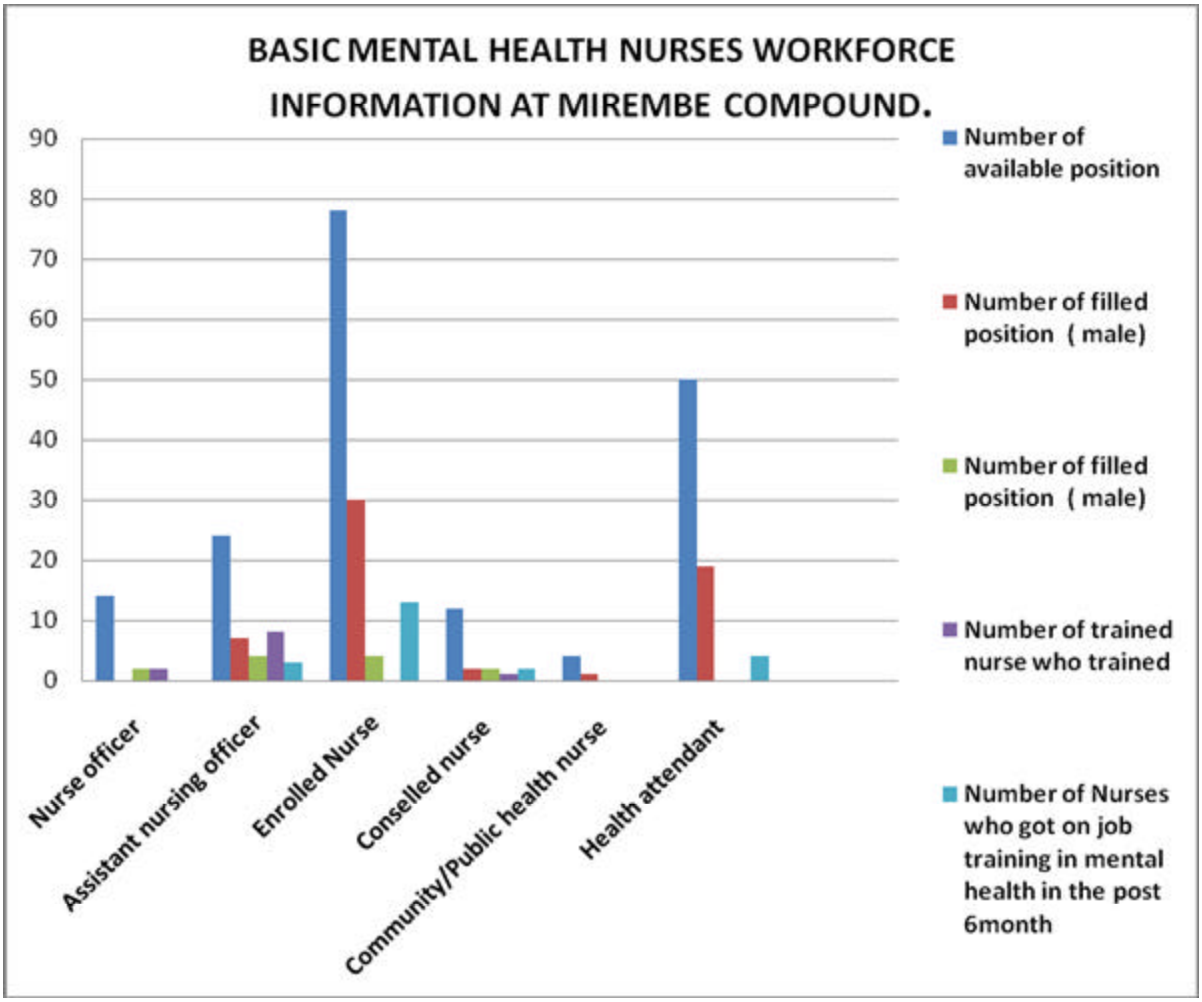
Note; At Mirembe compound and Isanga Institute the available number of nurses were further categorized based on sex as in the qualitative part participants shared a lot about the critical shortage of male nurses.

Table 2: Basic mental health nurses' workforce information at Isanga Institute (2012)



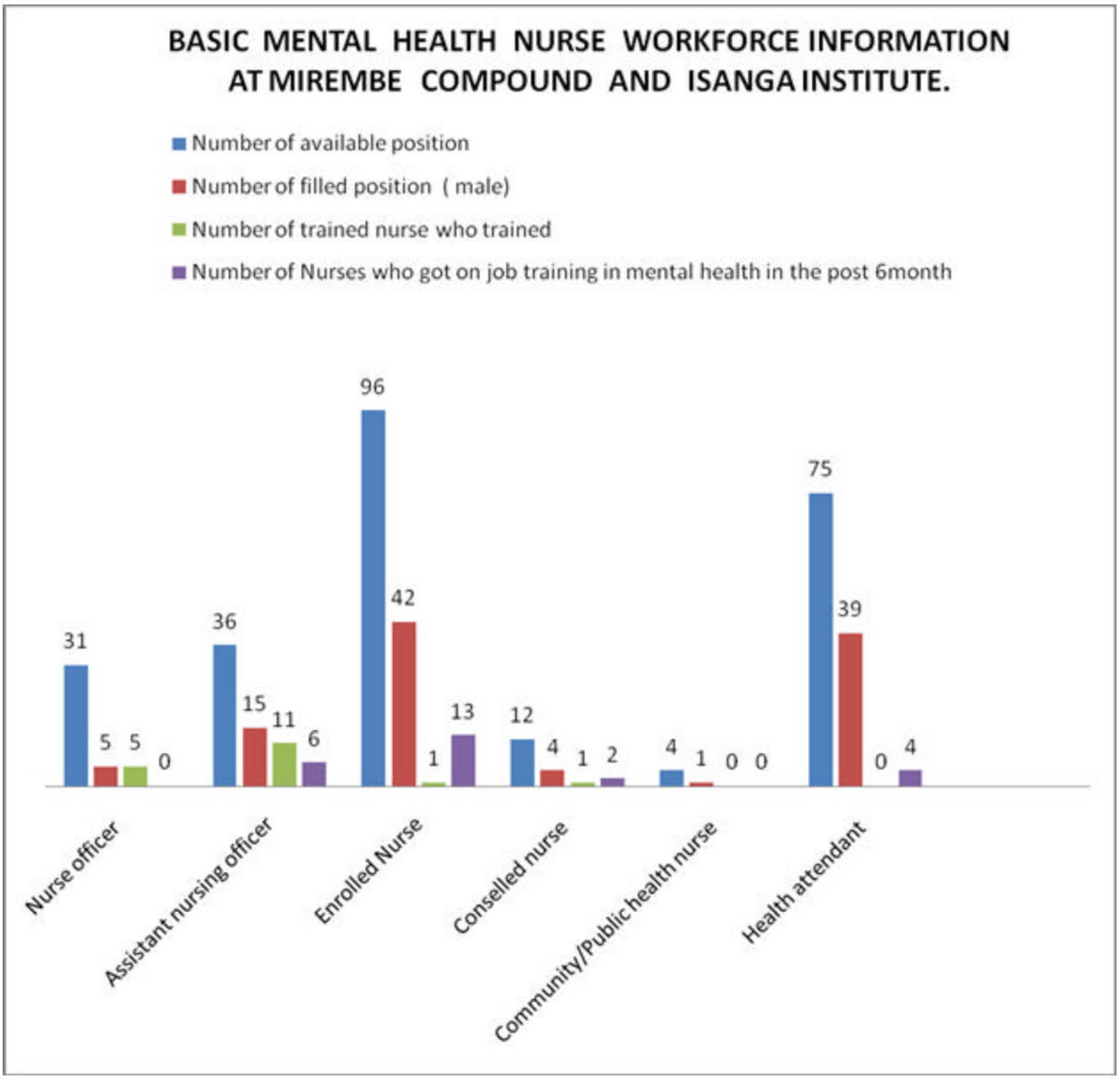
Interpretation: From the above data it shows that at Isanga there was 82.4 % deficit of NO, deficit of ANO was 66.7% and deficit of EN was 55.6%. With exclusion of health attendants, the filled positions were 31.9% with a deficit of 68.1% while in terms of number of nurses trained in mental health available nurses were 43.8% and the deficit of nurses trained in mental health was 85.1%.

TABLE 3: Basic mental health nurses workforce information at Mirembe compound.



Interpretation: From the above data it shows that at Mirembe Compound, there was 85.7 % deficit of NO, deficit of ANO was 54.2% and deficit of EN was 56.4%, deficit of counselors was 66.7% and deficit of community mental health nurses was 75% With exclusion of health attendants, the filled positions were 39.4% with a gap of 60.6% while in terms of number of nurses trained in mental health; available nurses were 21.2% meaning that 78.8 % of nurses were not trained in mental health; and the deficit of nurses trained in mental health was 91.7%.

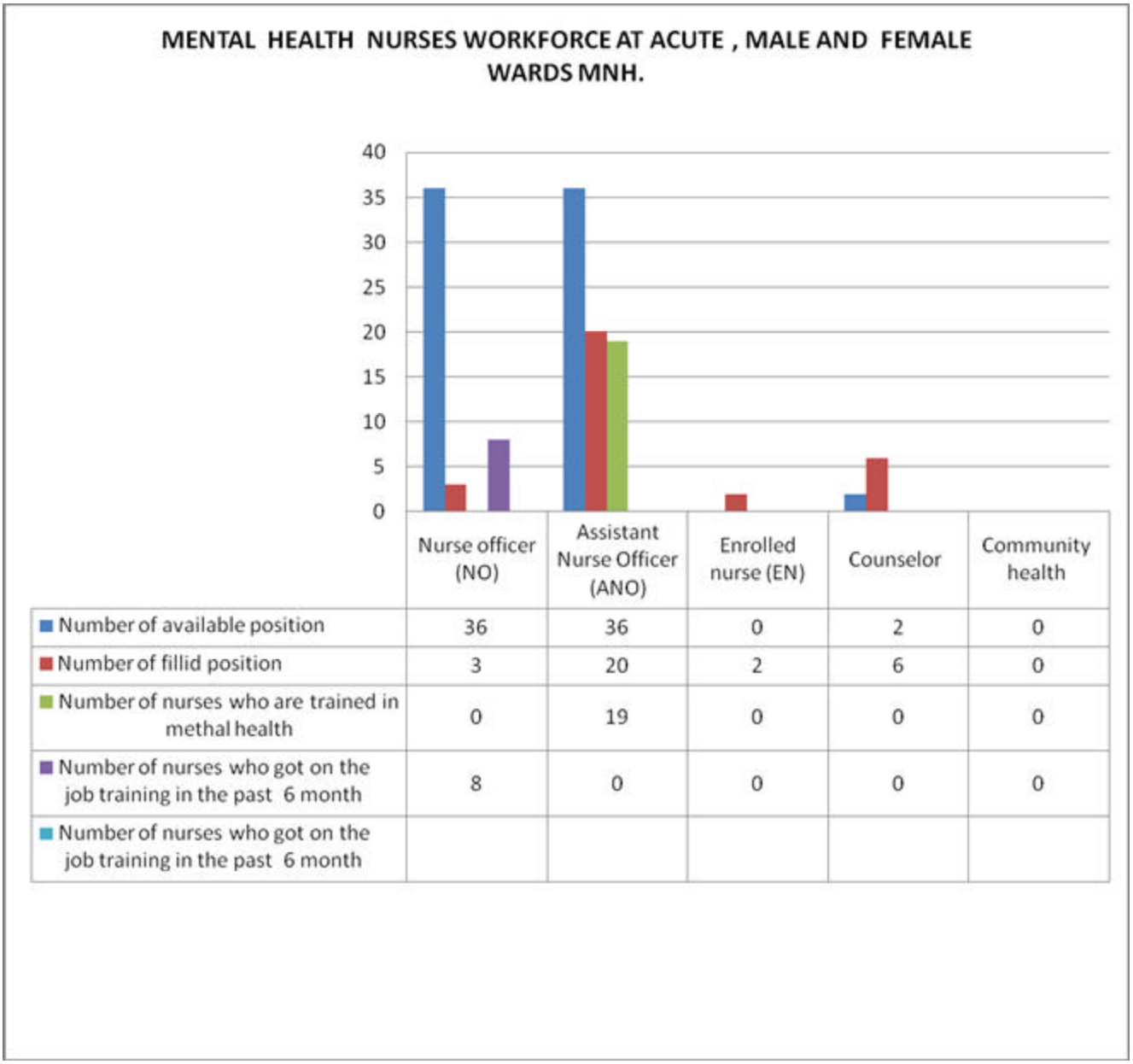
Table 4: Basic Mental health nurses workforce information at Mirembe Hospital (Mirembe compound and Isanga Institute).



Interpretation: From the above data it shows that at Isanga there was 83.9 % deficit of NO, deficit of ANO was 58.3% and deficit of EN was 56.3%, deficit of counselors was 66.7% and deficit of community mental health nurses was 75%. With exclusion of health attendants, the filled positions

were 37.4% with a deficit of 62.6% hence the workload was tripled while in terms of number of nurses trained in mental health available nurses were 26.9% meaning that 73.1 % of nurses were not trained in mental health; and the deficit of nurses trained in mental health was 89.9%.

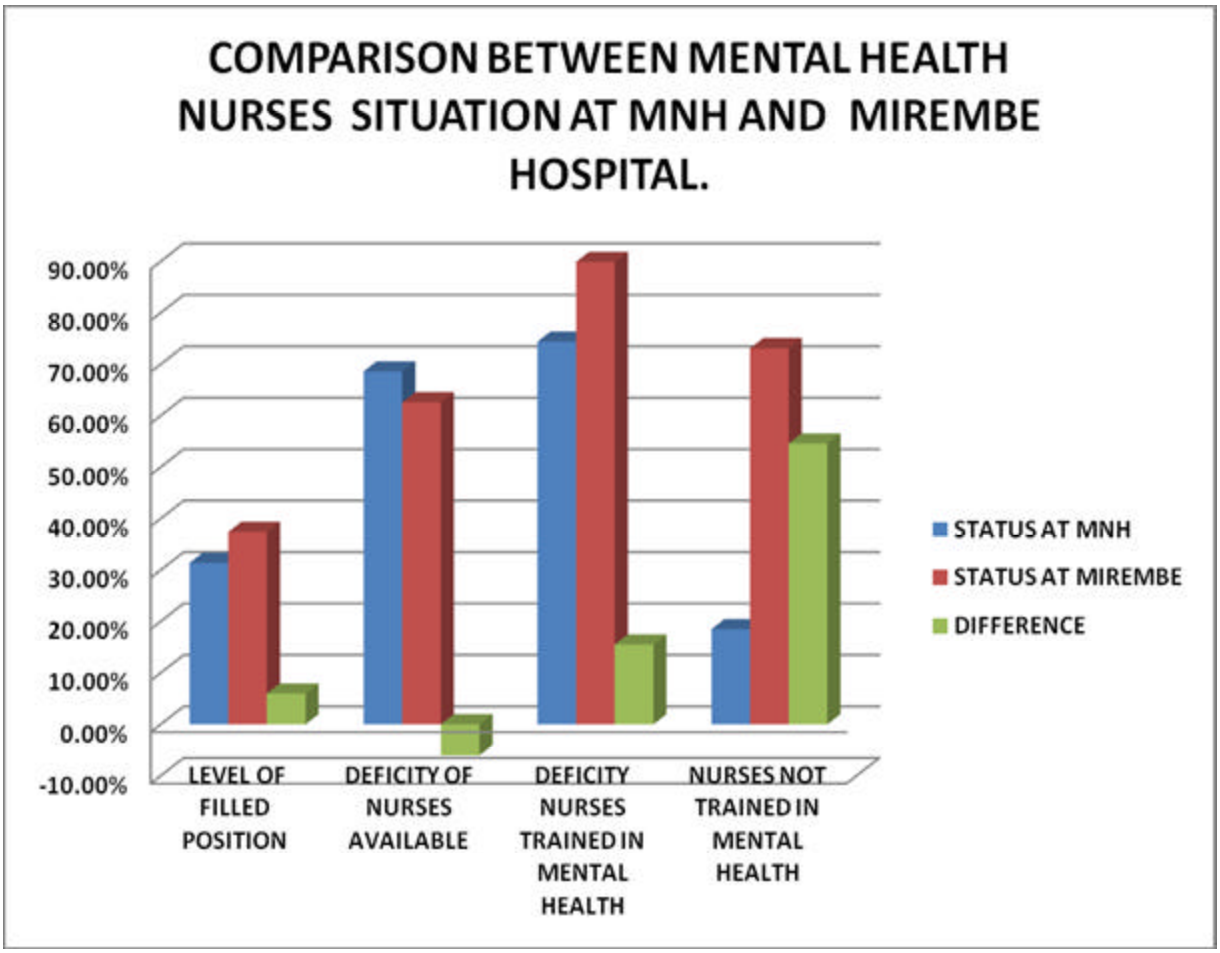
Table 5: Basic Mental health nurses workforce information at MNH (Acute, Male and Female wards).



	Nurse officer (NO)	Assistant Nurse Officer (ANO)	Enrolled nurse (EN)	Counselor	Community health
Number of available position	36	36	0	2	0
Number of fillid position	3	20	2	6	0
Number of nurses who are trained in methal health	0	19	0	0	0
Number of nurses who got on the job training in the past 6 month	8	0	0	0	0
Number of nurses who got on the job training in the past 6 month					

Interpretation: From the above data it shows that at MNH (Acute, Male and Female wards), there was 91.7% deficit of NO, deficit of ANO was 44.4% and deficit of EN was not required though in these there were 2 Enrolled nurses. The filled positions were 31.4% with a deficit of 68.6% hence the workload was tripled while in terms of number of nurses trained in mental health available nurses were 81.5% meaning that 18.5 % of nurses were not trained in mental health; and the deficit of nurses trained in mental health was 74.4%.

Table 6: Comparison between Mental health nurses situation at MNH and Mirembe Hospital



Quality of care provision at MNH and Mirembe based on the quality indicators used.

Treatment:

Indicator: 1. Visits during acute phase treatment of depression

% of persons with new diagnosis of major depression who receive at least three medication visits or at least eight psychotherapy visits in a 12- week period

Table 7: Visits during acute phase treatment of depression

	MNH	Mirembe National Hospital
Per cent	0	25
Remark	**Absolutely poor**	**Poor**

Indicator: 2. Hospital readmissions for psychiatric patients

% of discharges from psychiatric in patient care during a 12 – month reporting period readmitted to psychiatric in – patient care that occurred within 7 and 30 days

Table 8: Hospital readmissions for psychiatric patients

	MNH	Mirembe National Hospital
Per cent	44.2	22.3
Remark	**Marginal poor**	**Good**

Indicator: 3. Length of treatment for substance – related disorders

% of persons initiating treatment for substance - related disorder with treatment lasting at least 90 days

Table 9: Length of treatment for substance – related disorders

	MNH	Mirembe National Hospital
Per cent	66.7	52
Remark	**Very good**	**Good**

Indicator: 4. Patients' daily progress report

% of persons admitted to psychiatric in patient care that have at least two daily progress nursing report in the past 7 days

Table 10: Patients' daily progress report

	MNH	Mirembe National Hospital
Per cent	66.7	25
Remark	**Very good**	**Poor**

Indicator: 5. Different treatment modalities provided

% of persons admitted to psychiatric in patient care who have attended at least two sessions of psychotherapy, Cognitive behavioral therapy and occupational therapy within 7 days.

Table 11: Different treatment modalities provided

	MNH	Mirembe National Hospital
Per cent	10	4.4
Remark	**Absolutely poor**	**Absolutely poor**

Indicator: 6. Millue therapy

% of persons admitted to psychiatric in patient care out of the bed capacity of the ward/facility on average in the past 7 days.

Table 12: Millue therapy convenience

	MNH	Mirembe National Hospital
Per cent	20	33.3
Remark	**Absolutely poor**	**Absolutely poor**

Continuity:

Indicator: 7. Continuity of visits after hospitalization for dual psychiatric/substance-related conditions

% of persons discharged with dual diagnosis of psychiatric disorder and substance abuse with at least four psychiatric and at least with four substance abuse visits within the 12 months after discharge.

Table 13: Continuity of visits after hospitalization for dual psychiatric/substance-related conditions

	MNH	Mirembe National Hospital
Per cent	NA	NA
Remark	**No comment**	**No Comment**

Indicator: 8. Continuity of visits after mental health – related hospitalization

% of persons hospitalized for psychiatric disorder or substance related disorder with at least one visit per month for 6 months after hospitalization.

Table 14: Continuity of visits after mental health – related hospitalization

	MNH	Mirembe National Hospital
Per cent	NA	49.8
Remark	**No Comment**	**Marginal poor**

Coordination:

Indicator: 9. Case management for severe psychiatric disorders

% of persons with specified severe psychiatric disorder in contact with the health care system who receive case management (All types)

Table 15: Case management for severe psychiatric disorders

	MNH	Mirembe National Hospital
Per cent	66.7	60.2
Remark	**Very good**	**good**

Table 16: Range of per cent-age for quality evaluation

Per cent range	**Qualitative value for QI No. 1, 3, 4, 5, 6, 7, 8, and 9**	**Qualitative value for QI No. 2**
0 - 20	Absolute poor	excellent
21 - 40	Poor	Very good
41 - 50	Marginal Poor	Good
51 - 60	Good	Marginal Poor
61 - 80	Very good	Poor
81 - 100	Excellent	Absolute poor

For the use of the Quality Assessment tool, nurses had the following comments including,

1. Indicators used were relevant, but there was no hospital system data base as there was no well organized computer system in the ward. Data base depended on paper work and books which were difficult to trace the in patients and discharge returns. Computer system would have been easier.
2. The nature of patients who are being admitted at Isanga Institute as it is a criminal mental hospital most of patients are from prisons, three quarters stays for more than three years for long term treatment and rehabilitation and that they receive mostly one or two patients per month, then some of the questions were found to be not applicable for that institute.
3. There was shortage of nurses especially male nurses and most of nurses are not trained in mental health nursing at Mirembe.

DISCUSSION

In this study, the status of care provided and factors affecting its quality were determined. The quality of care was more affected by un-conducive working environment, poor therapeutic environment mimicking prison situation, shortage of nurses trained and qualified in mental health, lack of motivation, and nurses' psychosocial characteristics. Under such condition, people with mental disorders have been affected in many ways including reduced access to mental health care, and for those with access inadequate care and treatment leading to frequent relapses and end user evaluations are stereotyped with complaints on their treatment as prisoners due to lack of space and for ensuring safety.

Working Environment.

Nurses had different perceptions on their working environment, it was perceived that the conducive environment in mental health setting is the one has adequate workforce who are well trained in mental health, adequate working space, safety, support from leaders, considers the care consumers' preferences and dignity, presence of motivation such as allowances; generally it involves all necessary rights of a health provider to be able to provide services to the extent of client satisfaction.

1.1 *Workforce*

The World Health Organization Regional Director when addressing the *Inter-country Workshop 2006* South-East Asia Region) Dr Samlee *referred* to the crisis in health workforce globally and in the South-East Asia Region in particular. In the same workshop, it was revealed that Nurses and Midwives at the regional and global levels were facing many challenges including shortages, migration, inadequate competency and low motivation that prevented them from providing effective services. To tackle the problems, it was suggested that a proper workforce strategic plan and workforce management, good governance and leadership, strong professional organization and good education were needed.

From this study the deficit of nurses almost doubled the number of nurse who was present in both facilities giving a reflection of tripling in workload to nurses while at Mirembe Hospital the deficit of nurses trained in mental health was 89.9% and 73.1 % of nurses were not trained in mental health where as at MNH only 18.5% were not trained in mental health, the deficit of nurses trained in

mental health was 74.4% which was almost three folds of the required mental health trained nursing staff. Shortage of qualified nurses in mental health had a major negative impact in quality of care provided. Nurses who had not been trained in mental health provided services through experiences which was been acquired just by looking what others do.

In Tanzania observation shows that the number of mental health nurses in practice is steadily declining and many replacements lack mental health nursing specialist education this situation creates acute shortage of adequately trained staff, which was also reported by Hegney (1996), as a result the quality of mental health care goes down. This study have revealed the same problem especially at Mirembe were the number of nurses who cease working either by death, retirement, detachment and for any other reasons outweighed their replacements in number as well as qualification. Furthermore this study found that the number of male nurses who were also helping in security matters was declining steadily and their replacement was females of young age who were working sometimes alone with assistance of health attendant in male wards.

Shortage of nurses led the hospital management to come up with a strategy of having two nursing shifts instead of three with some payment of extra duty allowances which had outstanding difference between the two hospitals, MNH had three to six folds as compared to Mirembe. In both facilities nurse complained on both getting too tired in providing care in such prolonged time and small amount in relation to the work they were doing and its nature. Dissatisfaction of health worker had an impact on quality of care they provided as some said that they currently working like watchmen in the ward, such statements expressed the level of burnout they are experiencing. Adverse effects such as firebreak out in the ward, suicide, acquiring nosocomial infections as they sleep on floor while in sedated with medications, and fighting was not easy to control when there is critical shortage of nurses as it was revealed in this study.

Mental health services need to be provided from general mental health nursing to specialized care that is there is a need to invest more in training more nurses in specific areas so as improve the quality of care and insure availability of all recommended therapies are provided to mentally ill patients. In this study it was found that due to shortage pharmacotherapy remained the preferable treatment modality and more practiced in both settings while other treatment modalities such as

psychotherapy, Cognitive behavioral therapies, family therapy, and occupational therapies had absolutely poor quality. Studies had found that psycho educational interventions involve interaction between the information provider and the mentally ill person (Xia, Merinder, Belgamwar, 2011). Psycho education programs for patients, families and caregivers aimed at coping with mental illness have been shown to improve adherence, reduce substance abuse, reduce relapse, and shorten hospital stay (Cassidy, Hill & O'Callaghan, 2001)

At Mirembe hospital major ward round to review patients as a team which could help to enable patients received a proper treatment or services on time did no longer exist. Furthermore inadequate funding of mental health services increased the gap of availability of services as there was cessation of community health services which nurses appreciated in reducing stigma toward people with mental health problems as well as reduction in readmissions as patients got right support domiciliary. WHA, (2005) reported that inadequate financial and human resource also contribute to lack of inadequate mental health care and the large gap between the number of people who need and those that who receive care, and this is especially true in low and middle income countries, where most of the countries devote less than one per cent of their health expenditure to mental health.

In this study it was also found that nursing activities which needed special training were being shifted to either completely non trained persons or non trained nurses in that particular field. In this case health attendant and enrolled nurses who were not trained in mental health were the work force at Mirembe Hospital, enrolled nurses were 73.1% of all nurses, most of nurses who were trained in mental health where also mostly occupied by administrative functions and teaching student.

1.2 **Milieu Therapy**

Therapeutic environment in which patients are hospitalized matters in recovery of patients to their possible optimal level of functioning. In this study it was revealed that the quality of the environment for patients was absolutely poor as there were congestions in the wards more than their planned capacity leading to some patients getting premature discharge, mixing acute and relieved patients, two patients sleeping in one bed others on floor.

Patient being enclosed all the time especially at MNH and acute wards at Mirembe hospital led to patients complaining of being treated as prisoners, and they sometimes planned to attack nurses because of the environment as it was reported by nurses. This aspect needs more exploration on how does it impact on patients' recovery as it may be contributing for MNH to have higher rate of readmission 44.2% than Mirembe 22.3% where there are few trained health worker in mental health compared to MNH.

Patients were being hospitalized in poor environments such as being enclosed most of the time limited relaxation and level of therapeutic interaction with their care providers who said they working like watchmen. Therapeutic relationship between nurse and patients unpredictable as patients claimed nurses to be responsible for them being enclosed. Therapeutic factors within therapeutic relationships relate to how the patient reacts to the interventions offered by the nurse. These relationships are therapeutic due to the patient requiring help from a state of despair and the professional nurse has an onus to provide this service or care (Scanlon, 2006)

There are many adverse consequences of inadequate treatment for psychiatric patients leading to homelessness, frequent relapses and readmissions eventually becoming a vicious cycle (WHO, 2008).In this study it was revealed that there were good case management for severe psychiatric disorders but visits during acute phase treatment of depression was not adequately done meanwhile other patients were being discharged prematurely for safety purposes all these revealed inadequate treatment of some cases.

Space in the mental health setting is increasingly becoming a problem to the extent that patients had no recreation space at MNH which they could use for relaxation and refreshing their minds while they are being assessed clearly by nurses. The existed hall has been planned for other activities such as ward round with a plan of building rooms for ECT and EEG. Ward round in this place minimized patients' confidentiality as it was open and other people pass most of the time.

Ward structure needed to allow a nurse to have a view on all patients also the ward needed to provide distinction between female and male patients. In this study it was found that private wing at MNH nurses had no direct view to the patient also in this section there was no partition for males and females hence patients could mix up anytime as sometime they moved from one room to

another nurses were worried of even patients falling in love to each other which was also risky for acquiring HIV.

1.3 Stigma

Advocacy against stigma to people with mental illness and nurses working in mental health units has not yet succeed as patients are stigmatized even with their family. In the community some patients missed early intervention as their families were afraid of being stigmatized if seen escorting the patients hence they preferred to escort the patient during the night time.

Studies found that regular psycho-education programs must be conducted in the community to educate the families about the nature of their relatives' illness and the need for sustained medical treatment (Thara, Padmavati, Aynkran &John, 2008). In this study it was found that there was adequate funding of mental health services that led to ceasing of some important services in mental health practice such as community mental health which resulted into families and community at large to miss some important aspects of mental health such mental health promotion and prevention of mental illness, and how they could support their beloved who had mental illness as a result readmission rate was high and some patients missed the necessary support from their families. Increasing mutual understanding and harmony among family members, strengthening the patient's functioning at home, increasing the family members' understanding of psychiatric symptoms and improving their caring skills are the most important tasks of community mental health nurses with regards to lightening the caregiver burden (Cheng, Huang, Hsu & Su, 2012). Community mental health nurses considered that they have the ability to teach clients about the importance of the medication regime and how to deal with side effects (Chieng, Huang, Hsu & Su, 2012) They (community nurses) also may help the clients to deal with their symptoms, promote relaxation, and help the client to take medication regularly, improve clients' self – care abilities and improve interaction between clients and families (Huang, Ma, Shih &Li, 2008)

1.4. Safety

In mental health facilities, safety for patients and staffs need to be given a considerable weight as the nature of the patients is not predictable. In this study it was found that some measures were being taken after experiencing adverse event and sometimes there no measure could be taken. Such

situation showed that nurses were sometimes hesitating to provide care or become more defensive (in this study they called to discipline a patient) to patients when they felt their safety could be jeopardized.

The study also revealed high level of being demoralized from nurses who where in one time injured by patients in the course of care provision as there was no compensation to them and sometime they were discouraged with the policy that those who could be compensated were those who lost part of their body.

In this study it was also found that female nurses faced challenges to handle male patients especially when they are aggressive, presence of male nurses in each shift helped to minimize the problem of insecurity.

In this study it was evidenced that safety could be maximized by exercising team work among nurses also with other staff from different disciplines, use of installed alarm system and whistles. At Mirembe there was no alarm system which was installed and new employees were not provided with whistles, missing any means for easy communication created fear among staff nurses and affected their performance as they reported.

It was also found that patients could grab nurses 'pens and use them to attack nurses thus creating the sense of keeping pens and other tools which can be used as weapon more so as they cannot be taken or accessed by the patients.

1.5. Supplies medication

Absence of most of the medicine used in the hospital pharmacies leads to challenge nurses to whom patients complained and demanded medication from them. Other patients could not afford to purchase these medicine from private pharmacies so leading to patients' poor medication adherence as a result it could lead to relapse to some patient the situation which in turn results into congestion in the wards. It was also revealed that there was high rate of readmissions especially at MNH which was 44.2% while at Mirembe it was 22.3 % which was partly contributed by poor drug adherence.

Nurses reported to have problems in accessing medicines for new admitted patients during the week end days as pharmacies get closed. To have a multidisciplinary team all members of the team they need to available when needed. It was found that there were inadequate supply of working tools the situation which led nurses to improvise some such as tearing bed sheets for making restraining belt but these had some defects to patients as patients sometime developed bruises even to open wounds also it was wastage of bed sheets . There was a need of purchasing special restraining belts and other supplies needed for holistic nursing care for improvement.

1.6. Team Work

Health workers in mental health institutions need to work together as a team in all circumstances for the purpose of helping the patient and improving mental health services, once there were no collaborations nurses were the vulnerable group to be subjected into risk of being injured by aggressive patient. Nurses worked most of the time in collaborations with doctors but surprisingly the study found that some doctors were escaping to handle aggressive patients and leave them to nurses only furthermore they encourage each other to leave the place in case of such situation. The situation affects nurses in one way or another in their mental health practice.

1.7. Nurses preferences

Psychological skills have been reported several times by nurses to be helpful for them in mental health practice, it helps them even when there is misunderstanding among patients or there are some patients who are aggressive also due to shortage nurses coaches health attendants to help them in case.

Continuous Professional Developement

2.1 Professional training

It is believed that quality education would produce qualified practitioners who can make a difference in nursing and midwifery care and contribute greatly to the health care system and the health of the people. (WHO, 2006)

This study revealed that qualified practitioner made more or less minor difference from those who were not that much qualified. In the quality assessment tool the quality of care were more or less the same while at MNH there were more trained nurses and more than 10 psychiatrists while at

Mirembe had one psychiatrist with nurses who were not trained in mental health. For this case further study need to be undertaken as it was not known for some indicator such as rate of readmissions Mirembe could have some confounding factors as patients could be readmitted in their regions the situation which was different from Muhimbili that in Dar es Salaam psychiatric patients were referred directly to MNH.

It was revealed in this study that despite of not having professional training in their formal nursing training, enrolled nurses continued providing mental health services for a number of years without having any training in mental health. These nurses at one time became in charges in the wards, and that nurses appreciated the need of having nurses who were trained in mental health and those who were not trained shared the way they are affected in provision of care which they had never been trained to provide, some saying long working experience helped them in provision of care. Nurses who had no training in mental health needed to get on job training of some basic aspects on mental health to help them in their performance.

Nurses required assistance aiming at encouraging and uplifting their competences and skills in provision of care to mentally ill patients. The needed support explored was mainly access to information especially research findings through internet and doing their research, supportive supervision and psychological support. Limited access to resources for updating knowledge of nurses hinders them to gain new information for improving their mental health services, available resources such as computer; internet should be used to serve the purpose.

2.2 Use of guideline in care provision

The ethical mandate of the practice is to ensure that vulnerable persons who have entrusted their lives to the mental health nurse are cared for in a way that achieves; healing, restores dignity, and makes complex medical treatments safe and effective, (Cathcart, 2008)".

It was revealed in this study that nurses were not sure of presence of guidelines in their work stations hence it was difficult for them to understand whether they providing care in with what was stipulated in the guidelines.

Nurses' Motivation in Mental Health Practice

Lack of motivation was found to be one among other major reasons which made retention and engagement of nurses in their work to be to be difficult. Motivations which were explored in this study included promotions, having good salaries, good leadership, recognition and being valued by having transport or having nursing staff houses and allowances such as; night, risk, extra duty and hardship allowances.

Nurses commented on their leaders that motivation to them was not necessarily money but appreciation of what good they were doing matters a lot in motivating them in their work. Due to lack of motivation led nurses to work in routine bases, loose interest in their work some wish to change their profession.

It was revealed that recognizing one part of the team among many which are also important have significant impact in health care settings. Nurses were demoralized with being unrecognized of their expertise in mental health service provision and felt undervalued as the management and other stakeholders recognized doctors who were said to clerk and discharge patients while those who are taking care of the patient all the time are not recognized. Respondents (nurses) stated they felt undervalued in comparison with and by non-mental health colleagues in Australia, Crowther and Ragusa, (2007). This situation led nurses not to use their knowledge and skills fully in provision of mental health services.

Psychosocial dynamics

4.1. Social dynamics

It was revealed from this study that nurses were living away from their work places the situation which led them to use some of their time to travel to and from their work stations. In Dar es Salaam the infrastructure was not as friendly as nurses had to wake early morning and return home late the situation which made nurses to miss their families.

Nurses' families had to be considered as they may have children who later may be of unsound social aspects since they miss their parents' guidance for most of the time. Economic status of

nurses was not sufficient to enable them rent houses near their work places. Nurses working in mental health facilities used much of their time at work due to the available shortage so they also missed social interactions with their community members. Nurses needed to have houses close their working stations at least to be able to have some time to take care of their families.

4.2. Psycho economic dynamics

Life experiences from retired nurses in the community triggered worried of nurses about their life in future as it was revealed from their experiences that nurses' low economic status imposed them into early death after retiring.

For some nurses became tired due to fasting as they could not afford to have lunch and they were staying with the patients the whole day taking care of the patients at one point they failed to adhere to ethical issues.

4.3 Physiological

Backbone related health problems have been observed to be increasing to date. In this study nurses were complaining of having back ache due to workload they have. After working for long shift and providing care to huge number of patients nurses get so tired especially when they are supposed to walk for long distance to look for public transport to their homes.

How mental health nurses can help improve mental health care

Nurses were found to work in shifts and stayed with patients all the time. Internal influential characteristic of caring led nurses to work hard despite of presence of other factors for example during health care workers' strike nurses continued providing care. As it was also revealed by McBride, (2007) that nurses have been particularly effective in addressing some of the mental health problems of those two ends of the developmental spectrum.

Since nurses have been working and available to patients all of the time despite of all other limiting factors, their working sprit can be utilized in mental health promotion, prevention and alleviation of suffering. So having motivated and well trained nurses in mental health, nurses can make a tremendous change in quality of mental health care services.

The study revealed that the environment for treating the patients contributed to use of more force in treating the patient, which was sometimes unethical as the later did not have much trust to nurses since they perceived to be cared in prison so they were ready for fight. The trend of care improvement was reported to drop down as compared to previous years and this has been contributed by shortage of staff, supplies and lack of motivation to staffs which led to poor engagement, ceasing of some sections like community mental health which was used to make community education and follow up, relatives are not provided with adequate education during discharge of their family members they were just instructed to take medicines and the date of coming back in the clinic, nurses had no time to provide other treatment modalities such condition has also been pointed to be a contributing factor for relapse of patients within short period of time after discharge. Other studies also had identified similar issues that had impact on mental health practice; Significant issues that impact on practicing as a mental health nurse include staff shortages (Gibb, 2000; Hegney & McCarthy, 2000; Hegney et al., 2001), deinstitutionalization (Allan, 2001; Sands, 2004), generational issues that affect how mental health nurses view their work (Crowther&Kemp, 2009), changes to undergraduate nurse education (Allan, 2001; Brown, 1988), consumer stigma (Allan, 2001; McColl, 2007), the lack of opportunity for promotion, and violence and bullying (Allan, 2001).

Nurses' suggestion in improving the quality of mental health practice.

In this study nurses suggested that in order to have quality of mental health care improved, there was a need improving the working environment which could motivate nurses and increase their engagement in their work. In this case they further insisted the need of having more males in hospitalized care settings. Nurses who were specifically trained in particular areas of mental health were needed as it was observed that in the country there was no nurse trained in forensic and child and adolescent psychiatry. Multidisciplinary teamwork was found to be crucial in mental health as absence of one discipline delayed the needed care to the patient.

The government had to provide adequate budget for financing mental health services which could enable to have effective community mental health nursing and training to nurses working in mental health settings.

Strengths and Limitations of the study

Using qualitative method in conducting this study coupled by a cross sectional quality assessment were found to be suitable in understanding the quality of care in tertiary hospitals as well as the factors which affected mental health practice in the nursing perspective. Collecting information from two different national hospitals and one institute, mixing participants of different experiences, use of exploratory questions in FGD and IDI, Observation and were sufficient to provide rich data which enhanced reliability and validity of this study which gave a clear picture of mental health practice in nursing perspectives

Limitations refer to theoretical and methodological restrictions or weaknesses in a study that may decrease the generalizability, (Burns & Grove, 2009). The following were limitations of this study and the way they were taken care of;

1. Nurses' educational differences would be a confounding factor as there was significant education and training differences among nurses especially at Mirembe as most of them were enrolled nurses (who were not trained in mental health issues) and some registered nurses most were upgraded hence the researcher tried to balance by having a mixture pertaining level of education.
2. Nurse's attitude emerged hence and it was doubted to affect the reality, to minimize the effect the FGDs were very participatory so as participants were free to challenge each other to increase clarity.
3. Only nurses from two tertiary hospitals were involved in the study also the quality assessment tool measured the output of all staffs worked in mental health facilities.

Conclusion and recommendations

This study explored how nurses working in mental health settings perceived on what could affect them in their mental health practice. Working environment has tremendous effect to people who receive and those who provide practice in mental health facilities. Non conducive environment in

which there are low motivation to nursing staffs, lack of on job training for long time, limited infrastructure in mental health facilities, high workload, unguaranteed safety at work place, and less supportive nursing leadership in mental health units affect nurses' engagement, hence decrease in performance and quality of care. On the other hand quality of care depends on other factors including adequate qualified nurses trained in mental health coupled by having specialized in specific areas requiring such people for example child and adolescence, and forensic nursing; accessibility to various treatment modalities, good environments for hospitalized patients, adequate funding of mental health services, effective community mental health nursing and multidisciplinary teamwork.

Future research should investigate whether these findings remain consistent in other mental health facilities also there is a need to undergo study to find the impact of patients being enclosed in the wards for most of their hospitalized period.

This study suggests that in order to have quality of mental health care improved; there is a need of improving the working environment for motivating nurses and increase their engagement in their work, improving the environment for hospitalized patients which has indicated to have some impact on recovery of the patients, to have adequate mental health nurses male nurses being more in number and those who were specifically trained in particular areas of mental health were needed as it was observed that in the country there was no nurse trained in forensic and child and adolescent psychiatry, to have effective community mental health nursing and training to nurses working in mental health settings. Also multidisciplinary teamwork was found to be crucial in mental health as absence of one discipline delayed the needed care to the patient. In order to have all these issues possible, the government has to provide adequate budget for financing mental health services.

Advocating mental health need to be multi-sector to involve all stakeholders led by the ministry responsible for health. The element of mental health cuts across all issues concerning health and socio-economic development hence they should be integrated in other programs such as RCH, HIV/AIDS, Cancer, Economic development, mental health is enormously vital.

Community mental health nursing needed to be reinitiated and strengthened so as the community can easily get education about mental health also families having people with mental illness could get support more easily. Mental wellbeing of each individual has vital role in development of particular country, which is a call for having effective community mental health nursing in place.

The results can be used to influence health policy makers to reduce the burden to nurses, patients, families and hospital managements in improving quality of care and life of patients with their families. Also results of this study will guide interventions that are evidence based and lead to improved staff engagement, mental health practice performance and patient experiences and outcomes.

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Appendix A

Semi structured interview guide for focused group discussion.

1. Please would you tell me about what do you understand the term "working environment"?
2. How is your working environment in this institution? *(Probe: lack of accidents at work, trends of care improvements, multidisciplinary team work , being valued, having enough supplies)*
3. What influences you to honestly work hard in mental health settings *(Probe: motivation and the kind of motivation)*

4. Would you explain about what makes it difficult for you to provide quality care and management to your clients?
   (Probe: work force- number, knowledge and skills; resilience; support and training; policy guidelines; stress; burnout; working environment; administration; find out "ask why" to each factor mentioned by the participant; stigma; on job training; complicated patients' conditions; nurses' well being-how does their work impact their life status?))

5. On your view, what helps you in mental health practice? (*Probe: therapeutic relationships-nurse-patient/&family, nurse – coworker; communication skills; therapeutic environment; existence of policy guidelines; support and training, caregivers involvement, having many skilled and highly trained mental health nurses*)

   May you elaborate on how you apply them?

6. If you are given a chance for further training/education, which career would you prefer?

Appendix B

This form shall be filled up by the interviewee after consenting the participant before discussion. This will help to build rapport and enable the participant to be more open during the discussion as their personal information will not have been disclosed as a result of their participation in this study.

Demographic data

I.D. number (Unique research number assigned to individuals) ...……..

Date of birth: ……..

Sex: Male …….. Female ……..

Mobile phone number ……

Education/training

Basic education level (Education prior to start of professional training): ……..

Category of nursing: ……

Personnel: Trained in mental health nursing ……., Non- trained in mental health nursing ……

Basic entry professional training: ……, …….., ……. (Expressed by type, date and Number of years in training)

Post-basic training: ……., ……., …… (Any extended accredited professional training beyond basic qualification undertaken expressed by type, date, and funding source)

Work related information

Organization Employment agent: ……..

Number of years in the mental health setting: ……

Title: ……

Type of job (Primary function) performed: ……..

(Clinical, administration, community mental health nurse),

Employment status: …….. (Full-time or part-time)

Appendix C

Semi structured interview guide for In Depth Interview.

Demographic data

I.D. number (Unique research number assigned to individuals) ...……..

1. What is your age?
2. Sex

Education/training

3. What is your basic education level (Education prior to start of professional training)
4. What is your category of nursing?
5. Personnel: (Trained/Non - trained in mental health nursing)
6. What was your basic entry professional training? (Expressed by type, date and Number of years in training)

Probe {Post-basic training, (Any extended accredited professional training beyond basic qualification undertaken expressed by type, date, and funding source)}

Work related information

7. What is your Organization Employment agent?
8. For how long have you worked as a mental health nurse in this institution?
9. What is your title? *Probe { Type of job (Primary function) performed(Clinical, administration, community mental health nurse)}*
10. What is your employment status? (Full-time or part-time)
11. Please would you tell me about what do you understand the term "working environment"?
12. How is your working environment in this institution? *(Probe: lack of accidents at work, trends of care improvements, multidisciplinary team work , being valued, having enough supplies)*
13. What influences you to honestly work hard in mental health settings *(Probe: motivation and the kind of motivation)*

14. Would you explain about what makes it difficult for you to provide quality care and management to your clients?

(Probe: work force- number, knowledge and skills; resilience; support and training; policy guidelines; stress; burnout; working environment; administration; find out "ask why" to each factor mentioned by the participant; stigma; on job training; complicated patients' conditions; nurses' well being-how does their work impact their life status?))

15. On your view, what helps you in mental health practice? (*Probe: therapeutic relationships-nurse-patient/&family, nurse – coworker; communication skills; therapeutic environment; existence of policy guidelines; support and training, caregivers involvement, having many skilled and highly trained mental health nurses*)

    May you elaborate on how you apply them?

16. If you are given a chance for further training/education, which career would you prefer?

Appendix D

Quality assessment tool
Introduction:

Hello. My name is Paul Magesa. I am a nurse working on a research project aiming at exploring factors affecting mental health practice in Dar es Salaam and Dodoma, Tanzania focusing in the nursing perspective.. Now, I would like to gather some of the quality performance indicators for your facility/unit/ward. The information will be analyzed to measure the quality of care and what affects mental health practice in nursing perspective at the tertiary hospitals in Tanzania.

There will be no consequence for your facility to provide any data; rather, the information obtained from your unit/ward will be used to inform management about measures to improve provision of quality mental health services.

This process of data collection will take about 60 minutes of your time. You are not going to be paid for your time. However, I'm appreciating your time for the support you provide to me.

Fill in the correct information as per instructions in each section.

Basic Mental health nurses workforce information. This will help to inform the analysis and explore if the number of positions or vacancies has an influence on quality of mental health practice.

Designation	**Number of available positions**	**Number of filled positions**	**Number of nurses who are trained in Mental health.**	**Number of nurses who got on job training in mental health in the past 6 months**
Nurse officer				
Assistant Nurse Officer				
Enrolled nurse				
Counselor				
Community/Public health nurse				
Health attendant*				

*If they are providing mental health services to the patients.

Some indicators to be used to measure the quality of care will be based on;

Treatment:

- % of persons with new diagnosis of major depression who receive at least three medication visits or at least eight psychotherapy visits in a 12- week period.
- % of discharges from psychiatric in patient care during a 12 – month reporting period readmitted to psychiatric in – patient care that occurred within 7 and 30 days.
- % of persons initiating treatment for substance - related disorder with treatment lasting at least 90 days.
- % of persons admitted to psychiatric in patient care who have at least two daily progress nursing report in the past 7 days
- % of persons admitted to psychiatric in patient care who have attended at least two sessions of psychotherapy, Cognitive behavioral therapy and occupational therapy within 7 days.
- % of persons admitted to psychiatric in patient care out of the bed capacity of the ward/facility on average in the past 7 days.

Continuity:

- % of persons discharged with dual diagnosis of psychiatric disorder and substance abuse with at least four psychiatric and at least with four substance abuse visits within the 12 months after discharge.
- % of persons hospitalized for psychiatric disorder or substance related disorder with at least one visit per month for 6 months after hospitalization.

Coordination:

- % of persons with specified severe psychiatric disorder in contact with the health care system who receive case management. (All types).

Quality indicators

Indicator: 1 **Visits during acute phase treatment of depression**	% of persons with new diagnosis of major depression who receive at least three medication visits or at least eight psychotherapy visits in a 12- week period.
Actual data source (list):----------	
Numerator: Number of persons with new diagnosis of major depression who receive at least three medication visits or at least eight psychotherapy visits in a 12- week period. ***If not available write NA*** ☐	**Denominator:** Total number of persons with new diagnosis of major depression diagnosed in a 12- week period. ***If not available write NA*** ☐

Indicator: 2 **Hospital readmissions for psychiatric patients**	% of discharges from psychiatric in patient care during a 12 – month reporting period readmitted to psychiatric in – patient care that occurred within 7 and 30 days.
Actual data source (list):----------	
Numerator: Total number of persons readmitted to psychiatric in – patient care that occurred within 7 and 30 days after discharge in the past 12 months. ***If not available write NA*** ☐	**Denominator:** Total number of persons discharged from psychiatric in patient care during a 12 – month. ***If not available write NA*** ☐

Indicator: 3 Length of treatment for substance – related disorders	**%** of persons initiating treatment for substance - related disorder with treatment lasting at least 90 days.
Actual data source (list):----------	
Numerator: number of persons initiating treatment for substance - related disorder with treatment lasting at least 90 days ***If not available write NA*** ☐	**Denominator:** Total number of persons initiating treatment for substance - related disorder with treatment in the past 90 days. ***If not available write NA*** ☐

Indicator: 4 Patients' daily progress report	% of persons admitted to psychiatric in patient care who have at least two daily progress nursing report in the past 7 days
Actual data source (list):----------	
Numerator: Total number of persons admitted to psychiatric in patient care who have at least two daily progress nursing report in the past 7 days. ***If not available write NA*** ☐	**Denominator**: Total number of persons admitted to psychiatric in patient care for at least 7 days. ***If not available write NA*** ☐

Indicator: 5 Different treatment modalities provided	% of persons admitted to psychiatric in patient care who have attended at least two sessions of psychotherapy, Cognitive behavioral therapy and occupational therapy within 7 days.
Actual data source (list):----------	
Numerator: Total number of persons admitted to psychiatric in patient care who have attended at least two sessions of	**Denominator**: Total number of persons admitted to psychiatric in patient care in the past 30 days.

psychotherapy, Cognitive behavioral therapy and occupational therapy within 7 days in the past 30 days. ***If not available write NA*** ☐	***If not available write NA*** ☐

Indicator: 6 **Millue therapy**	% of persons admitted to psychiatric in patient care out of the bed capacity of the ward/facility on average in the past 7 days.
Actual data source (list):----------	
Numerator: Total number of persons admitted to psychiatric in patient care out of the bed capacity of the ward/facility on average in the past 7 days. ***If not available write NA*** ☐	**Denominator**: Total number of persons admitted to psychiatric in patient care on average in the past 7 days. ***If not available write NA*** ☐

Indicator: 7 **Continuity of visits after hospitalization for dual psychiatric/substance-related conditions**	% of persons discharged with dual diagnosis of psychiatric disorder and substance abuse with at least four psychiatric and at least with four substance abuse visits within the 12 months after discharge.
Actual data source (list):----------	
Numerator: Total number of persons discharged with dual diagnosis of psychiatric disorder and substance abuse with at least four psychiatric and at least with four substance abuse visits within the 12 months after discharge. ***If not available write NA*** ☐	**Denominator**: Total number of persons discharged with dual diagnosis of psychiatric disorder and substance abuse discharged in the past 12 months. ***If not available write NA*** ☐

Indicator: 8 **Continuity of visits after mental health – related hospitalization**	% of persons hospitalized for psychiatric disorder or substance related disorder with at least one visit per month for 6 months after hospitalization.
Actual data source (list):----------	
Numerator: Total number of persons hospitalized for psychiatric disorder or substance related disorder with at least one visit per month for 6 months after hospitalization. ***If not available write NA*** ☐	**Denominator**: Total number of persons who were hospitalized for psychiatric disorder or substance related disorder and have been discharged in 12 months ***If not available write NA*** ☐
Indicator: 9 **Case management for severe psychiatric disorders**	– % of persons with specified severe psychiatric disorder in contact with the health care system who receive case management. (All types).
Actual data source (list):----------	
Numerator: Total number of persons with specified severe psychiatric disorder in contact with the health care system who receive case management in the past 90 days. (All types). ***If not available write NA*** ☐	**Denominator**: Total number of persons with specified severe psychiatric disorder hospitalized in the past 90 days. (All types). ***If not available write NA*** ☐

Comments/observations/notes on quality indicators:

Appendix E

CONSENT FORM

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

DIRECTORATE OF RESEARCH AND PUBLICATIONS, MUHAS

ID-NO

Consent to participate in a study about factors affecting mental health practice in Dar es Salaam and Dodoma, Tanzania.

Greetings! My name is Paul Magesa. I am a nurse working on a research project aiming at exploring factors affecting mental health practice in Tanzania focusing in nursing perspective.

Purpose of the Study

The purpose of this research is to explore factors affecting mental health practice in Tanzania focusing in nursing perspective. This will raise a profile of evidence based mental health practice challenges in Tanzania and it will provide evidence based recommendations for improvement to the governing bodies.

What Participation Involves

If you agree to join the study, you will be interviewed and the information that you are going to give will be recorded with a digital recorder and the researcher will also note down important points. You will be asked about your experiences in mental health practice, factors those make it difficult for you to provide care and management to clients, critical components of mental health practice in nurses' view and how do they put them into action and challenges you are facing while working in mental health settings. It will take about 60-120 minutes to complete the focused group discussion /40 - 60 minutes for the in depth interview.

Confidentiality

All information we collect on the digital recorder and notes will be entered into computers with only the study identification number. All information that will be collected from you will be protected. The study will not include details that directly identify you, such as your name. Only a participant identification number will be used in the interview. Only a small number of researchers will have direct access to the interview. If this study is published, or presented at a scientific meeting, names and other information that might identify you will not be used.

Risks

We do not expect that any harm will happen to you because of participating in this study.

Rights to Withdraw and Alternatives

Taking part in this study is completely your choice. You are free not to respond to a question if you feel uncomfortable to disclose information. You can stop participating in this study at any time, even if you have already given your consent. If you refuse now, but wish to enter the study later, we will be ready to accept you. Refusal to participate, or withdrawal from the study, will not involve penalty or loss of **any** benefits to which you are otherwise entitled.

Benefits

There are no direct benefits to you. However if you agree to participate in this study, your contribution will be useful in improving mental health nursing practice of which both you and your clients will benefit.

In Case of Injury

We do not anticipate that any harm will occur to you relative as a result of participation in this study. However, if any physical/psychological injury resulting from participation in this research should occur, we will provide you with medical/psychological treatment according to the current standards of care in Tanzania. There will be no additional compensations to you.

Who to Contact

If you ever have questions about this study, you should contact the study Coordinator or the Principal Investigator Paul Magesa (0713 599593) Muhimbili University of Health and Allied Sciences, P.O. Box 65001, Dar es Salaam). If you ever have questions about your rights as a participant, you may call the Principle Investigator or Prof. M. Aboud, Director of Research and Publications at MUHAS, P.O. Box 65001, Dar es Salaam. Tel: 2150302-6.

Signature:

Do you agree to participate?

Participant agrees …… Participant does NOT agree ……..

I, _____ have read the contents in this form. My questions have been answered. I agree to participate in this study.

Signature of participant _____

Signature of researcher _____ Date_____

Kiambatanisho A

Mwongozo wa mahojiano katika kikundi - Kiswahili

1. Tafadhali unaweza kunieleza unaelewa nini kuhusu neon, “mazingira ya kazi”
2. Mazingira yako ya kazi yakoje katika taasisi hii? *(Dodosa: ukosefu wa ajali kazini, mwelekeo wa uboreshaji wa huduma/kujali, kuthaminiwa, uwepo wa vitendea kazi vya kutosha)*
3. *Ni kitu gani kinachokusukuma ufanye kazi kwa dhati na juhudi kubwa katika kingo cha Afya ya Akili? (Dodosa: Motisha na aina ya motisha)*

4. Je, unaweza kunielezea kuhusu kinachofanya iwe vigumu kwako katika utoaji wa huduma na kuwajali wateja/wagonjwa?
   (Dodosa: idadi ya watendaji, ujuzi na maarifa, kunyumbuka/kuvumilia na kujirudi, kuungwa mkono na mafunzo, miongozo ya kisera, shinikizo, choka sana kwa ajili ya jitihada ya muda mrefu, mazingira ya kazi, utawala; {chimba zaidi, uliza kwa nini kwa kila kitakachotajwa na mshiriki, unyanyapaa, mafunzo kazini, hali ngumu ya mgonjwa, hali ya maisha ya muuguzi – kazi yao ina athari gani kwa maisha yao)

5. *Kwa mawazo/maoni yako, ni vitu gani vya muhimu ambavyo ni sehemu ya utendaji katika huduma ya afya ya akili*
   (Dodosa: uhusiano wa kitabibu muuguzi-mgonjwa/familia, muuguzi na wafanyakazi wengine; ujuzi wa mawasiliano; mazingira tiba; uwepo wa miongozo ya kisera; kuungwa mkono na mafunzo, dawa, kazi tiba na tiba ya kisaikolojia, ushirikishwaji wa wanandugu wanaomhudumia mgonjwa, kuwa na wauguzi wengi wenye ujuzi na mafunzo ya hali ya juu katika afya ya akili).
   Unaweza kuelezea jinsi unavyoyatekeleza? Kama hapana. Kwa nini?

6. Kama ukipewa fursa ya kujiendeleza kielimu utapendelea kusoma kitu gani?

Kiambatanisho B

Fomu hii itajazwa na mtafiti baada ya kuapata ridhaa ya mshiriki kabla ya kuuliza maswali ya mahojiano. Hii itasaidia kujenga mahusiano mazuri na itamwezesha mshiriki kuwa wazi zaidi wakati wa mazungumzo au mahojiano kwani taarifa zake binafsi zitakuwa hazijawekwa wazi kwa sababu ya ushiriki wake katika utafiti huu.

Taarifa binafsi.

Namba ya utambulisho (Namba maalumu ya kiutafiti aliyopewa mshiriki) ...……..

Tarehe ya kuzaliwa: ……..

Jinsia: Mwanaume …….. Mwanamke ……..
Namba ya simu ya mkononi ……

Elimu/Mafunzo

Kiwango cha elimu (Elimu kabla ya kuanza mafunzo ya kitaaluma): ……..

Kundi katika Uuguzi: (Afisa muuguzi, Afisa muuguzi msaidizi, Muuguzi): ……

Ikama: Nimepata mafunzo ya uuguzi wa afya ya akili ……., Sijapata mafunzo ya uuguzi wa afya ya akili. ……

Mafunzo ya awali ya kitaaluma: ……, ……., ……. (Ielezwe kwa Aina, Tarehe, na Idadi ya miaka katika mafunzo)
Mafunzo baada ya mafunzo ya awali: ……., ……., …… (Mafunzo yoyote ya kitaaluma baada ya mafunzo ya awali yaliyoidhinishwa, yaanishwe kwa; Aina, Tarehe, Chanzo cha pesa)

Taarifa kuhusiana na kazi

Mwajiri: ……..

Idadi ya miaka katika kitengo cha afya ya akili: ……

Cheo: ……
Aina ya kazi (majumu ya msingi) unayoifanya: ……..
(kufanya kazi wodini{clinical},utawala, muuguzi wa afya ya akili kwenye jamii)

Aina ya ajira: …….. (Muda wote au muda wa ziada)

Kiambatanisho C

Mwongozo wa mahojiano ya kina - Kiswahili

Taarifa binafsi.

1. Namba ya utambulisho (Namba maalumu ya kiutafiti aliyopewa mshiriki) ...……..

2. Una umri gani?

   Elimu/Mafunzo

3. Una kiwango gani cha elimu (Elimu kabla ya kuanza mafunzo ya kitaaluma)

4. Upo katika kundi gani katika fani ya Uuguzi? (Afisa muuguzi, Afisa muuguzi msaidizi, Muuguzi)

5. Ikama: Je, umepata mafunzo ya uuguzi wa afya ya akili?

6. Mafunzo ya awali ya kitaaluma ni ya aina gani? (Ielezwe kwa Aina, Tarehe, na Idadi ya miaka katika mafunzo)
7. Umewahi kupata mafunzo baada ya mafunzo ya awali: (Mafunzo yoyote ya kitaaluma baada ya mafunzo ya awali yaliyoidhinishwa, yaanishwe kwa; Aina, Tarehe, Chanzo cha pesa)

   Taarifa kuhusiana na kazi

8. Mwajiri wako ni nani? (Taasisi/Wizara ya Afya na Ustawi wa Jamii)
9. Umefanya kazi kwa muda gani katika kitengo cha afya ya akili?
10. Ni nini cheo chako hapa?
11. Aina ya kazi (majumu ya msingi) unayoifanya. (kufanya kazi wodini{clinical},utawala, muuguzi wa afya ya akili kwenye jamii)
12. Aina ya ajira una yoifanya. (Muda wote au muda wa ziada)

13. Tafadhali unaweza kunieleza unaelewa nini kuhusu neno, “mazingira ya kazi”

Mazingira yako ya kazi yakoje katika taasisi hii? *(Dodosa: ukosefu wa ajali kazini, mwelekeo wa uboreshaji wa huduma/kujali, Motisha, kuthaminiwa, uwepo wa vitendea kazi vya kutosha)*

14. Ni kitu gani kinachokusukuma ufanye kazi kwa dhati na juhudi kubwa katika kingo cha Afya ya Akili? *(Dodosa: Motisha na aina ya motisha)*

15. Je, unaweza kunielezea kuhusu kinachofanya iwe vigumu kwako katika utoaji wa huduma na kuwajali wateja/wagonjwa?

(Dododsa: idadi ya watendaji, ujuzi na maarifa, kunyumbuka/kuvumilia na kujirudi, kuungwa mkono na mafunzo, miongozo ya kisera, shinikizo, choka sana kwa ajili ya jitihada ya muda mrefu, mazingira ya kazi, utawala; {chimba zaidi, uliza kwa nini kwa kila kitakachotajwa na mshiriki, unyanyapaa, mafunzo kazini, hali ngumu ya mgonjwa, hali ya maisha ya muuguzi – kazi yao ina athari gani kwa maisha yao)

16. *Kwa mawazo/maoni yako, ni vitu gani vya muhimu ambavyo ni sehemu ya utendaji katika huduma ya afya ya akili*

(Dodosa: uhusiano wa kitabibu muuguzi-mgonjwa/familia, muuguzi na wafanyakazi wengine; ujuzi wa mawasiliano; mazingira tiba; uwepo wa miongozo ya kisera; kuungwa mkono na mafunzo, dawa, kazi tiba na tiba ya kisaikolojia, ushirikishwaji wa wanandugu wanaomhudumia mgonjwa, kuwa na wauguzi wengi wenye ujuzi na mafunzo ya hali ya juu katika afya ya akili).

Unaweza kuelezea jinsi unavyoyatekeleza? Kama hapana. Kwa nini?

17. Kama ukipewa fursa ya kujiendeleza kielimu utapendelea kusoma kitu gani?

Kiambatanisho D

Fomu ya taarifa na ridhaa ya mshiriki.

CHUO KIKUU CHA AFYA NA SAYANSI SHIRIKISHI MUHIMBILI

KURUGENZI YA UTAFITI NA UCHAPISHAJI

Na. ya Utambulisho | | | | | | | | | | |

Idhini ya kushiriki utafiti kuhusu hali zinazoathiri utendaji katika utoaji wa huduma ya afya ya akili, Dar es Salaam na DodomaTanzania.

Salaam! Jina langu ni Paul Magesa. Ni muuguzi ninayefanya kazi katika mradi wa utafiti unaolenga kuchunguza hali zinazoathiri utendaji katika utoaji wa huduma ya afya ya akili Tanzania, hususani katika mtazamo wa kiuuguzi.

Lengo la utafiti

Lengo la utafiti huu ni kugundua hali zinazoathiri utendaji katika utoaji wa huduma ya afya ya akili Tanzania, hususani katika mtazamo wa kiuuguzi. Hii itaongeza ufahamu wa uhalisia kwa kuzingatia ushahidi kuhusu changamoto katika utendaji kuhusu afya ya akili Tanzania na itatoa maoni kutokana na ushahidi kwa ajili ya maboresho kwenye vyombo husika vya utawala.

Mambo muhimu katika kushiriki kwenye utafiti huu

Kama utakubali kushiriki katika tafiti hii, utahojiwa na maelezo utakayoyatoa yatarekodiwa na kinasa sauti pia naweza kuandika baadhi ya vitu muhimu.Utaulizwa kuhusu uzooefu wako katika utoaji wa huduma ya afya ya akili, hali zinazopelekea utaji wa huduma kwa wateja kuwa mgumu, vitu muhimu kabisa katika utoaji wa huduma ya afya ya akili kwa maoni yako na jinsi unavyovifanyia kazi au kuvitekeleza, na changamoto unazozikabili kwa kufanya kazi katika idara ya afya ya akili. Itachukua takribani dakika 60 – 90 kukamilisha majadiliano katika kikundi ambapo utakuwa na wenzio kama wanne, itachukuwa takribani dakika 40 hadi 60 kwa majadiliano ya kina.

Usiri

Taarifa zote zitakazokusanywa kupitia kinasa sauti na muhtasari zitaingizwa kwenye kinakirishi (kompyuta) , huku namba ya utambulisho tu katika utafiti itatumika. Taarifa zote zitakazokusanywa kutoka kwako zitalindwa. Utafiti huu hautajumuisha taarifa ya ambayo moja kwa moja inakutambulisha wewe kama mtoa taarifa, kwa mfano jina lako. Namba ya utambulisho katika kushiriki utafiti huu peke yake ndiyo itatumika katika mazingira yote ya utafiti. Idadi ndogo sana ya watafiti watakaokuwa uwezo wa kufungua na kuona taarifa zitakazokusanywa katika utafiti huu. Na kama utafiti huu utachapishwa au kuonyeshwa katika mikutano ya kisayansi basi majina na taarifa nyingine zinazoweza kukutambulisha wewe moja kwa moja hazitatumika.

Madhara

Hatutegemei kuwa madhara yoyote yanaweza kukupata kwa kushiriki katika utafiti huu.

Haki ya kujitoa na njia mbadala za kushiriki

Kushiriki katika utafiti huu ni uamuzi wako. Uko huru kutokujibu swali lolote ambalo kwa sababu yoyote ile unaona si vyema kulitolea jibu. Kama italazimu, uko huru kutoshiriki katika utafiti huu hata kama awali ulikuwa tayari umeshatoa idhini ya kushiriki. Vile vile, kama ukikataa na baadaye ukaona uko tayari kushiriki, tutakuwa tayari kukupokea tena. Uamuzi wako wa kukataa kushiriki ama kujitoa kuendelea na ushiriki katika utafiti huu hakuta sababisha wewe kupewa adhabu ama kupoteza mafao ya aina yoyote ambayo ni haki yako ya msingi.

Mafao

Hakuna mafao ya moja kwa moja. Hata hivyo kama utakubali kushiriki katika utafiti huu, mchango wako utakuwa na manufaa hasa katika kubuni njia na mbinu za kuboresha utendaji wa kiuguzi katika kitengo cha afya ya akili ambapo wewe pamoja na wateja/wagonjwa mtanufaika.

Kama ikitokea umedhurika

Hatutarajii kama kushiriki katika utafiti huu kutaleta madhara yoyote kwako. Hata hivyo, kama katika hali yoyote ungali ukishiriki katika utafiti huu ukapatwa na madhara ya kimwili/viungo, tutakupatia wewe matibabu kulingana na taratibu za utoaji huduma ambao Tanzania kama nchi imejiwekea. Hakutakuwa na fidia ya moja kwa moja kwako.

Mtu wa kuwasiliana naye

Kama una maswali zaidi juu ya utafiti huu, tafadhali wasiliana na mtafiti mkuu Bw. Paul Magesa (0713 599593) Chuo Kikuu cha Afya na Sayansi Shirikishi Muhimbili, S.L.P.65004, Dar es Salaam). Pia kama una maswali juu ya haki zako katika kushiriki kwenye utafiti huu unaweza wasiliana na mtafiti mkuu au Prof. M. Aboud, Mkurugenzi wa tafiti na machapisho hapa chuoni, S.L.P 65001, Dar es Salaam. Simu: 2150302-6.

Sahihi:

Unakubali kushiriki katika utafiti huu?

Nakubali: …… Sikubali: ……..

Mimi, _____ Nimesoma kwa umakini kilichoandikwa katika fomu hii.. Maswali yangu yote yamejibiwa.

Nakubali kushiriki katika utafiti huu.

Sahihi ya mshiriki_____

Sahihi ya mtafiti _____Tarehe: _____

APPENDIX E

IMPLEMENTATION PLAN

S/No.	Activity	2011		2012					
		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
1.	Developing draft of a study proposal								
2.	Finalizing the study proposal								
3.	Seeking for ethical clearance								
4.	Obtaining permission from authorities								
5.	Pre-testing data collection instrument								
6.	Refining data collection instrument								
7.	Preparing dummy and master sheets								
8.	Collecting data								
9.	Data processing and analysis								
10.	Report writing								
11.	Disseminating study results								
12.	Publishing study results								
13.	Project management								

APPENDIX F

BUDGET AND JUSTIFICATION

Budget estimates for proposal write up and conducting research.

SN	ITEM	DESCRIPTION OF ITEM	UNIT	QUANTITY REQUIRED	RATE PER UNIT	SUBTOTAL	TOTAL(Tshs)
1.	Stationary	Photocopy papers	Ream	2	10,000	10,000	
		Ruled papers	Ream	2	9,000	18,000	
		Punching machine	Each	1	5,000	5,000	
		Stapling machine	Each	2	4,000	8,000	
		Staple pins	Box	2	2,000	2,000	
		Ball pen	Box	1	10,000	10,000	
		Pencil	Dozen	1	2,500	2,500	
		Correcting fluid	Each	3	500	1,500	
		Bags for carrying documents	Each	3	15,000	45,000	
		Safe box	Each	1	100,000	100,000	
		Printer	Each	1	400,000	400,000	**1,608,000/=**
		Note books	Each	3	2,000	6,000	
		Laptop	Each	1	1,000,000	1,000,000	
2.	Data collection instruments	? Digital Voice recorder	Each	1	300,000	300,000	**360,000/=**
		? Alkaline battery	Pair	12	5,000	60,000	
3.	Travelling for data collection and procedures	? 1 Principle Investigator	day	11	80,000	880,000	**880,000/=**
4.	Refreshments	Refreshment for the participants	Each	25	10,000	250,000	**250,000/=**

5.	Dissemination of research results	Venue Flip charts Soft drinks and snacks Drinking water	Room Each Each Each	1 1 50 50	0 3,000 2,000 500	0 3,000 100,000 25,000	**128,000/=**
6.	Contingency	10% of the total cost					**322,600/=**
GRAND TOTAL						**3,548,600/=**	