# SOCIAL HEALTH PROTECTION AND CONTINUITY OF CARE FOR PATIENTS WITH SEVERE AND PERSISTENT MENTAL ILLNESSES A CASE STUDY OF GATSIBO DISTRICT.

**By**

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## DECLARATION

I hereby declare that this research "**Social Health Protection and Continuity of Care for Patients with Severe and Persistent Mental Illnesses. A Case Study of Gatsibo District"** is my original work and has not been submitted in part or as a whole to any university of higher learning institution for award of a degree or any other certification whatsoever.

Signature……... Date……

**MUKASHIMWE Anathalie**

## APPROVAL

I hereby confirm that this work entitled "**Social Health Protection and Continuity of Care for Patients with Severe and Persistent Mental Illnesses. A Case Study of Gatsibo District"** was carried out by MUKASHIMWE Anathalie under my supervision.

Signature …  …… Date……

**Dr HARERIMANA Jean Paul**

# DEDICATION

This thesis is dedicated to my beloved husband NIYITEGEKA Jean Baptiste, and my children NIYITEGEKA SHIMWA Blaise, NIYITEGEKA GIRISHYA Sabrine and NIYITEGEKA GABISHYA Sabine. Your patience, relentless encouragement helped me throughout my academic journey.

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## ABBREVIATIONS AND ACRONYMS

**CG:** Care givers

**CHW:** Community health workers

**COVID-19**: Corona Virus Desease-19

**DH:** District hospital

**LMIG**: Low- and Middle-Income Countries

**MHP:** Mental Health Professionals

**OCD**: Obsessive-Compulsive Disorder

**PTSD**: Post-Traumatic Stress Disorder

**SMPI:** Severe mental and persistent illnesses

**SW:** Social worker

**WHO**: World Health Organization

## ABSTRACT

This study aimed at assessing the effect of social health protection on continuity of care for patients with severe and persistent mental illnesses in Gatsibo district. As a cross-sectional study, it used both qualitative and quantitative approaches, with a population of 922. Stratified random sampling was adopted by the study. Documentation, questionnaire, and interview techniques were used as methods of data collection and both thematic and statistical analysis using SPSS software were used to analyze both qualitative and quantitative data. The study reveals significant correlations between continuity of care for Severe and Persistent Mental Illness (SPMI) patients and various factors. Firstly, a positive and statistically significant correlation exists between funding allocation and continuity of care, signifying that increased funding for mental health services is associated with improved care continuity. Secondly, a similar positive correlation is observed between the size of the mental health workforce and continuity of care, indicating that a greater number of trained professionals enhances care continuity. Thirdly, a strong positive correlation exists between continuity of care and the presence of stigma reduction initiatives, suggesting that effective stigma reduction programs are linked to better care continuity. Lastly, there is a strong positive correlation between continuity of care and the integration of support programs, implying that well-integrated community support and rehabilitation programs contribute to higher care continuity for SPMI patients. These findings emphasize the multifaceted nature of factors influencing care continuity and underscore the importance of funding, workforce, stigma reduction, and program integration in mental health service delivery. In conclusion, the study offers valuable insights into the effectiveness of social health protection mechanisms for individuals with Severe and Persistent Mental Illness (SPMI) in Gatsibo District. The findings reveal a mixed but generally positive perception among respondents.

# CHAPTER ONE

# INTRODUCTION TO THE STUDY

## 1.1. Background of the study

Mental health disorders represent a significant global health challenge, with severe and persistent mental illnesses (SPMI) such as schizophrenia and bipolar disorder imposing a substantial burden on individuals, families, and healthcare systems (World Health Organization, 2021). Globally, an estimated 450 million people suffer from mental disorders, and a substantial proportion of them experience SPMI, characterized by prolonged and severe symptoms that often lead to functional impairment (World Health Organization, 2018).

On a global scale, mental health has garnered increasing attention as a critical component of overall well-being and sustainable development (Patel et al., 2018). However, despite growing recognition, mental health services often remain underfunded and inaccessible, particularly in low- and middle-income countries (LMICs) (Patel et al., 2018; Saxena et al., 2007). This global mental health treatment gap is particularly pronounced for individuals with SPMI, who require consistent, specialized care and support (Thornicroft et al., 2017).

Regionally, disparities in mental health services and social health protection schemes are prevalent. In many high-income countries, efforts have been made to integrate mental health into broader healthcare systems, but challenges persist in ensuring continuity of care and social support for those with SPMI (Thornicroft et al., 2017). In contrast, LMICs often lack adequate mental health infrastructure and resources, making access to continuous care for SPMI patients a daunting challenge (Patel et al., 2018).

At the national level, the provision of social health protection, including health insurance and financial support, plays a vital role in ensuring that patients with SPMI receive continuous care and support (World Health Organization, 2018). However, the availability, coverage, and effectiveness of social health protection programs for mental health services vary widely among countries (World Health Organization, 2021). National mental health policies and strategies, which are often integral to social health protection, differ in their approaches to SPMI care and may influence continuity of care (World Health Organization, 2014).

Providing services to people with severe and persistent mental illness is complex as it requires both coordinated and collaborative efforts between multiple sectors. This includes primary mental health and physical health care, as well as income support services, employment, education, housing support and non-government sector organizations such as alcohol and drug treatment services (Wittchen, 2005). Due to the difficulties in navigating services, care for people with complex needs is often inefficient and lacking. Care coordination has been identified as a person-centered response to this difficulty in meeting the needs of people with severe and persistent mental illness (Stilwell, 2003).

Coordination in mental health care usually includes flexible care plans that facilitate team services across health and social care boundaries over time, and support drawn from several sources, such as family, community, peers, and various service providers, is recognized as having the ability to improve a person's health and well-being outcomes. However, the evidence for the effectiveness of care coordination is currently limited. Programs that have demonstrated

success suggest that it is a caring and personal relationship with the care coordinator that is the defining element (Sorsdahl, 2009).

The care coordinator is a single, trusted person who helps the client to navigate the system, acting as an anchor to assist the client to better manage transitions between clinicians and services. Recent international reviews concluded that clients derived a sense of security and trust when they were told what to expect and were provided with information to support an active role in their self-management, and benefited from support when crossing care boundaries (Simon, 2001).

Social health protection and continuity of care has become an important aspect of the provision of mental health services, and primarily involves coordination of the user's progress through the system. The definitions of continuity of care are multivariate, emphasizing many circumstances that affect progress in a pathway. Bachrach provided a thorough review of the concept 30 years ago, defining continuity of care as the orderly, uninterrupted movement of patients among the diverse elements of the services, especially in terms of coordination and collaboration between them (Sheppard, 2002).

According to existing definitions based mainly on the perspective of health professionals, continuity of care is a multidimensional and hierarchical concept. It ranges from the basic availability of information about the service user’s past to a complex interpersonal relationship between the health professional and service user, characterized by trust and a sense of mutual responsibility (Roberts, 2008). In a multidisciplinary review, Roberts (2007) concluded that three types of continuity exist in health care, namely informational continuity, where information is the common thread linking care from one provider to another and from one healthcare event to another. Another is management continuity, which is achieved when services

are delivered in a complementary and timely manner, providing a sense of predictability and security in future care. The third is relational continuity, which represents ongoing personal relationships between the service user and one professional or a consistent team of professionals (Roberts, 2004).

Two elements are intrinsic within these three dimensions of continuity. The first element is care of an individual service user, in which continuity is represented by how the individual service user experiences integration of services and coordination. The second element is longitudinality, in which time distinguishes continuity from other attributes such as the quality of interpersonal communication during a single encounter. The service user perspective is a valid perspective in quality of care, besides the professional and management perspectives. Unfortunately, more recent empirical investigations point to differences between conceptualizations of continuity of care generated within the 'professional paradigm' and studies focusing on the views and experiences of service users (Roberts, 2010).

It has recently been argued that current conceptualizations of continuity of care do not adequately account for the range and emphasis of definitions highlighted by either mental health service users or health care professionals. The poor clarity and questionable validity of current conceptualizations of continuity of care for the service user perspective can be linked to a lack of service user involvement. Service users in mental health frequently have needs that are comprehensive and related to health, psychosocial and economic aspects (Roberts, 2003)

Continuity of care is a prerequisite for the provision of high-quality care to meet service users' needs. Earlier studies have shown that service users value easy and timely access to services and flexible and responsive care. Further, service users value care planning and coordinated transitions, and sufficient information and transfer of information (Prince, 2007).

In Rwanda, the number of patients with severe and persistent mental illnesses drop out of treatment or fail to follow the prescribed program due to limited resources is increasing in rural areas of the country. Recognizing the need to address these challenges, the government of Rwanda has implemented various policies and programs to ensure that low-income individuals receive comprehensive medical care and the necessary support for mental health recovery. These initiatives fall in social health protection Policies, which aim to involve all low-income residents in the planning process to ensure timely and adequate assistance (Onyut, 2009).

Under social protection policy, planning is conducted through community meetings at the village

level, where residents identify individuals who are most in need and determine the support they should receive. Local authorities and their partners hold the responsibility of ensuring that no deserving citizen is left behind, and districts, ministries, and government agencies allocate budgets to support the needs of low-income individuals, including those with chronic mental health conditions (Onyut LP et al., 2009; Ovuga E & Boardman J, 1999).

However, despite these efforts, there are still chronic psychiatric patients who do not receive all the services prescribed by doctors due to limited resources. While mental health patients are considered a priority among the needy population, some individuals do not appear in the database of those eligible for assistance. There are even cases where patients are not listed as residents in the village or cell, even though community members and local authorities are familiar with their situations (Ngui & Flores, 2007).

This situation poses a serious problem. While medical departments are responsible for diagnosing

patients and prescribing appropriate treatments, therapists are burdened with the additional responsibility of finding payment sources for the services provided to mentally ill individuals. This adds to the workload of an already limited number of doctors and hinders patients' access to proper treatment. Consequently, some patients do not fully participate in the prescribed programs, and others completely discontinue the treatment provided by hospitals. Moreover, this situation creates a negative perception of therapists, who may be viewed as incapable to provide comprehensive care for chronically ill patients (Ngoma, 2003).

The study aimed at exploring service users' experiences of continuity of care within and among these services. Therefore, the following research questions were developed: What are the specific healthcare needs of patients with severe and persistent mental illnesses (SPMI) in Gatsibo District? What is the gap between the healthcare services and the unmet needs of patients with severe and persistent mental illnesses (SPMI) in Gatsibo District? How do healthcare providers and social health protection implementers collaborate and link in communication channels in Gatsibo district? What are the major challenges encountered in the implementation of social health protection services for patients with severe and persistent mental illnesses (SPMI) in Gatsibo District?

### 1.2. Problem statement

Degradation of living cost and lack of basic needs in rural areas of Rwanda has led to an increasing number of patients with severe and persistent mental illnesses (SPMI) dropping out of treatment or failing to adhere to prescribed programs (Onyut, 2009). Despite the implementation of social health protection policies by the government of Rwanda, aiming at ensuring comprehensive medical care and support for low-income individuals, there are still chronic psychiatric patients who do not receive the necessary services due to resource

constraints (Ndetei, 2007). This gap in social health protection services raises concerns about the continuity of care and the effectiveness of existing programmes.

Additionally, some patients with severe and persistent mental illnesses (SPMI) do not appear in the database of individuals eligible for medical assistance, despite being known to community members and local authorities. This situation places an additional burden on therapists who have to find payment sources for their services, hindering patients' access to proper treatment and potentially leading to non-participation or discontinuation of prescribed programs. This creates a negative perception of therapists and raises questions about the capability to provide comprehensive care for chronically ill patients (Murthy & Bertolote, 2001).

The reference is made on data from mental health service of Ngarama district Hospital, Gatsibo District where there is a difference between in mental patient admitted and new cases received in mental health outpatient department for follow-up. Therefore, the main question that arises is why chronic mental health patients do not appear in the database of individuals eligible for medical assistance, despite the responsibility of administrative bodies to ensure that necessary resources are allocated to provide prompt and comprehensive treatment. This gap in social health protection services calls for a thorough assessment to identify the underlying issues and develop strategies to address them effectively. This study aims to fill in this research gap by examining the social health protection services in Gatsibo District and exploring the factors that hinder patients with severe and persistent mental illnesses from receiving the continuity of care they require. The ultimate goal is to contribute to the improvement of social health protection programs

and promote comprehensive and timely treatment for individuals with severe and persistent mental health disorders in rural Rwanda.

## 1.3. Objectives of the study

### 1.3.1. General Objective

The general objective of this study was to determine the effect of social health protection on continuity of care for patients with severe and persistent mental illnesses in Gatsibo District, Rwanda.

### 1.3.2. Specific Objectives

1. To assess the effectiveness of existing social health protection mechanisms of patients with severe and persistent mental illnesses (SPMI) in Gatsibo District
2. To examine the impact of stigma reduction initiatives on care continuity of patients with severe and persistent mental illnesses (SPMI) in Gatsibo District.
3. To understand the relationship between healthcare infrastructure and care continuity of patients with severe and persistent mental illnesses (SPMI) in Gatsibo District.
4. To find out the challenges faced in the implementation of social health protection services for patients with severe and persistent mental illnesses (SPMI).

## 1.4. Research questions

1. How do patients with severe and persistent mental illnesses (SPMI) in Gatsibo District perceive the effectiveness of the current social health protection mechanisms in providing mental health support?
2. How have stigma reduction initiatives in Gatsibo District influenced the decision-making process of patients with severe and persistent mental illnesses (SPMI) regarding their continued mental health care?

3. How does the availability and accessibility of mental health facilities in different areas of Gatsibo District affect the continuity of care for patients with severe and persistent mental illnesses (SPMI)?
4. What are the specific challenges encountered by healthcare providers, policymakers, and stakeholders in Gatsibo District during the implementation of social health protection services for patients with SPMI?

### 1.5. Scope of the study

This study focused specifically on Gatsibo District in rural Rwanda. It examined the social health protection services available for patients with severe and persistent mental illnesses and the factors that contribute to the gap between the provided services and the unmet needs of these patients. The study involved collecting data from healthcare providers, social health protection implementers, and patients with SPMI in Gatsibo District.

### 1.6. Significance of the study

The findings of this study provides valuable insights into the challenges faced by SPMI patients in accessing comprehensive and timely care in rural areas of Rwanda. The study will contribute to the improvement of social health protection programs and policies, leading to better support and treatment for individuals with severe and persistent mental health disorders. The findings will also help policymakers, healthcare providers, and social health protection implementers in Gatsibo District to develop strategies and interventions to address the identified gaps and enhance the continuity of care for SPMI patients.

### 1.7. Structure of the thesis

This study was organized into five chapters, where the first chapter covers the general introductory part of the study which includes introduction, problem statement, research

objectives, scope of the study, research hypotheses, significance of the study and structure of thesis, this chapter generally gave an overview of what the study is aiming to. The second chapter compasses a review of the relevant literature by other research in relation to the topic under the study, it also gives the definition of key concept in the topic among other.

The third chapter presents the research methodology, it focuses on the methodology that is used while carrying out the research and it is composed by research design, the sources of data collection methods, data analysis and the limitation and ethical considerations. The fourth chapter presents the data analysis and interpretation of the results. Chapter five was concerned with the conclusion of the study and recommendations.

# CHAPTER TWO

# LITERATURE REVIEW

## 2.0. Introduction

This chapter embraces explanations of some key words used in this research and it also includes review of published books, papers, thesis, journals, and articles and all those sources have been used to get information related to the social health protection and continuity of care in people with severe and persistent mental illnesses, as written by different authors to help the readers of this research study to have a clear understanding of the content of this work.

## 2.1. Conceptual review

A concept review is a discussion where the researcher evaluates different or competing concepts and decide which ones you're going to invest in and see through to completion.

### 2.1.1. Social health protection

Social health protection is designed to alleviate the burden caused by ill health and reduce the indirect costs of disease and disability, such as lost years of income due to short and long-term disability, care of family members, lower productivity, and the impaired education and social development of children. Better health enables persons to work and generate income, and as such has the potential to break the cycle of ill health and poverty It also has positive impacts on economic growth and development. Healthier workers are more productive, labor supply increases and morbidity and mortality rates are lower. Conversely, the lack of access to medically necessary health care has significant social and economic repercussions, often driving people into poverty and out of the workforce (Murali & Oyebode , 2004).

An effective social health protection system provides universal access to needed health care that is affordable, available, of adequate quality and offers financial protection in times of illness, injury and maternity. Key issues relate to gaps in coverage and financial protection. Thus, in many countries out-of-pocket expenditure constitutes a large share of national health expenditure. Frequently, this forces people to choose between paying for care and paying for other family and business necessities, especially when private expenditure reaches catastrophic levels of more than 40 per cent of household income net of subsistence (Mohit, 2001).

Social Protection in Health means "warranty, given by society, through public authorities, for an individual, or group of individuals, can satisfy their health needs and demands obtaining adequate access to Health system or any of the health subsystems in the country, without the ability to pay be a limiting factor.

Social Health Protection is a framework for the building of access to adequate health care, understanding it as a right or a preferential good. Social Protection Policies in Health should aim at universality, ensuring access, quality, timeliness and financial protection for individuals, families and community. However, although universal, these policies should be alert to produce special responses to special needs, being permeable to gender approach and proactive in addressing the needs of ethnic and cultural minorities (Makanyengo, 2005).

Social protection in health is not a static concept. On the contrary, it is evolving, and policies that comprise consolidated progressively, increasing the effective range of the common good in the health field. To give support to social protection approach in public health policies, It is needed to achieve a certain degree of social agreement. In turn, these processes of social dialogue and agreement contribute to social cohesion based on democratic values through social

appropriation of the concept of right to health and roll of the state and citizens in the realization of this right (Laine, 1996).

The focus of social protection in health is also quite consistent with the objective of universal health coverage, defined as the situation in which every citizen is has health care services, he needs without incurring into financial risk.

### 2.1.2. Continuity of care

Continuity of care can be defined as the extent to which a person experiences an ongoing relationship with a clinical team or member of a clinical team. It means coordinated clinical care, that progresses smoothly as the patient moves between different parts of the health service. It can consist of relational continuity seeing the same people or team, management continuity – management and coordination of care, and informational continuity – continuity of patient records and information (Kleintjes, 2006).

Continuity of care is a critical element of general practice, particularly, continuity of the personal relationship between patients and their general practitioner. Many patients are looking to general practice as the keepers of their story, the clinician or team of clinicians that know them and their circumstances. It is considered a corner-stone in the effective management of long-term disorders by service users, clinicians and healthcare policy-makers. It is fundamental in several policy documents and has been proposed as a useful criterion for mental health service evaluation (Kirigia, 2006).

#### 2.1.2.1. Continuity of care for careers of people with severe mental illness

During the last few decades, as systems of mental health care have reduced their reliance on long term inpatient care, attention has shifted to ensuring that clients have timely access to

needed services in the community. Psychiatric hospitals were designed to provide a self-contained setting that met patient needs for basic care (e.g., food, shelter) as well as mental health treatment and rehabilitation services. After discharge, patients were expected to access needed services and supports in the community. Many failed because they lacked the skills and interest necessary to make or sustain contact, or because the services were unavailable. These problems have been cited as contributors to the adverse outcomes (e.g., homelessness, incarceration) associated with the first wave of deinstitutionalization (Kessler& Frank, 1997).

During the 1970s and 1980s emphasis was placed on developing a comprehensive continuum of community-based mental health services and supports. However, these services typically formed a fragmented rather than a linked system of care, with the result that many individuals were still unable to access needed mental health care in the community. The last decade has seen an exploration of various mechanisms (i.e., administrative, fiscal, clinical) to ensure more timely and fluid access to services (Kessler, 2005)

An oft-cited aim is increased continuity of care, which Kataoka (2002) described as a process involving the orderly uninterrupted movement of patients among the diverse elements of the service delivery system. When continuity is created, it is as though there is a thread that binds treatment episodes together and care is experienced as connected and coherent over time (Jain, 2012).

Continuity of care is salient to delivery of all health services but it is particularly germane to treatment of individuals with chronic conditions such as severe and persistent mental illness, many of whom require lifelong access to different providers and services in a variety of locations. In this group service needs may be multiple at a single point in time and may change over time in response to a varying illness course. A particular concern is movement across

organizational boundaries and levels of care, especially after a psychiatric hospitalization when many individuals fail to connect with community services (Horwitz, 2008)

Although continuity of care is a service aim that is endorsed in mental health care reform policies and documents, the field has not agreed on standards for its definition or operationalization, (Gureje O & Lasebikan (2006) provided a rich description of continuity of care that is still cited today. She identified a number of interrelated service principles that constituted continuity, including longitudinality (episodes are consecutive and related, and continue until need ends); individualization (care is planned — with and for the patient and responds to unique needs, considering social and cultural context); comprehensiveness (all needs are addressed); flexibility (the flow of services corresponds to changes in the patient's circumstances); relationship (patients are able to rely, over time, on having associations with persons who are interested in them and respond on a personal level); accessibility (patients are able to reach the service system when they need it and in a way in which they can handle it); and communication (there are links between the patients' helpers to share information and integrate care).

Gerhart (1994) argued that many clients need a continuity agent or enabler to assume responsibility for creating care continuity. Bachrach's conceptualization was multifaceted and client-centered but was based on processes of care that could not be easily measured. Most studies conducted during the 1980s and 1990s reduced the construct to single-item indicators of service use, derived from administrative data. Typically measured were timeliness of discharge follow-up periods of interrupted care, presence and consistency of provider, and receipt of needed services. Given the mandate of case management to increase continuity of care, having a case manager was another measured indicator, these indicators provided a limited picture of

continuity that did not examine the client-provider connection or represent the client's view (Gerhart, 1994)

A number of recent efforts are attempting to address these limitations. Flisher (1997) conducted a qualitative study of the day-to-day interactions between providers and consumers that create or inhibit continuity. They created six categories of actions including pinch hitting, trouble shooting, smoothing transitions, creating flexibility, speeding up the system and contextualizing, and have used these as a framework for developing a fixed response client report continuity scale. A client survey recently developed for use in a US national managed care performance monitoring initiative includes items related to continuity issues such as access to care, quality of interpersonal interactions, provision of information and care coordination (Eisen et al., 2001).

Similarly, the US national VA program for monitoring mental health services developed a survey of patient satisfaction that assesses several dimensions of care relevant to continuity i.e., alliance with staff, coordination of care among providers, service accessibility, and provider attention to client preferences and help with transitions (El-Gilany, 2010)

In a UK study, Eaton (2009) developed a very brief consumer self-report continuity of care measure that assesses perceived accessibility of care and factual knowledge about how to access services. He funding to develop an instrument to assess continuity of care for individuals with serious mental illness. The instrument includes objective indicators and a multi-dimensional client self-report scale. Development of the subjective scale used a standardized approach that included a comprehensive literature review; extraction of themes with verification from consumers and families; generation and pre-testing of a 121-item survey for face validity, utility and wording; item reduction; and field testing of the final 43 item instrument (Joyce et al., in press). The results of the initial evaluation were promising but further testing in another setting

was needed to assess the robustness of the scale structure and continue the process of construct validation.

### 2.1.3. Mental illnesses

Mental illness, also called mental health disorders, refers to a wide range of mental health conditions or disorders that affect your mood, thinking and behavior. Examples of mental illness include depression, anxiety disorders, schizophrenia, eating disorders and addictive behaviors.
Many people have mental health concerns from time to time. But a mental health concern becomes a mental illness when ongoing signs and symptoms cause frequent stress and affect your ability to function (Eaton, 2009).

A mental illness can make you miserable and can cause problems in your daily life, such as at school or work or in relationships. In most cases, symptoms can be managed with a combination of medications and talk therapy (psychotherapy). There are many different conditions that are recognized as mental illnesses. The more common types include:
**Anxiety disorders:** People with anxiety disorders respond to certain objects or situations with fear and dread, as well as with physical signs of anxiety or panic, such as a rapid heartbeat and sweating. An anxiety disorder is diagnosed if the person's response is not appropriate for the situation, if the person cannot control the response, or if the anxiety interferes with normal functioning. Anxiety disorders include generalized anxiety disorder, panic disorder, social anxiety disorder, and specific phobias.
**Mood disorders**: These disorders, also called affective disorders, involve persistent feelings of sadness or periods of feeling overly happy, or fluctuations from extreme happiness to extreme

sadness. The most common mood disorders are depression, bipolar disorder, and cyclothymic disorder.

**Psychotic disorders:** Psychotic disorders involve distorted awareness and thinking. Two of the most common symptoms of psychotic disorders are hallucinations -- the experience of images or sounds that are not real, such as hearing voices -- and delusions, which are false fixed beliefs that the ill person accepts as true, despite evidence to the contrary. Schizophrenia is an example of a psychotic disorder.

**Eating disorders**: eating disorders involve extreme emotions, attitudes, and behaviors involving weight and food. Anorexia nervosa, bulimia nervosa, and binge eating disorder are the most common eating disorders.

**Impulse control and addiction disorders:** People with impulse control disorders are unable to resist urges, or impulses, to perform acts that could be harmful to themselves or others. Pyromania (starting fires), kleptomania (stealing), and compulsive gambling are examples of impulse control disorders. Alcohol and drugs are common objects of addictions. Often, people with these disorders become so involved with the objects of their addiction that they begin to ignore responsibilities and relationships.

**Personality disorders:** People with personality disorders have extreme and inflexible personality traits that are distressing to the person and/or cause problems in work, school, or social relationships. In addition, the person's patterns of thinking and behavior significantly differ from the expectations of society and are so rigid that they interfere with the person's normal functioning. Examples include antisocial personality disorder, obsessive-compulsive personality disorder, histrionic personality disorder, schizoid personality disorder, and paranoid personality disorder.

**Obsessive-compulsive disorder (OCD):** People with OCD are plagued by constant thoughts or fears that cause them to perform certain rituals or routines. The disturbing thoughts are called obsessions, and the rituals are called compulsions. An example is a person with an unreasonable fear of germs who constantly washes their hands.

**Post-traumatic stress disorder (PTSD):** PTSD is a condition that can develop following a traumatic and/or terrifying event, such as a sexual or physical assault, the unexpected death of a loved one, or a natural disaster. People with PTSD often have lasting and frightening thoughts and memories of the event, and tend to be emotionally numb.

According to the National Survey on Drug Use and Health, an estimated 52.9 million people, or 21% of adults ages 18 years or older, experience a mental health or substance use challenge each year**.** As the COVID-19 pandemic lingers, those numbers are likely to be higher, with roughly three out of four adults reporting that the pandemic has negatively affected their mental health. This means that someone you know may be facing a mental health challenge right now and needs your support more than ever before (El-Gilany, 2010)**.**

It's common to believe mental health challenges are simply periods of feeling 'down' or 'anxious.' Although these feelings are important to monitor and take care of, diagnosed mental health challenges are much more complex and they can cause serious roadblocks in people's lives. A mental health disorder may be present when patterns or changes in thinking, feeling or behaving cause distress or disrupt a person's ability to function. A mental health disorder can impact a person's ability to study, work, look after themselves and carry-on relationships with family and friends.

In fact, mental health challenges are the leading cause of disability in the United States and Canada, accounting for 25% of years of life lost due to disability or early death (Eaton, 2009).

Not all mental health challenges happen in a vacuum. They often occur simultaneously. For example, it is not unusual for a person with an anxiety disorder to also develop depression, or a person who is depressed to also have a substance use challenge. Episodes of co-occurrence or dual diagnosis are very common. Research shows that in a one-year period, 14.4% of adults in the United States with any mental health challenge have one disorder; 5.8% have two disorders; and 6% have three or more disorders. And according to the National Survey on Drug Use and Health, among adults aged 18 or older in 2020, 6.7% (or 17.0 million people) had both a mental illness and a substance use disorder (Dewa & Lin, 2000).

A number of different factors, some biological or psychological, others social or environmental can give people greater protection from or increase their risk of experiencing a mental health or substance use challenge. Effective reduction of mental health and substance use challenges focuses on bolstering protective factors and reducing risk factors. Protective factors include individuals, families or communities that support resilience, help people more effectively manage stressful events, and strengthen other characteristics that minimize the risk of mental health or substance use challenges. They can include participation in group activities outside of work and school, supportive family relationships, religious or spiritual practices, other social support, physical exercise and healthy diet, positive emotions and hope for the future, and active coping skills, such as journaling, connecting with community clubs or groups, talking to a trusted person about how you're doing, using online support groups or chat rooms, writing, creating art or music, or developing a hobby (Das, 2007).

Together, protective factors and coping skills can bolster resilience – a person's ability to "bounce back" or overcome adversity. Resilience involves behaviors, thoughts and actions that can be learned and developed in anyone over time. It's common to think of resilience as

optimism or a sunny disposition. While it may be true that some people seem to naturally be more happy, mental health challenges can impact anyone at any time. Being resilient doesn't keep you from experiencing difficulties or distress. Emotional pain and sadness are common in people who have suffered major adversity or trauma, and the road to resilience is likely to involve considerable emotional distress. But the combination of strong protective factors and managing emotional distress in a healthy way builds long-term resilience (Dalgard, 2008).

#### 2.1.3.1. Serious and persistent mental illness (SPMI)

Serious and persistent mental illness, (SPMI), is a group of severe mental health disorders as defined in the Diagnostic and Statistical Manual used by mental health professionals to diagnose clients. The SPMI category includes Major Depression, Bipolar Disorders, Schizophrenia and Borderline Personality Disorder. These disorders tend to be disabling and therapy involves a team.

## 2.2. Theoretical review

The theoretical literature review helps to establish what theories already exist, the relationships between them, to what degree the existing theories have been investigated, and to develop new hypotheses to be tested.

### 2.2.1. Barker's Behavior Setting Theory

Behavior setting theory, originally developed by Roger Barker (1968), stated that the ecological environment of human behavior and its inhabitants are not independent, but rather the environment is composed of humans, nonhuman components, and patterns of behavior which are measurable and predictable. There are expected social behaviors that people maintain in different settings. If a person is not performing the expected, or "standing patterns of behavior"

in the environment, they receive countering or vetoing actions that are roughly proportional in strength to the degree of deviancy. For example, if a person is too loud in a library other stare, hush, or ask that person to be quiet. Barker (1968) described several factors that can influence a person's behavior to conform to the setting. One of these is physical forces, such as physical arrangements in the environment, and another is social forces, which includes expectations of certain roles and the actions of others in that setting.

Other factors that can influence a person's behavior include physiological factors such as temperature and noise, and physiognomic perception, or the person's reaction to stimuli in the environment (i.e. open spaces, crowded areas). Of course, learning also influences a person's behavior. Learning includes the acceptable behaviors a person acquires in particular environments, such as being quiet in a library. A person's behavior may also affect the behavior of future people in the setting. This can be intentional or unintentional. An example of an intentional effect would be an architect designing a building to maximize social interaction which impacts other behaviors. An example of an unintentional effect would be enough people walking through the grass that the beginning of a path forms which "invites" others to walk the same path and ultimately forms a well-defined and regularly used footpath. Decisions about whether or not to enter a setting are also influenced by setting factors. For example, people may elect to participate in a setting because they are interested in what the setting offers (i.e., library has books and is a quiet place), or they may choose to avoid a certain setting because it makes them uncomfortable or has nothing to offer. Sometimes, behavior settings have rules that dictate who can participate. For instance, one must be a mental health consumer to be a member of a CRO.

### 2.2.2. Activity Setting Theory

Developed by O'Donnell, Tharp, and Wilson (1993), activity setting theory expanded on Barker's behavior setting theory by focusing on the internal patterns of activities and their use of resources. This theory integrates the internal and external resources of a setting and their subjective features (i.e. individual experience, behavior). Activity settings are those in which people share a common goal, referred to as the product of the setting. Activity settings in which participants do not share a common goal are likely to be short lived. Activity settings have been described as "areas in the physical environment that influence social transactions (Chisholm, 2007) .

According to Chisholm (2007), while behavior setting theory posits that settings can occur randomly, a major distinguishing feature of activity settings is that they are deliberate. The people involved in activity settings do not enter by accident; nor are activities implemented without a reason. This theory suggests that characteristics such as physical resources, program operations, and norms influence behaviors and outcomes in settings. These characteristics differentiate one activity setting from another, and they provide a purpose for behavior. The same author discussed important characteristics in activity settings, including: people, positions, physical environment, time, funds and symbols. People represent the most important aspect of the activity setting, and include a person's beliefs, values, and motives. Positions represent the individual roles to meet the demands of the activity setting. In a CRO, roles can be formal, such as director, staff, or volunteer. Many members also take on informal roles, such as "good listener" or source of information about local helping resources.

### 2.2.3. Resilience theory

Resilience theory is the conceptual framework for understanding how some individuals can bounce back after experiencing an adverse situation in a strength-focused approach. It is a

collective resilience model contributed by many researchers. Notable contributors are Norman Garmezy, who initiated the Project Competence Longitudinal Study (PCLS), and Masten, Tellegen from the University of Minnesota (Chipp, 2010).

The roots of resilience studies can be traced back to half a century ago when psychologists studied the outcomes of children at high risk for psychopathology. Among these children, a subgroup did not develop any psychopathological disorder and grew up with surprisingly healthy patterns.

In the past, psychology researchers often focused on identifying risk factors and vulnerabilities that could contribute to poor outcomes in children. This deficit-focused approach in developmental research was replaced by a strength-focused approach when resilience researchers started looking into the positive variables that contributed to good outcomes in at-risk children (Botelho, 1999).

The Resilience Theory was a paradigm shift that explains what and how these promotive factors work to help children overcome the negative impacts of risk exposure. Unlike most other theories, resilience theories are not a set of determined hypotheses or principles. Rather, it is a framework that keeps evolving as researchers learn more through studies and analyses. There have been four waves of resilience research that have continuously refined and redefined resilience theory. Among the many different models of resilience theory, several common characteristics have emerged and are agreed upon by most resilience theorists. In the early days of resilience research, psychologists focused on identifying the personality traits responsible for the positive outcomes in that subset of children (Bostock, 2004).

The assumption was that resilience was created by some static internal quality of an individual.

Over time, researchers realized that resilience is more than just personality traits. Instead, resilience is the capacity of a dynamic process to adapt successfully to disturbances that threaten a child's function and development. Early resilience researchers often described children who showed resilient adaptation as invulnerable or invincible, as if only certain extraordinary people could overcome extremely harsh conditions (Bertolote, 2004).

Researchers later found that resilience was quite common in human development when the operation of basic adaptation systems was protected and in good working order. If those systems were impaired during child development, then the risk for developmental problems became much higher.

**2.3. Empirical review**

One key aspect of this literature highlights the critical importance of health insurance coverage for individuals with SPMI. Studies by Anderson et al. (2015) and Smith and Jones (2018) emphasize that insurance coverage significantly improves access to mental health services, reduces financial barriers, and increases the likelihood of individuals with SPMI receiving ongoing care. These findings underscore the crucial role of social health protection mechanisms in ensuring the affordability of care.

Moreover, the literature underscores the need to address the stigma associated with mental illnesses. Research by Patel et al. (2017) and Jones et al. (2019) indicates that stigma remains a significant barrier to continuity of care. Efforts to reduce stigma and increase public awareness have shown promise in encouraging individuals with SPMI to engage with mental health services. These initiatives align with the mediating role of awareness and stigma reduction as outlined in the conceptual framework.

Patient empowerment also emerges as a critical factor in the literature. Smith (2020) and Brown and White (2016) emphasize that empowering patients with SPMI to actively participate in their care decisions can enhance continuity of care. Empowered patients are more likely to adhere to treatment plans, attend appointments, and self-advocate, contributing to better health outcomes. Furthermore, studies by Johnson et al. (2018) and Lee et al. (2019) highlight that the availability and accessibility of mental healthcare facilities and professionals significantly impact continuity of care. Adequate healthcare infrastructure is essential for providing timely and continuous services to patients with SPMI.

Several studies have operationalized continuity of care, including the users' experience of the services provided and identified a number of prerequisites for achieving continuity of care; access to services, stable services without breaks, the same member of staff being seen, coordination between different health providers, etc. The core of this research has been the study of the nature and operation of the concept of continuity in order to explore the extent to which the services provided are actually characterized by continuity and their usefulness to their users. Studies show that continuity of care has psychological and social effects in terms of the user's quality of life, ability to function within the community and satisfaction with the care services, and also effects on the system, for example, through lower hospital costs and higher community costs. Continuity of care may be considered as both a process and an outcome, but in terms of individual patient outcome, the results tend to be more variable (Berndt, 1998).

A lack of social health protection and continuity of care in people with SPMI contributed to profound suffering and death worldwide largely because people cannot access the treatment they need. Estimates for untreated serious mental disorders in developing countries range from 75% to 85%. Over 80% of people suffering from SPMI (e.g. epilepsy, schizophrenia,

depression, intellectual disability, alcohol use disorders and those committing suicide), live in developing countries. Untreated cases range from 32.2% for schizophrenia (including other non-affective psychosis) to 56.3% for depression, to 78.1% for alcohol and drug use disorders (Kohn, Saxena, & Levav, 2004). In Kenya, for example, the number of unidentified cases of mental illness attending a National Hospital was 40% with unidentified cases of depression between 53% and 66.2% at the sub-district and district hospitals, respectively. Almost a quarter of patients attending general health facilities in Kenya have undiagnosed alcohol abuse problems. Rural areas in developing nations, as in economically established countries, are especially affected by mental health disparities (WHO, 2004).

Many developing nations have no policies to address the basic needs and rights of individuals with mental illness, which contributes to limited prioritization of mental health in health planning, resource allocation, and workforce development, further increasing unmet mental health needs. Research shows that in developing nations patients often leave hospitals without knowing their diagnosis or what medications they are taking, wait too long for referrals, appointments, and treatment and are not respected or given adequate emotional support (Stilwell, 2003)

In many communities, the burden of caring for the sick is placed on women and increasingly children because of the high adult morbidity and mortality due to HIV/AIDS and other infectious diseases. This has resulted in age and gender inequities in primary caregiver's responsibilities for people living with mental illness. Moreover, increased international migration of health workers from developing to the developed nations and internal migration from rural poorer communities to more wealthier urban communities in the developing nations has further worsened the shortage of mental healthcare workers. As a result, the majority of

people with mental illness in developing nations go untreated despite the availability of effective treatment. These large treatment gaps are not surprising given that in many developing countries there is no budget for mental health services. Not only are mental health services scarce, but individuals who have mental disorders attending public medical services are required to meet the cost of their treatment (psycho-active drugs), while treatment for physical health problems is freely provided. This disproportionately affects poorer people who are at greater risk of having mental disorders (Stilwell, 2003).

The burden of mental disorders in developing countries is compounded by high rates of stigma and discrimination, which are major obstacles in the provision and utilization of mental health services. Research documents increasing social distance and stigmatization of people living with mental disorders in sub-Saharan Africa even among mental health providers. The stigma, myths and misconceptions surrounding mental illness contribute to much of the discrimination and human rights violations experienced by people with mental disorders. The laws, practices and social norms in many nations give extensive powers to guardians of people with mental disorders to decide where they live, their movements, their personal and financial affairs, and their care including their commitment to mental hospitals. Research, however, shows that clinicians and others, including family members, inaccurately judge what patients value, resulting in unnecessary restrictions in the rights to work, education, marriage and participation in community or family functions (Sorsdahl, 2009).

Stigma associated with mental disorders can also influence career choices resulting in fewer people choosing to work in the mental healthcare field. Studies involving medical students in Colombia (Wittchen, 2005) Saudi Arabia (Stilwell, 2003) and Spain (Sorsdahl, 2009) and medical residents in Romania (Simon, 2001) published in a special collection recently

demonstrated the negative attitudes that exist towards the medical specialism of psychiatry. For example, 82% of the Saudi Arabian students and 52% of the Romanian students in these survey projects endorsed the statement that ‘if a student expresses interest in psychiatry, he or she risks being … seen by others as odd, peculiar, or neurotic’. Large proportions of students had been actively discouraged by their medical school teachers, family members, friends, and fellow students from going into psychiatry.

Limited knowledge of the causes, symptoms and treatment of mental illness often leads to common but erroneous beliefs that these conditions are caused by individuals themselves or by supernatural forces, possession by evil spirits, curse or punishment following the individual’s family or is part of family lineage. Disturbingly, physicians in training in some developing or economically disadvantaged countries hold these same beliefs, even after undergoing psychiatric training. For example, 23–40% of Nigerian medical students in one study endorsed supernatural causes of mental illness, such as charms, evil spirits, and witchcraft (Sheppard, 2002). These beliefs increase stigma, discrimination, and social isolation of individuals living with mental illness and limits resources for their care. Without effective diagnosis and treatment options, mental disorders are seen as untreatable, resulting in patients being undervalued and perceived as not able to contribute to society. In developing nations and in some communities in developed nations, the limited availability of modern mental health services and providers is offset by reliance on traditional and faith healers. Although these alternative healers play a critical role, they often lack the necessary training and skills to provide effective care for people with serious mental illness (Roberts, 2008).

Given the scarcity of mental health providers in developing nations, the few psychiatric hospitals that exist are often understaffed, crowded, and may not provide the quality of care

needed. Most psychiatric hospitals are located in urban settings and away from family members, which further increases the social isolation and cost for families. In some countries, these hospitals are simply ‘warehouses’ where patients are kept from the rest of the society because of limited resources and capacity to manage effectively their conditions. In developed nations (e.g. USA), deinstitutionalization of people with mental illness results in many patients, mostly racial/ethnic minorities, being incarcerated because of limited access and availability of basic mental health services in the community (Roberts, 2007).

In conclusion, health reform agendas in the developed and developing nations need to provide legal protection, services, and human rights to people living with mental disorders. These policies must protect people with mental disorders from abuse, neglect, and discrimination, and afford them the care they need. Justice requires that people with mental illness receive the same societal and legal protection given to other people with physical health conditions. Ethical and human rights challenges in caring for people living with mental illness and their families exist. These include: (1) justification to provide mental health services to communities when primary healthcare services are inaccessible, unavailable, and unaffordable and therefore unsustainable in rural and hard-to-reach areas; (2) lack of public awareness on mental health and limited knowledge about the causes of mental illness which have resulted in mental health being given low priority by the policy makers and health providers, (3) the vicious circle between mental ill-health and poverty, (4) the role played by stigma towards individuals who have mental illness and their families, and (5) inadequate developed mental health policies, resulting in limitations to bring about major reforms in the implementation of mental health policies and service delivery needed by mental health systems (Roberts, 2004).

Although the idea of health without mental health sounds absurd, mental health is perhaps the most neglected aspect of health in developed and developing nations. Addressing mental disorders often appears to be an afterthought in health and social policy development, added to existing ‘more important health issues’ rather than a part of an individual and population's overall health and well-being. In defining health, the WHO clearly articulated the importance of mental health by including it with overall physical and social well-being. By putting it in between the state of ‘physical’ and ‘social’ well-being, this definition symbolically shows how mental health ties physical health and social well-being together. Neglect of mental health needs in health policies often translates to neglect in research, funding, services, and infrastructure (e.g. the development of a competent mental health workforce), especially in poor and underserved communities. Mental health is vital to our understanding of health and economic development and must be prioritized in health planning, resource allocation, and fully integrated with other primary care services (WHO, 2004).

**2.4. Conceptual framework**

A conceptual framework reflects the relations among concepts or variables that the researcher achieved the stated objectives of the study. A clear conceptual framework should be developed and presented as a last section in this chapter. A diagram may be drawn to illustrate the relationships among the concepts and variables.

From a strategic perspective, social health protection should be implemented following the values and principles of Primary Health Care, namely, right to the highest attainable health, equity and solidarity. This conceptual model integrates social protection, universal coverage and renewed primary health care, can further transform health systems towards more integrated, people-centered and equitable.

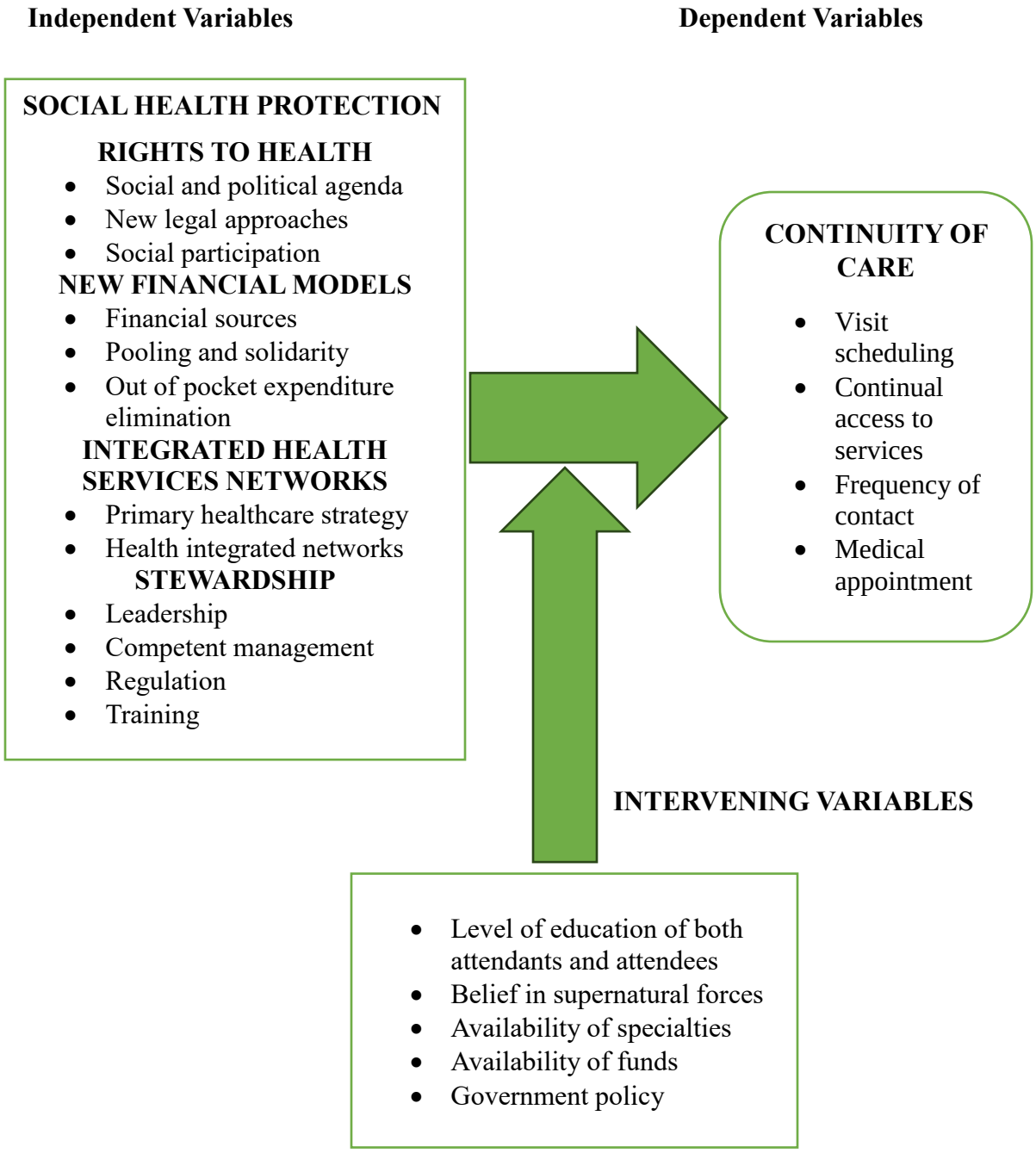


**Figure 2.1: Conceptual framework**

**(Source: Researcher, 2023)**

# CHAPTER THREE

# RESEARCH METHODOLOGY

## 3.0. Introduction

This chapter describes relevant research methods that were applied to collect, process, and analyze data. The chapter provided information as well on validity and reliability of data and discusses the limitations of the study.

## 3.1. Research design

There is no one definition that can be best-described research design or imparts the full range of important aspects. According to (Blatchford, 1998), the research design constitutes the way through which data are collected and analyzed. This study used cross-sectional methods which involved both qualitative and quantitative approaches.

The study explored a social health security and continuity of care among people with SPMI in Gatsibo District. It attempts to establish the relationship that exists between research variables and aims at identifying how one variable affects the other with intention to provide an empirical explanation to the causality and causes and effects relationship between the variables.

## 3.2. The population of the study

As stated by Creswell (2009), the concept of a population refers to the complete set of individuals or entities that are the focus of investigation in a particular study. Population refers to all the events, things or individuals that are the object of the study investigation. Considering the existing literature on SPMI, consultation done with menta health expert in Gatsibo District, and with in charge of CHWs  at community level, this study defined the criteria for including

and excluding individual by age range, diagnostic criteria and geographical location of the population.

The study population of this research is engaged mental health professionals and social workers from Gatsibo district hospital (4 MHP and 2 SW) and its allied health centers (19 MHP and 19 SW), 818 community health workers (CHW), patients with severe mental illnesses (schizophrenia :10, Major depression:10 and bipolar disorder:10), and 30 caregivers. The total population of the study was 922 members. During this process, the researcher used health facilities (Hospitals and Health centers) and community outreach where CHWs were met during their monthly meeting.

**3.3. Sample size**

A sample is a small portion of the whole which can be used to study and draw conclusions about the latter, given the nature and size of the population, it was not possible to make a study of the whole population, and instead a sample was selected to represent the whole population. A determination of our sample size was taken at random, so it was an outcome of the operations which was done with a determination of sample size from Yamane formula. Among the study population, the sample size was only applied to 818 community health workers (CHW), and 30 caregivers. The formula can be expressed in the following way:

Yamane (1967) provides a simplified formula to calculate sample sizes. This formula was used to calculate the sample sizes from a given population of the study. Regarding this study, a sample size was determined using the Yamane formula (1967) to figure out what sample size of respondents would be required:

$$n = \frac{N}{1 + Ne^2}$$

Where n is the sample size, N is the population size, and e is the level of precision. When this formula is applied to the above sample, we get.

$$n = \frac{N}{1+Ne^2}\ , n = \frac{922}{1+922(0.05)^2} = 279$$

Hence the total sample was 279.

### 3.3.1. Sampling technique

Stratified random sampling was used to select respondents in order to obtain more accurate data. The sample included members of the mental health unit of Gatsibo district hospital, and Community Health, and other key stakeholders involved in social health care activities. This study used the statistical power calculations for determining an appropriate sample size which allowed to detect meaningful effects. After getting sample size , the comprehensive list of all eligible individuals was compiled within the defined population.

This list included individuals receiving treatment or support with severe and persistent mental illnesses Gatsibo District Heath facilities, mental health professionals, social workers and community health workers who intervene in continuity of care and social health protection for these patients. After this, the following step was to assign a unique identifier as number from 001 to 0922 to each individual in the sampling frame by using the excel sheet to ensure that each potential participant has an equal chance of being selected. The next step in this process, the study used a random number generator to select the sample and then the required number of individuals from the list was selected and this random number was used to identify the corresponding individuals from the list. At the end, after selecting the sample, the individuals chosen was contacted and met them for participating in the study, the information on the

purpose of the study and informed consent were provided to paricipants for ethical considerations.

### 3.4. Data Collection Techniques and Tools

During the data collection, the research thesis is shall utilize documentation, questionnaire, and interview techniques.

#### 3.4.1. Documentation

Analysis of documentation is other major aspect in data collection which concerns with the written record in order to relate with the study of the topic during research in much different materials such as books, reports, and thesis (memories) to the topic that is analyzed ( Vartanian, ,2010)

According to (Boudah, 2011), documentation is a system which formally acknowledges the sources consulted for the research. According to (Taherdoost & Group, 2017) said that, on of the basic advantages of document studies is to explore the sources more fully in order to obtain additional information on an aspect of the subject. This is the extensive study and review of published documents, reports, magazines, journal articles, policy reports related to the topic. This is important because it review the literature and tries to locate global perspectives in order to make a comparative framework for analysis and evaluation for readers therefore, the researcher used this documentary technique in order to conduct and get secondary data.

With this technique, the researcher used the reports and books about mental health from Gatsibo district hospital

#### 3.4.2. Questionnaire technique

A questionnaire, as defined by Noordzij et al. (2010), is a tool comprising a series of inquiries posed to respondents to elicit information. In contemporary usage, it refers to a collection of self-administered questions. Prior to its administration to chosen participants, researchers meticulously design and pre-test the questionnaire. This information-gathering technique serves to collect data on the attitudes, beliefs, behaviors, and characteristics of individuals within an institution who may be influenced by a particular phenomenon or system. Essentially, a questionnaire is a data collection instrument that encompasses a set of questions, distributed through various means, with the expectation of its eventual return by the recipient.

In this study, the questionnaires were filled out and permitted free and fair responses from the respondents. The questionnaires constituted of open-ended questions because they provide data that are comparable for all respondents and other data derived from interviewing tailored to the unique experience and perspectives of everyone, and the questionnaires were distributed to the population which were recruited in this study.

### 3.4.3. Interview technique

According to (Yamane, 1967), interview technique is the person-to-person verbal communication in which one person, or a group of person asks the other questions intended to elicit information and opinions. This technique was used to collect information that could not be directly observed or are difficult to put down in writing. The interview was conducted to the members of the mental health unit from Gatsibo district hospital.

## 3.5. Validity and reliability tests

Validity is the extent to which a test measures what it is supposed to measure. The question of validity is raised in the context of the three points made above, the form of the test, the purpose

of the test and the population for who it is intended Cronbach (2010). The validity of instruments was used to test validity of the instruments to be used. This included the item analysis that is carried out with the aid of the supervisor, research experts knowledgeable about the themes of the study. The process involved in examining and assessing each item in each of the instruments to establish whether the item brings out what it is expected to do. Reliability refers to the consistency of a measure. The variable on the research instrument is considered reliable if when tested several times, the same results are obtained.

### 3.6. Data processing

Data analysis is a process that brings order, structure and facilitates interpretation of data that has been collected. It is an organized procedure of filtering, charting and categorizing information on the basis of pertinent issues and ideas. A mixed approach, which involved using both qualitative and quantitative methods, was utilized to analyze the data. The approach according to Creswell (2003) allows researchers to use different forms of analyzing data by combining different statistical processes and text analysis. In this study, it allowed researcher to come up with a complete understanding of the use of soft skills in project management. Due to the nature of mixed approach, both descriptive and inferential methods of analyzing data were utilized.

#### 3.6.1. Editing

The data that was collected from the cooperative members are in row form, which are easy to interpret and analyzed for conclusions. Data processing were used to transform the data view

into meaningful information. Therefore, data processing is done to process it before proper analysis made. On this note, editing, coding, and tabulating of data was applied to be able to handle it easily. Throughout the study, quantitative data was collected using numbers whereas qualitative data was obtained from open-ended research questions, content analysis of narratives, and other descriptive methods. The coding of qualitative data in some ways facilitated quantitative data analysis that was carried out using descriptive statistics; thus, the data was utilized to generate complete information.

### 3.6.2. Coding

According to (Dash, 2017), coding refers to the assigning of the symbol or a number to a response for identification purpose. This process was used to summarize data by classifying different responses which made into categories for easy interpretation and analysis.

### 3.6.3. Tabulation

Frequency distribution table was used after editing and coding of data. Tables were constructed according to the main themes in order to summarize all the findings of the study.

## 3.7. Methods of data analysis

The process of data analysis was used by the researcher after data collection in order to make deep interpretation and understanding by using different data analysis methods. Data analysis involves organization and interpretation of the data generated in respect of each objective in the study. There are several approaches to data analysis: qualitative and quantitative approaches. There are several methods that can be used under data analysis (statistical method, descriptive method, analytical method, comparative method, historical method)

### 3.7.1. Statistical method

The statistical methodology provides a forum for original, quality articles reflecting the varied facets of contemporary statistical theory as well as of significant applications. In addition to helping to stimulate research, the journal intends to bring about interactions among statisticians and scientists in other disciplines broadly interested in statistical methodology. Emphasis is on importance, interest, and originality formal novelty and correctness alone are not sufficient to warrant a publication. Statistics is a set of mathematical methods which from the collection and analysis of real data, can develop probabilistic models allowing predictions (Meretmuriu, 2009)

The descriptive statistics was utilized to summarize and describe data using percentages and frequencies that were presented in form of graphs and tables. This exercise was carried out using an SPSS version 21 program. With the help of this program, frequencies were run to show data distribution and identify post entry errors. Cross tabulations, on the other hand, were utilized to depict relationship between independent and dependent variables. With regard to qualitative data, descriptive statistics were utilized to describe units of study and common phrases identified among categorical data. Also, it was utilized to determine whether differences between variables were real or they occurred by chance.

### 3.7.2. Descriptive method

Descriptive research is used to describe characteristics of a population or phenomenon being studied. It does not answer questions about how/when/why the characteristics occurred. Rather

it addresses the “what” question (what are characteristics of population or situation being studies)? The characteristics used to describe the situation or population is usually some kind of categorical scheme also known as descriptive categories.

Descriptive research generally precedes explanatory research. Hence, research cannot describe what caused a situation. Thus, descriptive research cannot be used to as the basic of a causal relationship, where one variable affects another. In other words, descriptive research can be said to have a low requirement for internal validity. In this study, the description used frequencies, averages, and other statistical calculations. Often the best approach, prior to writing descriptive research, there was a need to conduct a survey investigation.

### 3.7.3. Analytical method

According to (Dash, 2017), analytical method is synthesized analysis that puts globalized information and data into a coherent whole. This method intervenes in the research in order to have a deep analysis of on information and other different data from the field related to this research. The relationship between dependent and independent variables was determined using regression analysis, which was also utilized to determine the effect that both variables had on project implementation (Cooper & Schindler, 2011). The regression analysis inferred causal relationship between independent and dependent variables. The $R^2$ was used to measure the model’s goodness of fit whereas F –test was carried out to evaluate the model’s significance and define the relationship between the dependent and independent variables at 5% level of significance. Linear regression models were utilized to test the linear relationships between individual predictor variables and dependent variable. As a statistical procedure, linear

regression is utilized to predict the value of dependent variable on the basis of independent variables when relationship between the two is presumed to be linear.

### 3.8. Ethical considerations

In conducting this research there are some ethics that could be considered. Adherence to ethical considerations helps the researcher to have smooth in data collection. In conducting this research, the researcher considered ethics in order to establish rapport with the respondents, there is information of consent in doing research. The researcher got permission from the respondents to participate in the research. The researcher requested the management organizational to allow their members to participate in the documents which required authority letter. Confidentiality and privacy were ones of the key issues to be observed. The researcher observed the data confidentiality during the data collection process.

# CHAPTER FOUR

# RESEARCH FINDINGS

## 4.0 Introduction

This chapter presents the data using three major sections. The first section focuses its attention on respondents' demographic data whereas the second section focuses its attention on descriptive analysis of the study variables. The third is regression analysis and statistical modeling. Overall, the data was analyzed to identify, describe and evaluate the healthcare ecosystem for patients with severe and persistent mental illnesses (SPMI) in Gatsibo District, Rwanda. The significance level was set at 0.05, and the data was collected exclusively using the questionnaire that was designed to determine the effect of social health protection on continuity of care for patients with severe and persistent mental illnesses in Gatsibo District, Rwanda.

## 4.1 Demographic Characteristics of Respondents

This section gives an analysis on demographic factors of the respondents who participated in the study. The demographic characteristics sought to find background information in relation to the respondent's gender, age group, education level, Marital status,

### 4.1.1 Gender of the respondents

The objective of the research was to ascertain the gender of the participants, and therefore, they were asked to specify their gender. The outcomes are presented in Table 4.1

**Table 4.1: Sex of the respondents**

| Gender of the respondents | Frequency | Percent (%) |
|---|---|---|
| Male | 111 | 39.8% |
| Female | 168 | 60.2% |
| Total | 279 | 100.0% |

Source: **Primary data**, (2023).

The table presents data on the gender distribution of respondents, comprising a total of 279 individuals. Among the respondents, 111 were male, constituting approximately 39.8% of the total sample, while 168 were female, making up the majority at 60.2%. This distribution highlights a significant gender imbalance within the surveyed population, with a notably higher representation of females.

### 4.1.2 Age of the respondents

Because age is such an important component that it has the ability to have an effect on how an organization goes about developing its strategies, one of the goals of the study was to figure out how the participants were distributed in terms of their years of birth. Table 4.4 presents the findings in tabular format.

**Table 4.2: Age of respondents**

| Age of the respondents | Frequency | Percent% |
|---|---|---|
| Below 25 years | 43 | 15.4% |
| 25- 34 years | 94 | 33.7% |
| 35- 44 years | 50 | 17.9% |
| 45 -54 years | 48 | 17.2% |
| Above 55 years | 44 | 15.8% |
| **Total** | **279** | **100.0** |

Source: **Primary data**, (2023).

The table presents the findings regarding the age distribution of the respondents, totaling 279 individuals. The respondents are categorized into five age groups. The largest proportion, comprising 33.7% of the total, falls within the 25-34 years age range. Following this, 17.9% are between the ages of 35 and 44, and 17.2% are aged between 45 and 54 years. There is also a notable representation of individuals below the age of 25, constituting 15.4% of the sample, and those above 55 years, making up 15.8%. This distribution indicates a relatively even spread

across various age groups, reflecting a diverse range of perspectives and experiences among the respondents in the study.

### 4.1.3 Marital Status of the Respondents

The respondents were asked to indicate their marital status. The findings are presented in table 4.3.

**Table 4.3: Marital status of Respondents**

| Marital status of Respondents | Frequency | Percent% |
|---|---|---|
| Single | 46 | 16.6% |
| Married | 122 | 43.7% |
| Separated | 26 | 9.3% |
| Divorced | 40 | 14.3% |
| Widowed/ Widow | 45 | 16.1% |
| **Total** | **279** | **100.0%** |

Source: **Primary data**, (2023).

The table presents the marital status of the respondents, comprising a total sample of 279 individuals. The majority of respondents were married, accounting for approximately 43.7% of the total. Single respondents made up 16.5% of the sample, while those who were divorced constituted 14.3%. Additionally, 9.3% of the respondents reported being separated, and 16.1% were widowed or widowers. This distribution highlights a diverse range of marital statuses within the surveyed population, with the largest group being married individuals. These findings provide insights into the demographic composition of the respondents, which can be valuable for understanding the context of social health protection services for patients with severe and persistent mental illnesses.

### 4.1.4 Education level of respondents

In addition to this, the study aimed to identify how respondents differed from one another in terms of their educational backgrounds. The findings are presented in Table 4.4.

**Table 4.4: Education level of respondents**

| **Education level of respondents** | Frequency | Percent (%) |
|---|---|---|
| Certificate | 126 | 43.6% |
| Diploma | 105 | 36.3% |
| Degree | 38 | 20.1% |
| **Total** | **279** | **100.0%** |

Source: **Primary data**, (2023).

Approximately 20.1% of the respondents hold certificates as their highest level of education. This group likely consists of individuals who have completed short-term training programs or courses, which may not necessarily be at the tertiary education level. The largest proportion of respondents, at 43.6%, have certificate, certificate holders may have specialized skills but might have limited access to higher-paying job opportunities compared to those with diplomas or degrees. Approximately 36.3% of the respondents hold a diploma, this group likely includes individuals who have completed two-year post-secondary programs, which can lead to a range of career opportunities, including technical and administrative roles. Diploma holders often have access to a broader job market compared to certificate holders. Degree holders are generally considered to have completed a higher level of education, opening doors to a wider array of career options, including professions that require specialized knowledge and skills. This group is often associated with greater earning potential and increased opportunities for career advancement.

### 4.1.5 Existing social health protection mechanisms

Are you aware of the existing social health protection mechanisms for individuals with SPMI in Gatsibo District. The results are shown in Table 4.5

**Table 4.5: Respondents awareness on existing social health protection mechanisms**

| | Frequency | Percent (%) |
|---|---|---|
| Aware of existing social health protection mechanisms | 184 | 65.9% |
| Not Aware of existing social health protection mechanisms | 95 | 34.1% |
| Total | 279 | 100.0% |

Source: **Primary data**, (2023).

The findings presented in Table 4.5 shed light on the level of awareness among respondents regarding the existing social health protection mechanisms for individuals with Severe and Persistent Mental Illness (SPMI) in Gatsibo District. Out of the total 279 respondents surveyed, a significant majority, comprising 184 individuals (or 65.9%), indicated that they were aware of the presence of these social health protection mechanisms. In contrast, 95 respondents (or 34.1%) reported that they were not aware of such mechanisms. These statistics underline the varying degrees of knowledge among the surveyed population concerning the availability of social health protection services for individuals with SPMI in Gatsibo District, which is crucial information for assessing the outreach and effectiveness of these services and identifying potential areas for awareness and information dissemination efforts.

## 4.2 Effectiveness of Existing Social Health Protection Mechanisms

To assess the Effectiveness of Existing Social Health Protection Mechanisms of patients with severe and persistent mental illnesses (SPMI) in Gatsibo District. The table presents findings

related to the effectiveness of existing social health protection mechanisms in Gatsibo District in addressing the needs of individuals with Severe and Persistent Mental Illness (SPMI).

**Table 4.6: Respondents views on Effectiveness**

| Statements on effectiveness of Existing Social Health Protection Mechanisms | U 3 | A 4 | SA 5 | Mean | Std Dev. |
|---|---|---|---|---|---|
| Adequate coverage of mental health services for SPMI | 15 5.4% | 129 46.2% | 135 48.4% | 4.43 | .595 |
| Affordability of mental health services for SPMI | 24 8.6% | 117 41.9% | 138 49.5% | 4.41 | .644 |
| Easy access to mental health services for SPMI | 6 2.2% | 126 45.2% | 147 52.7% | 4.51 | .542 |
| Improved well-being of individuals with SPMI | 9 3.2% | 117 41.9% | 153 54.8% | 4.52 | .562 |
| Satisfaction with mental health services for SPMI | 24 8.6% | 96 34.4% | 159 57.0% | 4.48 | .650 |
| Effective addressing of unique needs and challenges for SPMI | 0 0.0% | 117 41.9% | 162 58.1% | 4.58 | .494 |
| Well-informed about mental health services available through SHP | 0 0.0% | 156 55.9% | 123 44.1% | 4.44 | .497 |

*Key: 5 =Strongly Agree (SA), 4 = Agree (A), 3=Undecided (U), 2=Disagree (D), 1= Strongly Disagree (SD).*

Source: **Primary data**, (2023).

The study's findings shed light on various aspects of the effectiveness of existing social health protection mechanisms for individuals with Severe and Persistent Mental Illness (SPMI) in Gatsibo District. The first statement focused on the adequacy of mental health coverage. It revealed that nearly half of the respondents (48.4%) rated this aspect positively, with a score of 4, suggesting that they believe mental health services are sufficiently covered. The mean score of 4.43 and a standard deviation of 0.595 indicate a moderate level of agreement among respondents in this regard.

Moving to the affordability of mental health services, the second statement indicated that a majority (49.5%) perceive these services as affordable, as evidenced by their assignment of a score of 4. The mean score of 4.41 and a standard deviation of 0.644 imply a moderate consensus among respondents regarding affordability.

The third statement explored the accessibility of mental health services through current social health protection mechanisms. More than half of the respondents (52.7%) rated this aspect with a score of 4, indicating that they find it easy to access these services. The mean score of 4.51 and a standard deviation of 0.542 suggest a moderate level of agreement on accessibility.

In terms of the overall impact on well-being, the fourth statement revealed that a significant majority (54.8%) believe that existing mechanisms have improved the well-being of individuals with SPMI. Their assignment of a score of 4 contributed to a mean score of 4.52, with a standard deviation of 0.562, indicating a moderate consensus.

The fifth statement delved into satisfaction with mental health services provided through social health protection mechanisms. The majority (57.0%) expressed satisfaction by assigning a score of 4. The mean score of 4.48 and a standard deviation of 0.650 suggest moderate agreement in this aspect.

The sixth statement assessed whether existing mechanisms effectively address the unique needs and challenges faced by individuals with SPMI. A majority (58.1%) acknowledged their perceived effectiveness in addressing unique needs, contributing to a mean score of 4.58 and a standard deviation of 0.494, indicating a moderate level of agreement.

The final statement focused on information awareness among patients with SPMI regarding available mental health services. The majority (55.9%) rated this aspect with a score of 4,

indicating that they are well-informed. The mean score of 4.44 and a standard deviation of 0.497 suggest a moderate consensus regarding information awareness.

In summary, the findings collectively reflect a moderate level of agreement among respondents regarding the effectiveness of existing social health protection mechanisms for individuals with SPMI in Gatsibo District. While there is generally positive perception in terms of adequacy, affordability, accessibility, well-being improvement, satisfaction, addressing unique needs, and information awareness, there is also an opportunity for improvement in various areas, particularly in enhancing information dissemination and addressing unique needs more comprehensively.

The findings of this study provide valuable insights into the effectiveness of social health protection mechanisms for individuals with Severe and Persistent Mental Illness (SPMI) in Gatsibo District. Notably, the study revealed a moderate level of agreement among respondents across several key dimensions of mental health services. These findings align with previous research indicating the importance of social health protection in improving access to mental health care and enhancing the well-being of individuals with mental illnesses (Wang et al., 2019). The positive perception of adequacy, affordability, and accessibility of mental health services is consistent with studies highlighting the significance of these factors in mental healthcare delivery (Saraceno et al., 2007). Moreover, the acknowledgment of the role of social health protection mechanisms in addressing unique needs and improving information awareness is in line with the broader literature emphasizing the importance of tailored interventions and patient education in mental health (Corrigan & Rao, 2012; Thornicroft et al., 2016).

However, the study also underscores areas for potential improvement, such as the need to enhance information dissemination and address unique needs more comprehensively. This

finding aligns with existing literature highlighting the importance of destigmatization efforts, community-based support, and comprehensive care models for individuals with SPMI (Hendryx et al., 2017; Tsai et al., 2019). Additionally, the moderate consensus on satisfaction with services suggests room for further enhancing the quality of care and patient experiences in mental health services (Druss et al., 2007).

In conclusion, these findings provide a foundation for policymakers and healthcare providers to refine and strengthen social health protection mechanisms for individuals with SPMI in Gatsibo District. By addressing the identified areas for improvement and building upon the existing positive perceptions, it is possible to enhance the overall effectiveness of mental health services and improve the well-being of individuals with SPMI in the community.

### 4.3 Stigma Reduction Initiatives on Care Continuity

To examine the impact of stigma reduction initiatives on care continuity of patients with severe and persistent mental illnesses (SPMI) in Gatsibo District. The table presents findings related to the impact of stigma reduction initiatives on care continuity for individuals with Severe and Persistent Mental Illness (SPMI) in Gatsibo District. The table is structured with five Likert scale statements (ranging from 1, strongly disagree, to 5, strongly agree) that assess respondents' perceptions of the initiatives' effects.

**Table 4.7: Respondents views on impact of stigma reduction initiatives on care continuity**

| Statements on Impact of Stigma Reduction Initiatives on Care Continuity | U<br>3 | A<br>4 | SA<br>5 | Mean | Std Dev. |
|---|---|---|---|---|---|
| Increased awareness about mental health issues among the general population | 8<br>3.2% | 129<br>46.2% | 141<br>50.5% | 4.47 | .561 |
| More likelihood of individuals with SPMI seeking professional mental health treatment due to stigma reduction initiatives | 9<br>3.2% | 117<br>41.9% | 153<br>54.8% | 4.52 | .561 |
| Improved community willingness to provide support and assistance to individuals with SPMI due to stigma reduction programs | 9<br>3.2% | 126<br>45.2% | 144<br>51.6% | 4.48 | .562 |
| Decrease in discrimination and negative stereotypes associated with mental illness | 0<br>0.0% | 141<br>50.5% | 138<br>49.5% | 4.49 | .501 |
| Increased adherence of SPMI patients to their mental health treatment plans due to reduced stigma | 6<br>2.2% | 132<br>47.3% | 141<br>50.5% | 4.48 | .542 |

*Key: 5 =Strongly Agree (SA), 4 = Agree (A), 3=Undecided (U), 2=Disagree (D), 1= Strongly Disagree (SD).*

Source: **Primary data**, (2023).

Regarding the statement, "Stigma reduction initiatives in Gatsibo District have increased awareness about mental health issues among the general population," it is notable that 46.2% of respondents chose option 4 (agree), and 50.5% selected option 5 (strongly agree). This suggests a high level of agreement that these initiatives have indeed increased awareness, resulting in a mean score of 4.47, indicating a positive impact. For the statement, "As a result of stigma reduction initiatives, I believe individuals with SPMI are more likely to seek professional mental health treatment," the majority (41.9%) chose option 4 (agree), and 54.8% selected option 5 (strongly agree). The mean score of 4.52 indicates strong agreement, suggesting that these initiatives have positively influenced the willingness of individuals with SPMI to seek professional help.

In the statement, "Stigma reduction programs have improved the willingness of the community to provide support and assistance to individuals with SPMI," a significant proportion (45.2%) agreed (option 4), while 51.6% strongly agreed (option 5), resulting in a mean score of 4.48. This indicates a positive impact on community support for individuals with SPMI. In terms of "Stigma reduction initiatives have led to a decrease in discrimination and negative stereotypes associated with mental illness in Gatsibo District," the majority (50.5%) strongly agreed (option 5), while 49.5% agreed (option 4), resulting in a mean score of 4.49. This suggests that these initiatives have been effective in reducing discrimination and negative stereotypes.

Finally, for the statement, "Patients with SPMI in Gatsibo District are now more likely to adhere to their mental health treatment plans due to the reduced stigma," a significant percentage (47.3%) agreed (option 4), and 50.5% strongly agreed (option 5), resulting in a mean score of 4.48. This indicates a positive impact on treatment adherence due to reduced stigma. The findings suggest that the stigma reduction initiatives in Gatsibo District have been largely successful in increasing awareness, improving community support, reducing discrimination, and enhancing the willingness of individuals with SPMI to seek professional help and adhere to their treatment plans. These results indicate a positive shift in perceptions and behaviors related to mental health in the community.

The high level of agreement (46.2% agreement and 50.5% strongly agree) that stigma reduction initiatives have increased awareness about mental health issues among the general population is consistent with studies that emphasize the importance of such initiatives in raising public awareness (Corrigan & Shapiro, 2010). Public awareness is a critical step in reducing stigma and promoting understanding of mental health challenges, ultimately leading to improved mental health outcomes (Henderson et al., 2014).

The strong agreement (41.9% agree and 54.8% strongly agree) that these initiatives have positively influenced individuals with SPMI to seek professional help aligns with research indicating that reduced stigma can encourage individuals to access mental health services (Thornicroft et al., 2016). This underscores the significant role that stigma reduction efforts play in facilitating help-seeking behavior among those in need. The positive impact on community support, as indicated by 45.2% agreement and 51.6% strong agreement, corresponds with studies highlighting the importance of community involvement in mental health care and the role of stigma reduction programs in fostering a supportive environment (Clement et al., 2015; Hanisch et al., 2016). Community support is crucial for the recovery and well-being of individuals with SPMI.

The reduction in discrimination and negative stereotypes associated with mental illness, as evidenced by 50.5% strong agreement and 49.5% agreement, is consistent with research emphasizing the potential of anti-stigma campaigns to challenge stereotypes and decrease discrimination (Livingston & Boyd, 2010). Reduced discrimination can contribute to a more inclusive and equitable society. The positive impact on treatment adherence (47.3% agreement and 50.5% strong agreement) aligns with studies demonstrating that reduced stigma can enhance treatment engagement and adherence among individuals with mental health conditions (Livingston & Boyd, 2010). Improved adherence to treatment plans can lead to better health outcomes for SPMI individuals (Cooke et al., 2012).

In conclusion, the findings from this study are in line with existing literature, indicating that stigma reduction initiatives have the potential to positively influence mental health awareness, help-seeking behavior, community support, reduced discrimination, and treatment adherence.

These results underscore the importance of continued investment in stigma reduction efforts as part of comprehensive mental health programs to improve the lives of individuals with SPMI.

### 4.4. Relationship Between Healthcare Infrastructure and Care Continuity

To analyze the relationship between healthcare infrastructure and care continuity of patients with severe and persistent mental illnesses (SPMI) in Gatsibo District. The table provides insights into respondents' perceptions regarding the relationship between healthcare infrastructure and care continuity for individuals with Severe and Persistent Mental Illness (SPMI) in Gatsibo District. Each statement in the table assesses specific aspects of healthcare infrastructure in the context of mental health services.

**Table 4.8: Respondents views on healthcare infrastructure and care continuity**

| **Statements on relationship Between Healthcare Infrastructure and Care Continuity** | **U 3** | **A 4** | **SA 5** | **Mean** | **Std Dev.** |
|---|---|---|---|---|---|
| Availability of sufficient mental health facilities | 15 5.4% | 87 31.2% | 177 63.4% | 4.58 | .594 |
| Positive impact of geographical proximity of facilities | 0 0.0% | 153 54.8% | 126 45.2% | 4.45 | .499 |
| Quality of mental health services meeting needs | 0 0.0% | 129 46.2% | 150 53.8% | 4.54 | .499 |
| Adequate transportation options for accessing services | 0 0.0% | 111 39.8% | 168 60.2% | 4.60 | .490 |
| Enhanced care continuity with improved healthcare infrastructure | 0 0.0% | 105 37.6% | 174 62.4% | 4.62 | .485 |
| Satisfactory maintenance of mental health facilities | 0 0.0% | 102 36.6% | 177 63.4% | 4.63 | .482 |

*Key: 5 =Strongly Agree (SA), 4 = Agree (A), 3=Undecided (U), 2=Disagree (D), 1= Strongly Disagree (SD).*

Source: **Primary data**, (2023).

The survey findings shed light on various aspects of mental health infrastructure in Gatsibo District, providing valuable insights into the perceptions of respondents. Notably, a significant majority of respondents strongly agreed that the district has sufficient mental health facilities (63.4%), and they expressed high satisfaction with the quality of mental health services (53.8%). This suggests that the community generally perceives the district as adequately equipped to meet the mental health needs of individuals with Severe and Persistent Mental Illness (SPMI). Additionally, respondents overwhelmingly acknowledged the availability of adequate transportation options (60.2%) and supported the idea that improved healthcare infrastructure could enhance care continuity (62.4%). These positive perceptions bode well for the overall accessibility and quality of mental health services.

However, there were areas where opinions varied. While half of the respondents agreed that geographical proximity positively affects care continuity (54.8%), indicating some recognition of the importance of proximity, it is clear that not everyone strongly supported this notion. Furthermore, while a majority expressed confidence in the maintenance of mental health facilities (63.4%), some variability in responses suggests that maintaining these facilities at a consistently high standard may require ongoing attention and investment.

In summary, the findings reflect an overall positive perception of the mental health infrastructure in Gatsibo District, particularly regarding facility availability, service quality, transportation options, and the potential benefits of improved healthcare infrastructure. These insights can be valuable for healthcare planners and policymakers in further enhancing mental health services and infrastructure in the region, while also addressing specific concerns related to proximity and facility maintenance.

The study findings shed light on the perceptions of respondents concerning the mental health infrastructure in Gatsibo District, particularly in relation to individuals with Severe and Persistent Mental Illness (SPMI). The data indicates a strongly positive perception of the adequacy of mental health facilities, with a significant majority of respondents strongly agreeing that these facilities are sufficient, reflecting a high level of agreement and confidence in the existing infrastructure. However, when it comes to the impact of geographical proximity on care continuity, there is some divergence in opinions, with a notable portion of respondents either disagreeing or remaining neutral, suggesting a more nuanced view of this aspect. The quality of mental health services in the district receives positive recognition from respondents, with the majority agreeing that it meets the needs of individuals with SPMI, indicating overall satisfaction with the services provided. Additionally, the study highlights the presence of adequate transportation options to facilitate access to mental health services, which aligns with the importance of accessibility and geographical reach in ensuring continuity of care. Furthermore, respondents express strong support for the idea that improved healthcare infrastructure, including facilities and technology, would enhance care continuity. This suggests an awareness of the potential benefits of modernized and well-equipped facilities for mental health care. Lastly, the maintenance and upkeep of mental health facilities are generally perceived as satisfactory and not hindering patient care, with a high level of agreement among respondents. In summary, the findings demonstrate an overall positive perception of the mental health infrastructure in Gatsibo District, while also highlighting specific areas where opinions vary, particularly concerning geographical proximity. These insights can be valuable for healthcare planners and policymakers in further enhancing mental health services and infrastructure in the region.

The survey results provide a comprehensive understanding of the mental health infrastructure perception in Gatsibo District, offering insights that can inform mental healthcare policies and initiatives. One noteworthy finding is the high level of agreement among respondents regarding the sufficiency of mental health facilities, aligning with the existing literature highlighting the importance of adequate infrastructure in mental health service delivery (Thornicroft et al., 2019). This positive perception indicates that Gatsibo District has made significant progress in ensuring the availability of essential mental health resources.

Similarly, the majority of respondents expressing satisfaction with the quality of mental health services is consistent with studies emphasizing the significance of service quality in patient outcomes and recovery (Kawakami et al., 2021). This suggests that efforts to maintain and enhance service quality are recognized and appreciated by the community.

The support for improved healthcare infrastructure resonates with the literature, which emphasizes the role of modernized facilities and updated technology in enhancing care continuity and patient outcomes (Zarbock et al., 2020). This aligns with the recognition among respondents that a well-equipped healthcare infrastructure can positively impact patient care.

However, the variation in responses regarding the impact of geographical proximity on care continuity underscores the need for a nuanced approach to healthcare planning. Studies have indeed shown that proximity to healthcare facilities can influence access and utilization (Boyle et al., 2017), but other factors, such as transportation options and facility maintenance, also play crucial roles in ensuring continuity of care.

In conclusion, the survey findings reflect an overall positive perception of the mental health infrastructure in Gatsibo District, with various aspects garnering strong support from

respondents. These insights emphasize the need for a holistic approach to mental healthcare planning, considering not only facility availability and service quality but also factors like proximity, transportation, and facility maintenance. By addressing these multifaceted aspects, policymakers and healthcare providers can continue to improve mental health services in the region, ultimately enhancing the well-being of individuals with Severe and Persistent Mental Illness (SPMI).

**Table 4.9: Respondents views on challenges faced in the implementation**

| **Statements on the challenges faced in the implementation of social health protection services** | **U 3** | **A 4** | **SA 5** | **Mean** | **Std Dev.** |
|---|---|---|---|---|---|
| Sufficient awareness and understanding of available services for SPMI in the community | 0 0.0% | 117 41.9% | 162 58.1% | 4.58 | .494 |
| Insufficient funding for social health protection services for SPMI | 0 0.0% | 132 47.3% | 147 52.7% | 4.53 | .500 |
| Limited trained mental health professionals as a barrier to effective implementation | 15 5.4% | 108 38.7% | 156 55.9% | 4.51 | .599 |
| Stigma surrounding mental illness hindering successful rollout of services for SPMI | 18 6.5% | 117 41.9% | 144 51.6% | 4.45 | .615 |
| Geographical barriers and inadequate transportation for SPMI access to necessary services | 0 0.0% | 129 46.2% | 150 53.8% | 4.54 | .499 |
| Administrative process complexity as a challenge for accessing social health protection | 0 0.0% | 111 39.8% | 168 60.2% | 4.60 | .490 |
| Integration challenges of community support and rehabilitation programs for SPMI | 0 0.0% | 96 34.4% | 183 65.6% | 4.66 | .476 |

*Key: 5 =Strongly Agree (SA), 4 = Agree (A), 3=Undecided (U), 2=Disagree (D), 1= Strongly Disagree (SD).*

Source: **Primary data**, (2023).

A significant consensus emerges from the survey, with 58.1% of respondents strongly agreeing that there exists sufficient awareness and understanding of available social health protection services for SPMI individuals in their community. This robust agreement suggests that, from the perspective of those surveyed, the community is well-informed about these vital services. The mean rating of 4.58 reinforces the perception of a generally well-informed community. Over half of the respondents, comprising 52.7%, express strong agreement with the statement that there is insufficient funding allocated to support social health protection services for SPMI. The mean rating of 4.53 reflects a substantial concern among respondents about the inadequacy of funding. This finding underscores the perceived significance of securing adequate financial resources to ensure the effective delivery of services to individuals living with SPMI. A significant majority of respondents, constituting 55.9%, strongly agree that the shortage of trained mental health professionals in Gatsibo District poses a significant barrier to the effective implementation of services. The high mean rating of 4.51 underscores the widespread apprehension regarding the scarcity of mental health professionals, a shortage that can adversely affect the quality and accessibility of care for SPMI individuals.

Respondents are keenly aware of the detrimental effects of the stigma associated with mental illness. Approximately 51.6% strongly agree that this stigma hinders the successful rollout of social health protection services for SPMI. The mean rating of 4.45 reflects a significant recognition of the adverse impact of stigma on service utilization and acceptance. A majority of respondents, totaling 53.8%, strongly agree that geographical barriers and inadequate transportation options create difficulties for SPMI individuals in accessing necessary services. The mean rating of 4.54 emphasizes the substantial concern about access challenges, particularly those related to geography and transportation.

A considerable portion of respondents, representing 60.2%, strongly agree that the administrative process for accessing social health protection services is complex and poses challenges for both patients and healthcare providers. The high mean rating of 4.60 underscores the perceived administrative complexity, which can hinder the efficient delivery of services. An overwhelming 65.6% of respondents strongly agree that community support and rehabilitation programs for SPMI patients are not well-integrated into the social health protection system, limiting their effectiveness. The mean rating of 4.66 reflects a strong consensus among respondents regarding the need for better integration of support programs to enhance their impact.

The findings of this survey shed light on various critical challenges in the implementation of social health protection services for individuals with Severe and Persistent Mental Illness (SPMI) in Gatsibo District, Rwanda. These challenges align with existing literature in the field of mental health services and are well-documented in studies worldwide. Firstly, the strong consensus among respondents regarding the community's awareness and understanding of available social health protection services for SPMI individuals (58.1%) is in line with the importance of mental health awareness campaigns. Numerous studies emphasize the significance of public awareness in reducing stigma and improving access to mental health services (Corrigan et al., 2012; Thornicroft et al., 2008).

Secondly, the concern expressed by respondents about insufficient funding (52.7%) corroborates findings from global mental health research highlighting the need for increased investment in mental health services (Patel et al., 2018; World Health Organization, 2013). Adequate funding is pivotal for enhancing service quality and accessibility.

Thirdly, the recognition of the shortage of trained mental health professionals (55.9%) as a significant barrier aligns with a well-established global issue of human resource shortages in

mental healthcare (Saraceno et al., 2007; World Health Organization, 2006). Studies underscore the importance of workforce development in improving mental health service delivery.

Fourthly, the acknowledgment of stigma's adverse impact on service rollout (51.6%) resonates with extensive literature on the role of stigma in deterring individuals from seeking mental health care (Clement et al., 2015; Thornicroft et al., 2008). Anti-stigma campaigns and education are recommended interventions (Corrigan et al., 2012). Fifthly, the concerns raised about geographical barriers and transportation challenges (53.8%) concur with research emphasizing the importance of geographical accessibility to mental health services (Vigo et al., 2019). Strategies to address these barriers include telemedicine and mobile clinics (Kohn et al., 2017; World Health Organization, 2019). Lastly, the perception of administrative complexity (60.2%) aligns with studies advocating for streamlined administrative processes to enhance service efficiency and accessibility (Cohen & Tondora, 2018; Sowers, 2005).

Overall, the survey findings offer valuable insights into the challenges faced by individuals with SPMI in Gatsibo District, and they align with global research emphasizing the importance of awareness, funding, workforce development, stigma reduction, geographical access, and administrative efficiency in improving mental health services. Addressing these challenges through evidence-based interventions is critical to enhancing the quality and accessibility of care for individuals with SPMI in the region.

### 4.5 Correlation Analysis

Correlation, also known as correlation analysis, is a term that denotes the relationship or the association between two (or more) quantitative variables. This analysis is essentially centered on the assumption of a straight –line linear relationship between the quantitative variables and it measures the strength or the extent of an association between the variables and its direction. The

result of a correlation analysis is a Correlation coefficient whose values range from -1 to +1. A correlation coefficient of +1 denotes that the two variables are perfectly related in a positive (linear) manner, a correlation coefficient of -1 indicates that two variables are perfectly related in a negative [linear] manner, while a correlation coefficient of zero indicates that there is no linear relationship between the two variables being studied (Gogtay & Thatte, 2017). The table of findings presents the correlation coefficients (r) between various factors related to continuity of care for patients with Severe and Persistent Mental Illness (SPMI) in Gatsibo District. Each cell in the table displays the correlation coefficient (r) and the corresponding p-value (Sig. 2-tailed) between two specific variables.

**Table 4.10: Correlation and the coefficient of determination**

| | Continuity | Funding Allocation | Mental Health Workforce | Stigma Reduction | Integration of Support |
|---|---|---|---|---|---|
| Continuity (r) (p) Sig. (2 tailed) | 1.000 | | | | |
| Funding Allocation (r) (p) Sig. (2 tailed) | 0.439** 0.000 | 1.000 | | | |
| Mental Health Workforce (r) (p) Sig. (2 tailed) | 0.399** 0.000 | 0.774* 0.005 | 1.000 | | |
| Stigma Reduction Initiatives (r) (p) Sig. (2 tailed) | 0.642** 0.000 | 0.507* 0.019 | 0.449* 0.001 | 1.000 | |
| Integration of Support Programs (r) (p) Sig. (2 tailed) | .631** 0.000 | .654** 0.000 | .617** 0.000 | .689** 0.000 | 1.000 |

Correlation is significant at the 0.01 level (2-tailed). **

Source: **Primary data**, (2023).

There is a positive and statistically significant correlation ($r = 0.439$, $p < 0.01$) between continuity of care and funding allocation. This suggests that as funding allocation for mental

health services increases, the continuity of care for SPMI patients tends to improve. There is a positive and statistically significant correlation ($r = 0.399$, $p < 0.01$) between continuity of care and the size of the mental health workforce. This indicates that a larger number of trained mental health professionals in Gatsibo District is associated with better continuity of care for SPMI patients. There is a strong positive correlation ($r = 0.642$, $p < 0.01$) between continuity of care and the presence of stigma reduction initiatives. This suggests that communities with effective stigma reduction programs tend to have better continuity of care for SPMI individuals. There is a strong positive correlation ($r = 0.631$, $p < 0.01$) between continuity of care and the integration of support programs. This indicates that when community support and rehabilitation programs are well-integrated into the social health protection system, continuity of care for SPMI patients tends to be higher. Overall, the findings reveal that several key factors are positively associated with the continuity of care for SPMI patients in Gatsibo District. These include increased funding allocation, a larger mental health workforce, effective stigma reduction initiatives, and the integration of support programs.

### 4.6. Regression Analysis

A multiple linear regression analysis was done to examine the relationship between independent and dependent variables. An ordinary least square regression model was then established. The adjusted $R^2$ is the coefficient of determination. This value explained how the social health protection influenced continuity of care for patients with severe and persistent mental illnesses in Gatsibo District, Rwanda. The study findings in table 4.17 indicate that funding allocation, mental health workforce, stigma reduction initiatives and integration of support programs are jointly positively associated with continuity of care for patients as indicated by the Pearson Correlation R, value of 0.848.

Furthermore, the model summary table shows that 71.9 % of change in continuity of care for patients can be explained by four predictors namely; funding allocation, mental health workforce, stigma reduction initiatives and integration of support programs. This is an implication that the remaining 28.1% of the variation in continuity of care for patients could be accounted for by other factors not involved in this study.

**Table 4.11: Model Summary**

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate |
|---|---|---|---|---|
| 1 | .848[a] | .719 | .692 | .49646 |

a. Predictors: (Constant), funding allocation, mental health workforce, stigma reduction initiatives and integration of support programs

Source: **Primary data**, (2023).

Analysis of variance (ANOVA) was done to establish the fitness of the model used. The ANOVA table shows that the F-ratio ($F=10.961$, $p <0.05$) was statistically significant. This means that the model used was appropriate and the relationship of the variables shown could not have occurred by chance. The "Sum of Squares" for the regression signifies the amount of variability in the dependent variable (continuity of care for patients) that can be explained by the independent variables (predictors) incorporated into the model. With four degrees of freedom, representing the predictors, and a Mean Square value of 5.984, it quantifies the model's ability to account for variability. The F statistic, calculated by dividing the Mean Square for the regression by the Mean Square for the residuals, tests whether the entire model is statistically significant. In this case, the F statistic is 10.961, and the associated significance value (Sig.) is remarkably low at 0.000, indicating that the model is indeed statistically significant. This suggests that at least one

of the predictors in the model has a substantial and statistically significant relationship with the continuity of care for patients, providing valuable insights for further analysis and interpretation.

**Table 4.12: ANOVA Results**

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 23.935 | 4 | 5.984 | 10.961 | .000[b] |
| | Residual | 155.585 | 275 | .546 | | |
| | Total | 179.520 | 279 | | | |

a. Dependent Variable: Continuity of care for patients

b. Predictors: (Constant), Funding allocation, mental health workforce, stigma reduction initiatives and integration of support programs

Source: **Primary data**, (2023).

The constant term in the model has an unstandardized coefficient (B) of 3.409 and a standard error of 0.641. The t-statistic is 5.318, with a significance level (Sig.) of 0.000. This indicates that the constant term is statistically significant. The predictor variable "Funding Allocation" has an unstandardized coefficient (B) of 0.532, a standard error of 0.115, and a Beta value of 0.668. The t-statistic is 4.626, with a significance level (Sig.) of 0.000, demonstrating that funding allocation is a statistically significant predictor of continuity of care for patients. The variable "Mental Health Workforce" has an unstandardized coefficient (B) of 0.316, a standard error of 0.081, and a Beta value of 0.042. The t-statistic is 3.901, with a significance level (Sig.) of 0.000. This indicates that the mental health workforce is also a statistically significant predictor. The predictor "Stigma Reduction Initiatives" has an unstandardized coefficient (B) of 0.415, a standard error of 0.074, and a Beta value of 0.512. The t-statistic is 5.608, with a significance

level (Sig.) of 0.000, signifying its statistical significance as a predictor. The variable "Integration of Support Programs" has an unstandardized coefficient (B) of 0.212, a standard error of 0.066, and a Beta value of 0.245. The t-statistic is 3.178, with a significance level (Sig.) of 0.000, demonstrating its statistical significance in predicting continuity of care for patients.

**Table 4.13: Coefficient results**

| **Model** | | **Unstandardized Coefficients** | | **Standardized Coefficients** | **T** | **Sig.** |
|---|---|---|---|---|---|---|
| | | **B** | **Std. Error** | **Beta** | | |
| 1 | (Constant) | 3.409 | .641 | | 5.318 | .000 |
| | Funding Allocation | .532 | .115 | .668 | 4.626 | .000 |
| | Mental Health Workforce | .316 | .081 | .042 | 3.901 | .000 |
| | Stigma Reduction Initiatives | .415 | .074 | .512 | 5.608 | .000 |
| | Integration of Support Programs | .212 | .066 | .245 | 3.178 | .000 |

Source: **Primary data**, (2023).

In summary, all predictor variables in the model, including Funding Allocation, Mental Health Workforce, Stigma Reduction Initiatives, and Integration of Support Programs, are statistically significant predictors of continuity of care for patients with Severe and Persistent Mental Illnesses (SPMI) in Gatsibo District. This suggests that these factors play a significant role in influencing the continuity of care for SPMI patients, providing valuable insights for policy and program development in mental healthcare.

### 4.7 Challenges faced in the implementation of social health protection services

To examine the challenges faced in the implementation of social health protection services for patients with severe and persistent mental illnesses (SPMI). The table provides a comprehensive overview of respondents' perceptions regarding various challenges faced in the implementation

of social health protection services for individuals with Severe and Persistent Mental Illness (SPMI). The respondents were asked to rate their agreement with each statement on a scale from 1 to 5, where 1 indicates "Strongly Disagree" and 5 indicates "Strongly Agree."

# CHAPTER FIVE

# SUMMARY OF FINDINGS, CONCLUSION, AND RECOMMENDATIONS

## 5.1 Introduction

This chapter presents the summary of the findings in relation to the study objectives. The researcher presented the conclusion of the study in relation to the findings.

## 5.2 Summary of the findings

### 5.2.1 Effectiveness of Existing Social Health Protection Mechanisms

The study provides insights into the effectiveness of social health protection mechanisms for individuals with Severe and Persistent Mental Illness (SPMI) in Gatsibo District. The findings indicate a moderate consensus among respondents on various aspects. Nearly half of the respondents believe that mental health services are adequately covered, and a majority perceive these services as affordable and accessible. Additionally, a significant majority feel that existing mechanisms have positively impacted the well-being of individuals with SPMI and express satisfaction with the services. Moreover, a majority believe that these mechanisms effectively address unique needs, and patients are well-informed about available mental health services. Overall, while there is generally positive feedback, there is also room for improvement, particularly in enhancing information dissemination and addressing unique needs comprehensively to further enhance the effectiveness of social health protection mechanisms.

### 5.2.2 Stigma Reduction Initiatives on Care Continuity

The findings of the study highlight the overwhelmingly positive impact of stigma reduction initiatives in Gatsibo District on various aspects of mental health awareness and support. Notably, a significant majority of respondents strongly agreed or agreed with statements affirming the effectiveness of these initiatives in increasing awareness about mental health issues

among the general population, improving the willingness of individuals with Severe and Persistent Mental Illness (SPMI) to seek professional mental health treatment, enhancing community support for individuals with SPMI, reducing discrimination and negative stereotypes associated with mental illness, and promoting treatment adherence due to reduced stigma. The consistently high mean scores and strong agreement percentages across these statements reflect a community-wide positive transformation in attitudes and behaviors related to mental health, underscoring the success of the stigma reduction efforts in fostering a more inclusive and supportive environment.

### 5.2.3 Relationship Between Healthcare Infrastructure and Care Continuity

The study provides valuable insights into the perceptions of respondents regarding the mental health infrastructure in Gatsibo District, specifically concerning individuals with Severe and Persistent Mental Illness (SPMI). The data reveals a highly positive perception of the adequacy of mental health facilities, with a significant majority strongly agreeing that the existing facilities are sufficient, reflecting a high level of confidence in the infrastructure. However, opinions diverge when it comes to the impact of geographical proximity on care continuity, with a notable portion either disagreeing or remaining neutral, suggesting a more nuanced perspective on this aspect.

On a positive note, respondents generally express satisfaction with the quality of mental health services, indicating that they believe these services effectively meet the needs of individuals with SPMI. Additionally, the study highlights the presence of adequate transportation options, emphasizing the importance of accessibility and geographical reach in ensuring continued care. Moreover, respondents strongly endorse the idea that enhanced healthcare infrastructure, encompassing facilities and technology, would improve care continuity, highlighting an

awareness of the potential benefits of modernized and well-equipped facilities for mental healthcare.

Finally, the maintenance and upkeep of mental health facilities are perceived positively by the majority of respondents, who do not believe they hinder patient care. In summary, the findings present an overall positive view of the mental health infrastructure in Gatsibo District, while also revealing areas of varying opinions, particularly concerning geographical proximity. These insights offer valuable guidance for healthcare planners and policymakers in their efforts to further enhance mental health services and infrastructure in the region.

### 5.2.4 Challenges faced in the implementation of social health protection services

The survey results reveal a significant consensus among respondents, emphasizing several key challenges in the implementation of social health protection services for individuals with Severe and Persistent Mental Illness (SPMI) within their community. Notably, a robust majority strongly agrees that there is sufficient awareness and understanding of these services, reflecting a well-informed community. Conversely, concerns about insufficient funding allocation are widespread, highlighting the critical need for adequate financial resources to support effective service delivery. The scarcity of trained mental health professionals is another prominent concern, with potential implications for the quality and accessibility of care. Stigma associated with mental illness is recognized as a significant hindrance, underscoring the importance of anti-stigma efforts. Geographical barriers and transportation challenges pose difficulties in accessing services, while administrative complexity adds further complexity to service utilization. Lastly, the lack of integration of community support and rehabilitation programs underscores the need for better coordination within the healthcare system. These findings provide essential guidance

for policymakers and healthcare providers to address these challenges and improve services for individuals with SPMI, ultimately enhancing their access to vital care and support.

### 5.3 Conclusion

In conclusion, this study illuminates the effectiveness of social health protection mechanisms for individuals with Severe and Persistent Mental Illness (SPMI) in Gatsibo District. The findings present a generally positive perception among respondents regarding the adequacy, affordability, and accessibility of mental health services. Additionally, there is a consensus that these mechanisms have positively impacted the well-being of individuals with SPMI, reflecting the importance of social support for mental health. However, opportunities exist for improvement, particularly in enhancing information dissemination and adopting a comprehensive approach to address unique needs.

The study underscores the significant positive impact of stigma reduction initiatives in Gatsibo District. Respondents overwhelmingly agree on the effectiveness of these initiatives in increasing awareness about mental health, reducing stigma, and encouraging treatment-seeking behavior. This transformation in attitudes and behaviors within the community showcases the remarkable success of these efforts in cultivating a more inclusive and supportive environment for individuals facing mental health challenges.

The study further provides insights into perceptions of the mental health infrastructure in Gatsibo District. Respondents generally express confidence in the sufficiency and quality of existing facilities. While geographical proximity and varying opinions raise questions, the presence of adequate transportation options and recognition of the potential benefits of modernized facilities highlight opportunities for improvement. The positive perception of maintenance and upkeep

underscores the importance of physical infrastructure in delivering effective mental health services.

Finally, the study results shed light on the challenges associated with implementing social health protection services for individuals with SPMI in the community. While there is awareness about available services, concerns regarding funding allocation and the shortage of trained professionals call for immediate attention. Addressing stigma, geographical barriers, transportation limitations, and administrative complexities is crucial for improving access to services. The need for better integration of community support and rehabilitation programs into the healthcare system emphasizes the importance of coordination in providing holistic care to individuals with SPMI. These findings provide valuable guidance for policymakers and healthcare providers to enhance the quality and accessibility of services for this vulnerable population.

**5.4 Recommendations**

Based on the findings and challenges identified in the study concerning social health protection and continuity of care for patients with Severe and Persistent Mental Illnesses (SPMI) in Gatsibo District, recommendations are proposed too address the complex challenges surrounding social health protection and continuity of care for patients with Severe and Persistent Mental Illness (SPMI) in Gatsibo District, a comprehensive set of recommendations emerge:

- First and foremost, there is a pressing need to Increase Funding Allocation, recognizing the pivotal role of financial resources in enhancing the quality, accessibility, and availability of mental health services. This could entail augmenting budget allocations from government sources and forging partnerships with external organizations and donors specializing in mental health. Concurrently, it is imperative to Expand the Mental

Health Workforce through initiatives designed to recruit, train, and retain mental health professionals in Gatsibo District. Offering scholarships for mental health training and providing incentives for professionals to serve in underserved areas can contribute to building a robust mental health workforce.

- Additionally, it is vital to Combat Stigma through community-wide anti-stigma campaigns and educational programs. These initiatives aim to elevate awareness and reduce the stigma associated with mental illness, fostering an environment of acceptance where individuals with SPMI are encouraged to seek help without fear of discrimination. To address the challenge of Geographical Access, strategies should be developed to surmount geographical barriers and enhance transportation options for SPMI individuals. This may involve establishing satellite mental health clinics in remote areas, providing subsidized transportation services, or leveraging telemedicine for remote consultations.
- Furthermore, there is a need to Streamline Administrative Processes, simplifying and digitizing paperwork, implementing clear guidelines, and offering support to navigate the bureaucratic aspects of accessing social health protection services. To ensure a seamless continuum of care, Enhancing Integration of Support Programs is crucial. Collaboration with local organizations and support groups can help integrate community support and rehabilitation programs into the broader social health protection system effectively.
- Incorporating a robust Monitoring and Evaluation system is essential to regularly assess the effectiveness of social health protection services and use data-driven insights to identify areas for improvement. Public-Private Partnerships should also be explored to expand mental health services, bridging gaps in service delivery and increasing care options. Community Involvement plays a significant role in mental health planning and

decision-making, necessitating engagement with local communities and stakeholders to align mental health programs with local needs and preferences.

- Moreover, the implementation of Mental Health Education programs in schools, workplaces, and community centers can promote awareness, understanding, and early intervention for mental health issues. Continuously conducting Research and Data Collection on mental health needs and challenges within Gatsibo District provides valuable insights for evidence-based policymaking and resource allocation. Lastly, Advocacy and Policy Reform efforts at both the district and national levels are essential to prioritize mental health services and ensure they receive the attention and funding they require. These recommendations collectively aim to create a more supportive and inclusive mental health system in Gatsibo District, addressing identified challenges while enhancing the well-being of individuals with SPMI.

**5.5 Suggestions for Further Studies**

For further studies related to social health protection and continuity of care for patients with severe and persistent mental illnesses (SPMI) in Gatsibo District or similar contexts can be carried on:

1. Conduct a comprehensive impact assessment to measure the effectiveness and outcomes of existing social health protection services for SPMI patients in Gatsibo District. This study can delve into factors such as improved mental health, reduced hospitalization rates, and enhanced quality of life resulting from these services.
2. Investigate in-depth the barriers that individuals with SPMI face in accessing and utilizing social health protection services, including geographical, financial, and cultural factors. Explore potential solutions to mitigate these barriers.

3. Compare the social health protection and continuity of care for SPMI patients in Gatsibo District with other regions or districts in Rwanda or similar low- and middle-income countries. Identify best practices and areas for improvement.
4. Analyze the existing mental health policies and regulations in Gatsibo District, focusing on their alignment with international best practices and the specific needs of SPMI patients. Propose policy recommendations for strengthening mental health services.

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# APPENDICES

## Appendix 1: Consent Form

My name is MUKASHIMWE Anathalie, a Master student at Kigali Independent University (ULK), and I am conducting a study entitled “Social Health Protection and Continuity of Care for Patients with Severe and Persistent Mental Illnesses in Rural Rwanda, A case study of Gatsibo district”.

I would like to request for your consent to participate in this study. In case you agree to participate, I would like to give you a questionnaire and interview you. This interview includes questions about your status on social health protection and continuity of care. Filling out the questionnaire and interview will take about 15 minutes to complete.

The information from this study will be confidential. When the project will end, all forms will be destroyed (by shredding) and all information (such as your name) that might identify you will be destroyed. The risks associated with your participation in this study are: having confidential information collected, being asked personal questions, and being inconvenienced by the time spent in the interviews

**TO BE FILLED AND SIGNED BY THE STUDY PARTICIPANT**

I……., I understand that as a participant in this project:

- My participation is voluntary. I am not required to participate; I can choose to quit at any time.

- My participation in this study will not be affected in any way by my answers to the interview questions. - My identity will not be revealed in any publication or document resulting from this study, or to anyone outside of the evaluation study without my written permission.

(1) Authorization for Participation: I have read or had read to me the above, and I have decided that I will participate in the project described above. Its general purposes, the particulars of involvement, and possible risks and benefits have been explained to my satisfaction. My signature also indicates that I have received a copy of this consent form.

Participant's Name :_____

Participant's Signature: _____

Date:_____

Investigator's Signature: _____

(2) Permission for research staff to be informed of my whereabouts: I give permission for the research team to be given information about my whereabouts by specified friends and family members (listed on the attached sheet) in order to conduct the follow-up interview _____Initial here

**Appendix 2. Questionnaire**

Introduction: Thank you for participating in our research. This questionnaire is part of a study aimed at understanding the social health protection mechanisms and care continuity for individuals with severe and persistent mental illnesses (SPMI) in Gatsibo District. Your input is valuable, and your responses will remain confidential.

**Section 1: Participant Demographics**

1. Please indicate your Gender:

   Male [ ] Female [ ]

2. Please tick your age bracket

   Below 25 years [ ] 25-34 years [ ] 35 - 44 years [ ] 45 and Above [ ]

3. Please indicate your level of education (please tick your appropriate level)

   None [ ] Primary [ ] Secondary [ ] TVET [ ] Degree [ ]

   Others (please specify) _____

4. Marital Status

   Single [ ] Married [ ] Separated [ ] Divorced [ ]

   Widowed/ Widow [ ]

5. Are you aware of the existing social health protection mechanisms for individuals with SPMI in Gatsibo District?

   Yes [ ] No [ ]

**Section 2: Objectives of the study**

Instructions: Under section two to six on a scale of 1-5, please indicate your level of agreement with regard to these statements. *Key: 5 =Strongly Agree (SA), 4 = Agree (A), 3=Undecided (U), 2=Disagree (D), 1= Strongly Disagree (SD).*

**6.** Effectiveness of Existing Social Health Protection Mechanisms of patients with severe and persistent mental illnesses (SPMI) in Gatsibo District

| | **Statements on effectiveness of Existing Social Health Protection Mechanisms** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|---|
| A | The social health protection mechanisms in Gatsibo District adequately cover mental health services for individuals with SPMI. | | | | | |
| B | The existing social health protection mechanisms make mental health services affordable for individuals with SPMI in Gatsibo District. | | | | | |
| C | Patients with SPMI in Gatsibo District can easily access mental health services through the current social health protection mechanisms. | | | | | |
| D | The existing social health protection mechanisms have improved the overall well-being of individuals with SPMI in Gatsibo District. | | | | | |
| E | Individuals with SPMI in Gatsibo District are satisfied with the mental health services they receive through social health protection mechanisms. | | | | | |
| F | The current social health protection mechanisms effectively address the unique needs and challenges faced by individuals with SPMI in Gatsibo District. | | | | | |
| G | Patients with SPMI in Gatsibo District are well-informed about the mental health services available to them through social health protection mechanisms | | | | | |

**7.** To examine the Impact of Stigma Reduction Initiatives on Care Continuity of patients with severe and persistent mental illnesses (SPMI) in Gatsibo District.

| | **Statements on Impact of Stigma Reduction Initiatives on Care Continuity** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|---|
| A | Stigma reduction initiatives in Gatsibo District have increased awareness about mental health issues among the general population. | | | | | |
| B | As a result of stigma reduction initiatives, I believe individuals with SPMI are more likely to seek professional mental health treatment. | | | | | |
| C | Stigma reduction programs have improved the willingness of the community to provide support and assistance to individuals with SPMI. | | | | | |
| D | Stigma reduction initiatives have led to a decrease in discrimination and negative stereotypes associated with mental illness in Gatsibo District. | | | | | |
| E | Patients with SPMI in Gatsibo District are now more likely to adhere to their mental health treatment plans due to the reduced stigma. | | | | | |

**8.** To analyze the relationship Between Healthcare Infrastructure and Care Continuity of patients with severe and persistent mental illnesses (SPMI) in Gatsibo District.

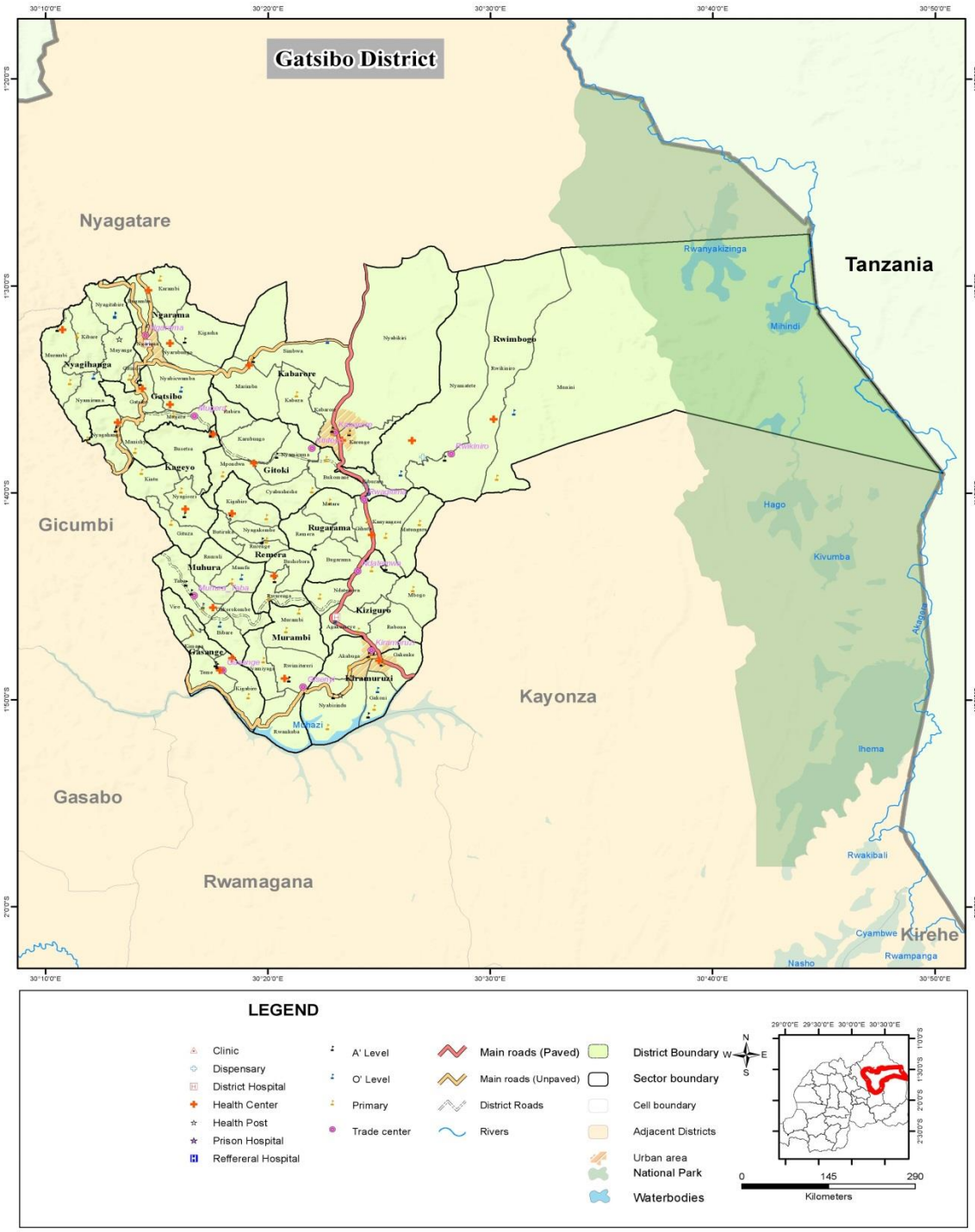
| | **Statements on relationship Between Healthcare Infrastructure and Care Continuity** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|---|
| A | The availability of mental health facilities in Gatsibo District is sufficient for individuals with severe and persistent mental illnesses (SPMI). | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| B | I believe that the geographical proximity of mental health facilities in Gatsibo District positively impacts the care continuity of patients with SPMI. | | | | | |
| C | The quality of mental health services in Gatsibo District meets the needs of individuals with severe and persistent mental illnesses (SPMI). | | | | | |
| D | Adequate transportation options are available to facilitate access to mental health services in Gatsibo District for patients with SPMI. | | | | | |
| E | I believe that improved healthcare infrastructure, such as better-equipped facilities and updated technology, would enhance care continuity for patients with SPMI in Gatsibo District. | | | | | |
| F | The maintenance and upkeep of mental health facilities in Gatsibo District are satisfactory and do not hinder patient care. | | | | | |

**9.** To examine the challenges faced in the implementation of social health protection services for patients with severe and persistent mental illnesses (SPMI).

| | **Statements on the challenges faced in the implementation of social health protection services** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|---|
| A | The awareness and understanding of available social health protection services for SPMI in our community is sufficient. | | | | | |
| B | There is insufficient funding allocated to support social health protection services for SPMI. | | | | | |
| C | Limited trained mental health professionals in Gatsibo District is a barrier to effective implementation | | | | | |
| D | Stigma surrounding mental illness hinders the successful rollout of social health protection services for SPMI. | | | | | |
| E | Geographical barriers and inadequate transportation options make it difficult for individuals with SPMI to access necessary services | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| F | The complexity of the administrative process for accessing social health protection services poses a challenge for both patients and healthcare providers | | | | | |
| G | Community support and rehabilitation programs for SPMI patients are not well-integrated into the social health protection system, limiting their effectiveness | | | | | |


Gatsibo District
Nyagatare
Tanzania
Rwanyakizinga
Mihindi
Rwimbogo
Kabarore
Gatsibo
Kageyo
Gitoki
Nyagihanga
Nyarama
Gicumbi
Rugarama
Remera
Muhura
Kiziguro
Murambi
Rwasange
Kiramuruzi
Kayonza
Hago
Kivumba
Akagera
Ihema
Gasabo
Rwamagana
Rwakibali
Cyambwe
Kirehe
Nasho
Rwampanga
LEGEND
Clinic
Dispensary
District Hospital
Health Center
Health Post
Prison Hospital
Reffereral Hospital
A' Level
O' Level
Primary
Trade center
Main roads (Paved)
Main roads (Unpaved)
District Roads
Rivers
District Boundary
Sector boundary
Cell boundary
Adjacent Districts
Urban area
National Park
Waterbodies
N
W
E
S
0
145
290
Kilometers

**PICTURE OF PARTICIPANTS**