PSYCHIATRIC MORBIDITY AMONG ADULT HIV/AIDS PATIENTS ATTENDING A COMPREHENSIVE CARE CENTRE AT A CITY COUNCIL CLINIC IN NAIROBI.

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A THESIS PRESENTED IN PARTIAL FULFILLMENT FOR THE REQUIREMENT OF DEGREE IN MASTER OF MEDICINE IN PSYCHIATRY AT THE UNIVERSITY OF NAIROBI

DECLARATION

I Dr. Pauline W. Ng'ang'a do hereby declare that this dissertation is my original work and has not been presented to any other university for the award of any other degree or diploma.

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ACKNOWLEDGEMENTS

I would like to recognize the many individuals and institutions who contributed towards the realization of this project and hence the success of my postgraduate training. First and foremost, I thank my supervisors Dr Muthoni Mathai and Dr Anne Obondo whose insight and vast experience in psychiatry and mental health in Kenya greatly enriched this work. I also acknowledge the faculty and postgraduate students at University of Nairobi's Department of Psychiatry who reviewed and critiqued this project. Last and most importantly, the staff, management and patients at Kangemi CCC who willingly participated in this study and shared their experience with me and colleagues for the betterment of HIV \ AIDS care in Kenya and similar settings. To all other individuals who contributed but are not mentioned in person, I am grateful for your input in this work.

DEDICATION

To HIV/ AIDS patients and caregivers in low income countries who continue to bear the burden of the HIV pandemic whose impact on various facets of life remains unknown.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical Research Foundation
ARV	Antiretroviral
CCC	Comprehensive Care Centre
CHASE	Coping with HIV/AIDS in the Southeast
HCSUS	HIV Costs and Services Utilization Study
HIV	Human Immunodeficiency Virus
KAIS	Kenya Aids Indicator Survey
KDHS	Kenya Demographic Health Survey
KNH	Kenyatta National Hospital
NIMH	National Institute of Mental Health
PLWA	People Living With AIDS
PMTCT	Prevention of Mother to Child Transmission
SPSS	Statistical Package for Social Sciences
UNAIDS	United Nations Programme on HIV/AIDS
USAID	United States International Development Agency
WHO	World Health Organization

DEFINITION OF TERMS.

Immunosuppression- Involves an act that reduces the activation or efficacy of the immune system.

Skilled – One who has completed formal training.

Somatization - Conversion of a mental state into physical symptoms.

Symptomatology- Combined symptoms of a disease.

Unskilled – One who has not received or completed formal training

ABSTRACT

Psychiatric morbidity has been associated with HIV disease since the beginning of the AIDS epidemic. Despite the fact that low income countries in Africa contribute up to 68% of the HIV infections worldwide, minimal research has been done in sub-Saharan Africa and in particular Kenya on the prevalence of various psychiatric morbidities associated with the infection. Studies indicate that HIV prevalence in Kenya is about 5.6%.

This was a descriptive cross – sectional study to investigate prevalence of psychiatric morbidity among 245 HIV/AIDS patients attending community based Comprehensive Care Centre Clinic atKangemi Health Centre.

Ethical approval to conduct the study was obtained from the KNH ethical committee and participation was voluntary following patient provision of signed informed consent.

Systematic random sampling was used to select the sample and the Mini – International Neuropsychiatric interview (M.I.N.I plus) was used to assess psychiatric morbidity.

Data analysis was done using the SPSS version 17. The sample characteristics was summarized using descriptive statistics including mean (SD) for continuous variables and frequency distribution for categorical variables. Inferential analysis based on the chi squared test was used to examine associations between psychiatric morbidity in HIV and patient demographic and socio-economic attributes and health status.

The mean age of the patients was 37.3 years (SD 9.2) with an age range from 19 to 70 years. Three-quarters (75.9%) of the patients were female.The median duration of HIV illness was 5 years (IQR 3 to 8) and among the 216 patients with recent CD4 counts, 64.4% had counts less than 500 cells per mm^3. The prevalence of psychiatric morbidity was 71.4% (175 out of 254). The leading psychiatric illnesses were: major depressive disorder (32.2%), suicidality (19.4%), PTSD (18.4%), dysthymia (17.6%) and obsessive compulsive disorder (17.6%).Out of 175 patients with psychiatric illnesses 71(40.6%) were diagnosed with a single psychiatric morbidity and the remaining had at least two psychiatric co morbidities.

After multivariable logistic regression analysisdepression was significantly associated with patientswho had monthly incomes oflessthan Kshs 3000 compared to patients earning morethan Kshs 3000 per month (OR = 0.56, 95% CI 0.33-0.96). A separate logistic regressionanalysis showed that employment (OR = 0.39, 95% CI 0.19-0.82) and marital

status (OR = 0.39, 95% CI 0.16-0.91) were negatively significantly associated with suicidality after adjusting for the effect of monthly income.

In conclusion, patients with HIV/AIDS receiving follow up care in Kenya experience considerable psychiatric morbidity and may benefit from more psychological counseling and psychiatric assessment and treatment to ensure complete mental wellbeing. In the long-term screening HIV/AIDS patients for psychiatric morbidity and integrating psychiatric services into routine care of HIV/AIDS patients will help address the highlighted problem.

CHAPTER ONE

1.0 Introduction

HIV/AIDS is a disease of both adults and children with 10% of all cases being children below 12 years of age. Sub-Saharan Africa remains the region most heavily affected by HIV. According to UNAIDS (1) about 68% of all people living with HIV resided in sub-Saharan Africa, a region with only 12% of the global population. Prevalence of HIV in Kenya remains high. Among adults, it is a disease predominantly of those in the reproductive age bracket (15-45 years) with a male to female ratio of about 1:1.2. However, in the age bracket of 19-30 years females far outnumber males.

Psychiatric symptoms and disorders are becoming increasingly evident in HIV infected patients. It is estimated that up to 70% patients with HIV suffer from acute psychiatric complications related to HIV infection at some time during the course of their illness. (2) These disorders tend to manifest differently at different stages of HIV disease. Some disorders appear both in the early and late stages of HIV/AIDS disease and others such as substance abuse and anxiety disorders can occur at any stage of the HIV/AIDS disease. Several studies done have shown high rates of psychiatric morbidity in HIV infected patients and therefore need for psychiatric evaluation and treatment to improve the quality of life for HIV/AIDS patients (3).

1.1 Background Information

It is over 25 years since HIV/AIDS was described in North America in May 1981. Since then HIV/AIDS has attained pandemic proportions the world over. According to UNAIDS World AIDS day report 2011, at the end of 2010, an estimated 34 million people [31.6 million–35.2 million] were living with HIV worldwide, up 17% from 2001. This reflects the continued large number of new HIV infections and a significant expansion of access to antiretroviral therapy, which has helped reduce AIDS-related deaths, especially in more recent years.

HIV destroys the immune system that defends the body against all kinds of infections. Due to this destruction; the body becomes weak and prone to infections by other germs that cause disease. The weakened body also becomes prone to attack by some cancers and lymphomas. In addition, HIV itself can also directly infect other parts and organs of the body.

AIDS is the stage of HIV disease which causes severe damage to the immune system. HIV attacks the immune system and leaves the body vulnerable to a variety of life threatening infections and cancers. Common bacteria, yeast, parasites and viruses that usually do not cause serious disease in people with healthy immune systems can cause fatal illness in people with AIDS.

Infection with HIV occurs by the transfer of blood, semen, vaginal fluid, pre-ejaculate or breast milk. Within these bodily fluids, HIV is present as both free virus particles and virus within infected immune cells. The four major routes of transmission are unprotected sexual intercourse, contaminated needles, breast milk, and transmission from an infected mother to her baby at birth (4).

1.1.1 HIV Infections and AIDS Deaths

HIV infection in humans is now pandemic. As of January 2006, the Joint United Nation Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) estimate that AIDS has killed more than 25 million people since it was first recognized on December 1, 1981, making it one of the most destructive pandemics in recorded history. It is estimated that about 0.6 percent of the world's population is infected with HIV. In 2005 alone, AIDS claimed an estimated 2.4 - 3.3 million lives, of which more than 570,000 were children. In 2009, there were an estimated 2.6 million people who became newly infected with HIV.According to World AIDS day report 2011; there were 2.7 million new infections in 2010.

UNAIDS estimated that there were 33.3 million people living with HIV at the end of 2009 compared with 26.2 million in 1999, a 27% increase. The number of annual AIDS-related deaths worldwide is steadily decreasing from the peak of 2.1 million in 2004 to an estimated 1.8 million in 2009. The decline reflects the increased availability of antiretroviral therapy, as well as care and support, to people living with HIV/AIDS, particularly in middle and low-income countries. Although the rate of new HIV infections has decreased, the total number of people living with HIV/AIDS continues to rise. In 2009, that number reached 22.5 million, 68% of the global total (5).

Global HIV/AIDS Prevalence

In Asia, an estimated 4.9 million people were living with HIV in 2009. The HIV prevalence is increasing in such low-prevalence in countries such as Bangladesh, Pakistan (where drug injecting is the main mode of HIV transmission), and the Philippines. Incidence fell by more

than 25% in India, Nepal, and Thailand between 2001 and 2009. The epidemic remained stable in Malaysia and Sri Lanka during this time period. Incidence increased by 25% in Bangladesh and Philippines between 2001 and 2009 even as the countries continue to have relatively low epidemic levels (5).

In Eastern Europe and Central Asia, the number of people living with HIV has almost tripled since 2000 and reached an estimated total of 1.4 million in 2009 compared with 760 000 in 2001. A rapid rise in HIV infections among people who inject drugs at the turn of the century caused the epidemic in this region to surge. Overall, the HIV prevalence is 1% or higher in two countries in this region, the Russian Federation and Ukraine, which together account for almost 90% of newly reported HIV diagnoses. At 1.1% [1.0%–1.3%], the adult HIV prevalence in Ukraine is higher than in any other country in all of Europe and Central Asia. Annual HIV diagnoses in Ukraine have more than doubled since 2001.The HIV epidemic in the Russian Federation also continues to grow, but at a slower pace than in the late 1990s. Newly reported HIV cases have increased in several countries in Central Asia, including Uzbekistan, which has the largest epidemic in Central Asia (5).

The HIV prevalence among adults in the Caribbean is about 1.0% [0.9%–1.1%], which is higher than in other regions outside sub-Saharan Africa (5).

The HIV epidemics in South and Central America have changed little in recent years. The total number of people living with HIV continues to grow to an estimated 1.4 million in 2009 from 1.1 million in 2001, due largely to the availability of antiretroviral therapy. About one third of all people living with HIV in Central and South America live in populous Brazil, where early and ongoing HIV prevention and treatment efforts have contained the epidemic. The adult HIV prevalence in Brazil has remained well under 1% for at least the past decade (5).

The total number of people living with HIV in North America and Western and Central Europe continues to grow and reached an estimated 2.3 million in 2009 (5).

Regional prevalence

Sub-Saharan Africa remains the region most heavily affected by HIV. In 2010, about 68% of all people living with HIV resided in sub-Saharan Africa, a region with only 12% of the global population. Sub-Saharan Africa also accounted for 70% of new HIV infections in 2010, although

there was a notable decline in the regional rate of new infections. The epidemic continues to be most severe in southern Africa, with South Africa having more people living with HIV (an estimated 5.6 million) than any other country in the world (5).

The largest epidemics in sub-Saharan Africa—Ethiopia, Nigeria, South Africa, Zambia, and Zimbabwe, have either stabilized or are showing signs of decline. The estimated 1.3 million people who died of HIV related illnesses in sub-Saharan Africa in 2009 comprised 72% of the global total of 1.8 million deaths attributable to the epidemic (5).

The epidemics in sub-Saharan Africa vary considerably, with southern Africa still the most severely affected. An estimated 11.3 million [10.6 million–11.9 million] people were living with HIV in southern Africa in 2009, nearly one third (31%) more than the 8.6 million [8.2 million–9.1 million] people living with HIV in the region a decade earlier (5).

The epidemics in East Africa have declined since 2000 but are stabilizing in many countries. The HIV incidence slowed in the United Republic of Tanzania to about 3.4 per 1000 person-years between 2004 and 2008. The national HIV prevalence in Kenya fell from about 14% in the mid-1990s to 5% in 2006. The HIV prevalence in Uganda has stabilized at between 6.5% and 7.0% since 2001. The HIV prevalence in Rwanda has been about 3.0% since 2005. The HIV prevalence in West and Central Africa remains comparatively low, with the adult HIV prevalence estimated at 2% or under in 12 countries in 2009 (Benin, Burkina Faso, Democratic Republic of the Congo, Gambia, Ghana, Guinea, Liberia, Mali, Mauritania, Niger, Senegal, and Sierra Leone). The prevalence of HIV is highest in Cameroon at 5.3%, Central African Republic 4.7%, Côte d'Ivoire 3.4%, Gabon 5.2% and Nigeria 3.6% (5).

The HIV/AIDS Prevalence in Kenya

Kenya is experiencing a mixed and geographically heterogeneous HIV epidemic with characteristics of both a "generalized" epidemic among the mainstream population, and a "concentrated" epidemic among specific most-at-risk populations (MARPs). The national prevalence in 2007 was estimated at 7.4% in the age group 15-49; and at 7.1% in age group 15-64. Incidence remains high at 132,000 adults, and 34,000 new pediatric infections per year, with approximately 1.4 million Kenyans currently living with HIV up from 722,869 in 2000. The

incidence remains high with 138,000 estimated new infections per year (132,000 adults and 34.000 pediatric infections (1).

The HIV epidemic shows regional heterogeneity. Nyanza province has an overall prevalence of 14 percent, double the level of the next highest provinces— Nairobi and Western, at 7 percent each. All other provinces have levels between 3 percent and 5 percent overall, except North Eastern province where the prevalence is about 1 percent. HIV prevalence is by far the highest among women who are widowed (43%) (5).

The main modes of transmission of HIV were found to vary geographically, reflecting the diverse type of epidemic faced by the country; injecting drug use accounts for 17% of incidence in the Coast Province, but less than 4% in Nyanza Province; transmission among men who have sex with men contributes to less than 6% of incidence in Nyanza but over 11% in Nairobi. An estimated 70% of the HIV infected people live in rural areas. Age and sex dimensions of the epidemic differ greatly, with prevalence peaking among women (13.3% among 30-34 years age group) earlier by a decade than among men (10.2% among the 40-44 years age group), reflecting both historical transmission patterns and significant levels of inter-generational sex (5).

1.1.2 Psychiatric morbidity and HIV

The psychiatric manifestations of HIV/AIDS are multiple and may be due to: virus invasion of the brain in up to 90% of the cases; sero-conversion from non-clinical AIDS stage; suspicion that one may be HIV-positive also known as the worried well; physical changes associated with disease progression, for example progressive weight loss, skin rashes and subtle loss of functional ability in the daily activities; opportunistic infections including tuberculosis, cryptococcal infection, toxoplasmosis; secondary spread of cancer such as lymphoma, kaposis sarcoma and news of positive HIV test result. However, psychiatric illness in HIV/AIDS patients is hardly recognized and therefore patients do not receive adequate attention (6).

The psychiatric disorders may include;

- Adjustment disorder with depressed or anxious mood.
- Manic disorder; depressive disorder
- Anxiety disorder; particularly panic disorder, generalized anxiety disorder,
- Obsessive-compulsive disorder, agoraphobia

- Schizophrenia ;HIV-associated dementia; delirium
- Alcohol or other substance dependence;
- Suicide and attempted suicide.

Between 75% and 90% of autopsies done on patients dying of HIV/AIDS reveal brain changes due to the disease. In 10% of people infected with HIV, neuropsychiatric manifestations are the first sign of the disease and overall, 50% of individuals with HIV develop sub cortical dementia (6).

HIV is an illness that requires long term care and treatment. Adherence is important in successful management of HIV. Psychiatric co-morbidity has been shown to impair adherence and could therefore lead to resistance.

1.2 Statement of the problem

HIV/AIDS remains the single most important health challenge facing the world. Of great importance is that, Psychiatric morbidity has been associated with the disease since the beginning of the HIV/AIDS epidemic.By the end of 2010, an estimated 34 million people [31.6 million–35.2 million] were living with HIV worldwide, an increase of 17% from 2001. (1). It is well established that neurological and psychiatric disorders frequently occur in subjects with HIV/AIDS. Approximately 65% of those who die with a diagnosis of AIDS exhibit significant mental and neurological impairment (7). Going by the current available knowledge on the psychiatric morbidities associated with HIV/AIDS, it is quite evident that several gaps still exist. Great emphasis therefore should be put on the psychiatric manifestations at different stages of infection in relation to the CD4 counts and the socio demographic factors associated with these disorders. There is need for additional data on psychiatric morbidity in HIV/AIDS for future planning and policy making regarding management of the disease. The high prevalence combined with the fact that Kenya has a relatively mature epidemic that has resulted in extremely high AIDS morbidity and mortality, has increasingly raised the demand for systematic delivery of health services including but not limited to ignored aspects of mental health given the complexity encountered in managing the disease. It is against this background that this study was designed and therefore sought to establish the prevalence of psychiatric morbidity among HIV/AIDS patients seen at Kangemi Health Centre clinic in Nairobi, Kenya.

CHAPTER TWO

2.0 Literature review

HIV/AIDS is associated with considerable psychiatric morbidity (3). Studies have shown that HIV infected patients have higher rates of psychiatric morbidity compared with the general population (8). At any stage of the illness, psychiatric disorders may develop. These disorders tend to manifest directly at different stages of the HIV disease. However there are no specific diseases for each stage. In this regard there is considerable overlap too. Some disorders appear both in the early and late stages of HIV/AIDS and others such as substance abuse and anxiety disorders can occur at any stage of the HIV/AIDS disease.

Psychiatric morbidity associated with HIV infections may include; mood disorders, substance abuse disorders, anxiety disorders and personality disorders (9). Psychosis, delirium and pain syndromes have also been reported. The suicide rate in the HIV population is also significantly higher than that of the general population (10).

International Studies

A study done on psychiatry morbidity in HIV infected male prisoners in Taiwan revealed that psychiatric morbidity was present in 46% of participants. The most prevalent was insomnia (46.6%) followed by depression (31.1%) (11).These prevalences are comparable to the HIV Costs and Services Utilization Study (HCSUS) done in San Francisco which indicated that nearly half (48%) of HIV infected individuals had a probable psychiatric disorder. The Coping with HIV/AIDS in the Southeast Study of individuals living with HIV/AIDS in the southeastern US documented a higher prevalence of 54%. HCSUS indicated that being unemployed or disabled, having more HIV-related symptoms and drug use were associated with greater risk of psychiatric disorder.

Co-morbid mental illness and substance abuse are also found at higher levels among HIV-infected individuals in comparison with the general population. A study of psychiatric co-morbidities among HIV infected individuals receiving care at infectious diseases clinic in North Carolina (n=1358) found even higher levels of co-morbid mental illness and substance abuse, as 23% experienced symptoms of both disorders (12).

Studies done in Netherlands, reported that the most often psychiatric complication among HIV infected outpatients were: mood, anxiety disorders and alcohol or non-opiate drug abuse. Among 32 HIV infected psychiatric outpatients studied, 62.5% of patients had major depression (n=10) and adjustment disorder with depression or anxious mood (n=10). The Study concluded that there was an increasing number of HIV infected patients presenting with psychiatric symptoms and hence need for more education of psychiatric and other health care professionals concerning specific aspects of HIV infection, homosexuality, prostitution and intravenous drug abuse (13).

A study on new-onset psychosis in HIV-infected patients done in San Diego, California in 1991, revealed that a common clinical feature noted in new-onset psychosis in HIV infected patients was acute or sub-acute onset of symptoms, which included delusions, hallucinations, bizarre behavior, mood or affective disturbances and mild memory or cognitive impairment (14). Another study done in New York on HIV-related cases among 2094 admission to a psychiatric hospital found that the largest category of HIV related admissions were patients experiencing functional or psychological complication of HIV infection or risk which accounted for 5.2% of the admissions (15).

Indian studies also concur with the fact that there is an increasing prevalence of psychiatric disorders among the HIV infected patients. A five year study done on HIV related admissions in a psychiatric hospital revealed that 69.7% had a diagnosis of alcohol dependence of which 11 patients had co-morbid psychiatric diagnosis in form of affective disorders (23%), 14% had psychosis, personality disorders were seen in 9 patients. In 19% the clinical manifestation was considered to be etiologically related to HIV infection (16).

Higher suicide rates have also been observed in people infected with HIV in the general hospital population. A retrospective study of 2363 psychiatric consultations done in 1989 and 1990 at an urban municipal teaching hospital in New York City revealed that the suicidal behavior was the reason for consultation in 21.8% of HIV positive persons and in 19.8% of persons with AIDS. It was the reason for consultation in only 13.9% of persons with unknown HIV sero status (10).

Regional studies

Most studies of psychiatric disorders associated with HIV/AIDS have been carried out in Europe and USA. A six month follow up study done in South Africa on persistence of psychiatric

disorders in a cohort of 65 HIV/AIDS patients recently diagnosed, revealed that 56% of patients had at least one psychiatric disorder at baseline and 48% of patients had at least one psychiatric disorder at 6 months. Depression and post-traumatic stress disorder (PTSD) were the most prevalent disorders at both baseline (34.9% and 14.8%) and follow up (26% and 20%) respectively. More than half of all the patients with depression at baseline improved (55%), but on follow up 8.1% had new onset of depression and 70.5% had PTSD. This study concluded that the rate of psychiatric disorder in HIV/AIDS patients was consistent over-time and emphasized the need and importance of regular evaluation for psychiatric disorders in HIV/AIDS patients (17).

Other studies done in South Africa among HIV infected individuals found the overall prevalence of depression, PTSD and alcohol dependence/abuse to be 14%, 51% and 7% among 465 patients enrolled into HIV care and treatment services near Cape Town, South Africa. The data demonstrated high level of depression, PTSD and alcohol dependence/abuse among HIV infected individuals in this setting (18).

Results from a study done on one hundred HIV infected patients attending the immunology clinics at the Universities and Pelonomi hospitals in Bloemfontein, South Africa found 35% of patients had major depressive disorder, 3% of dysthymic disorder while 6% had bipolar disorder. As regards anxiety disorders, panic disorder 37%, agoraphobia 9%, social phobia 15%, specific phobias 10%, obsessive compulsive disorder 3% and generalized anxiety disorder 21%, PTSD was diagnosed in 6% of the cases. The results concluded that psychiatric co-morbidity is common in HIV infected patients and the identification and treatment of their co-morbid psychiatric syndrome in HIV infected patients should be actively pursued as treatment could lead to an improvement in quality of life (19).

A significant relationship has been reported between rape and drug dependence, alcohol dependence, post-traumatic stress disorders and major depression in recently diagnosed HIV infected South African women. This study concluded that HIV positive women with a history of having been raped may experience a number of psychiatric disorders and therefore as part of the comprehensive medical care of HIV, it is important that health workers asses past sexual abuse and current psychiatric symptoms (20).

In Jos, Nigeria, a 5 year retrospective study of psychiatric morbidity in HIV/AIDS on a total of 420 confirmed cases of HIV/AIDS who were treated within the study period revealed that 120 patients i.e. 25% were referred for psychiatric consultation. The rate of referral was significantly associated with less advanced stage of the disease process (21).

Studies done in East Africa, though few, have reported similar findings as those done elsewhere in the world. Musisi et al found that up to 90% of patients with HIV/AIDS suffer from acute psychiatric complications of HIV/AIDS such as an adjustment disorder. Between one or two thirds will eventually suffer from a chronic psychiatric complication such as AIDS related dementia. Indeed, in a study undertaken among HIV/AIDS patients attending a TASCO clinic in Mulago, Kinyanda (2) found that 74% of them had significant psychological distress.

Local studies

In Kenya a few studies have addressed psychiatric morbidity and HIV/AIDS. A WHO Neuropsychiatry AIDS study revealed that the risk of subtle cognitive deficits may be increased in asymptomatic stages of HIV-1 infection (23).A study on Psychological Morbidity and HIV in Kenya found that there were no substantial differences found in Psychiatric Morbidity including depression between HIV positive workers and HIV negative controls. This study involved workers who attended an occupational health clinic in Kenya's Nyanza Province for statutory annual health checks during a 10 week period in 1994. Findings of this study contradicted those of other previous studies that had identified presence of substantial psychiatric morbidity and cognitive impairment in HIV infected patients (23).

A study on the prevalence of Mental Disorders in adults attending different general medical facilities in Kenya revealed that 42% of subjects had symptoms of mild and severe depression. The study concluded that most psychiatric disorders in general medical facilities remain undiagnosed and thus unmanaged (24).

A study done on Psychiatric Morbidity among HIV infected Children and Adolescents aged between 6 to 18 years attending a comprehensive care clinic for HIV/AIDS in a resource poor urban Kenyan community found that 48.8% of the children and adolescents in the study had at least one diagnosis of a psychiatric disorder or suicidality. This study concurred with similar studies on the need to integrate psychiatric services into the routine care of HIV infected patients. (25).

2.1 Significance and justification of the study

Due to the high prevalence rates of HIV/AIDS in Kenya and the challenges associated with coping with the disease, it is expected that psychiatric morbidity may be under diagnosed and may be impacting on quality of holistic care of HIV/AIDS patients. Studies done both locally and internationally have revealed that psychiatric morbidity is common in patients suffering from HIV/AIDS. It is worthy to note that psychiatric disorders have been identified as important contributors to poor compliance.

Few studies addressing Psychiatry morbidity in HIV/AIDS have been done in Kenya. Psychiatry morbidity among HIV children and adolescents by Kamau (25) found that 48.8% had a psychiatric diagnosis and suicidality. A study by Ng'ang'a (26) on Anxiety and Depression in HIV/AIDS adults attending CCC in KNH found that 15.5% and 7.25% of patients had moderate and severe levels of anxiety while 47.25% had depression.

It is in this regard that the study focused on identifying patients with psychiatric morbidity as co-morbidity in HIV/AIDS. The study brought out the importance of mental health care in managing HIV/AIDS patients and therefore need for early identification of patients with mental diseases in HIV/AIDS for appropriate intervention. The study has contributed new knowledge about psychiatric morbidity among adult HIV/AIDS patients and forms a basis for future research.

Although a lot is being done to address health and related issues of HIV/AIDS, the mental health of PLWA has not received adequate attention. This may partly be because there is deficit of skills among health workers. There is however enough evidence to indicate that mental wellbeing is an important factor in the recovery process in many illnesses and in adherence to treatment and adoption of a healthy life style. It is against this background that it is important to focus on AIDS related psychiatric disorders so that intervention programmes /strategies are developed to address the related issues.

2.2 Aim and objectives of the study

2.2.1 Aim

The main objective of this study was to establish the prevalence of psychiatric morbidity in HIV/AIDS patients attending a Health Centre based CCC.

2.2.2 Specific Objectives

1. To determine the prevalence of psychiatric morbidity among HIV/AIDS patients attending CCC at Kangemi Health Centre.
2. To determine the relationship between psychiatric morbidity and socio demographic factors of HIV/AIDS patients.
3. To determine occurrence of co morbidity with multiple psychiatric disorders in HIV/AIDS

CHAPTER THREE

3.0 Methodology

3.1 Study design

The study was a descriptive cross sectional study.

3.2 Study site

The study was carried out at the CCC in Kangemi Health Centre. The approximate number of CCC clients was 2135 of which 994 were on ARV drugs.

Comprehensive Care Centre concept was an initiative of WHO which was locally championed by KNH and was a model for HIV/AIDS Care and programs world over (27). The CCC was established with the support of the USAID through Family Health International and offers a whole range of HIV care including Nutrition, Counseling (adherence and supportive), Pharmaceutical Care, PMTCT, Laboratory diagnosis and monitoring to both adults and children.

Kangemi Health Centre is a level one public medical facility owned by the local authority in Nairobi Province, Westlands District, located in Kangemi. Kangemi is one of the Nairobi slums with a population of about 650,000 poor people.

Kangemi Health Centre is located 12 Kilometers from the city centre, Kangemi shopping centre off Waiyaki way. It has a bed capacity of 20 and renders the following services: Antenatal, Anti-retroviral therapy, Basic emergency, Obstetric care, Curative outpatient services, Family planning, Growth monitoring and promotion, HIV testing and counseling immunization, Prevention of mother to child transmission of HIV ,Tuberculosis diagnosis and treatment and Youth friendly services.

3.3 Study population

The population comprised of HIV/AIDS clinic attendees of CCC at the Kangemi Health Centre during the study period.

3.4 Sample Size Determination

The desired sample was arrived at by using the Fischer's formula (28):

$N = Z^2 * PQ/D^2$

Where:

N = is the desired sample size (minimal).

Z = the standard normal deviation usually set at 1.96 with confidence interval of 5% and power of 80%.

P = the proportion in the adult HIV positive population estimated to have psychological disorders reported at 90% in Uganda. (There is no recent estimate of proportion of HIV positive patients and psychiatric disorders in Kenya. Therefore, population estimated prevalence of psychiatric morbidity in Uganda of 90% was used.)

Q = 1.0 – P

D = precision around the estimate P set at 4%

$$N = (1.96)^2(0.9)\ (1.0\text{-}0.9)/0.04^2 = 216$$

The sample size was stepped up by 10% mainly due to foreseeable incomplete questionnaire; therefore the approximate population recruited in the study was 238.

3.5 Sampling Procedure

The patients were selected using systematic random sampling method. A sampling interval of every 5^{th} patient was used based on considerations of the clinic workload and the expected study duration. The study was conducted over a three-month period with the clinic operating twice a week (on Tuesdays and Thursdays) and serving approximately 80 eligible patients on each day of recruitment. The systematic sampling procedure was implemented based on order of client arrival at the clinic with the initial study participant selected at random. The recruitment wascontinueduntil the expected number of 238 patients was achieved. If any of the selected

patients' declined to sign the informed consent form, then the next available patient was picked for the study.

3.5.1 Inclusion criteria

Patients attending CCC at Kangemi Health Centre who were:

1. Age 18 years and above
2. Not on treatment for any psychiatric illness.

3.5.2 Exclusion criteria

1. Very sick patients not able to participate in an interview
2. Those on treatment for any Psychiatric illness.
3. New patients visiting CCC for the first time.

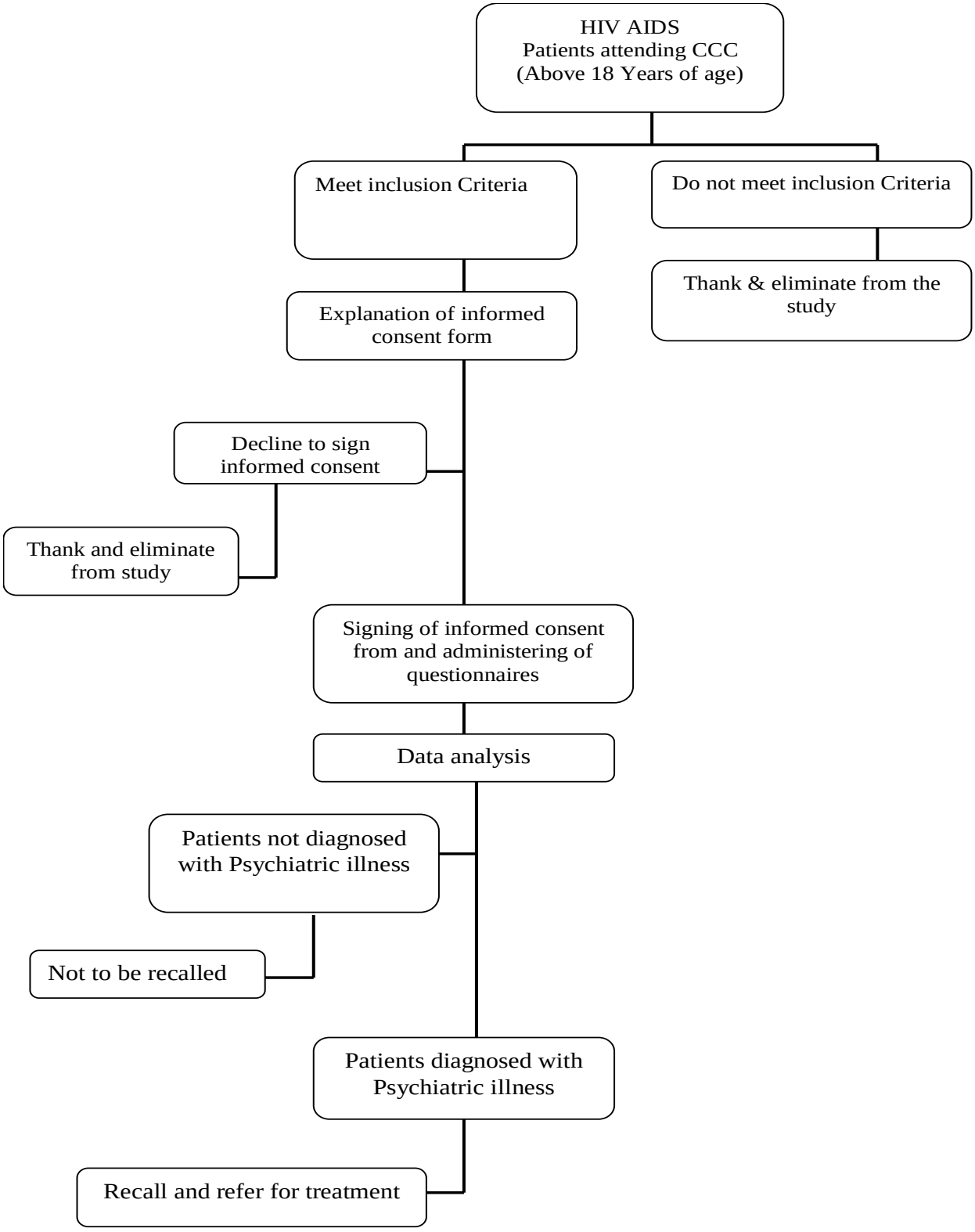
3.6 Data collection procedure

Data collection was conducted during regular clinic hours during a three-month period. The clinic operation hours were between 8am to 5pm every day of the week, but the HIV clinic was held on Tuesdays and Thursdays. A research assistant was stationed at the clinic on those particular days. On each day of data collection a random number scheme was used to select the first participant from the sampling frame. A sampling interval was then applied to recruit every fifth patient into the study. In case of refusals the next available patient was recruited.The participants who met the criteria of the study were briefed on the purpose of the study. Those willing to participate signed an informed consent form and completed the administered questionnaires; of which the researcher read the questions exactly the way they appeared in the questionnaires and their responses were recorded as answered. The respondents' queries were responded to appropriately. The following questionnaires were used in data collection.

i. Researcher Designed Socio Demographic questionnaire
ii. MINI Plus

Each questionnaire had the clinic code number of the participant (the sole purpose of having the code was to enable the researcher (only) to provide necessary intervention e.g. referral if need be and to ensure confidentiality.

3.6.1 Study flow chart



3.7 Data Collection Instruments

3.7.1 Socio demographic questionnaire

A questionnaire containing socio-demographic details was administered to each study respondent.

The socio demographic data contained in the questionnaire included information on gender, age, occupation, marital status, number of children, religion, income, level of education, HIV status of partner and children, duration of illness, latest CD4 count and presence of other illnesses.

3.7.2 MINI Plus

The Mini-International Neuropsychiatric Interview was developed jointly by psychiatrists and clinicians in the United States and Europe for DSM IV and ICD-10 psychiatric disorders. The M.I.N.I. Plus was designed as a brief structured interview for the major Axis I psychiatric disorders in DSM-IV, ICD-10 for epidemiological studies and multicenter clinical trials. Validation and reliability studies have been done and results indicate that the M.I.N.I has acceptably high validation and reliability scores. It can be administered in a much shorter period of time compared to other instruments and can be used by clinicians, after a brief training session. Lay interviewers require more extensive training (29, 30). This tool has been previously used successfully in other studies carried out in the general population in our country.

3.8 Variables

The main study variables are presented in table 3-1

3.8.1 Dependent Variable

The dependent variable in the study was prevalence of Psychiatry morbidity in HIV/AIDS patients attending CCC in Kangemi Health Centre. The M.I.N.I plus tool was used to measure Psychiatric illness.

3.8.2 Independent Variables

The independent variables comprised three major variable groupings namely, demographic factors, socio economic factors and opportunistic infections. Detailed description of individual variables within each variable group is shown in Table 3-1.

Table 3-1 Classification of Study variables

Independent variables	**Dependent variable**
Demographic factors: age, gender, number of children, education, marital status, religion. *Socio-economic factors*: occupation, income, employment status. *HIV related*: Opportunistic infections	Psychiatry morbidity in HIV/AIDS

3.9 Ethical consideration

The research process began by obtaining approval from the Department of Psychiatry, University of Nairobi, research permit from the Kenyatta National Hospital Research and Ethics committee as well as the Ministry of Education Science and Technology.

The procedures and the objectives of the study were explained to CCC, staff and the patients at the clinic. Explanation to the Head of the CCC facilitated their participation like requesting the patients to go to the consultation room from where the researcher explained to the respondent everything concerning the research and requested his/her informed consent. The details of the ethical considerations were laid down in the letter of consent namely: consent explanation, confidentiality, personal and general benefits, risk and right not to participate and right to withdraw anytime were explained to the respondents.

3.9.1 Consent Explanation

This was done in English and Swahili to accommodate the languages that are spoken in the study areas. The consent explanation covered the nature of the study, voluntary participation and the right to withdraw at any time without loss of benefits, issues of confidentiality and any risks and benefits to the individual and the community. No incentives for participation were offered.

3.9.2 Risks

Participants were informed about lack of invasive procedures and risks except that they may have emotional pain as they reflect on the experience related to their condition. Any participant found to be overwhelmed emotionally wascounseled appropriately and any who needed further intervention was referred appropriately.

Participation in the study did not directly or indirectly influence the care that patients received for their illness.

3.9.3 Confidentiality

Study respondents were assured of confidentiality and that their names were not going to be used on the study documents or for publication purposes, they were only identified by serial numbers. The Interview schedules were coded so that the names of the participants remained confidential. Information on the individual psychosocial distress was kept confidential. However the participants were required to write their names on the consent form (for legal purposes and for follow up of those who were found to have mental problems) and this form was stored separately from the research documents. All data collected was entered into a computer and kept under lock and key. The researcher was the only person allowed to access it. The computer used had a password and anti-virus to protect it from loss or modification of data and any unauthorized access.

3.9.4 Informed consent

A written informed consent was sought from the participants after full detailed explanation of the study. Thereafter respondents were informed that participation in the study was voluntary and that information collected wouldbe used only for the purpose of the study and not otherwise. They were informed that those who did not wish to participate in the study had the right to do so and would not be victimized in any way. Once consented, patients were asked to sign the forms.

3.10 Data Management

The researcher administered questionnaires to the individual respondents. At the end of each session the researcher inspected the filled questionnaires for completeness and validity of responses prior to storing them safely in preparation for analysis. Data was then coded prior to data entry.

3.12 Data Entry

A data base was designed with inbuilt consistency and validity checks to minimize data entry errors. Quality assurance of the data was ensured by conducting double entry for a random selection of questionnaires and checking for agreement between the double entered data and the initial data entry

3.13 Data analysis and presentation

The statistical package for social sciences (SPSS) version 17 for windows was used to analyze the data. Both descriptive and inferential statistics were applied. During descriptive analysis means and medians were calculated and frequencies determined for continuous and categorical variables, respectively. The results of the descriptive analysis were presented in narratives, tables, bar charts and pie charts. Based on scoring using the M.I.N.I plus the participants were assigned different psychiatric morbidities. An overall prevalence for psychiatric morbidity was determined by calculating the percentage of participants with any psychiatric illness. In the inferential analysis percentages of patients with different levels of the independent variable were compared using chi squared tests. A p value cut off of 0.05 was used to determine statistical significance.

The presentation of the analysis described above is illustrated in the dummy tables 3-2 and 3-3.

i) Descriptive analysis

Table 3-2: Demographic characteristics of HIV positive patients attending the CCC at Kangemi Health Centre

	Frequency (n)	Percent (%)
Gender		
Male	x	y
Female	x	y
Age category		
20-29 years	x	y
30-39 years	x	y
40-49 years	x	y
Highest level of education		
No formal education	x	y
Primary	x	y
Secondary	x	y

ii) Inferential analysis

Table 3-3: Patient characteristics and occurrence of psychiatric comorbidity

	Psychiatric morbidity		Chi (df)	P value
	Present	Absent		
	n (%)	n (%)		
Gender				
Male	x (y)	x (y)	χ (z)	p
Female	x (y)	x (y)		
Age category				
20-29 years	x (y)	x (y)	χ (z)	p
30-39 years	x (y)	x (y)		
40-49 years	x (y)	x (y)		
Highest level of education				
No formal education	x (y)	x (y)	χ (z)	p
Primary	x (y)	x (y)		
Secondary	x (y)	x (y)		

CHAPTER FOUR

4.0 Results

4.1 Participants' characteristics

The study planned to recruit a minimum of 238 HIV/ AIDS patients attending care at Kangemi CCC, but 245 patients were actually recruited into the study. The median age of the patients was 37 years (IQR 30-44 years), with an age range from 19 to 70 years. Table 4-1 summarizes the characteristics of the 245 patients. There were 186 (75.9%) females yielding a Male-to-Female ratio of 1:3. Out of the participants, 114 (46.5%) were married, 44 (18%) were widowed and 39 (15.9%) were single. One hundred and fourteen (48.6%) patients had primary level education and 89 (36.3%) had attained secondary level education. Protestants or Catholics accounted for 66.1% and 27.8% of participants, respectively.

Table 4-1: Demographic characteristics of adult HIV/ AIDS patients attending Kangemi CCC

		n	%
Patient's sex	Male	59	24.1
	Female	186	75.9
Marital status	Single	39	15.9
	Married	114	46.5
	Separated	22	9
	Divorced	26	10.6
	Widowed	44	18
Formal education	None	16	6.5
	Primary	119	48.6
	Secondary	89	36.3
	College/university	21	8.6
Religion	Catholic	68	27.8
	Protestant	162	66.1
	Other	15	6.1

The socioeconomic status of participating patients is summarized in table 4-2. One hundred and fourteen (46.58%) patients were currently employed. All patients reported engaging in some form of occupation and 171 (69.8%) were engaged in unskilled occupations. One hundred and twenty eight (52.2%) patients reported that they had a monthly income of at least KShs 3000.

Table 4-2: Socioeconomic characteristics of adult HIV/ AIDS patients attending Kangemi CCC

		n	%
Currently employed	No	131	53.5
	Yes	114	46.5
Monthly income	Less than Kshs 3000	117	47.8
	More than Kshs 3000	128	52.2
Occupation	Skilled	73	29.8
	Unskilled	171	69.8
	Student	1	0.4

4.2 HIV illness duration and latest CD4 count

The duration of HIV illness ranged from 2 months to 23 years, with a median duration of illness of 5 years (IQR 3 to 8). Table 4-3 shows that 43.7% of patients had HIV for periods of between 5 and 9 years. Out of the 216 patients reporting recent CD4 counts, 64.4% had counts less than 500 cells per mm^3.

Table 4-3: Duration of HIV illness (in years) and most recent CD4 count in patients at Kangemi CCC

		n	%
Duration of illness	Less than a year	10	4.1
	1-2 years	46	18.8
	3-4 years	47	19.2
	5-9 years	107	43.7
	10 years and above	35	14.3
CD4 count (n = 216)	< 500 cells/ mm^3	139	64.4
	≥500 cells/ mm^3	77	35.6

There were 198 (80.8%) patients who reported ever having had a spouse. Figure 2 shows that 44 (18%) spouses had died, most (33/ 44) of whom HIV status was unknown. Among the 154 spouses who were alive 66 (42.9%) were HIV positive and HIV status of 49 (31.8%) spouses was unknown.

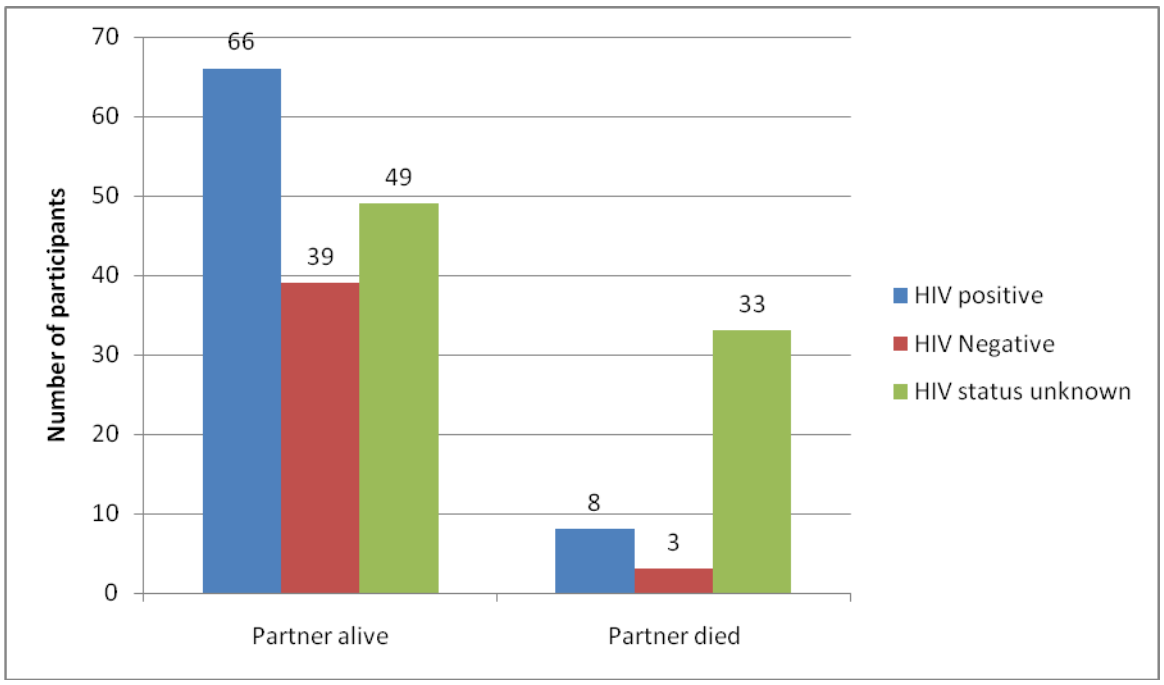


Figure 1: HIV status and vital status of spouses of HIV/ AIDS patients attending Kangemi CCC

The children of most (69.8%) HIV/ AIDS patients were HIV negative children. Twenty-six (10.6%) patients however had at least one HIV positive child (Figure 2).

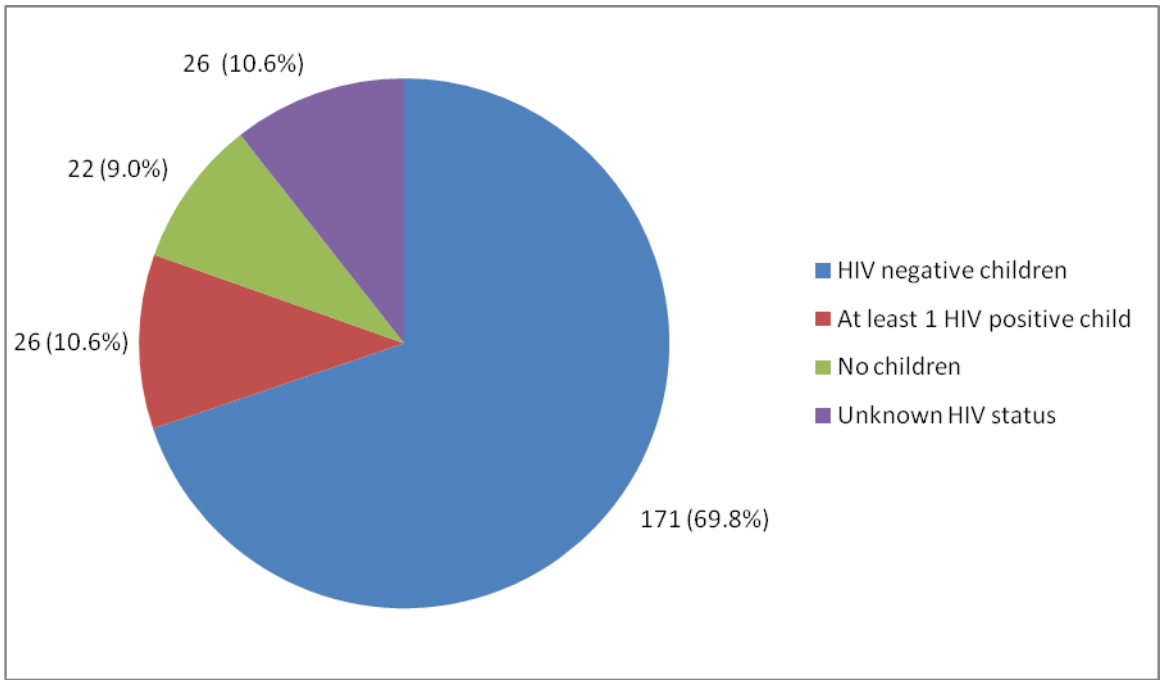


Figure 2: HIV status of children of HIV/ AIDS patients attending Kangemi CCC

4.3 Prevalence of psychiatric morbidity in HIV

Out of the 245 patients, a total of 175 were diagnosed with psychiatric morbidity using the mini tool. Therefore the prevalence of psychiatric morbidity in HIV/ AIDS patients attending Kangemi CCC was 71.4% as presented in figure 3.

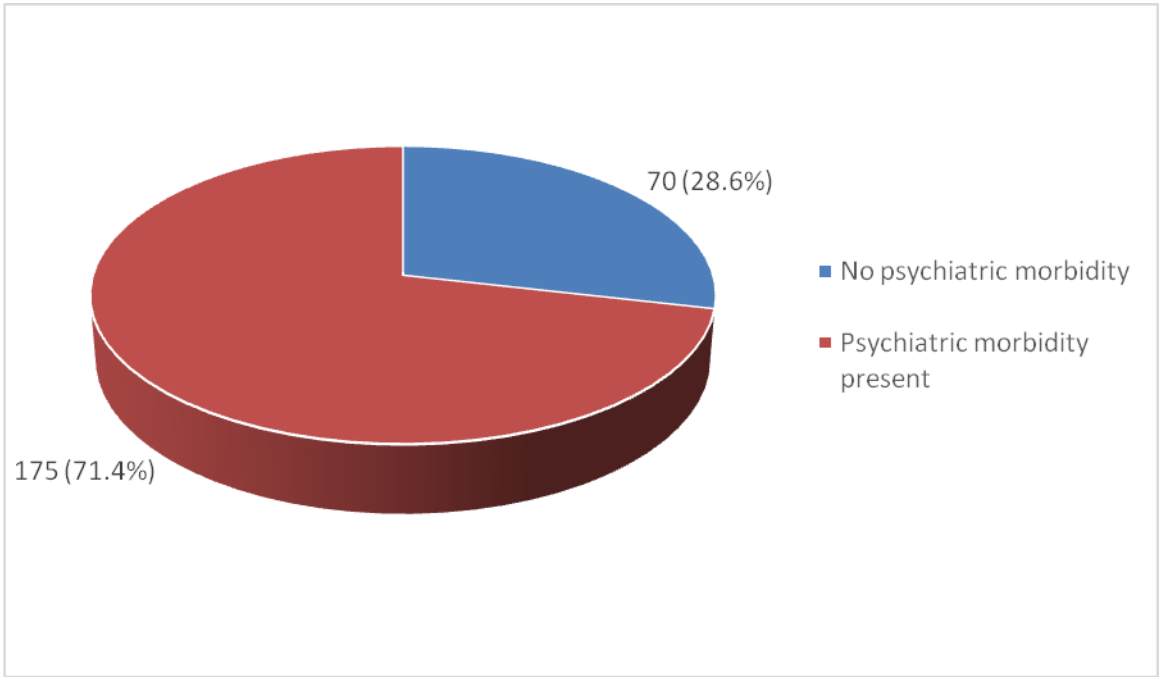


Figure 3: Prevalence of psychiatric morbidity among HIV/ AIDS patients attending CCC at Kangemi Health Centre

4.4 Psychiatric morbidity and socio-demographic factors

Psychiatric illness showed a statistically significant association with patient income (Table 4-4). The odds of psychiatric illness among patients with higher income (> Kshs 3, 000) was 45% lower than in patients with monthly incomes less than Kshs 3, 000 (65.6% versus 77.8%; OR = 0.55, 95% CI 0.31-0.96, p = 0.037).

The prevalence of psychiatric morbidity was not associated with patient age (p value = 0.248). The median age for patients with psychiatric morbidity was 36 years compared to 37 years in patients with no psychiatric morbidity. Gender, marital status, level of education, religion and employment status were not associated with psychiatric morbidity (Table 4-4).

Table 4-4: Psychiatric morbidity and socio-demographic factors in HIV/ AIDS patients at Kangemi Health Centre

		Psychiatric morbidity			
		Yes	**No**	**OR (95 % CI)**	**P value**
Employment status	Unemployed	98(74.8)	33(25.2)	1.0(Reference)	
	Employed	77(67.5)	37(32.5)	0.7(0.4-1.22)	0.21
Sex	Male	38(64.4)	21(35.6)	1.0(Reference)	
	Female	137(73.7)	49(26.3)	1.55(0.83-2.89)	0.172
Monthly income	Less than Kshs 3000	91(77.8)	26(22.2)	1.0(Reference)	
	More than Kshs 3000	84(65.6)	44(34.4)	0.55(0.31-0.96)	0.037
Level of formal education	None	11(68.8)	5(31.3)	1.0(Reference)	
	Primary	86(72.3)	33(27.7)	1.18(0.38-3.67)	0.769
	Secondary	65(73.0)	24(27.0)	1.23(0.39-3.91)	0.725
	College/ university	13(61.9)	8(38.1)	0.74(0.19-2.92)	0.666
Marital status	Single	27(69.2)	12(30.8)	1.0(Reference)	
	Married	81(71.1)	33(28.9)	1.09(0.49-2.41)	0.829
	Separated	17(77.3)	5(22.7)	1.51(0.45-5.05)	0.503
	Divorced	16(61.5)	10(38.5)	0.71(0.25-2.02)	0.522
	Widowed	34(77.3)	10(22.7)	1.51(0.57-4.02)	0.409
Religion	Catholic	50(73.5)	18(26.5)	1.0(Reference)	
	Protestant	116(71.6)	46(28.4)	0.91(0.48-1.72)	0.766
	Other	9(60.0)	6(40.0)	0.54(0.17-1.73)	0.3

4.5 Comorbidity with multiple psychiatric disorders in HIV/ AIDS patients

Out of 175 patients with psychiatric illness 71 were diagnosed with a single psychiatric morbidity and the remaining had at least two psychiatric co morbidities. 48 (19.6%) patients had two different psychiatric morbidities, 34 (13.9%) had three different morbidities (figure 4).

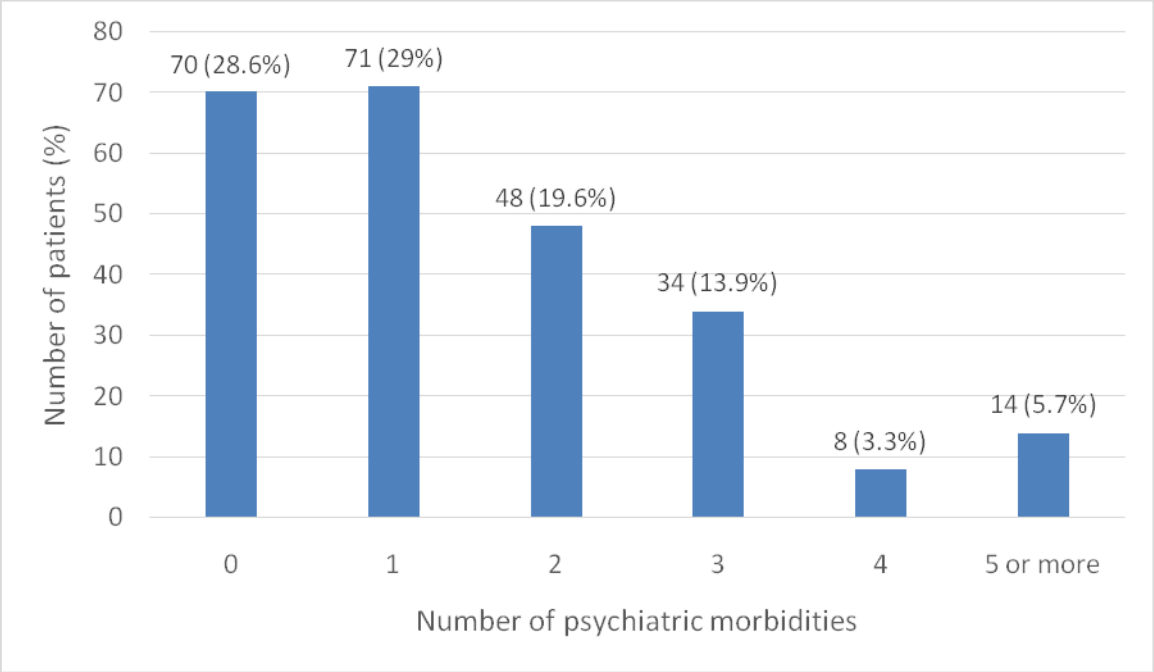


Figure 4: Number of psychiatric morbidities among HIV/ AIDS patients at Kangemi CCC

Table 4-5 presents the psychiatric diagnoses in HIV/ AIDS patients attending CCC. Major depressive disorder was the leading diagnosis occurring in 25 (10.2%) patients. Twenty one (8.6%) patients had dysthymia and 8 (3.3%) were diagnosed with major depressive disorder and PTSD. Panic disorder and manic disorder each occurred in 7 (2.9%) of the patients. The frequency distribution of the remaining psychiatric morbidities is shown in table 4-5. Other psychiatric comorbid diagnoses occurred in 34 (13.9%). The details of these other diagnoses are presented in appendix A.

Table 4-5: Psychiatric comorbidities among HIV/ AIDS patients in Kangemi Health Center

	n	%
No psychiatric morbidity	70	28.6
Major depressive disorder	25	10.2
Dysthymia	21	8.6
Major depressive disorder and PTSD	8	3.3
Panic disorder	7	2.9
Manic disorder	7	2.9
Dysthymia and PTSD	6	2.5
Major depressive disorder and suicidality	6	2.5
Major depressive disorder, suicidality and OCD	6	2.5
General anxiety disorder	5	2.0
Major depressive disorder, PTSD and OCD	5	2.0
Major depressive disorder and panic disorder	5	2.0
Major depressive disorder, suicidality and panic disorder	4	1.6
Manic disorder and psychosis	3	1.2
Suicidality	3	1.2
Dysthymia and suicidality	3	1.2
Major depressive disorder and OCD	3	1.2
Major depressive disorder, social phobia, OCD and PTSD	3	1.2
Major depressive disorder, suicidality and PTSD	3	1.2
PTSD	2	0.8
OCD and psychosis	2	0.8
Manic disorder, PTSD and psychosis	2	0.8
Manic disorder, PTSD and OCD	2	0.8
Manic disorder, social phobia, OCD, PTSD and psychosis	2	0.8
Manic disorder, social phobia, OCD, PTSD, psychosis and alcohol abuse	2	0.8
Dysthymia and antisocial personality disorder	2	0.8
Dysthymia and OCD and psychosis	2	0.8
Major depressive episode, suicidality, social phobia and OCD	2	0.8
Other comorbid illness pattern	34	13.9
Total	**245**	**100.0**

4.6 Major Depressive Disorder and patient characteristics

As shown in table 4-6, both patient income (p = 0.005) and gender (p = 0.027) were significantly associated with MDD prevalence. Female patients were two times more likely to suffer MDE compared to male patients (OR = 2.21; 95% CI 1.09-4.45). The odds of MDD among patients with monthly incomes above than Kshs 3, 000 was 54% lower than that of patients with incomes >Kshs 3, 000 (24.2% versus 41%; OR = 0.46, 95% CI 0.27-0.79).

Table 4-6: Socio-demographic characteristics of HIV/ AIDS patients and MDD diagnosis

		MDD				
		Yes	**No**	**OR**	**95% CI**	**p**
Employed	No	44(33.6)	87(66.4)	1.00		
	Yes	35(30.7)	79(69.3)	0.88	0.51-1.5	0.63
Gender	Male	12(20.3)	47(79.7)	1.00		
	Female	67(36.0)	119(64.0)	2.21	1.09-4.45	0.027
Income	Less than Kshs 3000	48(41.0)	69(59.0)	1.00		
	More than Kshs 3000	31(24.2)	97(75.8)	0.46	0.27-0.79	0.005
	None	5(31.3)	11(68.8)	1.00		
Education	Primary	37(31.1)	82(68.9)	0.99	0.32-3.06	0.99
	Secondary	34(38.2)	55(61.8)	1.36	0.43-4.25	0.597
	Tertiary	3(14.3)	18(85.7)	0.37	0.07-1.85	0.224
Marital status	Single	12(30.8)	27(69.2)	1.00		
	Married	34(29.8)	80(70.2)	0.96	0.43-2.11	0.912
	Separated	9(40.9)	13(59.1)	1.56	0.52-4.63	0.425
	Divorced	7(26.9)	19(73.1)	0.83	0.28-2.49	0.739
	Widowed	17(38.6)	27(61.4)	1.42	0.57-3.52	0.454
Religion	Catholic	19(27.9)	49(72.1)	1.00		
	Protestant	57(35.2)	105(64.8)	1.40	0.75-2.6	0.288
	Muslim or other	3(20.0)	12(80.0)	0.64	0.16-2.54	0.531

None of the patients' characteristics related to HIV diagnosis namely CD4 count, child and spousal HIV status or duration of HIV illness were significantly associated with MDD diagnosis (table 4-7).

Table 4-7: Patient HIV characteristics and MDD diagnosis

		MDD				
		Yes	**No**	**OR**	**95% CI**	**p**
CD 4 count	<500 cells/mm3	40(28.8)	99(71.2)	1.00		
	>500 cells/mm3	28(36.4)	49(63.6)	1.41	0.78-2.56	0.251
Child HIV status	Positive	10(38.5)	16(61.5)	1.00		
	Negative	55(32.2)	116(67.8)	0.76	0.32-1.78	0.525
	Unknown	9(34.6)	17(65.4)	0.85	0.27-2.62	0.773
	No children	5(22.7)	17(77.3)	0.47	0.13-1.68	0.246
Spouse HIV status	Alive & HIV positive	21(31.8)	45(68.2)	1.00		
	Alive & HIV negative	10(25.6)	29(74.4)	0.74	0.3-1.79	0.503
	Alive & status unknown	17(34.7)	32(65.3)	1.14	0.52-2.49	0.746
	Died/ HIV positive	3(37.5)	5(62.5)	1.29	0.28-5.89	0.746
	Died/ HIV negative	1(33.3)	2(66.7)	1.07	0.09-12.49	0.956
	Died/ status unknown	13(39.4)	20(60.6)	1.39	0.58-3.32	0.455
HIV duration	Less than 1 y	3(30.0)	7(70.0)	1.00		
	2-3 y	14(30.4)	32(69.6)	1.02	0.23-4.54	0.978
	4-5 y	13(27.7)	34(72.3)	0.89	0.2-3.98	0.881
	6-9 y	36(33.6)	71(66.4)	1.18	0.29-4.85	0.815
	10 y +	13(37.1)	22(62.9)	1.38	0.3-6.28	0.678
Partner alive	No	62(30.8)	139(69.2)	1.00		
	Yes	17(38.6)	27(61.4)	1.41	0.72-2.78	0.318

4.7 Suicidality and patient characteristics

The odds of a diagnosis of suicidality was 65% lower in employed (11.4%) compared to unemployed (26.7%) patients (OR = 0.35, 95% CI 0.18-0.71, p = 0.003). Patient income also showed a significant association with suicidality (table 4-8). Patients with higher income were at significantly lower risk of suicidality compared to those with low income (OR = 0.42, 95% CI 0.22-0.82, p = 0.01). Finally, the odds of a diagnosis of suicidality were lower in married patients compared to single patient (17.5% versus 33.3%, OR = 0.43, 95% CI 0.19-0.97).

Table 4-8: Socio-demographic characteristics of HIV/ AIDS patients and suicidality

		SUICIDALITY				
		Yes	**No**	**OR**	**95% CI**	**p**
Employed	No	35(26.7)	96(73.3)	1.00		
	Yes	13(11.4)	101(88.6)	0.35	0.18-0.71	0.003
Gender	Male	7(11.9)	52(88.1)	1.00		
	Female	41(22.0)	145(78.0)	2.10	0.89-4.97	0.091
Income	Less than Kshs 3000	31(26.5)	86(73.5)	1.00		
	More than Kshs 3000	17(13.3)	111(86.7)	0.42	0.22-0.82	0.01
Education	None	5(31.3)	11(68.8)	1.00		
	Primary	26(21.8)	93(78.2)	0.62	0.2-1.93	0.405
	Secondary	14(15.7)	75(84.3)	0.41	0.12-1.37	0.146
	Tertiary	3(14.3)	18(85.7)	0.37	0.07-1.85	0.224
Marital status	Single	13(33.3)	26(66.7)	1.00		
	Married	20(17.5)	94(82.5)	0.43	0.19-0.97	0.042
	Separated	3(13.6)	19(86.4)	0.32	0.08-1.27	0.104
	Divorced	4(15.4)	22(84.6)	0.36	0.1-1.28	0.115
	Widowed	8(18.2)	36(81.8)	0.44	0.16-1.23	0.117
Religion	Catholic	13(19.1)	55(80.9)	1.00		
	Protestant	33(20.4)	129(79.6)	1.08	0.53-2.21	0.828
	Muslim or other	2(13.3)	13(86.7)	0.65	0.13-3.25	0.6

None of the patients' characteristics related to HIV diagnosis namely CD4 count, child and spousal HIV status or duration of HIV illness were significantly associated with suicidality diagnosis (table 4-9).

Table 4-9: Patient HIV characteristics and suicidality diagnosis

		SUICIDALITY				
		Yes	**No**	**OR**	**95% CI**	**P**
CD 4 count	<500 cells/mm3	28(20.1)	111(79.9)	1.00		
	>500 cells/mm3	9(11.7)	68(88.3)	0.52	0.23-1.18	0.118
Child HIV status	Positive	6(23.1)	20(76.9)	1.00		
	Negative	38(22.2)	133(77.8)	0.95	0.36-2.54	0.922
	Unknown	2(7.7)	24(92.3)	0.28	0.05-1.53	0.141
	No children	2(9.1)	20(90.9)	0.33	0.06-1.85	0.21
Spouse HIV status	Alive & HIV positive	11(16.7)	55(83.3)	1.00		
	Alive & HIV negative	9(23.1)	30(76.9)	1.50	0.56-4.02	0.421
	Alive & status unknown	7(14.3)	42(85.7)	0.83	0.3-2.33	0.728
	Died/ HIV positive	1(12.5)	7(87.5)	0.71	0.08-6.4	0.764
	Died/ HIV negative	1(33.3)	2(66.7)	2.50	0.21-30.04	0.47
	Died/ status unknown	6(18.2)	27(81.8)	1.11	0.37-3.33	0.851
HIV duration	Less than 1 y	3(30.0)	7(70.0)	1.00		
	2-3 y	6(13.0)	40(87.0)	0.35	0.07-1.74	0.199
	4-5 y	7(14.9)	40(85.1)	0.41	0.08-1.97	0.264
	6-9 y	24(22.4)	83(77.6)	0.67	0.16-2.81	0.589
	10 y +	8(22.9)	27(77.1)	0.69	0.14-3.31	0.644
Partner alive	No	40(19.9)	161(80.1)	1.00		
	Yes	8(18.2)	36(81.8)	0.89	0.39-2.07	0.795

4.8 Multivariable analysis

Multivariable analysis was conducted by running two separate logistic regression models to identify significant associations between patient characteristics and the two leading psychiatric morbidities MDD and suicidality. Variable selection for the multivariable models was based on a cut off value of 0.05 for all associations examined in the bivariate analysis. All the patient factors that showed significant bivariate associations with MDD or suicidality were included all at once in multivariable regressions models. Odds ratio and 95% CI from the logistic regressions were reported. Likelihood ratio tests (LRT) were then used to determine if the model with explanatory factor had a better fit than the null model. The p-value from the LRT was used to determine statistical significance between the outcome and explanatory factor in the model.

4.9 MDD multivariable analysis

In the multivariable model, income of HIV positive patients attending comprehensive care was significantly associated with depression (table 4-10). The odds of depression was 44% lower (OR = 0.56, 95% CI 0.33-0.96) among patients with monthly income more than Kshs 3000

compared to patients earning less than Kshs 3000 monthly. Gender confounded the effect of income on depression. After adjusting for the effect of monthly income gender was no longer associated with depression (OR = 1.78, 95% CI 0.91-3.46).

Table 4-10: Multivariable logistic regression of factors associated with depression

		Odds Ratio	95% CI	P value
Gender	Male	1.00		
	Female	1.78	0.91-3.46	0.091
Income	Less than Kshs 3000	1.00		
	More than Kshs 3000	0.56	0.33-0.96	0.034
	Intercept	0.32	0.09-1.19	0.09

Table 4-11 presents the multivariable model of the factors that were significantly associated with suicidality in the bivariate analysis. Employment status was significantly associated with suicidality after adjusting for the effect of monthly income. The odds of suicidality was significantly lower among employed HIV participants compared to unemployed patients (OR = 0.39, 95% CI 0.19-0.82).

Table 4-11: Multivariable logistic regression of factors associated with suicidality

		Odds Ratio	95% CI	P value
Income	Less than Kshs 3000	1.00		
	More than Kshs 3000	0.56	0.28-1.12	0.101
Employed	No	1.00		
	Yes	0.39	0.19-0.82	0.013
Marital status	Single	1.00		
	Married	0.39	0.16-0.91	0.268
	Separated	0.36	0.09-1.53	
	Divorced	0.37	0.1-1.35	
	Widowed	0.40	0.14-1.13	
	Intercept	0.99	0.45-2.16	0.98

CHAPTER FIVE

5.0 Discussion

The purpose of this study conducted among people living with HIV in a low-income urban population receiving comprehensive care at Kangemi Health Centre was to determine the magnitude of psychiatric morbidity in HIV/AIDS patients in Kenya. The findings suggest that a good proportion (71%) of the HIV/AIDS patients attending CCC experience psychiatric problems ranging from minor to severe illnesses for which they may not be receiving treatment.

Socio demographic characteristics

The median age (37 years) and age range (19 to 70 years) of participants in this study concurs with previous studies (26) conducted in comparable populations. Most participants in a previous study examining depression in PLWAs were middle aged, with 39.8% of participants between age 30 and 39 years and 31% (40-49years).

An additional noteworthy finding related to participants' demographics in the current study was that three-quarters of the patients, (75.9%) were female. There are several plausible explanations to the disproportionate representation of women in the population of PLWA attending comprehensive care. Firstly, similar studies in African populations have revealed higher prevalence of HIV infection in women than men and biological explanations for this vulnerability have been proposed (31). Findings in the Kenya Aids Indicator Survey, revealed that women were more likely to be infected (8.4%) compared to men (5.4%). Ng'ang'a (26) found that most participants in her study were female (62%), with a Male-to-Female ratio of 1:1.6. Secondly, the higher female to male ratio in this study could be explained by the fact that women have been reported to have confiding relationships and have responsibility for the care of young children at home. They are therefore more likely to seek intervention in case of ill health compared to men (31).

Prevalence of psychiatric morbidity

There was indeed a high prevalence of psychiatric morbidity among PLWA in the current study with a prevalence rate of 71.4%. A similar study done in Uganda reported an even higher prevalence rate of 90% (2).

The most common psychiatric disorders in the current study were: Major Depressive Disorder (32.2%), Suicidality (19.4%), PTSD (18.4%), Dysthymia (17.6%) and Obsessive Compulsive Disorder (17.6%). Depression ranked high among the psychiatric illnesses and is also the most common mood disorder in general populations world- wide with a prevalence rate of 10-15 % (2). The prevalence of MDD of 32.2% reported in this study is comparable to a prevalence of 35% found in a South African study (19). Conversely, a previous study conducted in Kenyan population living with HIV in Nairobi applied the Becks Depression Index for diagnosing depression and reported a prevalence rate of 47.25% for depression(26). This prevalence is comparable to a cumulative prevalence of depressive disorder of 49.8% documented in the current study using MINI plus.

The use of different assessment approaches form a plausible explanation for variations in estimated prevalence of depression in similar HIV populations noted in the foregoing discussion. The comparative data were derived from studies that used different approaches to psychiatric morbidity assessment, namely the MINI-PLUS and the BDI tools, respectively. Therefore, the higher prevalence of depression found in this study could reflect differences in the sensitivity of the MINI-PLUS and BDI tools in diagnosing depression.Factors that could explain varying levels of exposure to negative life events example conflicts were not investigated in this study and future studies will be required to evaluate performance of different approaches to depression assessment on the estimated disease burdens.

Equally high prevalence of MDD was found in other parts of Africa- South Africa and Uganda where a prevalence of 40% was reported.Other studies reported a much lower prevalence of MDD, Chisanga et al in Zambia found a prevalence of 9.6%, Adewuya et al in Nigeria reported a prevalence of 11.4% and Marwick and Kaaya in rural Tanzania reported a prevalence of 2.7% (32, 33and 34). All three studies above derived from sub-Saharan Africa used international diagnostic criteria to make a diagnosis of MDD. In another study done in South Africa and Uganda a prevalence of 40% was reported (35, 36). This wide variability in rates of MDD has previously been noted by Judd and colleagues in a review of studies on MDD in HIV/AIDS. Judd et al (37) attributed these wide variations in rates of MDD to a number of factors many of which are still relevant today. These included; methodological challenges in assessing MDD in somatically ill patients, differences in the composition of the study samples on ‘at risk groups’ (commercial sex workers, injection drug abusers, men who have sex with men, discordant couples, high risk occupational groups and persons who acquired HIV perinatally) and on the

different HIV clinical stages, whether the study population was predominantly in patient or out-patient and geographical differences. Judd et al summarized their observation by stating that it was difficult to come to a clear conclusion about the prevalence of MDD in HIV/AIDS, a summary which still seems to be pertinent to the sub-Saharan African setting today.

Surprisingly, generalized anxiety disorder had a low prevalence of 2.5%. This study had a lower finding as compared to a similar South African study (19) which found a prevalence of 21%. A possible explanation for the lower prevalence in this study could be because new patients were excluded from the study and reports suggest that anxiety is prominent following initial HIV diagnosis and anxiety symptoms can frequently recur and escalate in response to disease progression. The participants in this study had a median duration of illness of 5 years. It is therefore assumed that participants in this study were already undergoing treatment, having gone through the various phases of management i.e. counseling, initiation and maintenance of drug therapy.

Conversely, the study found lower prevalence of alcohol dependence (3.3%), generalized anxiety disorder (2.5%), antisocial personality disorder (1.2%). The low prevalence of alcohol abuse in this study is surprising given the known levels of alcohol intake in general populations. Plausible explanations include the possibility that patients with alcohol use disorders may have dropped out of treatment and follow-up at the center. In addition, it is conceivable that patients with good adherence to ARV therapy and long term follow-up are also more likely to implement behavior changes in line with treatment recommendations. In this regard, the low prevalence of alcohol disorder may have been because majority of patients were taking anti-retroviral drugs. Alcohol and other habit forming drugs are contraindicated during ARV therapy therefore; patients were most likely following advice against alcohol consumption.

Psychiatric morbidity and social demographic characteristics

Psychiatric illness showed a statistically significant association with patient income. The odds of psychiatric illness among patients with higher income were 45% lower than in patients with less monthly income (less than Kshs 3000). A similar study (12) concurred with the findings; the study revealed that being unemployed was associated with greater risk for psychiatric disorder.

The study also revealed that prevalence of psychiatric illness was lower in patients whose children had unknown HIV status (53.8%) compared to those with HIV positive children (80.8%). Known HIV status in children of participants may play a role in heightening anxiety in

the study subject. This anxiety may be related to uncertainty about the ability to continue playing the caregiver role and the concern about the children's future. At the parental level anxiety may be due to illness anticipation, healthcare cost implication and from a social perspective the family lineage continuity.

Although female patients were two times more likely to suffer Major Depressive Disorder compared to male patients in the unadjusted analysis, this association was not seen after conducting an adjusted analysis including both gender and income. The results of the multivariable analysis therefore point to a confounding effect of gender on the association between income and MDD. With regard to this finding it is important to note that majority of the women were low income earners and may have been depending on their spouses for financial support and that financial instability has been previously associated with depression in HIV patients. Similar to the present study it is noteworthy that a previous study of the women involved in the HCSUS research indicated that women who are dependent on income assistance were more likely to experience psychiatric co-morbidity (12). A positive association between female gender and MDD in HIV/AIDS has previously been reported in Africa by both Kahazura et al in Uganda and Olley et al in South Africa (38, 39). Some of the gender differences in MDD have been attributed to the more likelihood of females than males to become victims of traumatic experiences such as sexual, physical and emotional abuse both in childhood and in adulthood.

Psychiatric co morbidities

Out of 175 patients with psychiatric illnesses 71(40.6%) were diagnosed with a single psychiatric morbidity and the remaining had at least two psychiatric co morbidities. The occurrence of co morbid psychiatric disorders is common in both general populations and HIV positive persons. Patients attending a HIV primary care clinic in South Africa were found to have a high prevalence of distress; the authors identified 52% of their participants as having significant depression and 65.6% had a history of a substance use disorder (40) In addition the current study was carried out in a resource poor setting. In these settings it is conceivable that issues related to resource-constraint such as medication, nutrition and poverty may have contributed to the reduced psychosocial wellbeing of patients and possibly the presence of psychiatric morbidity.

Study Limitations

In the assessment of psychiatric morbidity the current study did not account for the fact that HIV/ AIDS ARV therapy is associated with a considerable burden of psychiatric illness resulting from side effects of medication.Future studies could be designed to quantify the burden of psychiatric illness attributed to ARV therapy and pre-existing psychiatric illness.

The study was limited to Kangemi Health Centre CCC patients only, therefore, the findings of the study can be widely generalized to CCC facilities in Kenyan Health Centres located within urban areas. However, the findings may not apply in higher referral levels or in facilities offering some form of psychosocial support.

Conclusion

The results of this study show that patients with HIV/AIDS receiving follow up care experience considerable psychiatric morbidity. Of these patients with psychiatric morbidity, large proportions have comorbid psychiatric illness.Among the socio demographic factors analyzed, income status had a positive correlation with psychiatric illness particularly with depression. There is, therefore, need for more psychological counseling and psychiatric assessment and treatment to ensure mental wellbeing in patients being managed at the Comprehensive Care Centres in the country.

Recommendations

There is need to screen HIV/AIDS patients for psychiatric morbidity and integrate psychiatric services into routine care of HIV/AIDS patients.

There should be focus on early intervention campaigns to ease the burden brought about by HIV/AIDS, increase productivity, adherence and eventually reduce the cost of care.

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BUDGET

NO.	ITEM	COST(KSHS)
1.	Proposal writing Typing and type setting Printing and photocopying	19,000/=
2.	Data collection and entry	6,500/=
3.	Data analysis	46,000/=
4.	Final Dissertation	25,000/=
5.		
	TOTAL COST	96,500/=

Budget Justification

Item 1- Proposal writing- Kshs 19,000

Typing and type setting- 85 pages @ Kshs 50 = 4250 + 500 = Kshs 4,750

Printing and photocopying- 85 pages @ Kshs 10 per page = 850 per copy × 5 copies = Kshs 4,250

Internet costs (Literature review) – 10 GB @ Kshs 1000 per GB = Kshs 10,000

Item 2- Data collection and entry – Kshs 6,500

Study questionnaires - 250 copies ×2 pages =500 copies @ Kshs 3 = Kshs 1,500.

MS Access data base design costs = Kshs 5,000

Data entry costs – 2 data entry clerks × 15 days @ Kshs 500 per day = Kshs 15,000

Item 3 -Data analysis – Kshs 46,000

SPSS software licence – validity period 1 year – Kshs 16,000

Data analysts charges – Kshs 30,000

Item 4 - Final dissertation - Kshs 25,000

Typing and type setting- approx. 150 pages @ Kshs 50 = 7500 + 100 = Kshs 8,500

Printing and photocopying- approx. 150 pages @ Kshs 10 per page = 1500 per copy × 10 copies = Kshs 15,000

Binding – 6 copies @ Kshs 250 = Kshs 1,500

TIME FRAME

Activity number	Activity	Responsible officer	2013	2014
1	Proposal writing	Researcher or investigator Supervisors	Jan	
2	Submission of proposal for approval	Researcher or investigator	Jun	
3	Pretesting	Researcher or investigator	Nov	
4	Data collection	Researcher or investigator Supervisors		Feb-Apr
5	Data analysis	Researcher or investigator Biostatistician		Apr-May
6	Thesis Writing	Researcher investigator supervisors		Jun
7	Submission of thesis	Researcher or investigator		Jul

APPENDICES

Appendix A: Distribution of psychiatric diagnosis occurring only once in HIV/ AIDS patients attending CCC

	n	%
Antisocial personality disorder	1	0.4
Bulimia nervosa	1	0.4
PTSD and psychosis	1	0.4
OCD and bulimia nervosa	1	0.4
Manic disorder and PTSD	1	0.4
Manic disorder, OCD and PTSD and psychosis	1	0.4
Manic disorder, social phobia, OCD, alcohol dependence and psychosis	1	0.4
Manic disorder, social phobia, OCD, PTSD, psychosis and anorexia nervosa	1	0.4
Manic disorder, panic disorder and psychosis	1	0.4
Suicidality and generalized anxiety disorder	1	0.4
Suicidality and panic disorder	1	0.4
Suicidality, manic disorder and psychosis	1	0.4
Suicidality, manic disorder, OCD, alcohol dependence and psychosis	1	0.4
Suicidality, manic disorder, OCD, PTSD and psychosis	1	0.4
Suicidality, manic disorder, OCD, PTSD, psychosis and bulimia nervosa	1	0.4
Suicidality, manic disorder, social phobia, OCD, psychosis and bulimia nervosa	1	0.4
Dysthymia and psychosis	1	0.4
Dysthymia, PTSD, psychosis and bulimia nervosa	1	0.4
Dysthymia, OCD	1	0.4
Dysthymia and panic disorder	1	0.4
Dysthymia, panic disorder and psychosis	1	0.4
Dysthymia, panic disorder, alcohol dependence and psychosis	1	0.4
Dysthymia, suicidality and PTSD	1	0.4
Dysthymia, suicidality and OCD	1	0.4
Dysthymia, suicidality and panic disorder	1	0.4
Major depressive disorder and alcohol dependence	1	0.4
Major depressive disorder, OCD and bulimia nervosa	1	0.4
Major depressive disorder, OCD and alcohol dependence	1	0.4
Major depressive disorder, OCD, PTSD and alcohol dependence	1	0.4
Major depressive disorder and social phobia	1	0.4
Major depressive disorder, social phobia and OCD	1	0.4
Major depressive disorder, suicidality and bulimia nervosa	1	0.4
Major depressive disorder, suicidality and social phobia	1	0.4
Major depressive disorder, suicidality, social phobia and PTSD	1	0.4
Total	**34**	**13.9**

Appendix Bi: Informed Consent Explanation (English Version)

My name is Dr. Pauline Ng'ang'a. I am currently doing a Masters Degree course in Psychiatry at the University of Nairobi. I am doing research on prevalence of psychiatric morbidity among HIV/AIDS patients attending CCC at Kangemi Health Centre.

The information you give will be used for completion of my Masters Degree in Psychiatry at the same university.

The main aim of this letter is to request for your participation in this researchin whichI will ask questions which will be in form of questionnaires: socio-demographic, MINI Plus to determine the socio demographic variables associated with psychiatric morbidity in the above group. The exercise will take about 30-45 minutes.

Please note that:

- Your acceptance to participate in this study is voluntary.
- Your acceptance to participate in this study does not prevent you from withdrawing from the study at any time.
- Declining to participate or withdrawing from the study will not warrant any punishment or penalty i.e. you will not be denied the services that you are receiving.
- You will not receive any token or monetary benefit by participating in the study.
- Your personal details will be highly confidential.
- If after analysis I discover you have a problem I will refer you to the appropriate clinic for treatment.
- The results of this study could be used to introduce a component of Mental Health Care in managing HIV/AIDS patients.
- Part or whole of this study can be availed to you on request.
- There is no right or wrong answer.
- There will be no physically invasive procedures.

You are free to ask any questions that will allow you to understand the nature of the study. If you need to seek clarification you can contact me on 0722 874 000 or my supervisors:

Dr M. Mathai and Dr A. Obondo at the Department of Psychiatry University of Nairobi or

SECRETARY, K.N.H/U.o.N-ERC

P.O. BOX 19676 – 00202 K.N.H. NAIROBI

Appendix Bii: Informed Consent Explanation [Kiswahili]

Jina langu ni Dr. Pauline Ng'ang'a. ninaendelea na masomo yangu katika somo la magonjwa ya akili katika Chuo kikuu cha Nairobi. Ninafanya utafiti kuhusu kuwepo kwa magonjwa ya akili miongoni mwa wagonjwa ambao wako na virusi vya ukimwi katika Kituo cha afya cha Kangemi.

Ujumbe wowote utakaonipa utatumika kukamilisha somo langu la juu katika Chuo kikuu cha Nairobi.

Barua hii ni ya kuomba ushiriki wako katika utafifiti huu ambao nitauliza maswali yanayo husu magonjwa ya akili na pia maswali kuhusu maisha ya kila siku. Maswali yatachukua muda wa dakika thelathini hadi arobaini na tano.

Tafadahli kumbuka:
Haulazimishwi kushiriki katika utafiiti huu

- Ingawa umekubali kushiriki katika utafiti huu, unaweza kujiondoa kushiriki wakati wowote.
- Kukataa kushiriki katika utafiti huu haitakuwa na madahara yoyote kama kukatazwa kupokea huduma unazopokea.
- Hautapokea pesa ama msaada wowote kwa kukubali kushiriki katika utafiti huu.
- Ujumbe wowote utakaotoa katikia utafiti huu ni wa siri.
- Baada ya utafiti, nikigundua kwamba uko na shida yoyote, nitakuelekeza kwa kliniki inayofaa kwa matibabu.
- Matokeo ya utafiti huu yatatumika kuanzisha huduma ya afya ya akili kwa wagonjwa wenye virusi vya ukimwi.
- Unaweza kupata ujumbe wowote kuhusu utafiti huu, unapouhitaji.
- Hakuna jibu lililo sahihi au lisilo sahihi.
- Hakutakuwa na utafiti wa mwili.

Unaweza kuuliza maswali yoyote yanayohusu utafiti huu au maelezo zaidi kwa kunipigia simu kwenye nambari: 0722 874 000 au kwa wasimamizi wangu:

Dkt. M. Mathai and Dkt. A. Obondowa kitengo cha somo ya akili katika Chuo kikuu cha Nairobi ama

KARANI, K.N.H/U.o.N-ERC

S.L.P. 19676 – 00202

K.N.H. NAIROBI

Appendix C: Consent Declaration

I, the undersigned, do here by volunteer to participate in this study. The nature and purpose have been fully explained to me by

Dr. Pauline W. Ng'ang'a

I understand that all information gathered will be used for the purpose of the study only.

Name of Participant: ……

Signed..... Date.....……..

Signed by Dr. P. Ng'ang'a Date. ……..…….…….

SOCIO-DEMOGRAPHIC QUESTIONNAIRE

Study No._____

Date_____

1) Gender ☐ Male: ☐ Female:

2) Date of Birth: ……..

3) Marital status:

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Cohabiting

4) Number of children _____

5) Highest level of education:

- ☐ Nil
- ☐ Primary
- ☐ Secondary
- ☐ College
- ☐ University

6) Are you employed? ☐ Yes ☐ No

7) Occupation:

☐ Skilled

☐ Unskilled

☐ Student

8) Religion:

☐ Catholic

☐ Protestant

☐ Muslim

☐ Hindu

☐ African traditional

☐ Others (specify): …….

9.) Income (in Kshs):

☐ Less than 3000

☐ More than 3000

10) HIV related questions.

☐ Status of partner and children……

☐ Duration of illness……..……

☐ Latest CD4 Counts……..……

☐ Any HIV related illness (es)……..….

MINI PLUS

Mini International Neuropsychiatric Interview

English Version 5.0.0

DSM-IV

Y. Lecrubier, E. Weiller, T. Hergueta, P. Amorim, L.I. Bonora, J.P. Lépine

Hôpital de la Salpétrière - Paris - FRANCE.

D. Sheehan, J. Janavs, R. Baker, K.H. Sheehan, E. Knapp, M. Sheehan

University of South Florida - Tampa - USA.

Powers for her advice on the modules on Anorexia nervosa and Bulimia. Printed, 4 January, 1980

PATIENT'S NAME : _____	*PROTOCOL NUMBER :*_____
JINA LA MGONJWA: _____	*NAMBA YA PROTOKALI:* _____
DATE OF BIRTH : _____	*Time Interview Began :* _____
TAREHE YA KUZALIWA: _____	*Muda wa Kuanza Usaili :* _____
*INTERVIEWER'S NAME :*_____	*Time Interview Ended :* _____
JINA LA MSAILI : _____	*Muda wa Kumaliza Usaili :*_____
DATE OF INTERVIEW : _____	*TOTAL TIME :* _____
TAREHE YA USAILI : _____	*MUDA ULIOTUMIKA :* _____

MODULES VIHUNZI HURU	TIME FRAME MUDA	
A MAJOR DEPRESSIVE EPISODE TUKIO LA SONONA	Current (past 2 weeks) + Lifetime Kwa sasa(wiki 2) +siku za nyuma	
A'. MDE with melancholic features TUKIO LA SONONA lenye uzito wa moyo(hiari)	Current (past 2 weeks)	Optional
B DYSTHYMIA DISTHIMIA	Current (past 2 years)	
C SUICIDALITY HALI YA KUTAKA KUJIUA	Current (past month)	
D (HYPO) MANIC EPISODE TUKIO LA MANIA(MANIA NDOGO)	Current + Lifetime	
E PANIC DISORDER UGONJWA WA HOFU KUBWA	Lifetime + current (past month)	
F AGORAPHOBIA WOGA WA NAFASI ZA WAZI	Current	
G SOCIAL PHOBIA WOGA WA MKUSANYIKO WA WATU	Current (past month)	
H OBSESSIVE-COMPULSIVE DISORDER UGONJWA WA SHAUKU LAZIMISHO	Current (past month)	
I POSTTRAUMATIC STRESS DISORDER UGONJWA WA MSONGO BAADA YA MATUKIO MABAYA	Current (past month)	Optional
J ALCOHOL DEPENDENCE / ABUSE KUTAWALIWA NA POMBE / MATUMIZI MABAYA YA POMBE	Current (past 12 months)	
K DRUG DEPENDENCE / ABUSE (Non-alcohol) KUTAWALIWA / MATUMIZI MABAYA YA MADAWA YA KULEVYA (isiyo pombe)	Current (past 12 months)	
L PSYCHOTIC DISODERS MAGONJWA YA SAIKOSIS	Lifetime + Current	
M ANOREXIA NERVOSA UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KUTOKULA	Current (past 3 months)	
N BULIMIA NERVOSA UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KULA MNO	Current (past 3 months)	

O	GENERALIZED ANXIETY DISORDER UGONJWA WA WASIWASI MKUBWA	Current (past 3 months)	
P	ANTISOCIAL PERSONALITY DISORDER UGONJWA WA MAKUZI YA HULKA NA TABIA ZINAZOPINGANA NA JAMII	Lifetime	Optional

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GENERAL INSTRUCTIONS

The M.I.N.I. was designed as a brief structured interview for the major Axis I psychiatric disorders in DSM-IV and ICD-10. Validation and reliability studies have been done comparing the M.I.N.I. to the SCID-P and the CIDI. The results of these studies show that the M.I.N.I. has acceptably high validation and reliability scores, but can be administered in a much shorter period of time (mean 18.7 ± 11.6 min., median 15 min.) than the above referenced instruments. It can be used by clinicians, after a brief training session. Lay interviewers require more extensive training.

- Interview :

In order to keep the interview as brief as possible, inform the patient that you will conduct a clinical interview that is more structured than usual, with very precise questions about psychological problems which requires a yes or no answer.

- General format :
  The M.I.N.I. is divided into modules identified by letters, each corresponding to a diagnostic category.
  - At the beginning of each module (except for psychotic disorders module), screening question(s) corresponding to the main criteria of the disorder are presented in a gray box.
  - At the end of each module, diagnostic box (es) permit(s) the clinician to indicate whether the diagnostic criteria are met.

- Conventions :

  Sentences written in « normal font » should be read exactly as written to the patient in order to standardize the assessment of diagnostic criteria.

  Sentences written in « CAPITALS » should not to be read to the patient. They are instructions for the interviewer to assist in the scoring of the diagnostic algorithms.

  Sentences written in « bold » indicate the time frame being investigated. The interviewer should read them as often as necessary. Only symptoms occurring during the time frame indicated should be considered in scoring the responses.

  Sentences (in parentheses) are clinical examples of the symptom .These may be read to the patient to clarify the question.

  Answers with an arrow above them (➔) indicate that one of the criteria necessary for the diagnosis (es) is not met. In this case, the interviewer should go to the end of the module, to circle « NO » in all the diagnostic boxes and move to the next module.

When terms are separated by a *slash (/)*, the interviewer should read only those symptoms known to be present in the patient (for example, question A3).

- Rating instructions:
  All questions read must be rated. The rating is done at the right of each question by circling either YES or NO.

  The clinician should be sure that each dimension of the question is taken into account by the patient (i.e.: time frame, frequency, severity, « and/or » alternatives).

  Symptoms better accounted for by an organic cause or by the use of alcohol or drugs should not be coded positive in the M.I.N.I.. The M.I.N.I. Plus has questions that investigate these issues.

For any questions, suggestions, need for a training session or information about updates of the M.I.N.I., please contact:

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A. MAJOR DEPRESSIVE EPISODE
TUKIO LA SONONA

A1	Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?	NO	YES	1
	Je, ulishawahi kukosa raha muda mwingi wa siku, karibu kila siku, kwa muda wa wiki mbili zilizopita?	HAPANA	NDIYO	1
A2	In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time ?	NO	YES	2
	Katika wiki mbili zilizopita, je, umekosa hamu/ari katika vitu vingi au kukosa raha kwa muda mwingi katika vitu vilivyokuwa vikikufurahisha?	HAPANA	NDIYO	2
		➔		
	IS A1 OR A2 CODED YES?	NO	YES	
	JE, KIPENGELE A1 AU A2 KIMEJIBIWA NDIYO?	HAPANA	NDIYO	
A3	Over the past two weeks, when you felt depressed and/or uninterested :			
	Katika kipindi cha wiki mbili zilizopita, ulipojisikia kukosa raha na / au kutokuwa na ari:			
a	Was your appetite decreased or increased nearly every day or did your weight decrease or increase without trying intentionally? (i.e., ± 5 % of body weight or ± 3,5 kg or ± 8 lbs., for a 70 kg / 120 lbs. person in a month)	NO	YES	3
	Je, hamu yako ya kula ilipungua au kuongezeka, karibu kila siku? Uzito wako ulipungua au uliongezeka bila wewe kukusudia? (yaani ± 5 % ya uzito wako au kg. 3.5 katika mwezi)	HAPANA	NDIYO	3
	IF YES TO EITHER, CODE YES			
	IWAPO JIBU NI NDIYO KWA LOLOTE, JAZA NDIYO			

b	Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening, or sleeping excessively)? Je, ulipata shida ya usingizi karibu kila siku? (tabu ya kupata usingizi, kukatika usingizi katikati ya usiku, kuamka mapema sana, au kulala mno)	NO HAPANA	YES NDIYO	4 4
c	Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still, almost every day? Je, ulikuwa ukiongea au kutembea taratibu zaidi kuliko kawaida yako, au ulikuwa na hali ya kuhangaika, kutotulia, au kuwa na tatizo la kukaa kwa utulivu karibu kila siku?	NO HAPANA	YES NDIYO	5 5
d	Did you feel tired or without energy, almost every day? Je, ulijisikia mchovu au kutokuwa na nguvu karibu kila siku?	NO HAPANA	YES NDIYO	6 6
e	Did you feel worthless or guilty, almost every day? Je, ulijisikia huna thamani au kuwa na hali ya kujilaumu karibu kila siku?	NO HAPANA	YES NDIYO	7 7
f	Did you have difficulty concentrating or making decisions, almost every day? Je, ulikuwa na matatizo ya kuwa makini au kufanya maamuzi karibu kila siku?	NO HAPANA	YES NDIYO	8 8
g	Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead? Je, mara kwa mara ulifikiria kuhusu kujiumiza, au kutaka kujiua, au bora ufe?	NO HAPANA	YES NDIYO	9 9

ARE 3 OR MORE A3 ANSWERS CODED	NO	YES

A4 YES ?

(OR 4 A3 ANSWERS IF A1 OR A2 ARE CODED NO)

JE, VIPENGELE 3 AU ZAIDI VYA A3 VIMEJIBIWA NDIYO?

(AU MAJIBU 4 YA A3 IKIWA AI AU A2 VIMEJIBIWA HAPANA)

HAPANA	NDIYO
MAJOR DEPRESSIVE	
EPISODE CURRENT	
TUKIO LA SONONA KWA SASA	

IF PATIENT MEETS CRITERIA FORMAJOR DEPRESSIVE EPISODECURRENT :

IKIWA MGONJWA ATAFIKIA VIGEZO VYA TUKIO LA SONONA KWA SASA: ➔

A5 a	During your lifetime, did you have other periods of two weeks or more when you felt depressed or uninterested in most things, and had most of the problems we just talked about?	NO	YES 10
	Katika maisha yako, uliwahi kuwa na kipindi kingine cha wiki mbili au zaidi ambapo ulikosa raha au kukosa ari katika mambo mengi na kwamba umekuwa na shida kama zile tulizokwishazizungumza?	➔ HAPANA	NDIYO 10
b	Was there an interval of at least 2 months without depression and/or lost of interest between your current episode and your last episode of depression?	NO	YES 11
	Je, kulikuwa na kipindi cha angalau miezi 2 bila hali ya kukosa raha na /au kupoteza ari kati ya wakati huu na ulipokuwa na hali hii siku za nyuma?	HAPANA	HAPANA 11

IS A5b CODED YES ?

JE, KIPENGELE A5b KIMEJIBIWA NDIYO?

NO	YES
HAPANA	NDIYO
MAJOR DEPRESSIVE EPISODE PAST	
TUKIO LA SONONA WAKATI ULIOPITA	

A'. MAJOR DEPRESSIVE EPISODE WITH MELANCHOLIC FEATURES (optional)

A. TUKIO LA SONONA LILILOAMBATANA NA UZITO WA MOYO (HIARI)

IF THE PATIENT CODES POSITIVE FOR A MAJOR DEPRESSIVE EPISODE (A4 = YES), EXPLORE THE FOLLOWING :

KAMA MGONJWA ATADHIHIRISHA KUWA NA SONONA KWA SASA (A4 = NDIYO), CHUNGUZA YAFUATAYO:

A6 a	IS A2 CODED YES?	NO	YES	12
	JE KIPENGELE A2 KIMEJIBIWA NDIYO?	HAPANA	NDIYO	12
b	During the most severe period of the current depressive episode, did you lose your ability to respond to things that previously gave you pleasure, or cheered you up? Wakati wa hali mbaya zaidi ya sonona ya sasa, uliwahi kupoteza uwezo wa kufanya vitu ambavyo mwanzoni vilikuwa vikikupa furaha au kukuchangamsha?	NO	YES	13
	IF NO: When something good happens does it fail to make you feel better, even temporarily? KAMA JIBU NI HAPANA:Wakati jambo zuri linatokea, je, jambo	HAPANA	NDIYO	13
		➔		
	IS EITHER A6a OR A6b CODED YES?	NO	YES	
		➔		
	JE, KIPENGELE A6a AU A6b KIMEJIBIWA NDIYO?	HAPANA	NDIYO	
A7	Over the past two weeks period, when you felt depressed and uninterested : Katika kipindi cha wiki mbili zilizopita, ulipojisikia kukosa raha au kukosa ari:			
a	Did you feel depressed in a way that is different from the kind of feeling you experience when someone close to you dies?	NO	YES	14
	Je, ulikosa raha tofauti na vile unavyojisikia wakati unapofiwa na mtu wako wa karibu?	HAPANA	NDIYO	14
b	Did you feel regularly worse in the morning, almost every day?	NO	YES	15
	Je, ulijisikia kuwa na hali mbaya zaidi kwa kila asubuhi karibu kila siku?	HAPANA	NDIYO	15
c	Did you wake up at least 2 hours before the usual time of awakening and have difficulty getting back to sleep, almost every day?	NO	YES	16
	Je, ulikuwa ukiamka angalau masaa mawili kabla ya muda wako wa kawaida wa kuamka na kupata tabu ya kulala tena karibu kila	HAPANA	NDIYO	16

siku?

d	IS A3c CODED YES?	NO	YES	17
	JE, KIPENGELE A3c KIMEJIBIWA NDIYO?	HAPANA	NDIYO	17
e	IS A3a CODED YES (ANOREXIA OR WEIGHT LOSS ONLY)?	NO	YES	18
	JE, KIPENGELE A3a KIMEJIBIWA NDIYO (KUKOSA HAMU YA CHAKULA AU KUPUNGUA MWILI)?	HAPANA	NDIYO	18
f	Did you feel excessive guilt or out of proportion to the reality of the situation?	NO	YES	19
	JE, A3e IMEJIBIWA NDIYO (KUJILAUMU KUPITA KIASI, AU KUJILAUMU KUSIVYOSTAHILI)?	HAPANA	NDIYO	19

ARE 3 OR MORE A7 ANSWERS CODED YES?

NO YES

JE, VIPENGELE VITATU AU ZAIDI VYA A7 VIMEJIBIWA NDIYO?

HAPANA NDIYO

MAJOR DEPRESSIVE EPISODE

With Melancholic Features

CURRENT

TUKIO LA SONONA lililoambatana na uzito wa moyo KWA SASA

B. DYSTHYMIA
DISTHIMIA

IF PATIENT'S SYMPTOMS CURRENTLY MEET CRITERIA FOR MAJOR DEPRESSIVE EPISODE, DO NOT EXPLORE THIS MODULE

KAMA DALILI ZA MGONJWA KWA SASA ZINAFIKIA KIGEZO CHA TUKIO LA SONONA, USICHUNGUZE KIHUNZI HURU HIKI

		→		
B1	Have you felt sad, low or depressed most of the time for the last two years?	NO	YES	20
	Je, ulijisikia huzuni, mnyonge au kukosa raha muda mwingi kwa kipindi cha miaka miwili iliyopita?	HAPANA	NDIYO	20
			→	
B2	Was this period interrupted by your feeling OK for two months or more?	NO	YES	21
	Je, kipindi hiki kilikatizwa na hali ya kujisikia safi kwa muda wa miezi miwili au zaidi?	HAPANA	NDIYO	21
B3	During this period of feeling depressed most of the time :			
	Wakati wa kipindi hiki cha kujisikia kukosa raha muda mwingi:			
a	Did your appetite change significantly?	NO	YES	22
	Je, hamu yako ya kula ilibadilika kwa kiasi kikubwa?	HAPANA	NDIYO	22
b	Did you have trouble sleeping or sleep excessively?	NO	YES	23
	Je, ulipata tabu ya kupata usingizi au kulala mno?	HAPANA	NDIYO	23
c	Did you feel tired or without energy?	NO	YES	24
	Je, ulijisikia kuchoka au kukosa nguvu?	HAPANA	NDIYO	24
d	Did you lose your self-confidence?	NO	YES	25
	Je, ulipoteza uwezo wa kujiamini?	HAPANA	NDIYO	25

e	Did you have trouble concentrating or making decisions?	NO	YES	26
	Je, ulikuwa na tabu ya kuwa makini au ya kutoa maamuzi?	HAPANA	NDIYO	26
f	Did you feel hopeless?	NO	YES	27
	Je, ulijisikia kukosa matumaini?	HAPANA	NDIYO	27

➔

ARE 2 OR MORE B3 ANSWERS CODED YES? NO YES

➔

JE, VIPENGELE 2 AU ZAIDI VYA B3 VIMEJIBIWA NDIYO? HAPANA NDIYO

B4	Did the symptoms of depression cause you significant distress or impair your ability to function at work, socially, or in some other important way?	➔ NO	YES	28
	Je, dalili za kukosa raha zilikupa shida nyingi au kudhoofisha ufanisi wako kazini, kijamii, au katika njia nyingine muhimu?	➔ HAPANA	NDIYO	28

IS B4 CODED YES? NO YES

JE KIPENGELE B4 KIMEJIBIWA NDIYO? HAPANA NDIYO

DYSTHYMIACURRENT

DISTHIMIA KWA SASA

C. SUICIDALITY
HALI YA KUTAKA KUJIUA

In the past month did you :

Katika mwezi uliopita, je:

C1	Think that you would be better off dead or wish you were dead?	NO	YES	1
	Ulifikiria kwamba ni bora ungekufa?	HAPANA	NDIYO	1
C2	Want to harm yourself?	NO	YES	2
	Ulitaka kujidhuru?	HAPANA	NDIYO	2
C3	Think about suicide?	NO	YES	3
	Ulifikiria juu ya kutaka kujiua?	HAPANA	NDIYO	3
C4	Have a suicide plan?	NO	YES	4
	Ulikuwa na mipango ya kujiua?	HAPANA	NDIYO	4
C5	Attempt suicide?	NO	YES	5
	Ulijaribu kujiua?	HAPANA	NDIYO	5

In your lifetime

Katika maisha yako

C6	Did you ever make a suicide attempt?	NO	YES	6
	Ulishawahi, wakati wowote, kujaribu kujiua?	HAPANA	NDIYO	6

IS AT LEAST 1 OF THE ABOVE CODED YES?	NO	YES
JE, ANGALAU KIPENGELE KIMOJA KATI YA VYA HAPO	HAPANA	NDIYO

JUU, KIMEJIBIWA NDIYO?

IF YES, SPECIFY THE LEVEL OF SUICIDE RISK AS FOLLOWS :

KAMA NDIYO, ELEZA KIWANGO CHA HATARI YA KUJIUA KAMA IFUATAVYO:

C1 or C2 or C6 = YES : LOW

C1 au C2 au C3 = NDIYO : HATARI NDOGO

C3 or (C2 +C6) = YES : MODERATE

C3 au (C2 +C6) = NDIYO : HATARI YA KATI

C4 or C5 or (C3 + C6) = YES : HIGH

C4 au C5 au (C3 + C6) = NDIYO : HATARI KUBWA

SUICIDE RISK

CURRENT

HATARI YA KUJIUA

KWA SASA

LOW ☐

HATARI NDOGO ☐

MODERATE ☐

HATARI YA KATI ☐

HIGH ☐

HATARI KUBWA ☐

D. (HYPO) MANIC EPISODE
TUKIO LA MANIA (MANIA NDOGO)

D1 a	Have you ever had a period of time when you were feeling "up" or "high" or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol)			
	IF PATIENT IS PUZZLED OR UNCLEAR ABOUT WHAT YOU MEAN BY "UP" OR "HIGH", CLARIFY AS FOLLOW : By "up" or "high" I mean : having elated mood, increased energy, needing less sleep, having rapid thoughts, being full of ideas, having an increase in productivity, creativity, motivation or impulsive behavior.	NO	YES	1
	Je, ulishawahi kwa kipindi Fulani kujisikia una hali ya juu, au umejawa na nguvu au umesongwa kiasi cha kupatashida, au kwamba watu kukudhania kuwa sio mtu wa kawaida? (usichukulie muda ambao ulikuwa umedhurika kwa madawa au pombe)			
	KAMA MGONJWA ANAONEKANA KUTOELEWA MAANA YA "HALI YA JUU", FAFANUA KAMA IFUATAVYO : Hali ya juu ina maana ya kuwa na hali ya furaha; kuhitaji usingizi mchache;kuwa na fikra za haraka; kusongwa na mawazo; kuongezeka katika tija, ubunifu, motisha au tabia ya kuamua ghafla			
	IF YES :	HAPANA	NDIYO	1
	KAMA JIBU NI NDIYO :			
b	Are you currently feeling "up" or "high" or full of energy?	NO	YES	2
	Je, sasa hivi unajisikia kuwa na hali ya juu au kujawa na nguvu?	HAPANA	NDIYO	2
D2 a	Have you ever been persistently irritable, for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or over reacted, compared to other people, even in situations that you felt were justified? (Do not consider times when you were intoxicated on drugs or alcohol)			
	Je, umeshawahi kuwa mwenye kuudhika upesi kwa muda mrefu, kwa siku nyingi, kiasi kwamba ukawa na mabishano, au mapigano kwa maneno au vitendo, au kuwapigia kelele watu wasiokuwa wa familia yako?	NO	YES	3
	IF YES :			
	KAMA JIBU NI NDIYO :			
b	Are you currently feeling persistently irritable?	NO	YES	4
	Je, kwa sasa unajisikia kuwa mwepesi wa kuudhika kwa muda mrefu?	HAPAN	NDIY	4

		A	O
		➔	
	ARE D1a OR D2a CODED YES?	NO	YES
		➔	
	JE, KIPENGELE D1a AU D2a KIMEJIBIWA NDIYO?	HAPANA	NDIYO

D3 IF D1b OR D2b = YES : EXPLORE ONLY CURRENT EPISODE

IF D1b AND D2b = NO : EXPLORE THE MOST SYMPTOMATIC PAST EPISODE

KAMA D1B AU D2B = NDIYO: CHUNGUZA TUKIO LA SASA TU

KAMAD1B NA D2B = HAPANA: CHUNGUZA TUKIO LILILOPITA AMBALO LILIKUWA NA DALILI NYINGI ZAIDI

During the time(s) when you felt "high", full of energy and/or irritable did you :
Kwa muda ambao ulijisikia hali ya juu, kujawa na nguvu, au mwenyekuudhika upesi, je :

a	Feel that you could do things others couldn't do, or that you were an especially important person? Ulijisikiakuweza kufanya vitu ambavyo wengine hawawezi au kujiona kuwa mtu pekee muhimu	NO	YES	5
		HAPANA	NDIYO	5
b	Need less sleep (e.g., feel rested after only a few hours sleep)? Ulihitaji usingizi mchache (kwa mfano, kujisikisa mapumziko baada ya muda mdogo tu wa kulala)?	NO	YES	6
		HAPANA	NDIYO	6
c	Talk too much without stopping, or so fast that people had difficulty understanding? Uliongea sana bila kunyamaza, au kwa haraka zaidi kiasi kwamba watu wakapata tabu ya kukuelewa?	NO	YES	7
		HAPANA	NDIYO	7
d	Have thoughts racing? Umekuwa na mawazo ya harakaharaka	NO	YES	8
		HAPANA	NDIYO	8

e	Become easily distracted so that any little interruption could distract you? Ulikuwa mwepesi wa kuvurugwa kiasi kwamba hata kukatizwa kidogo kunakuvuruga?	NO HAPANA	YES NDIYO	9 9
f	Become so active or physically restless that others were worried about you? Ulikuwa mashuhuri au kutotulia kiasi kwamba watu wengine wakapata wasiwasi juu yako?	NO HAPANA	YES NDIYO	10 10
g	Want so much to engage in pleasurable activities that you ignored the risks or consequences (e.g., spending sprees, reckless driving, or sexual indiscretions)? Ulitaka sana kujiingiza katika shughuli za starehe na kutojali hatari zake au matokeo yake (mfano, kufanya shamrashamra, udereva wa kizembe, au ngono bila kujihadhari)?	NO HAPANA	YES NDIYO	11 11
	ARE 3 OR MORE D3 ANSWERS CODED YES OR 4 IF D1a = NO (PAST EPISODE) OR D1b = NO (CURRENT EPISODE)? JE, VIPENGELE 3 AU ZAIDI VYA D3 VIMEJIBIWA NDIYO AU VIPENGELE 4, IKIWA D1a = HAPANA (TUKIO LILILOPITA) AU D1b = HAPANA (TUKIO LA SASA)	➔ NO ➔ HAPANA	YES NDIYO	
D4	Did these symptoms last at least a week and cause significant problems at home, at work, or at school, or were you hospitalized for these problems? Je, dalili hizi zilidumu kwa muda wa angalau wiki moja na kusababisha matatizo makubwa nyumbani, kazini, kijamii, au shuleni, au alilazwa hospitalini kwa ajili ya matatizo haya? IF YES TO EITHER, CODE YES KAMA JIBU NI NDIYO KWA LOLOTE, JAZA NDIYO	NO HAPANA	YES NDIYO	12 12

IS D4 CODED NO? NO YES

JE, KIPENGELE D4 KIMEJIBIWA HAPANA? HAPANA NDIYO

HYPOMANIC EPISODE

TUKIO LA MANIA NDOGO

IF YES, SPECIFY IF THE EPISODE EXPLORED IS CURRENT OR PAST

KAMA NDIYO, ELEZA NI TUKIO LA SASA AU LILILOPITA

- *CURRENT*
- *KWA SASA*
- *PAST*
- *LILILOPITA*

IS D4 CODED YES? NO YES

JE, KIPENGELE D4 KIMEJIBIWA NDIYO? HAPANA NDIYO

MANIC EPISODE

TUKIO LA MANIA

IF YES, SPECIFY IF THE EPISODE EXPLORED IS CURRENT OR PAST

KAMA NDIYO, ELEZA NI TUKIO LA SASA AU LILILOPITA

- *CURRENT*
- *KWA SASA*
- *PAST*
- *LILILOPITA*

E. PANIC DISORDER
UGONJWA WA HOFU KUBWA

E1	Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way? Did the spells peak within 10 minutes? Je, kwa mara zaidi ya moja, umekuwa na vipindi vya kujisikia au kupatwa na wasiwasi wa ghafla, hofu, kutotulia au mashaka, hata katika mazingira ambayo watu wengi hawajisikii hivyo? Je, mshituko huo uliisha ndani ya dakika kumi? CODE YES ONLY IF THE SPELLS PEAK WITHIN 10 MINUTES JAZA NDIYO IKIWA TU MSHITUKO HUO ULIISHA NDANI YA DAKIKA KUMI	NO HAPANA	YES NDIYO	1 1
	IF E1 = NO, CIRCLE NO IN E5 AND SKIP TO F1 KAMA E1 = HAPANA, JAZA HAPANA KATIKA E5 NA NENDA KIPENGELE F1			
E2	At any time in the past, did any of those spells or attacks come on unexpectedly or spontaneously, or occur in an unpredictable or unprovoked manner? Katika wakati wowote uliopita, je, vipindi hivi au mishituko hiyo ilikuja bila kutegemea au kutokea katika namna isiyobashirika au kuchochewa? IF E2 = NO, CIRCLE NO IN E5 AND SKIP TO F1 KAMA E2 = HAPANA, JAZA HAPANA KATIKA E5 NA NENDA KIPENGELE F1	NO HAPANA	YES NDIYO	2 2
E3	Have you ever had one such attack followed by a month or more of persistent fear of having another attack, or worries about the consequences of the attack? Je, ulishawahi kupata tukio moja kama hilo lililofuatiwa na kipindi cha mwezi mmoja au zaidi cha kujisikia hofu ya tukio jingine au woga wa madhara ya tukio hilo? IF E3 = NO, CIRCLE NO IN E5 AND SKIP TO F1 KAMA E3 = HAPANA, ZUNGUSHIA HAPANA NA NENDA KIPENGELE F1	NO HAPANA	YES NDIYO	3 3
E4	During the worst spell that you can remember : Katika kipindi kibaya zaidi ambacho unakumbuka :			

a	Did you have skipping, racing or pounding of your heart?	NO	YES	4
	Je, moyo wako ulidundadunda, kwenda mbio, au kupiga kwa kasi?	HAPANA	NDIYO	4
b	Did you have sweating or clammy hands?	NO	YES	5
	Je, ulitokwa na majasho au mikono kuwa ya baridi?	HAPANA	NDIYO	5
c	Were you trembling or shaking?	NO	YES	6
	Je, ulitetemeka au kutikisika?	HAPANA	NDIYO	6
d	Did you have shortness of breath or difficulty breathing?	NO	YES	7
	Je, ulipata kutapia hewa au tabu ya kupumua?	HAPANA	NDIYO	7
e	Did you have a choking sensation or a lump in your throat?	NO	YES	8
	Je, ulihisi kupaliwa au donge kifuani kwako?	HAPANA	NDIYO	8
f	Did you have chest pain, pressure or discomfort?	NO	YES	9
	Je, ulipata maumivu ya kifua, shinikizo au usumbufu?	HAPANA	NDIYO	9
g	Did you have nausea, stomach problems or sudden diarrhea?	NO	YES	10
	Je, ulipata kichefuchefu, matatizo ya tumbo au kuharisha kwa ghafla?	HAPANA	NDIYO	10
h	Did you feel dizzy, unsteady, lightheaded or faint?	NO	YES	11
	Je, ulijisikia kizunguzungu, kutetereka, kichwa chepesi, au kuzirai?	HAPANA	NDIYO	11
i	Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part or all of your body?	NO	YES	12
	Je, vitu vilivyokuzunguka uliviona ni vya ajabu, sio halisi, upweke au vya kigeni, au je, ulijisikia upo kando ya, au kujitenga kutoka katika sehemu au mwili wako wote?	HAPANA	NDIYO	12
j	Did you fear that you were losing control or going crazy?	NO	YES	13
	Je, ulihofia kwamba umeshindwa kujizuia au umepata wazimu?	HAPANA	NDIYO	13
k	Did you fear that you were dying?	NO	YES	14
	Je, ulihofia kwamba unakufa?	HAPANA	NDIYO	14
l	Did you have tingling or numbness in parts of your body?	NO	YES	15
	Je, ulipatwa na msisimko au ganzi katika sehemu za mwili wako ?	HAPANA	NDIYO	15
	Did you have hot flashes or chills?	NO	YES	16

m	Je, ulipatwa na wekundu usoni (kuiva uso) u mzizimo wa baridi?	HAPANA	NDIYO	16

E5	ARE 4 OR MORE E4 ANSWERS CODED YES?	NO	YES	
	JE, VIPENGELE 4 AU ZAIDI VYA E4 VIMEJIBIWA NDIYO ?	HAPANA	NDIYO	
	IF E5 = NO, SKIP TO E7		*Panic Disorder*	
	KAMA E5 = HAPANA, NENDA KIPENGELE E7		*Life time*	
			Hofu kubwa	
			Maisha yote	

E6	In the past month, did you have such attacks repeatedly (2 or more) followed by persistant fear of having another attack?	NO	YES	17
	Katika mwezi mmoja uliopita, ulipatwa na matukio hayo kwa kujirudiarudia (mara 2 au zaidi) kufuatiwa na hofu ya kupata tukio jingine?	HAPANA	NDIYO	17
	IF E6 = YES, SKIP TO F1		*Panic Disorder*	
	KAMA E6 = NDIYO, NENDA F1		*Current*	
			Hofu kubwa	
			kwa sasa	

E7	ARE 1, 2 OR 3 E4 ANSWERS CODED YES?	NO	YES	18
			Limited Symptom Attacks	
			Lifetime	

F. AGORAPHOBIA
WOGA WA NAFASI ZA WAZI

F1	Do you feel anxious or particularly uneasy in places or situations from which escape might be difficult, and where help might not be available in case of panic attack, like being in a crowd, standing in a line (queue), when you are alone away from home or alone at home, or when crossing a bridge, traveling in a bus, train or car? Je, unajisikia wasiwasi au mashaka katika sehemu au mazingira ambapo unaweza kupata mshituko wa hofu kubwa au dalili zinazofanana na hofu kubwa tulizozizungumza hivi punde, na ambapo msaada unaweza usiwepo, au ambapo kukwepa kunaweza kuwa kugumu: kama kuwa kwenye kundi la watu wengi, kusimama kwenye foleni, ukiwa peke yako mbali na nyumbani, au upo nyumbani peke yako, au ukiwa unavuka daraja, kusafiri ndani ya basi, treni, au gari?	NO HAPANA	YES NDIYO	19 19

IF F1 = NO, CIRCLE NO IN F2

KAMA F1 = HAPANA, ZUNGUSHIA HAPANA KATIKA F2

F2	Do you fear these situations so much that you avoid them, or suffer through them, or need a companion to face them? Je, unahofia sana mazingira haya kiasi cha kujitenga nayo, au kuteseka kwa ajili ya mazingira hayo auunahitaji mwenzi kukabiliana nayo?	NO HAPANA	YES NDIYO

Agoraphobia

Current

Woga wa nafasi za wazi kwa sasa

IS F2 (CURRENT AGORAPHOBIA) CODED NO and IS E6 (CURRENT PANIC DISORDER) CODED YES? JE F2 (WOGA WA NAFASI ZA WAZI KWA SASA)	NO YES *PANIC DISORDER* *without Agoraphobia CURRENT*
IS F2 (CURRENT AGORAPHOBIA) CODED YES and IS E6 (CURRENT PANIC DISORDER) CODED YES?	NO YES *PANIC DISORDER* *with Agoraphobia* *CURRENT*
IS F2 (CURRENT AGORAPHOBIA) CODED YES andIS E5 (PANIC DISORDER LIFETIME) CODED NO?	NO YES *AGORAPHOBIA* *without history of* *Panic Disorder* *CURRENT*

G. SOCIAL PHOBIA

WOGA WA MKUSANYIKO WA WATU

G1	In the past month, were you fearful or embarrassed being watched, being the focus of attention, or fearful of being humiliated? This includes situations like speaking in public, eating in public or with others, writing while someone watches, or being in social situations. Katika mwezi uliopita, je ulipata hofu au shida ukiwa uanaangaliwa, ukiwa mlengwa, au hofu ya kufedheheshwa? Hii ni pamoja na mambo kama kuongea hadharani; kula hadharani au kula na watu, kuandika wakati mtu anakuangalia au kuwa katika mikusanyiko ya watu.	➔ NO	YES	1
G2	Is this fear excessive or unreasonable? Je hofu hii ni kubwa mno au yenye kuzidi?	➔ NO	YES	2
G3	Do you fear these situations so much that you avoid them or suffer through them? Je unahofia sana mazingira haya kiasi cha kujitenga nayo au kuteseka kwa ajili ya mazingira hayo.	➔ NO	YES	3
G4	Does this fear disrupt your normal work or social functioning or cause you significant distress? Je hofu hizi zinavuruga shughuli zako za kawaida au shughuli za kijamii au zinakusababishia shida kubwa.	NO	YES	4

IS G4 CODED YES?

Je kipengele G4 kimejibiwa ndiyo?

NO YES

SOCIAL PHOBIA

CURRENT

H. OBSESSIVE-COMPULSIVE DISORDER

SHAUKU LAZIMISHO

H1 In the past month, have you been bothered by recurrent thoughts, impulses or images that were unwanted, distasteful, inappropriate, intrusive or distressing? (e.g., the idea that you were dirty, contaminated or had germs, or fear of contaminating others, or fear of harming someone even though you didn't want to, or fearing you would act on some impulse, or fear or superstitions that you would be responsible for things going wrong, or obsessions with sexual thoughts, images or impulses, or hoarding, collecting, or religious obsessions.)

DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS.

DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO EATING DISORDERS, SEXUAL DEVIATIONS, PATHOLOGICAL GAMBLING, OR ALCOHOL OR DRUG ABUSE BECAUSE THE PATIENT MAY DERIVE PLEASURE FROM THE ACTIVITY AND MAY WANT TO RESIST IT ONLY BECAUSE OF ITS NEGATIVE CONSEQUENCES.

NO YES 1

H1 Katika mwezi ulioputa, je ulishawahi kukerwa na mawazo yenye kujirudiarudia, misukumo, au fikra ambazo hazihitajiki, za maudhi, zisizostahili, zenye kuingilia, au zenye kuleta shida? (mf: mawazo ya kwamba umchafu, umechafuliwa na vijidudu, au hofu ya kuwachafua wengine, au hofu ya kumdhuru mtu hata kama hukutaka kufanya hivyo, au kuhofia kutenda kwa msukumo, au hofu au imani za kichawi kwamba ungewajibika kwa mambo mabaya, au shauku yenye mawazo ya ngono, fikra au misukumo, au shauku ya kuhodhi, kukusanya au ya kidini).

(Usichanganye na wasiwasi juu ya matatizo halisi ya maisha, usichanganye na shauku zinazoendana moja kwa moja na magonjwa ya kula chakula, tabia za uasherati, kamari, au pombe au madawa ya kulevya kwa sababu, mgonjwa anaweza kupata starehe kutokana na tendo hilo na kutaka kujizuia kwa sababu tu ya matokeo hasi ya jambo hilo.

IF H1 = NO, SKIP TO H4

H2 Did they keep coming back into your mind even when you tried to ignore or get rid of them?

NO YES 2

IF H2 = NO, SKIP TO H4

JE, yanaendelea kukurudia ndani ya mawazo yako hata wakati unapojaribu kuyadharau au kujaondoa?

H3	Do you think that these obsessions are the product of your own mind and that they are not imposed from the outside? Je, unadhani kwamba shauku hizi zinatokana na mawazo yako mwenyewe na kwamba hazijalazimishwa kutoka nje?	NO	YES	3
H4	In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, arranging things, or other superstitious rituals ? Katika mwezi uliopita, je ulifanya kitu kwa kurudiarudia bila kuwa na uwezo wa kujizuia kufanya hivyo, kama vile kuosha au kusafisha sana, kuhesabu, kukagua vitu mara kwa mara, au kurudia, kukusanya, kupanga vitu, au matambiko mangine ya kishirikina.	NO	YES	4
	ARE H3 OR H4 CODED YES? JE KIPENDELE H3 AU H4 KIMEJIBIWA NDIYO?	➔ NO	 YES	
H5	Did you recognize that either these obsessive thoughts and / or these compulsive behaviors you can not resist doing them, were excessive or unreasonable? Je ulitambua kwamba kujiwa na mawazo haya au hizi tabia zisizodhibitika zimekuwa ni nyingi mno au zimezidi?	➔ NO	 YES	5
H6	Did these obsessive thoughts and / or compulsive behaviors significantly interfere with your normal routine, occupational functioning, usual social activities, or relationships, or did they take more than one hour a day? Je kujawa na mawazo haya na/au tabia zisizodhibitika kwa kiasi kikubwa kunaingilia zako za kawaida, shughuli za kikazi, kazi za kawaida za kijamii, au mahusiano, au yamechukua zaidi ya saa nzima kwa siku?	NO	YES	6

IS H6 CODED YES?

NO

OBSESSIVE-COMPULSIVE DISORDER

CURRENT

I. POSTTRAUMATIC STRESS DISORDER (optional)

UGONGWA WA MSONGO BAADA YA MATUKIO MABAYA (Hiari)

I1	Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Je, umewahi kupata au kushuhudia au kushughulika na matukio mabaya ikiwepo kifo au tishio la kifo au ajali mbaya kwako au mtu mwingine? EX OF TRAUMATIC EVENTS: SERIOUS ACCIDENT, SEXUAL OR PHYSICAL ASSAULT, A TERRORIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, HOLD-UP, FIRE, DISCOVERNG A BODY, UNEXPECTED DEATH, WAR, NATURAL DISASTER...	➔ NO	YES	1
I2	During the past month, have you re-experienced the event in a distressing way (i.e., dreams, intense recollections, flashbacks or physical reactions)? Kwa mwezi uliopita je umewahi kupata tena tukio hilo katika namna ya mashaka (Kama vile, ndoto, mkusanyiko mkali, kumbukumbu za ghafla, au kujibu kwa matendo)?	➔ NO	YES	2

I3	In the past month : Katika mwezi uliopita:			
a	Have you avoided thinking about the event, or have you avoided things that remind you of the event? Je, umewahi kujizuia kufikiria juu ya tukio hilo, au kujiepusha na vitu vinavyokukumbusha tukio hilo?	NO	YES	3
b	Have you had trouble recalling some important part of what happened? Je, umepata tabu ya kukumbuka baadhi ya sehemu muhimu juu ya kilichotokea?	NO	YES	4
c	Have you become less interested in hobbies or social activities? Je umekuwa na mvuto hafifu kwa mambo uyapendayo au kazi za kijamii?	NO	YES	5
d	Have you felt detached or estranged from others? Je, ulijisikia umejitenga au kutenganisha na wengine?	NO	YES	6

e	Have you noticed that your feelings are numbed? Je, ulitambua kwamba mawazo yako ni mazito?	NO	YES	7
f	Have you felt that your life would be shortened because of this trauma? Je, ulijisikia kwamba maisha yako yangekuwa mafupi kutokana na tukio hili?	NO	YES	8
		➔		
	ARE 3 OR MORE I3 ANSWERS CODED YES? JE, VIPENGELE VITATU AU ZAIDI VYA I3 VIMEJIBIWA NDIYO?	NO	YES	

I4 In the past month :

Katika mwezi uliopita:

a	Have you had difficulty sleeping? Je ulipata tabu ya usingizi?	NO	YES	9
b	Were you especially irritable or did you have outbursts of anger? Je ulikuwa mwenye kuudhika upesi, au ulipatwa na milipuko ya hasira?	NO	YES	10
c	Have you had difficulty concentrating? Je, umepata tabu ya kuwa makini?	NO	YES	11
d	Were you nervous or constantly on your guard? Je, ulikuwa na wahaka/wasiwasi au muda wote kujilinda?	NO	YES	12
e	Were you easily startled? Je, ulikuwa mwepesi wa kushtushwa?	NO	YES	13
		➔		
	ARE 2 OR MORE I4 ANSWERS CODED YES? JE VIPENGELE 2 AU ZAIDI YA I4 VIMEJIBIWA NDIYO?	NO	YES	

I5	During the past month, have these problems significantly interfered with your work or social activities, or caused significant distress? Katika mwezi uliopita, je matatizo haya kwa kiasi kikubwa yalivuruga utendaji wa kazi yako au shughuli za kijamii au kusababisha mashaka makubwa?	NO	YES	14

IS I5 CODED YES? NO

JE I5 IMEJIBIWA NDIYO? *POSTTRAUMATIC STRESS DISORDER*

CURRENT

J. ALCOHOL ABUSE AND DEPENDENCE

MATUMIZI MABAYA NA KUTAWALIWA NA POMBE

J1	In the past 12 months, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?	➔ NO	YES	1
J1	Katika miezi 12 iliyopita, ulishawahi kuwa na vinywaji vitatu au zaidi vya pombe ndani ya kipindi cha masaa matatu katika matukio m atatu au zaidi/			
J2	In the past 12 months : Did you need to drink more in order to get the same effect that you did when you first started drinking? Katika miezi 12 iliyopita: Je, ulihitaji kunywa zaidi ili upate matokeo sawa nay ale uliyokunywa mara ya kwanza?	NO	YES	2
a	When you cut down on drinking did your hands shake, did you sweat, or feel agitated? Or, did you drink to avoid these symptoms or to avoid being hangover, e.g., "the shakes", sweating or agitation? Je, wakati ulipoacha kunywa mikono yako ilitetemeka ulitokwa na majasho, au kujisikia wasiwasi?	NO	YES	3
	Je, ulikunywa ili kuondoa dalili hizi au kuepuka kuwa mchovu, mfano mtetemeko, kutokwa majasho au wasiwasi? IF YES TO EITHER, CODE YES KAMA NI NDIYO KWA CHOCHOTE, JIBU NDIYO			
b	During the times when you drank alcohol, did you end up drinking more than you planned when you started? Wakati ambapo umelewa pombe, je uliishia kunywa zaidi kuliko ulivyopanga mwanzoni?	NO	YES	4
c	Have you tried to reduce or stop drinking alcohol but failed? Je ulijaribu kupunguza au kuacha ulevi ikashindikana?	NO	YES	5
d	On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol? Katika siku ambazo umelewa, je ulipoteza muda mwingi kupata pombe, kunywa au kupata nafuu kutoka katika athari za pombe?	NO	YES	6

e Did you spend less time working, enjoying hobbies, or being with others because of your drinking?

Je ulitumia muda mchache kufanya kazi kufurahia uvipendavyo au kuwa na wenzako kwa sababu ya ulevi wako?

NO YES 7

f Have you continued to drink even though you knew that the drinking caused you health or mental problems?

Je uliendelea kulewa japo kuwa ulifahamu kuwa ulevi ulikusababishia matatizo ya kiafya na kiakili?

NO YES 8

ARE 3 OR MORE J2 ANSWERS CODED YES?

JE VIPENGELE VITATU AU ZAIDI VYA J2 VIMEJIBIWA NDIYO?

NO YES

ALCOHOL DEPENDENCE CURRENT

➔

DOES THE PATIENT CODES POSITIVES FOR ALCOHOL DEPENDENCE?

NO YES

J3 In the past 12 months :

Katika miezi 12 iliyopita:

a Have you been intoxicated, high or hangover more than once when you had other responsibilities at school, at work, or at home? Did this cause any problems?

Je, umewahi kurukwa akili, kuwa na hali ya juu, au kuwa na uchovu wa pombe zaidi ya mara moja wakati ambapo ulikuwa na majukumu mengine shuleni, kazini au nyumbani? Je hili litaleta matatizo yeyote?

CODE YES ONLY IF THIS CAUSED PROBLEMS

(JIBU NDIYO IKIWA TU HILI LILILETA MATATIZO)

NO YES 9

b Were you intoxicated in any situation where you were physically at risk, e.g., driving a car, riding a motor bike, using machinery, boating, etc? NO YES 10

Je, ulirukwa akili katika mazingira yeyote ambapo ulikuwa hatarini mf. Kuendesha gari, kuendesha pikipiki, kutumia mashine, kusafiri kwa mashua, etc.

c Did you have any legal problems because of your drinking, e.g., an arrest or disorderly conduct? NO YES 11

Je ulipata matatizo yeyote ya kisheria kwa sababu ya ulevi wakomfa. Kutiwa mbaroni au kufanya vurugu?

d Did you continue to drink even though your drinking caused problems with your family or other people? NO YES 12

Je, uliendelea kulewa japokuwa ulevi wako ulisababisha matatizo kwa familia yako au watu wengine?

ARE 1 OR MORE J3 ANSWERS CODED YES?

JE KIPENGELE KIMOJA AU ZAIDI CHA J3 KIMEJIBIWA NDIYO?

NO
YES

ALCOHOL ABUSE

CURRENT

CARD OF SUBSTANCES

AMPHETAMINE	GASOLINE	MORPHINE
CANNABIS	GLUE	OPIUM
COCAINE	GRASS	PALFIUM
CODEINE	HASHISH	PCP
CRACK	HEROIN	RITALIN

DICONAL	LSD	TEMGESIC
ECSTASY	MARIJUANA	THC
ETHER	MESCALINE	TOLUENE
FREEBASE	METHADONE	TRICHLORETHYLENE

K. NON-ALCOHOL PSYCHOACTIVE SUBSTANCE USE DISORDERS

UGONJWA WA MATUMIZI YA MADAWA YA KULEVYA AMBAYO SI POMBE

K1 a	Now, I am going to show you (SHOW THE CARD OF SUBSTANCES) / to read to you, a list (READ THE LIST BELOW) of street drugs or medicines. In the past 12 months, did you take any of these drugs, more than once, to get high, to feel better or to change your mood? Sasa ninakuonyesha (ONYESHA KADI YA MADAWA) / ninakusomea orodha ya madawa ya mitaani. Katika miezi 12 iliyopita, je ulitumia dawa yeyote katika hizi zaidi ya mara moja, ili uwe na hali ya juu, kujisikia mbora zaidi, au kubadilisha hali yako?	➔ NO	YES

CIRCLE EACH DRUG TAKEN :

Stimulants: amphetamines, « speed », crystal meth, « rush », Dexedrine, Ritalin, diet pills.

Cocaine: snorting, IV, freebase, crack, « speedball ».

Narcotics: heroin, morphine, dilaudid, opium, demerol, methadone, codeine, percodan, darvon.

Hallucinogens: LSD (« acid »), mescaline, peyote, PCP (« angel dust », « peace pill »), psilocybin, STP, « mushrooms », ecstasy, MDA, or MDMA.

Inhalants: « glue », ethyl chloride, nitrous oxide, (« laughing gas »), amyl or butyl nitrate (« poppers »).

Marijuana: hashish (« hash »), THC, « pot », « grass », « weed », « reefer ».

Tranquilizers: quaalude, Seconal (« reds »), Valium, Xanax, Librium, Ativan, Dalmane, Halcion, barbiturates, Miltown.

Miscellaneous: steroids, nonprescription sleep or diet pills. Any others ?

SPECIFY MOST USEDDRUG(S) :
_____

ZUNGUSHIA KILA DAWA ULIYOTUMIA:

Vichangamsho:Amphetamini

Cokein:

Nakotiks:

Hallucinogens:

Inhalants:

Marijuana:

Tranquilizers:

Nyinginezo:

ELEZA DAWA / MADAWA UTUMIAYO ZAIDI:_____

b SPECIFY WHICH WILL BE EXPLORED IN CRITERIA BELOW :

- IF CONCURRENT OR SEQUENTIAL POLYSUBSTANCE USE :
  EACH DRUG (OR DRUG CLASS) USED INDIVIDUALLY •

  MOST USED DRUG (OR DRUG CLASS) ONLY •
- IF ONE DRUG (OR DRUG CLASS) USED :
  SINGLE DRUG (OR DRUG CLASS) ONLY •

ELEZA NI DAWA IPI IPO NDANI YA VIGEZO HAPA CHINI:

b. KAMA NI MATUMIZI YA PAMOJA AU YENYE KUFUATANA YA DAWA ZAIDI YA MOJA:

- KILA KUNDI LA DAWA KUTUMIKA PEKE YAKE •
- KUNDI LA DAWA LINALOTUMIKA ZAIDI TU •
- NI DAWA MOJA TU / KUNDI LA DAWA IMETUMIKA •

K2 Considering your use of [NAME THE SELECTED DRUG / DRUG CLASS] in the past 12 months :

Fikiria matumizi yako ya madawa (TAJA JINA LA DAWA / KUNDI LA DAWA LILILOCHAGULIWA), katika miezi 12 iliyopita:

a Have you found that you needed to use more of [NAME OF SELECTED DRUG / DRUG CLASS] to get the same effect that you did when you first started taking it?

NO YES 1

Je, uliona kwamba unahitaji kutumia zaidi (Jina la dawa au kundi la dawa lililochaguliwa) ili kupata athari sawa na ile ulipotumia mara ya kwanza?

b	When you reduced or stopped using [NAME OF SELECTED DRUG / DRUG CLASS] did you have withdrawal symptoms (aches, shaking, fever, weakness, diarrhea, nausea, sweating, heart pounding, difficulty sleeping, or feeling agitated, anxious, irritable or depressed) ? Or did you use any drug(s) to keep yourself from getting sick (WITHDRAWAL SYMPTOMS) or so that you would feel better? IF YES TO EITHER, CODE YES Wakati ulipopunguza au kutotumia (JINA LA DAWA / KUNDI LA DAWA LILILOCHAGULIWA) Je, ulipatwa na dalili zinazotokana na kuacha madawa? (Maumivu, kutetemeka, homa, udhaifu, kuharisha, kichefuchefu, kutokwa jacho, moyo kudunda, tabu ya usingizi, kujisikia wasiwasi, dukuduku, mwenye kuudhika upesi, au mwenye huzuni). Je ulitumia dawa/madawa yeyote ili kukufanya usiumwe (dalili za kuacha dawa) au kukufanya ujisikie vizuri zaidi? IKIWA JIBU NI NDIYO KWA SWALI LOLOTE, JAZA NDIYO	NO YES	2
c	Have you often found that when you used [NAME OF SELECTED DRUG / DRUG CLASS], you ended up taking more than you thought you would? Je, mara kwa mara ulijiona kwamba wakati unatumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), uliishia kutumia nyingi zaidi kuliko uwezo wako?	NO YES	3
d	Have you tried to reduce or stop taking [NAME OF SELECTED DRUG / DRUG CLASS] but failed? Je, ulijaribu kupunguza/kuacha kutumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA) lakini ukashindwa?	NO YES	4
e	On the days that you used [NAME OF SELECTED DRUG / DRUG CLASS], did you spend substantial time (>2 hours), obtaining, using or recovering from the effects, or thinking about it? Katika siku ambazo ulitumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA) Je, ulipoteza muda mwingi (> masaa 2) kupata, kutumia au kupata nafuu kutoka katika madawa au kufikiria juu ya madawa?	NO YES	5
f	Did you spend less time working, enjoying hobbies, or being with family or friends, because of your drug use?		

Je, ulitumia muda mchache kufanya kazi, kufurahia uvipendavyo, au kuwa na familia yako au marafiki kwa sababu ya kutumia kwako madawa? NO YES 6

g Have you continued to use [NAME OF SELECTED DRUG / DRUG CLASS] even though it caused you health or mental problems? NO YES 7

Je, uliendelea kutumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), japokuwa ilikusababishia matatizo ya kiafya na kiakili?

ARE 3 OR MORE K2 ANSWERS CODED YES? NO

SPECIFY DRUG(S) : _____ *DRUG(S) DEPENDENCE*

CURRENT

JE VIPENGELE 3 AU ZAIDI VYA K2 VIMEJIBIWA NDIYO?

TAJA DAWA / MADAWA:_____

➔

DOES PATIENT CODES POSITIVE FOR DRUG DEPENDENCE? NO YES

K3 In the past 12 months :

Fikiria matumizi yako ya madawa (Jina la kundi la dawa lililochaguliwa)

Katika kipindi cha miezi 12 iliyopita:

a Have you been intoxicated, high, or hangover from [NAME OF SELECTED DRUG / DRUG CLASS], more than once when you had other responsibilities at school, at work, or at home? Did this cause any problem? (CODE YES ONLY IF THIS CAUSED PROBLEMS) NO YES 8

Je, umewahi kurukwa akili, kuwa na hali ya juu, au kuwa na uchovu wa dawa (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), zaidi ya mara moja, wakati ambapo ulikuwa na majukumu mengine shuleni, kazini au nyumbani? Je hili lilileta matatizo yeyote?

(JAZA NDIYO IKIWA TU HILI LILILETA MATATIZO)

b	Have you been high or intoxicated from [NAME OF SELECTED DRUG / DRUG CLASS] in any situation where you were physically at risk (e.g., driving a car, or a motorbike, using machinery, boating, etc.)? Je, umewahi kujisikia na hali ya juu au kurukwa akili kutokana na (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA) katika mazingira yeyote ambapo ulikuwa hatarini (mfano, kuendesha gari, kuendesha pikipiki, kutumia machine, kusafiri kwa mashua, nk).	NO	YES	9
c	Did you have any legal problems because of your [NAME OF SELECTED DRUG / DRUG CLASS] use, e.g., an arrest or disorderly conduct? Je, ulipata matatizo yeyote ya kisheria kwa sababu ya matumizi ya madawa mf. Kutiwa mbaroni au kufanya vurugu.	NO	YES	10
d	Did you continue to use [NAME OF SELECTED DRUG / DRUG CLASS] even though it caused problems with your family or other people? Je uliendelea kutumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), japokuwa ilisababisha matatizo kwa familia yako au watu wengine	NO	YES	11

ARE 1 OR MORE K3 ANSWERS CODED YES?

SPECIFY DRUG(S) :
_____

JE, KIPENGELE KIMOJA AU ZAIDI CHA K3 KIMEJIBIWA NDIYO?

TAJA DAWA/MADAWA
:_____

NO
DRUG(S) ABUSE CURRENT
NDIYO
HAPANA

MATUMIZI YA MADAWA KWA SASA

L. PSYCHOTIC DISORDERS
MAGONJWA YA SAIKOSIS

ASK FOR AN EXAMPLE OF EACH QUESTION ANSWERED POSITIVELY. CODE YES ONLY IF THE EXAMPLES CLEARLY SHOW A DISTORTION OF THOUGHT OR OF PERCEPTION OR IF THEY ARE NOT CULTURALLY APPROPRIATE.

BEFORE CODING, INVESTIGATE WHETHER DELUSIONS QUALIFY AS « BIZARRE ».

DELUSIONS ARE BIZARRE IF: CLEARLY IMPLAUSIBLE, ABSURD, NOT UNDERSTANDABLE, AND CANNOT DERIVE FROM ORDINARY LIFE EXPERIENCE.

HALLUCINATIONS ARE RATED BIZARRE IF: A VOICE COMMENTS ON THE PERSON'S THOUGHTS OR BEHAVIOR, OR WHEN TWO OR MORE VOICES ARE CONVERSING WITH EACH OTHER.

OMBA MFANO KWA KILA SWALI LINAJIBIWA NDIYO. JAZA NDIO IWAPO TU MIFANO INAONYESHA WAZI MABADILIKO YA MAWAZO AU UTAMBUZI AU KAMA HAIHUSIANI NA MILA NA DESTURI KABLA YA KUJAZA CHUNGUZA IWAPO IMANI ZA UWONGO ZINA SIFA ZA KUWA SI ZA KAWAIDA.

IMANI POTOFU AMBAZO "SI ZA KAWAIDA" KAMA: ISIYOWEZEKANA KUWA KWELI, UPUUZI, ISIYOELEWEKA, NA ISIYOTOKANA NA MAISHA YA KAWAIDA.

HISIA POTOFU AMBAZO "SI ZA KAWAIDA" NI KAMA: SAUTI KUELEZEA JUU YA MAWAZO YA MTU AU TABIA, AU WAKATI SAUTI 2 AU ZAIDI ZINAZUNGUMZA ZENYEWE.

Now I'm going to ask you about unusual experiences that some individuals may experience.

Sasa ninakuuliza kuhusu matukio yasiyo ya kawaida ambayo watu wanapata.

				BIZARRE	
L1 a	Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you? Je, umewahi kuamini kwamba watu wanakupeleleza, au kwamba mtu anapanga njama juu yako, au kujaribu kukudhuru? KUMBUKA: Ulizia mifano ili kupata uhalisia.	NO	YES	YES	1
b	IF YES: Do you currently believe these things? KAMA NDIYO: Je kwa sasa unaamini mambo haya?	NO	YES	YES ➔ L6a	2
L2 a	Have you ever believed that someone was reading your mind or could hear your thoughts or that you could actually read or hear what another person was thinking? Je, umewahi kuamini kwamba mtu alikuwa anasoma mawazo yako au kuweza kusikia mawazo yako, au kwamba wewe kuweza kusoma mawazo ya mtumwingine au kusikia kile anachowaza mtu mwingine?	NO		YES	3

b	IF YES: Do you currently believe these things? KAMA NDIYO: Je kwa sasa unaamini mambo haya?	NO		YES ➔ L6a	4
L3 a	Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self ? Have you ever felt that you were possessed? Je, umewahi kuamini kwamba mtu au nguvu Fulani kutoka nje zimeweka mawazo ndani yako na kwamba umekuwa siyo wewe mwenyewe, au imekufanya utende matendo ambapo haikuwa kawaida yako? Je, umewahi kujisikia kama kwamba umemilikiwa? *TABIBU*: ULIZIA MIFANO NA UONDOE YEYOTE ISIYOHUSIANA NA KURUKWA AKILI	NO		YES	5
b	IF YES: Do you currently believe these things? KAMA NDIYO: Je, kwa sasa unaamini mambo haya?	NO		YES ➔ L6a	6
L4 a	Have you ever believed that you were being sent special messages through the TV, radio or newspaper, or that a person you did not personally know was particularly interested in you? Je, umewahi kuamini kwamba umekuwa ukipokea ujumbe maalum kupitia TV, redio, au magazeti, au kwamba mtu usiyemjua akawa amevutiwa na wewe?	NO	YES	YES	7
b	IF YES: Do you currently believe these things? KAMA NDIYO: Je, kwa sasa unaamini mambo haya?	NO	YES	YES ➔ L6a	8
L5 a	Have your relatives or friends ever considered any of your beliefs strange or out of reality? ANY DELUSIONAL IDEAS NOT EXPLORED IN QUESTIONS L1 TO L4, E.G., OF GRANDIOSITY, RUIN, GUILT, HYPOCONDRIASIS. Je, ndugu zako au marafiki walishawahi kuona kwamba imani zako ni za ajabu au si za kawaida? Tafadhali, naomba mifano. *MSAILI:* Jaza ndiyo ikiwa tu mifano inaonyesha wazi kuwa ni imani za uwongo ambazo hazikuelezwa katika maswali L1 mpaka L4, mfano, za kujifaharisha, za unyong'onyevu, za maangamizi, kuwa na hatia, n.k.	NO	YES	YES	9
b	IF YES: Do they currently consider your beliefs strange? KAMA NDIYO: Je, kwa sasa wanaona imani zako ni za ajabu?	NO	YES	YES	10
L6 a	Have you ever heard things other people couldn't hear, such as voices? HALLUCINATIONS ARE CODED « BIZARRE » ONLY IF PATIENT	NO	YES	YES	11

ANSWERS YES TO THE FOLLOWING :

Did you hear a voice commenting on your thoughts or behavior, or did you hear two or more voices talking to each other?

Je umewahi kusikia mambo ambayo wengine hawasikii, kama vile sauti?

HISIA POTOFU ZINAKUWA "SI ZA KAWAIDA" IKIWA TU MGONJWA ANAJIBU NDIYO KATIKA SWALI LIFUATALO:

Je ulisikia sauti ikielezea mawazo yako au tabia au kusikia sauti mbili au zaidi zikizungumza zenyewe?

b	IF YES: Have you heard these things in the past month? KAMA NDIYO: Je, umesikia vitu hivi ndani ya mwezi 1 uliopita?	NO	YES	YES ➔ L8b	12

L7 a	Have you ever had visions when you were awake or have you ever seen things other people couldn't see? CODE YES ONLY IF THE VISIONS ARE CULTURALLY INAPPROPRIATE. Je, umewahi kuwa na ndoto wakati yu macho au kuona vitu ambapo watu wengine hawavioni? TABIBU: chunguza ili kujua kama havihusiani na mambo ya kimila na desturi?	NO	YES	13
B	IF YES: Have you seen these things in the past month? : INTERVIEWER'S JUDGMENT : KAMA NDIYO: Je umeviona vitu hivi katika mwezi mmoja uliopita? UAMUZI WA TABIBU	NO	YES	14
L8 b	IS THE PATIENT CURRENTLY EXHIBITING INCOHERENCE, DISORGANIZED SPEECH, OR MARKED LOOSENING OF ASSOCIATIONS? JE MGONJWA KWA SASA ANAONYESHA MAMBO YASIYOELEWEKA, MANENO YASIYO NA MPANGILIO, AU MAMBO YASIYOUNGANIKA.	NO	YES	`115
L9 b	IS THE PATIENT CURRENTLY EXHIBITING DISORGANIZED OR CATATONIC BEHAVIOR? JE KWA SASA MGONJWA ANAONYESHA TABIA ISIYOELEWEKA AU KUZUBAA?	NO	YES	16
L10b	ARE NEGATIVE SYMPTOMS OF SCHIZOPHRENIA, E.G. SIGNIFICANT AFFECTIVE FLATTENING, POVERTY OF SPEECH (ALOGIA) OR AN INABILITY TO INITIATE OR PERSIST IN GOAL			

DIRECTED ACTIVITIES (AVOLITION), PROMINENT DURING THE INTERVIEW? NO YES 17

L10b

JE, DALILI HASI ZA SKIZOFRENIA, MFANO KUTODHIHIRISHA HISIA, UPUNGUFU WA MANENO YA KUSEMA (KUTOSEMA) AU KUTOWEZA KUANZISHA AU KUDUMU KATIKA SHUGHULI MAALUM, ZINAONEKANA WAKATI WA USAILI?

L11 FROM L1 TO L10 : NO YES

- ARE 1 OR MORE « b » QUESTIONS CODED YES BIZARRE?

OR

- ARE 2 OR MORE « b » QUESTIONS CODED YES (RATHER THAN YES BIZARRE)?

PSYCHOTIC SYNDROME CURRENT

L11

- JE KIPENDELE KIMOJA AU ZAIDI VYA MASWALI (b) KIMEJIBIWA NDIYO SI YA KAWAIDA?

AU

- JE, VIPENGELE 2 AU ZAIDI VYA MASWALI (b) VIMEJIBIWA NDIYO (BADALA YA NDIYO SI YA KAWAIDA).

L12 FROM L1 TO L7 : NO YES

- ARE 1 OR MORE « a » QUESTIONS CODED YES BIZARRE?

OR

- ARE 2 OR MORE « a » QUESTIONS CODED YES (RATHER THAN YES BIZARRE)?

(CHECK THAT THE 2 SYMPTOMS OCCURRED DURING THE SAME TIME PERIOD)

PSYCHOTIC SYNDROME LIFETIME

OR

- IS L11 CODED YES?

L12

- JE, KIPENGELE 1 AU ZAIDI YA MASWALI (a) VIMEPITIWA NDIYO SI YA KAWAIDA?

AU

- JE, VIPENGELE 2 AU ZAIDI VYA MASWALI (a) VIMEJIBIWA NDIYO (BADALA YA NDIYO SI YA KAWAIDA)

UAMUZI WA TABIBU

CHUNGUZA KAMA DALILI 2 ZILITOKEA WA KATI MMOJA

AU

- JE, KIPENGELE L11 KIMEJIBIWA NDIYO?

L13a IF L12 IS CODED YES OR AT LEAST ONE YES FROM L1 TO L7 :

DOES THE PATIENT CODE POSITIVE FOR EITHER

MAJOR DEPRESSIVE EPISODE (CURRENT OR PAST)

OR MANIC EPISODE (CURRENT OR PAST)?

➔

NO YES

L13a KAMA L12 IMEJIBIWA NDIYO NA ANGALAU NDIYO MOJA KUTOKA L1 MPAKA L7:

JE DALILI HIZO ZIMEJIBIWA NDIYO KWA AIDHA

TUKIO LA SONONA, (KWA SASA)

AU TUKIO LA MANIA, (KWA SASA AU MUDA ULIOPITA)?

b You told me earlier that you had period(s) when you felt depressed/ high/ persistently irritable.

Were the beliefs and experiences you just described (SYMPTOMS CODED YES FROM L1 TO L7) restricted exclusively to times when you were feeling depressed / high / irritable?

Kama L13 imejibiwa ndiyo:

Uliniambia mwanzoni kwamba kulikuwa na vipindi ambavyo ulijisikia (huzuni/hali ya juu/mwepesi wa kuudhika mara zote).

Je, imani na matukio uliyoyaeleza hivi punde (dalili zimejibiwa ndiyo kutoka L1 mpaka L7).vimekuwepo pale tu ulipojisikia huzuni/hali ya juu/mwenyekuudhika?

NO YES 18

IS L13b CODED YES?

JE, L13b IMEJIBIWA NDIYO?

NO YES

MOOD DISORDER WITH PSYCHOTIC FEATURES

CURRENT

M. ANOREXIA NERVOSA

UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KUTOKULA

				Ft	☐☐
M1 a	How tall are you?	|__|__|__|		Ins	☐☐
	Una urefu kiasi gani?			Cm	☐☐☐
				Lbs.	☐☐☐
b	What was your lowest weight in the past 3 months?	|__|__|__|		Kg	☐☐☐
	Ni uzito upi mdogo kuliko wote katika miezi mitatu iliyopita.				
c	IS PATIENT'S WEIGHT LOWER THAN THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? SEE TABLE BELOW JE, UZITO WA MGONJWA NI MDOGO KULIKO KIWANGO KINACHOLINGANA NA UREFU WAKE? (ANGALIA JEDWALI CHINI)	➔ NO	YES		1
	In the past 3 months :	➔			
M2	Katika miezi 3 iliyopita: In spite of this low weight, have you tried not to gain weight? Pamoja na uzito huu mdogo, je ulijaribu kutoongeza uzito?	NO	YES		2
M3	Have you feared gaining weight or becoming fat, even though you were underweight? Je, ulihofia kuongezeka uzito au kuwa mnene hata kama ulikuwa na uzito mdogo?	➔ NO	YES		3
M4a	Have you considered yourself fat or that part of your body was too fat?	NO	YES		4
a	Je ulijiona wewe mwenyewe mnene, au sehemu ya mwili wako nene sana?				
b	Has your body weight or shape greatly influenced how you felt about yourself? Je, uzito wa mwili wako au umbile umeathiri kwa kiasi kikubwa jinsi unavyojiona?	NO	YES		5

c	Have you thought that your current low body weight was normal or excessive? Je, ulifikiria kwamba uzito wako mdogo wa sasa ni kawaida au umezidi?		NO YES	6
		➔		
M5	ARE 1 OR MORE M4 ANSWERS CODED YES? JE, KIPENGELE KIMOJA AU ZAIDI VYA M4 VIMEJIBIWA NDIYO?		NO YES	
		➔		
M6	FOR WOMEN ONLY: During the last 3 months, did you miss all your menstrual periods when they were expected to occur (when you were not pregnant)? Kwa wanawake tu: Katika miezi mitatu iliyopita, Je ulikosa siku zako zote za hedhi pale ambapo ulizitarajia kutokea (wakati hukuwa mjamzito)?		NO YES	7

FOR WOMEN: ARE M5 AND M6 CODED YES? FOR MEN: IS M5 CODED YES? KWA WANAWAKE: JE, M5 NA M6 VIMEJIBIWA NDIYO? KWA WANAUME: JE, M5 IMEJIBIWA NDIYO?	NO YES *ANOREXIA NERVOSA* *CURRENT*

TABLE HEIGHT / WEIGHT THRESHOLD (HEIGHT-WITHOUT SHOES; WEIGHT-WITHOUT CLOTHING)

HEIGHT(cm) UREFU (sm)	140	145	150	155	160	165	170	175	180	185	190
Females Wanawake WEIGHT (kg) UZITO (kilo)	37	38	39	41	43	45	47	50	52	54	57
Males Wanaume	41	43	45	47	49	51	52	54	56	58	61

THE WEIGHT THRESHOLDS ABOVE ARE CALCULATED AS A 15% REDUCTION BELOW THE NORMAL RANGE FOR THE PATIENT'S HEIGHT AND GENDER AS REQUIRED BY DSM-IV.

N. BULIMIA NERVOSA

UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KULA MNO

N1	In the past three months, did you have eating binges or times when you ate a very large amount of food within a 2-hour period? Katika miezi mitatu iliyopita, je uliwahi kula kupita kiasi au wakati ambapo umekula chakula kingi sana ndani ya masaa mawili?	➔ NO	YES	8
N2	In the last three months, did you have eating binges as often as twice a week? Katika miezi 3 iliyopita, je umewahi kula kupita kiasi kila mara, mara 2 kwa wiki?	➔ NO	YES	9
N3	During these binges, did you feel that your eating was out of control? Katika milo hii, ulijisikia kwamba kula kwako ni kwa kushindwa kujitawala?	➔ NO	YES	10
N4	Did you do anything to compensate for, or to prevent a weight gain from these binges, like vomiting, fasting, exercising or taking laxatives, enemas, diuretics (fluid pills), or other medications ? Je ulifanya kitu chochote kufidia, au kuzuia kuongezeka uzito kutokana na milo hii, kama vile kutapika, kushinda na njaa, kufanya mazoezi, kumeza dawa za kuharisha, enema, kuongeza mkojo au dawa nyinginezo?	➔ NO	YES	11
N5	Does your body weight or shape greatly influence how you feel about yourself? Je uzito wako au umbile lako linaathiri kwa kiasi kikubwa jinsi unavyojiona?	➔ NO	YES	12
N6	DOES THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?	NO	YES	13

IF N6 = NO, SKIP TO N8

N7 Do these binges occur only when you are under _____kg/lbs.*? NO YES 14

- TAKE THE THRESHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT / WEIGHT TABLE IN THE ANOREXIA NERVOSA MODULE

Je, milo hii ya kupita kiasi hutokea pale tu una uzito chini ya kilo _____?

- ANDIKA KIWANGO CHA UZITO KINACHOLINGANA NA UREFU WA MGONJWA KUTOKA KATIKA JEDWALILILILOPO KWENYE KIHUNZI CHA UGONJWA WA KUTOKULA

N8 IS N5 CODED YES AND N7 CODED NO (OR SKIPPED)?

JE, N5 IMEJIBIWA NDIYO N7 IMEJIBIWA HAPANA (AU IMERUKWA KWA SABABU DALILI ZA MGONJWA HAZIFIKII VIGEZO VYA UGONJWA WA KUTOKULA)?

NO

BULIMIA NERVOSA

CURRENT

IS N7 CODED YES?

JE, N7 IMEJIBIWA NDIYO?

ANOREXIA NERVOSA

Binge-Eating/Purging Type

CURRENT

O. GENERALIZED ANXIETY DISORDER

UGONJWA WA WASIWASI MKUBWA

O1 a	Have you worried excessively or been anxious about several things of day to day life, at work, at home, in your close circle over the past 6 months? DO NOT CODE YES IF THE FOCUS OF THE ANXIETY IS CONFINED TO ANOTHER DISORDER EXPLORED PRIOR TO THIS POINT SUCH AS HAVING A PANIC ATTACK (PANIC DISORDER), BEING EMBARRASSED IN PUBLIC (SOCIAL PHOBIA), BEING CONTAMINATED (OCD), GAINING WEIGHT (ANOREXIA NERVOSA)...	→ NO	YES	1
O1 a	Are these worries present most days? Je, ulikuwa na woga sana au kupata wasiwasi juu ya mambo mawili au zaidi (mf. Pesa, afya ya watoto, msiba) kwa kipindi cha miezi 6 iliyopita? Zaidi ya watu wengi webgine wanavyokuwa? Je, woga huu unakuwepo karibu siku zote?	→ NO	YES	2
O2	Do you find it difficult to control the worries or do they interfere with your ability to focus on what you are doing? Je unapata tabu kujizuia na woga, au je inavuruga uwezo wako wa kuwa makini kwa unachokifanya?	→ NO	YES	3
O3	FROM O3a TO O3f, CODE NOTHE SYMPTOMS CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT When you were anxious over the past 6 months, did you, almost every day : Waakati ulipokuwa na wasiwasi katika miezi 6 iliyopita, je, muda mwingi:			
a	Feel restless, keyed up or on edge? Ulijisikia kutotulia, kuamshwa, au mwenye kiherehere?	NO	YES	4
b	Feel tense? Ulijisikia kukakamaa?	NO	YES	5

c	Feel tired, weak or exhausted easily? Ulijisikia kuchoka, mdhaifu, au kuchoka mapema?	NO	YES	6
d	Have difficulty concentrating or find your mind going blank? Ulipata tabu ya kuwa makini, au kuona unapoteza kumbukumbu?	NO	YES	7
e	Feel irritable? Ulijisikia mwenye kuudhika upesi?	NO	YES	8
f	Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)? Ulipata tabu ya usingizi (tabu ya kupata usingizi, kuamka katikati ya usiku, kuamka mapema asubuhi, au kulala mno)?	NO	YES	9

ARE 3 OR MORE O3 ANSWERS CODED YES?

JE VIPENGELE 3 AU ZAIDI VYA O3 VIMEJIBIWA NDIYO?

NO

GENERALIZED ANXIETY DISORDER

CURRENT

P. ANTISOCIAL PERSONALITY DISORDER (optional)
UGONJWA WA MAKUZI YA HULKA NA TABIA ZINAZOPINGANA NA JAMII (hiari)

P1	Before you were 15 years old, did you : Kabla hujawa na umri wa miaka 15, je:			
a	Repeatedly skip school or run away from home overnight? Ulikuwa ukitoroka shule mara kwa mara au kuondoka nyumbani usiku?	NO	YES	1
b	Repeatedly lie, cheat, « con » others, or steal? Ulikuwa ukidanganya mara kwa mara, ukilaghai, kutapeli wengine, au kuiba?	NO	YES	2
c	Start fights or bully, threaten, or intimidate others? Ulianzisha ugomvi au kudhulumu, kutishia au kutisha wengine?	NO	YES	3
d	Deliberately destroy things or start fires? Kwa makusudi uliharibu vitu au kuwasha moto?	NO	YES	4
e	Deliberately hurt animals or people? Kwa makusudi kuwadhuru wanyama au watu?	NO	YES	5
f	Force someone to have sex with you? Kumlazimisha mtu kufanya mapenzi na wewe?	NO	YES	6
		➔		
	ARE 2 OR MORE P1 ANSWERS CODED YES? JE, VIPENGELE 2 AU ZAIDI VYA P1 VIMEJIBIWA NDIYO?	NO	YES	
P2	DO NOT CODE YES THE BEHAVIORS BELOW IF THEY ARE EXCLUSIVELY POLITICALLY OR RELIGIOUSLY MOTIVATED USIJIBU NDIYO KWA TABIA ZILIZO HAPA CHINI IKIWA ZIMESABABISHWA NA MAMBO YA KISIASA AU KIDINI Since you were 15 years old, have you: \ Tangu umri wa miaka 15, je:			
a	Repeatedly behaved in a way that others would consider irresponsible, like failing to pay for things you owed, deliberately being impulsive or deliberately not working to support yourself? Mara kwa mara ulikuwa na tabia ambayo watu wengine wangeona kama ni kutowajibika, kama vile kushindwa kulipa madeni, kwa makusudi kuwa jazba au kwa makusudi kutofanya kazi ili kujitegemea?	NO	YES	7
b	Done things that are illegal even if you didn't get caught (i.e., destroying property, shoplifting, stealing, selling drugs, or committing			

	a felony)? Hufanya mambo kinyume cha sheria hata kama hukutiwa mbaroni (kama vile, kuharibu mali, kuiba vitu dukani, wizi, kuuza madawa ya kulevya, au kufanya kosa la jinai)?	NO	YES	8
c	Been in physical fights repeatedly (including physical fights with your spouse or children)? Ulikuwa ukipigana mara kwa mara (ikiwemo kupigana na mke / mume wako au watoto)	NO	YES	9
d	Often lied or « conned » other people to get money or pleasure, or lied just for fun? Mara kwa mara kudanganya au "kutapeli" watu wengine ili kupata pesa au starehe, au kudanganya kwa kuchekesha watu tu?	NO	YES	10
e	Exposed others to danger without caring? Kuwaweka wengine katika hatari bila ya kujali?	NO	YES	11
f	Felt no guilt after hurting, mistreating, lying to, or stealing from others, or after damaging property? Kujiona huna hatia baada ya kuleta madhara, kufanya maovu, kudanganya, au kuwaibia watu, au baada ya kuharibu mali?	NO	YES	12

ARE 3 OR MORE ITEMS FROM P2 CODED YES?

JE, VIPENGELE 3 AU ZAIDI VYA P2 VIMEJIBIWA NDIYO?

NO
YES

ANTISOCIAL PERSONALITY DISORDER

LIFETIME

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

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2241349, 310571, 2219420
Fax: +254-20-318245, 318249
Email: secretary@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No.

Date:

7th February, 2014

NACOSTI/P/14/0949/733

Dr. Pauline Wanjiru Nganga
University of Nairobi
P.O.Box 30197-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Psychiatric morbidity among adult HIV/AIDS patients attending a comprehensive care centre at a city council clinic in Nairobi,"*** I am pleased to inform you that you have been authorized to undertake research in **Nairobi County** for a period ending **31st December, 2014.**

You are advised to report to **the County Commissioner, County Director of Education and County Coordinator of Health, Nairobi County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

DR. M. K. RUGUTT, PhD, HSC.
DEPUTY COMMISSION SECRETARY
NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION

Copy to:

The County Commissioner
The County Director of Education
The County Coordinator of Health
Nairobi County.

Recd On 14/2

Please accord the necessary support

Ministry of Health

Telegrams: "PRO-MINHEALTH", Nairobi
Telephone: Nairobi 217131/313481
Fax: 217148
E-mail: pmonairobi@yahoo.com

COUNTY MEDICAL OFFICE HEADQUARTERS
NAIROBI COUNTY
NYAYO HOUSE
P.O. Box 34349-00100
NAIROBI

When replying please quote

PMO/NRB/OPR/VOL1-2/40
Ref: No. ----------

11th February 2014

Dr. Pauline Wanjiru Nganga
University of Nairobi
P.O Box 30197-00100
NAIROBI

RE: RESEARCH AUTHORIZATION

Following your letter dated 7th February, 2014 for conducting research on **"Psychiatric morbidity among adult HIV/AIDS patients attending a comprehensive care centre at a city council clinic in Nairobi".** I am pleased to inform you that you have the support of the County Health Operational Research Technical working group to undertake research in Nairobi County Health Facilities.

On completion of your study, we request that you submit **one hard copy and one copy in PDF** of the research dissertation to our operational research technical working group.

For COUNTY DIRECTOR
OF HEALTH
NAIROBI COUNTY

MR. RAPHAEL K. MULI
FOR: COUNTY DIRECTOR OF HEALTH - NAIROBI

C.C. Sub-County Medical Officer of Health
Westlands

CONDITIONS

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit
2. Government Officers will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2) hard copies and one(1) soft copy of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

REPUBLIC OF KENYA

NACOSTI

National Commission for Science, Technology and Innovation

RESEARCH CLEARANCE PERMIT

Serial No. A 954

CONDITIONS: see back page

THIS IS TO CERTIFY THAT:
DR. PAULINE WANJIRU NGANGA
of UNIVERSITY OF NAIROBI, 402-208
ngong,has been permitted to conduct research in *Nairobi County*

on the topic: *PSYCHIATRIC MORBIDITY AMONG ADULT HIV/AIDS PATIENTS ATTENDING A COMPREHENSIVE CARE CENTRE AT A CITY COUNCIL CLINIC IN NAIROBI.*

for the period ending:
31st December,2014

Permit No : NACOSTI/P/14/0949/733
Date Of Issue : 7th February,2014
Fee Recieved :Kshs 1,000.00

.....
Applicant's Signature

.....
Secretary
National Commission for Science, Technology & Innovation