

## ORIGINAL RESEARCH

# Mental health policy implementation as an integral part of primary health care services in Oshana region, Namibia

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**Received:** March 3, 2016

**Accepted:** June 1, 2016

**Online Published:** June 27, 2016

**DOI:** 10.5430/jnep.v6n11p53

**URL:** <http://dx.doi.org/10.5430/jnep.v6n11p53>

## ABSTRACT

Despite the 1990 reforms to the health system in Namibia, mental health still receives low priority. Coupled with limited resources, health policies are directed at addressing communicable and life-threatening diseases. On the primary health care (PHC) level, health care services are either completely absent or, at best, fragmented. Therefore, an assessment of the implementation of the mental health policy that was launched in 2005 in the Oshana region of Namibia was undertaken in order to assess the extent to which the mental health policy had been implemented. The aim of the study was to explore and describe the extent of implementation and identify the challenges faced by nurses in PHC settings.

A quantitative, explorative, descriptive design was used, where a total of 42 nurses from 13 health facilities in the Oshana region were conveniently included in the study. Data were collected using a self-administered questionnaire that included both open and closed-ended items. The study found that health care workers on the ground were expected to implement the policy, without have been provided with the crucial tools for implementing it, such as training, implementation guidelines, supervision, infrastructure to support the services and the materials needed to provide the services. In addition, although 77% of the research participants had received training in mental health, none expressed confidence in delivering mental health services on a PHC level. As a result, such services are not available in 94% of the health facilities in the region. This finding supports Gilson *et al.*'s (2008) bottom-up model of policy implementation, which holds that in order to implement a policy fully and successfully, sufficient resources for implementation at multiple levels are required.

The findings call for articulated plans to address the challenges experienced in mental health policy implementation in Namibia in order to allow for the early identification of the burden associated with mental disorders.

**Key Words:** Mental health, Primary health care, Policy

## 1. INTRODUCTION

Health care services in Namibia are provided by the government of the day through the Ministry of Health and Social

Services (MoHSS) and the private sector. These health care services are a combination of primitive, preventive, curative and rehabilitative services. In order to render these services,

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the MoHSS is divided into 13 operational health regions corresponding to the 13 delimited political and administrative regions. These regions are further divided into 34 districts. The districts are managed by District Coordinating Committees which are responsible for providing basic health care services. In the Oshana region, the delivery of health care services is offered through a comprehensive primary health care (PHC) approach, which is both the foundation and the cornerstone of the provision of basic health care. Basic health care services are rendered to patients at health care facilities and such services include dressings, screening, routine vaccination, family planning, tuberculosis treatment, antenatal care, postnatal care and growth monitoring, health education and counselling.

For a long time, mental health services were only available at the mental health units at the Windhoek Central Hospital and the Oshakati Intermediate Hospital. These services followed a curative approach (curative based) whereby the patient was admitted and received treatment and when the condition became stable he or she would be discharged.<sup>[1]</sup> Access to mental health care was limited because the treatment and follow-up services were only available at regional and district hospitals, despite the fact that more than 60% of the Namibian population live in rural areas.<sup>[2]</sup>

However, the literature seems to suggest that this pattern of curative-based health care, where patients with mental health needs have to travel from remote areas to urban facilities, is no longer seen as the most appropriate for health care provision. This follows the adoption of a PHC approach for the entire population of Namibia at a cost that the community and the country can afford.<sup>[3]</sup> The purpose of a PHC approach was to implement the health policies of the Government of the Republic of Namibia and to enable service providers to plan integrated and holistic health services in health facilities at the community level, so that these could provide comprehensive health services, including health centres and district hospitals. It was also intended to link these facilities to a rational hierarchical referral system. This would consequently enable the development of a comprehensive continuum of illness prevention and health promotion organised in line with the life cycle from conception to old age.

Good progress has also been made in the utilisation of and access to service delivery, with an estimated 80% of the population living within ten kilometres of a public health facility.<sup>[4]</sup>

The World Health Organization (WHO) recommends that mental health care should be decentralised and integrated into the existing PHC system with the necessary tasks being carried out as far as possible by general health workers rather

than specialists in psychiatry.<sup>[5]</sup> Accordingly, it was envisaged that mental health services would be addressed by the elements that are appropriate for the treatment of common diseases and injuries so as to minimise the aggravation of disabilities caused by physical, mental, social and spiritual factors.<sup>[6]</sup> The inclusion of mental health services in PHC is important for the following reasons:

Mental disorders make up five of the ten leading causes of health disability and, by 2020, it is predicted that unipolar depression will be the second most disabling health condition in the world.<sup>[7]</sup> The fact sheet produced by the WHO<sup>[8]</sup> suggests that mental illness is on the increase worldwide and today as many as 1,500 million people worldwide are estimated to be suffering from some kind of neuropsychiatric ailment at any given time. Three-quarters of these people live in developing countries. Mental health conditions are among the major causes of disability in the Namibian population. The 2006–07 Demographic and Health Survey<sup>[9]</sup> found that the disability rate in Namibia was 3.1%; of this 15% (7,360) comprised people registered as living with mental health problems.

This study on mental health policy implementation as an integral part of PHC services in the Oshana region was based on the conceptual framework derived from the bottom-up approach to policy implementation by Gilson *et al.*<sup>[10]</sup> The framework used in this study actually consists of five sections or components. However, only four components were discussed, namely, policy implementers, bureaucratic authority, top-down and sometimes conflicting top-down policy directives, and national managers.

### 1.1 Implementing mental health care in primary health care in other countries

Mental health services in Uganda were decentralised in the 1960s, and the mental health unit is now located at the regional referral hospitals. These units are managed by psychiatric clinical officers.<sup>[10]</sup> In the past, services were plagued by low staff morale, a chronic shortage of drugs and a lack of funds for community activities. Most people had little understanding of mental disorders or did not know that effective treatment and services were available. Up to 80% of patients went to traditional healers before reporting to the health system.

In Zimbabwe, a national policy for mental health was implemented to address mental issues.<sup>[11]</sup> Mental health care services in Zimbabwe are centralised in the PHC system and actual treatment of severe mental disorders is available at the primary level.<sup>[12]</sup> Primary health care workers have the capacity to handle patients with severe psychosis and refer

only those that they feel require specialised services.

In Tanzania, despite the availability of resources, health programme managers were not able to carry out the activities required for implementing certain policy. This was because managers were resistant to the rushed top-down way the policy had been imposed on districts.<sup>[10]</sup>

In South Africa the mental health policy was implemented in Mpumalanga province. In terms of this policy, two different models were used to integrate mental health in PHC, with all PHC facilities providing an integrated service.<sup>[3]</sup> In that country, the mental health nurse's primary function is to conduct routine assessments of patients with mental disorders, to dispense psychotropic medication, to recommend medication changes to medical officers and to provide counselling. In Mpumalanga, after 10 years of integration, the integrated PHC services resulted in an increase from 0 to 83% in primary care clinics providing mental health services.<sup>[3]</sup> A good example is Zambia, where the implementers were expected to implement the policy but were not properly consulted on how the policy should be implemented.<sup>[13]</sup>

In Nigeria, a study was conducted<sup>[14]</sup> to explore mental health nurses' experiences of providing mental health services in an attempt to understand policy implications and identify the difficulties and challenges related to delivering mental health care services. The study found that mental health services for River State and the surrounding states in the Niger Delta are available only at the neuropsychiatric Rumuigbo Hospital in Port Harcourt city, River State. Moreover, they are provided only in curative-based health care institutions. The challenges nurses face in implementing the mental health policy result from a lack of political support, a lack of training and inadequate allocation of resources for hospital renovations, a lack of equipment and a lack of funding for drugs, the cost of which makes them unaffordable.<sup>[15]</sup>

In Namibia, the major gaps in health care delivery currently are the availability, accessibility and efficient management of service provision.<sup>[4]</sup> On the urban fringe and in rural areas this translates to time, cost, comfort, convenience and safety, all of which may affect care-seeking practices and the demand for modern health care. A health system where the lower-level facilities offer cost-effective services may function poorly and often results in an overload of the higher hierarchy of health facilities where health provision is more expensive. This has the effect of overburdening the national health budget. It also decreases the efficiency and effectiveness of health services and health programmes because delays in simple health interventions result in life-threatening complications leading to high fatality rates.<sup>[16]</sup> In this study, Countries from low and middle income were compared to

draw lesson learnt, and identify challenges they had faced in implementing their mental health policies. However, just like Namibia, No country has managed to achieve the full spectrum of reform required to overcome all the barriers.<sup>[17]</sup>

## 1.2 Problem statement

Despite the efforts of the MoHSS<sup>[1]</sup> in March 2005 to develop and launch a policy on mental health services, it would seem that the policy has not been implemented effectively. Moreover, it is unclear whether this policy has been properly and effectively implemented within the PHC approach. This statement can be substantiated by the researcher, who while working as a registered nurse in PHC facilities, did not observe any progress in or effects of policy implementation. If the policy had been properly implemented, then the effects of this implementation, including improved mental health service availability, follow-up treatment, rehabilitation and referral, would have been visible. This was not the case, however. As a result, many mental and neurological disorders are attended to by traditional healers and church ministers. This has happened in Rundu, for example, where mentally ill patients are taken to pastors instead of seeking help from the hospital.<sup>[18]</sup> Moreover, it was not clear whether registered nurses are ready to implement the mental health policy in a PHC services context.

## 1.3 Aim of the study

The purpose of the study was to explore and describe the implementation of the mental health policy in PHC services and to identify the associated challenges faced by nurses in PHC settings.

## 1.4 Research question

The following question was posed: What are the challenges facing nurses and health programme administrators in implementing mental health policy in PHC services in the Oshakati district of the Oshana region?

## 1.5 Research objectives

To explore and describe the extent to which registered nurses and health programme administrators are implementing Namibia's mental health policy in the Oshana region. To identify the challenges hindering the implementation of the Namibian mental health policy in PHC services in the Oshana region.

## 2. RESEARCH METHOD AND DESIGN

A quantitative, explorative, descriptive and contextual design was used to explore and describe the challenges registered nurses are facing in implementing the Namibian mental health policy as an integral part of PHC services in Oshana

region. The study was descriptive as it attempted to describe the views and lived experiences of registered nurses regarding the implementation of mental health policy in PHC services, as expressed by the respondents.<sup>[19]</sup>

**2.1 Population**

Population is referred to as the entire group of people that meet a designated set of criteria.<sup>[20]</sup> This study consisted of two populations: firstly, 52 registered nurses working in PHC facilities, whose duty is to provide mental health services at the facility level; and secondly, 12 health programme administrators who are responsible for coordinating mental health activities, as well as guiding the implementation of mental health policy at the regional level. The inclusion criterion was registered nurses working in PHC, as their job description includes the implementation of this policy. The exclusion criterion was all registered nurses not working in PHC settings in the Oshana region. Researchers usually work with samples rather than the whole population as it is more economical and practical to implement in order to obtain reasonable information from the sample.<sup>[20]</sup>

**2.2 Sampling and sample size**

In this study the researcher decided to include all health care providers working in clinics and health centres as participants. A sample of (n = 64) registered nurses responded to the questionnaire distributed during the study (see Table 1).

**Table 1.** Registered nurse and health programme administrators

Occupational groups	Questionnaires sent out	Responses (n)
Registered nurse	61	52
Health programme administrators	12	12
Total (n)	73	64

**2.3 Data collection method**

Two questionnaires were used to collect data for this study: a questionnaire designed for registered nurses which consisted of closed-ended questions and one for the health programme administrators which comprised open-ended questions.

**2.4 Data analysis**

Data analysis was done in two parts: Firstly, the data gathered from the questionnaires was presented as descriptive statistics and evaluated with quantitative, computerised statistical techniques, using SPSS version 22.0. To evaluate the data, the researcher enlisted the assistance of a professional statistician.<sup>[21]</sup> Secondly, analysis of the data obtained from the open-ended questionnaire was carried out using a thematic analysis and this data was also used to do a content analysis.<sup>[21]</sup>

**2.5 Ethical considerations**

Permission to conduct the study was sought from the MoHSS. Authorisation was also obtained from the managers of the hospital and from the regional director of the Oshana region. The consent form attached to the questionnaire had to be completed and signed by both the participants and the researcher to serve as consent for participation in the study. Confidentiality was assured by using an questionnaire that was completed anonymously. The rights of the participants, including voluntary participation and withdrawal at any time without repercussions, were emphasised.

**3. RESULTS**

**3.1 Biographical information**

The biographical information provided by both instruments was analysed together. This information pertained to participants’ age, position held at the health centre and clinics, highest qualifications, years of experience, and professional rank.

**3.2 Categories of participants**

The biographical information was grouped into two categories; namely, registered nurses and health programme administrators. The total population for this study was made up of 64 (100%) participants (see Table 2). Registered nurses made up 52 (81.25%) of the 64 (100%) participants, while the 12 health programme administrators made up the balance (18.75%) of the 64 (100%) participants of the total population group.

**Table 2.** Categories of participants (n = 64)

Groups of participants	Responses (n)	Percentage (%)
Registered nurse	52	81.2
Health programme administrators	12	18.8
Total (n)	64	100.0

**3.3 Age of participants**

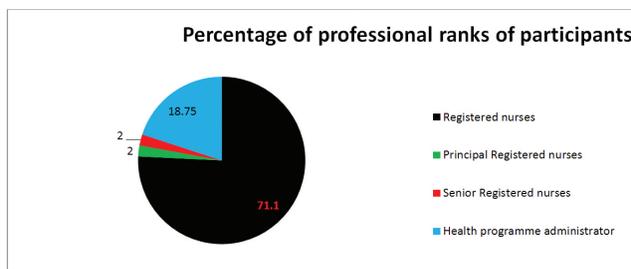
The participants’ ages (see Table 3) ranged between 20 and 60 years. From the data obtained it was noted that the greatest number of participants, that is, 18 (28.1%) out of 64 (100%) currently working in the Oshakati district of the Oshana region were between the ages of 41 and 50 years, with the second largest age group of 16 (25%) falling into the 31 to 40-year age group. Participants were not required to give their specific age as a way to ensure confidentiality.

**Table 3.** Age of participants (n = 64)

Age of participants	Responses (n)	Frequency (%)
20–30 years	16	25.0
31–40 years	15	23.4
41–50 years	18	28.2
51–60 years	15	23.4
Total (n)	64	100.0

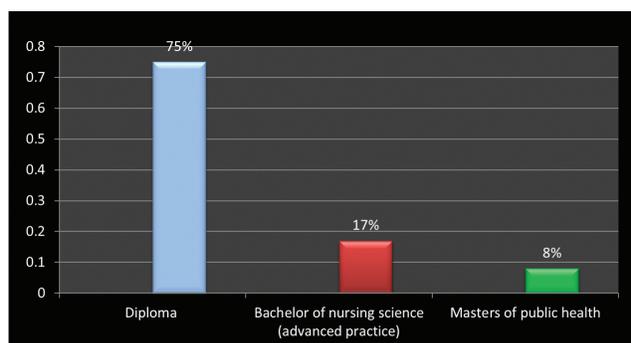
**3.4 Professional ranks of participants**

Of the nurses who took part in the study, 96.2% fell into the category of registered nurse, while 1.9% were principal registered nurses and the remaining 1.9% were senior registered nurses (see Table 3). This distribution is a result of the fact that the study focused mainly on the registered nurses because they are the only category of nurses at PHC clinics and health centres that is trained in basic mental health (see Figure 1).



**Figure 1.** Professional rank of participants (n = 64)

More than half (75%) of the surveyed PHC providers had obtained a basic diploma that included training in mental health nursing to enable them to deliver mental health care in a PHC setting. About 18% of respondents had an additional qualification at the degree level and 8% had a postgraduate diploma (see Figure 2).



**Figure 2.** Highest qualifications of participants (n = 64)

**3.5 Mental health services**

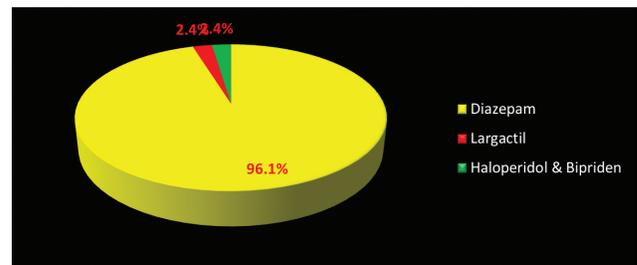
A total of 49 (94.2%) respondents revealed that there are currently no mental health services available in the Oshana region for patients who might present to clinics and health centres with mental health needs. The rest of participants indicated that there are mental health services available in the PHC services of Oshana region; however, this accounted for just 5.8%; three participants in this study (see Table 4).

**Table 4.** Mental health services availability in primary health care (n = 52)

Response	Frequency	Percent (%)
Valid		
yes	3	5.8
no	49	94.2
Total	52	100.0

**3.6 Availability of psychotropic medication**

Respondents attributed the absence of psychotropic medicine to the medicines restriction as set out in the NEMLIST and the Medicine and the Substance-related Act, which specify the level of care at which the medicine may be ordered and prescribed. Diazepam was the only medicine reported by respondents to be available in 96.1% (40) health facilities in the region. The other psychotropic medicines available, as reported by 2.2% of participants, included largatil, haloperidol and biperiden. These were reported to be available only at some health centres (see Figure 3).



**Figure 3.** Availability of psychotropic medication (n = 52)

**3.7 Training in mental health**

The study explored whether nurses working in a PHC setting had basic training in mental health. The detail of this information is outlined in Table 5.

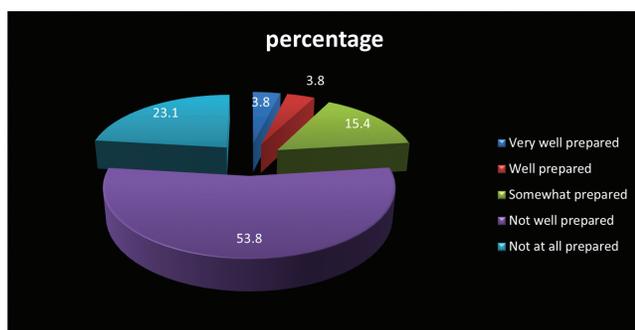
**Table 5.** Nurses’ training in mental health (n = 52)

Responses	Frequency	Percent (%)
Valid		
yes	40	76.9
no	12	23.1
Total	52	100.0

The study showed that 40 (76.9%) of the 52 surveyed reg-

istered nurses had received basic training in mental health during their pre-service training.

A total of 40 (53.8%) respondents in this study indicated that they were not prepared to deliver mental health services as part of the package they provided to their patient. Health providers felt that they require training over and above their basic training if they are to have the knowledge and skills needed to provide health care to people with mental health problems. The results revealed a general lack of preparedness among health workers to have mental health added to their list of care responsibilities, or to have it integrated with PHC (see Figure 4).



**Figure 4.** Nurses' preparedness to deliver mental health services in primary health care setting

On the question of whether mental health should be part of PHC, all 12 (100%) participants revealed that there is no specific programme or focal person under which mental health services fall. These should, according to the policy be present; indeed, the policy emphasises that a focal person be identified to coordinate mental health issues.<sup>[1]</sup> The participants who completed this self-administered questionnaire pointed out that there is a lack of public mental health leadership, both at district and regional level, for guiding the review of policy implementation. Accordingly, there is no one available to do the monitoring and evaluation, conduct the progress/review meeting, or draw up the quarterly and annual reports that are emphasised in the policy.<sup>[1]</sup>

According to the results of this study, all 12 (100%) respondents indicated that mental health policy services are not fully integrated as part of PHC services. The implementation of other policies in the region, such as those related to tuberculosis (TB), Prevention of Mother to Child Transmission and the Expanded Programme on Immunization, are clearly visible in contrast to the mental health policy. The 12 health programme administrators indicated that little had been done in the way of orientation since the inception of the mental health policy. In comparison, policies for the other

programmes had been preceded by the intensive training and orientation of policy implementers to enable them to implement such policies properly.

#### 4. DISCUSSION OF FINDINGS

In the discussion on these findings, it has been noted that integrating mental health services into PHC is critical to improving and promoting the mental health of the Namibian population. Therefore, the results of this study support the need for well-articulated plans to address the challenges to mental health policy implementation in Namibia if the burden associated with mental disorders is to be reduced. This study found that mental health policy implementation inclined towards the Gilson *et al.*'s bottom-up model which holds that in order to bring about full and successful implementation of a policy, sufficient resources for implementation at multiple levels are required – national, state, district and facility.

This study found that while health care workers on the ground were expected to implement the policy, crucial aspects were not in place to help the implementers to actualise the implementation of the policy. This lack included areas as such as the budget, human resources, medication, infrastructure and mental health leadership. Furthermore, the absence of a good referral system between primary and secondary care in the Oshana region severely undermines the effectiveness of the mental health care delivered at PHC level. Although the policy as a document is in place in most health facilities there has been very little support for its implementation at any of the levels. As a result, mental health services are not available in 94% of the health facilities in the region. According to Nsingo,<sup>[22]</sup> for any policy implementation to be successful, those involved in the implementation must first be thoroughly trained on the policy content so that they have sufficient information.<sup>[22]</sup> This includes knowing whom to work with, their roles in implementing the policy and the people who are the appropriate beneficiaries of the policy.

The findings of this study reveal that 77% (40) of the nurses who completed the questionnaire had been trained in mental health during their pre-service training; however, none of them expressed confidence in delivering a mental health service to their clients. This situation was attributed to a lack of the knowledge and skills needed to deliver mental health services, such as identifying and treating mental illness. These results were found to be consistent with those of previous similar studies conducted in South Africa, Zambia and Uganda, except for the fact that their implementers were trained to enable them to implement the policy. Many of the participants suggested that they would like to be trained and be clinically supervised in the area of implementing the mental health policy.

According to Buse *et al.*'s<sup>[23]</sup> model of bottom-up policy implementation, it is risky to assume that putting good policies in place will guarantee their automatic flow into successful ground-level implementation. While the policy implementers are expected to implement this mental health policy, it was the duty of the regional health programme administrators to see to it that registered nurses (implementers) at the health facility level were well supported and supervised to implement the policy. In this study, 98% (49) of the participants (registered nurse) indicated that they had never been supervised in the area of mental health to enable them to implement the policy. According to Dreyer,<sup>[24]</sup> there is a trend in policy implementation of ignoring the policy implementer, and it is common to observe a gap between what is planned and what actually occurs as a result of a policy.

Based on Gilson *et al.*'s<sup>[10]</sup> bottom-up model of policy implementation, it is argued that it is essential to communicate with the people implementing the policy in order to build their support for the implementation and to deal with their concerns. This has been observed in other countries such as Zambia, Zimbabwe, Uganda and South Africa, where registered nurses were given the opportunity to attend in-service training, workshops and refresher courses. It would seem from the studies conducted in Zimbabwe, Zambia and Uganda that the way in which the mental health policy was implemented in Namibia is totally different from these countries in the sense that implementers in Namibia were not involved in certain necessary activities in the same way as implementers in other countries were.

The results of this study support the conceptual framework of the study, which claims that policies are likely to be affected by other policies that provide conflicting guidance on related topics. For example, while the Namibian mental health policy emphasises that psychotropic medication should be available in the primary health setting, the NEMLIST does not make any provision for some medication to be available at health centres and clinics.<sup>[1]</sup> As a result, programme implementers could choose one policy to implement in this case, while ignoring others which, in this case, are the mental health policy.<sup>[24]</sup>

This study indicated that training of general health care workers would equip them with the skills needed to manage cases of mental illness appropriately. Accordingly, the detection and management of mental health problems should be improved so that people will be more willing to access care, care will be brought closer to the communities, there will be more human resources and there will likely be fewer patients.

Currently, mental health disorders pass through the hands of PHC providers unnoticed; little is done to identify them

and nothing is done or offered in terms of management. This results in continued ill health, dysfunction and poor quality of life.

## 5. CONCLUSIONS

The study produced some key findings. There is clear evidence that the policy has not been implemented as prescribed in the policy document. Moreover, a number of challenges hindering the implementation of the policy were found. These were identified by the participants as including conflicting policies and the lack of guidelines for identifying and managing mental health disorders.

The results of the study revealed that there is a lack of supervisory support by general health service managers at all levels, from facility managers to regional health managers. In addition, there are restrictions that prohibit primary care nurses from prescribing common psychotropic medication; there is a shortage of mental health professionals to provide on-going supervision and support to primary care practitioners; and there is a lack of training among the policy implementers in the identification and management of mental disorders.

## 6. RECOMMENDATIONS

It is recommended that the study of mental health policy implementation as an integral part of PHC services in the regions be continued. As current data are minimal, further studies could perhaps increase the scope of mental health policy implementation within the regions. Studies should also be performed to determine the strategies or guidelines that may be used to facilitate the implementation of mental health policy as an integral part of PHC services.

## ACKNOWLEDGEMENTS

We would like to thank all the respondents who completed the questionnaires for this study. Without their participation this study would not have been even a success or even possible. We also thank the Ministry of Health and Social Services for having granted us permission to conduct research on its health facilities. Mr Daniel Opotamutale Ashipala was the main investigator in this study and was involved in the conceptualisation, data collection, data analysis as well as the writing of the manuscript. This research work was conducted for the fulfilment of a Master's degree in Nursing Science at the University of Namibia. Dr Wilma Wilkinson and Prof Agnes van Dyk were the supervisors in this study.

## CONFLICTS OF INTEREST DISCLOSURE

The authors declare that they have no financial or personal relationship(s) which may have inappropriately influenced them in writing this article.

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