Letters to the Editor

Attitudes to depression among community health workers in Kenya

Dear Editor:

Human resources devoted to health systems in sub-Saharan Africa are scarce, and in order to bring health care to the population, strategic primary care structures have evolved. The Kenyan primary health care system has several tiers. The first tier consists of a community health worker, an unpaid volunteer, who receives some regular training from their local primary health care centre to which they are attached. Duties of the community health worker have hitherto been focussed on physical health and include health promotion activities, identifying illness, referral to primary health care centres, and supporting those who are ill. The second and third tiers are the dispensary and primary health care centres and the fourth tier is the district hospital.

This study sets out to examine the knowledge, attitude and practice pertaining to depression among volunteer community health workers in Kenya, in order to inform policy and implementation.

Depressive illness is under-diagnosed and under-treated in primary health care setting throughout the world (Üstün & Sartorius, 1993). There have been a number of studies of the fourth tier of Kenya's primary care system. A Kenyan study of attenders at rural and semi-urban district hospitals reported prevalence rates of 26% and 31% for psychiatric morbidity in rural and urban settings respectively (Dhapdale *et al*., 1983). A further Kenyan study of 200 attenders at two district hospital outpatient reported a prevalence rate of 32% for psychiatric morbidity (Dhapdale & Ellison, 1983); of these 35% had a diagnosis of depressive illness and 27% anxiety neurosis. An additional Kenyan study of attenders at district hospitals reported a prevalence rate of 63% for psychiatric morbidity (Sebit, 1996); the proportion of those with depressive illness and neurotic disorders was 34% and 20%. Another Kenyan study of 881 attenders at four district hospitals reported a prevalence rate of 9.2% for depressive disorders (Dhapdale *et al*., 1989); this doubled if anxiety and phobic neuroses were included.

There have been fewer studies of Kenya's third tier. One study of 140 attenders at a suburban "walk-in" primary health care clinic, based on clinical diagnosis, reported a prevalence rate of 20% for psychiatric morbidity (Ndetei & Muhangi, 1979), while another reported a prevalence rate amongst consecutive attenders of 46% (Kiima, 1979 MMed thesis); although the precise prevalence rates for depressive illness and anxiety disorder were not provided, the authors reported that these two diagnostic categories accounted for most of the psychiatric morbidity, and that nonetheless depression and anxiety were never recorded by the health workers as a reason for consultation. Similarly an examination of primary health care consultation records in a number of other primary health care clinics in Kenya (authors, unpublished data) also showed that depression and anxiety were never recorded as a reason for consultation.

A study comparing the attitudes of general practitioners and psychiatrists to depression, using the *Depression Attitude Questionnaire* (Botega *et al*., 1992), from the United Kingdom reported that general practitioners were less comfortable then psychiatrists in managing depression and found the work less rewarding and harder than psychiatrists (Kerr *et al*., 1995). Another United Kingdom study of general practitioners, using the same questionnaire, reported the measure of ease of identifying depression reported in this questionnaire did not match their actual clinical practice (Dowrick *et al*., 2000). A study comparing the attitudes of general practitioners and psychiatrists to depression, using the Depression Attitude Questionnaire (Botega *et al*., 1992), from Brazil reported that: 42% of general practitioners believed that it was difficult to differentiate unhapiness from depressive illness; over 60% of general practitioners reported that antidepressants produced satisfactory treatment response, but would refer patients needing antidepressants or psychotherapy would be referred to a specialist; and about 50% found depression "heave gonig" and "unrewarding" (Botega & Silveria, 1996). An Australian study of general practition-

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ers, psychiatrists and clinical psychologists, using case vignettes, reported that: two-thirds of the professional groups agreed that each of the three professional groups can help depression, antidepressants, counselling and cognitive behaviour therapy; however, psychiatrists, compared to the other two professional groups were less likely to rate psychological and lifestyle interventions as helpful and psychologists were less likely to rate medical interventions as helpful (Jorm *et al*., 1997). A study in Singapore using case vignettes reported that: there was little difference in the recognition of depression between psychiatrists and general practitioners, but general practitioners were more likely to focus on non-specfic management approaches (Chen *et al*., 2000). Another study using case vignettes in Singapore reported the primary care practitioners were more likely to hold negative views about the outcome of depression after professional interventions (Kua *et al*., 2000). A recently published study for data collected in 1997 in Kenya reported that district health workers did not think general health workers ought to manage most psychiatric disorders even if they were capable of doing so (Muga & Jenkins, 2008a). A recent study of primary health care workers in Tanzania, using the *Depression Attitudes Questionnaire* (Botega *et al*., 1992), reported that the majority of respondents felt the rates of depression had increased in recent years, believed that life events were important in the aetiology of depression, and generally held positive views about pharmacological and psychological interventions for depression, prognosis and their own involvement in the treatment of depressed patients (Mbatia *et al*., 2009). The latter is the only extant study of attitudes towards depression amongst primary care health workers in sub-Saharan Africa.

Primary care staff are spread very thinly in Kenya, and the volunteer community health workers, which have thus far only been used for physical health issues such as immunisation programmes may be able to make key contributions to the identification and management of mental disorders including depression. Therefore, a study to ascertain the current status of the knowledge, attitude and practice pertaining to depression among volunteer community health workers in Kenya was designed to inform mental health policy development and implementation.

METHODS

Study population

The study population in Kenya comprised all the volunteer community health workers from the Maseno Division, which covers a population of 50,000 in the Kisumu district (first tier). The volunteer community health workers work in their own villages, and each is linked to a primary care health centre where they periodically receive *ad hoc* training on specific topics such as reproductive health or immunisations. They usually do not receive formal pay, apart from subsistence when they attend training, but may receive payment at times from patients. They tend to be retired civil servants.

Study Instrument

The Depression Attitude Questionnaire (DAQ) (Botega *et al*., 1992) is a 22-item self completed questionnaire which assesses health workers knowledge and attitude towards the causes, consequences and treatment of depression. Each question has four possible responses: strongly disagree, moderately disagree, moderately agree and strongly agree. The DAQ was translated into Luo and back translated into English, and the back translation confirmed the accuracy of the original translation into Luo. Some questions were adapted for local circumstances. Although it was originally devised for use in the United Kingdom, it has been successfully used in a number of other countries, including Brazil (Botega & Silveira, 1996) and Abu Dhabi (McCall & Saeed, 2006).

Method of administration of the DAQ

The volunteer community health workers were contacted by the senior nurse (JA) based at Chulaimbo primary health care centre in the week preceding the study and invited to assemble at the primary health care centre on a specified day, when they were asked to complete the DAQ. Those who were unable to read had the DHQ questions read out to them.

Data analysis

The data was transcribed onto an SPSS sheet, entered into a computerised database and analysed using SPSS. Simple descriptive statistics were used to describe the responses to the questions on the DAQ. For the purpose of analysis the categories of strongly disagree and moderately disagree were collapsed into a single category of disagree; the same was repeated for the two categories of agree.

RESULTS

All 62 volunteer community health workers in the Maseno Division completed the DAQ. Two-thirds of the respondents were females, and only 40% had completed secondary school education. Two-thirds were farmers and 16% were otherwise unemployed. Two-third had more than five years experience as community health workers. Table I illustrates the responses to the DAQ questions.

Tabella I – *Kenyan responses to DAQ.*

DAQ question	Disagree N (%)	Angree N (%)	Dont' know (%)
During the last 5 years I have seen an increase in the number of patients presenting with depressive symptoms	7 (11.3)	53 (85.5)	2 (3.2)
The majority of depression we see originates from recent misfortune	5 (8.1)	56 (90.3)	1 (1.6)
Most depressive disorders improve without medication	34 (54.8)	26 (45.2)	0 (0)
Biochemical abnormality is at the basis of more severe depression	11 (17.7)	51 (82.3)	0 (0)
Difficult to differentiate unhappiness or a clinical depressive disorder that needs treatment	12 (19.4)	50 (80.6)	0 (0)
It is possible to distinguish two groups of depression, one psychological in origin and the other caused by biochemical mechanisms	25 (40.3)	37 (58.7)	0 (0)
Beconing depressed in a way that people with poor stamina deal with life diffculties	25 (40.3)	35 (59.7)	0 (0)
Depressed patients are more likely to have experienced deprivation in early life than other people	21 (33.9)	41 (66.1)	0 (0)
I feel comfortable dealing with depressed patients	11 (17.7%)	51 (80.3)	0 (0)
Depression reflects a characteristic response which is not amenable to change	43 (69.4)	18 (29.1)	1 (1.6)
Becoming depressed is a natural part of becoming old	45 (72.6)	17 (27.5)	0 (0)
The community health worker could be a useful person to support depressed patients	2 (3.2)	60 (96.8)	0 (0)
Working with depressed patients is heavy going	7 (11.3)	55 (85.7)	0 (0)
There is little to be offered to depressed patients who do not respond to what community health workers do	40 (65.5)	21 (33.8)	1 (1.6)
It is rewarding to look after depressed patients	2 (3.2)	60 (96.8)	0 (0)
Psychotherapy tends to be succesful with depressed	43 (69.4)	18 (29)	1 (1.6)
If depressed patients need antidepressants, they are better off with psychiatrists than with community health workers	21 (33.9)	41 (66.2)	0 (0)
Antidepressant usually produce a satisfactory result in the treatment of depressed patients in general practice	9 (14.5)	53 (85.5)	0 (0)
Psychotherapy for depressed patients should be left to a specialist	49 (79)	11 (20.9)	0 (0)
If psychotherapy were freely available, this would be more beneficial than antidepressants for most depressed patients	2 (3.2)	60 (96.7)	0 (0)
Depression is a sign of weakness	29 (46.8)	27 (43.6)	6 (9.7)

Rates of depression

The vast majority of volunteer community health workers perceived an increase in the rates of depression in the last five years.

Stigmatising attitudes to depression

Almost two-thirds of community health workers believed that becoming depressed is a way that people with poor stamina deal with life difficulties. Almost half of the community health workers believed that depression is a sign of weakness. About two-thirds of community health workers disagreed with the statement that becoming depressed is part of growing old.

Ability to diagnose depression and categorising depression

About four-fifths of community health workers reported difficulties in differentiating between unhappiness and

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a clinical depressive disorder that requires treatment. Nevertheless, the majority of community health workers felt that it is possible to distinguish two main groups of depression, one psychological in origin and the other caused by biological mechanisms.

Causes of depression

The vast majority of community health workers acknowledged the role of life events in the development of depression. The majority of community health workers believed that depressed patients are more likely to have experienced deprivation early in life than other people; the majority of community health workers believed that biochemical abnormality was the basis of severe depression.

Attitudes to treating depression

The vast majority of community health workers felt comfortable dealing with depressed patients. The vast majority of community health workers felt that they could be a useful person to support depressed patients. The majority of community health workers felt that it was rewarding to work with depressed patients, but found working with depressed patients "heavy going". Two-thirds of community health workers disagreed with the statement that there is little to be offered to those depressed patients who do not respond to treatment from them.

Treatment of depression

About 50% of community health workers disagreed with the statement that depressive disorders improve without medication. Over two-thirds of community health workers disagreed with the statement that psychotherapy tends to be unsuccessful with depressed patients. The vast majority of community health workers believed that psychotherapy would be more beneficial than antidepressants for most depressed patients. Two-thirds of community health workers believed that if depressed patients need antidepressants, they would be better off with psychiatrists than community health workers. Four-fifths of community health workers disagreed with the statement that psychotherapy for depressed patients should be left to specialists.

Prognosis of depression

Over two-thirds of community health workers disagreed with the statement that depression reflects a characteristic change which is not amenable to change. Almost four-fifths of community health workers felt that antidepressants usually produce a satisfactory result in the treatment of depressed patients in general practice.

DISCUSSION

This is one of only two studies examining the attitudes to depression amongst community health workers in sub-Saharan Africa. The finding that the majority of volunteer community health workers felt that rates of depression had increased in recent years, believed that life events were important in the aetiology of depression, and generally held positive views about pharmacological and psychological treatments of depression, prognosis and their own involvements is consistent with similar findings for primary health care workers in neighbouring Tanzania (Mbatia *et al*., 2009). The finding that the majority of volunteer community health workers had difficulties in differentiating between unhappiness and clinically significant depression was not observed in Tanzania (Mbatia *et al*., 2009), but was reported in a similar study of general practitioners in Brazil (Botega & Silviera, 1996). The finding that majority of the volunteer community health workers felt that becoming depressed is a way that people with poor stamina deal with life difficulties was also observed among primary health care workers in Tanzania (Mabatia *et al*., 2009) but not amongst general practitioners in the United Kingdom (Kerr *et al*., 1995).

The Kenyan government health policy of 1982 envisioned the incorporation of mental health care into primary health care in keeping with the Alma-Ata declaration (World Health Organisation, 1979). However, while the general population supported this approach (Muga & Jenkins, 2008b) implementation has been hampered by a number of factors including lack of human and financial resources (Kiima *et al*., 2004), and attitudes of district level health workers (Muga & Jenkins, 2008a) who consider that people with mental disorder need to see a specialist, Kenya has a population of 37 million and had 23 psychiatrists in 2001, rising to 45 in 2008 in the public sector, and a 500 psychiatric nurses of whom only 250 are deployed in mental health. There are around 5000 primary health care workers. Thus volunteer community health workers can be a very helpful adjunct to the pri-

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mary care services and have already been successfully used in programmes for immunisation, antenatal and postnatal care. They live locally to the populations they serve, and are well known and accepted in their communities. They currently receive regular brief topic based education sessions from their local linked primary health care workers. The current national health sector strategic plan has called for mental health to be included in their regular education sessions and in their normal roles of detection and support. Therefore the ability to conduct such training and supervise CMWs in mental health work has been included in a national mental health training programme for Kenya's primary care staff (Jenkins *et al*., in preparation).

CONCLUSION

The high prevalence of common mental disorders in primary health care attenders requires detection and treatment by members of primary health care teams. The findings of this study that volunteer community health workers have generally positive attitudes towards the treatment of depression and a willingness to receive training in the detection and management of depression lends support to a concerted national effort to train community health workers as part of the mental health programme.

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