KNOWLEDGE AND UTILIZATION OF CONTRACEPTIVES BY WOMEN WITH MENTAL ILLNESS ATTENDING PSYCHIATRIC OUTPATIENT SERVICES AT MATHARI NATIONAL TEACHING AND REFERRAL HOSPITAL

A DISSERTATION SUBMITTED TO THE UNIVERSITY OF NAIROBI IN PART FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF DEGREE OF MASTER OF MEDICINE IN PSYCHIATRY

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TABLE OF CONTENTS

TITLE.

DECLARATION i

APPROVAL ii

ACKNOWLEDGEMENT iii

TABLE OF CONTENTS iv

LIST OF TABLES vii

LIST OF ABBREVIATIONS viii

ABSTRACT ix

CHAPTER ONE 1

INTRODUCTION 1

1.0 Introduction 1

1.1 Background 1

CHAPTER TWO 3

LITERATURE REVIEW 3

2.1 Importance of Contraception in mental health. 3

2.1.1Etiology of mental illnesses 3

Table 1: A Table of Risk factors and antecedents of schizophrenia (adopted from the African text book of clinical psychiatry and mental health).Source:(Sartorius, *et al.* 1966) 4

2.1.2 Mental health and parenting 5

2.1.3 Mental Health and HIV AIDS 5

2.1.4 Pregnancy and Mental Health 6

2.2 Contraceptive Counseling in Mental Health 7

2.3 Contraceptive Knowledge and Utilization in Mental Health 8

2.4 Conceptual framework 10

2.5 Problem Statement 12

2.6 Rationale 13

2.7 Study questions 14

2.8 Objectives 14
2.8.1 Broad objective……14
2.8.2 Specific objectives…….....14
2.9 Hypothesis…….....14

CHAPTER
THREE……..……...15

METHODOLOGY…….…..…….....15
3.1 Study design…….....15
3.2 Study area…….....15
3.3 Study population……15
3.3.1 Inclusion criteria…….....15
3.3.2 Exclusion criteria…….....15
3.4 Sample size calculation…….....15
3.5 Sampling method……...16
3.6 Study implementation…….....16
3.7 Flow Chart of Study Implementation……..……...18
3.8 Data collection instruments……19
3.8.1 Pretesting……19
3.8.2 Reliability and Validity……..……....19
3.8.3 Variables…….20
3.8.4 Quality Assurance Procedures ……..……..20
3.9 Ethical considerations……....21
3.9.1 Data management, Analysis and Presentation……....21
3.9.2 Limitations……..22
3.9.3 Time Lines……..23
CHAPTER FOUR……...24

RESULTS ……..….24

4.1 Sample Description……....24

4.1.1 Demographics characteristics…….….24

4.1.2 Psychiatric Diagnosis……..…26

4.1.3 Contraceptive Counseling……..……..…26

4.1.4 Knowledge of Contraceptives…….27

4.1.5 Utilization of Contraceptives …….30

4.1.6 Knowledge of side effects and their remedy by contraceptive users …….32

4.1.7 Place of sourcing contraceptives by users ……....……33

4.1.8 Reproductive History by respondents ……...……34

CHAPTER FIVE…….35

5.0 DISCUSSION……...……35

5.1 Social Demographic Characteristics ……..……...35

5.2 Psychiatric Diagnosis……..…….…..35

5.3 Contraceptive counseling……..…….36

5.4 Contraceptive Knowledge…….……36

5.5 Contraceptive Utilization……...37

5.6 Reproductive History of respondents…….39

5.7 Conclusion…….…39

5.8 Recommendations……..…40

REFERENCES……..……...41

APPENDICES……..……...46

APPENDIX I: Budget (amount in kenya shillings…….……..46

APPENDIX II: Informed Consent Explanation Form……....48

APPENDIX III: Informed Consent Form ……..……....50

APPENDIX IV: Curriculum Vitae …….....51

APPENDIX V: Questionnaires…….……...…52

LIST OF TABLES

Table 1: A Table of Risk factors and antecedents of schizophrenia (adopted from the African text book of clinical psychiatry and mental health).Source:(Sartorius, *et al.* 1966)…….....4

Table 2a Social-demographic Characteristics……..24

Table 2b Social-demographic characteristics (continued)……...25

Table 3: Psychiatric Diagnosis ……...26

Table 4: Contraceptive counseling in the last One Year……..26

Table 5: Knowledge of contraceptive Methods ……..27

Table 6: knowledge of safe days…….28

Table 7: Factors associated with Knowledge of Contraceptive methods in Bivariate analysis at 95% confidence……29

Table 8: Independent factors associated with knowledge of Contraceptive Methods in Multivariate Analysis at 95% confidence……29

Table 9: Current and previous utilization of contraceptives ……...30

Table 10: Factors associated with current Contraceptive Utilization in Bivariate analysis at 95% confidence. ……..31

Table 11: Independent factors associated with current utilization of contraceptives by multivariate analysis at 95% confidence……..32

Table 12: Contraceptive counseling on alternative methods, side effects and their remedies….33

Table 13: knowledge and place of sourcing contraceptives…….33

Table 14: Reproductive history ……...34

LIST OF ABBREVIATIONS

MNTRH	-	Mathari National Teaching and Referral Hospital
KDHS	-	Kenya Demographic Health Survey
MDG	-	Millennium Development Goals.
HIV	-	Human Immunodeficiency Virus
CDC	-	Centers for Disease Control
UK	-	United Kingdom
IV	-	Intravenous
ART	-	Anti Retroviral Therapy
PMTCT	-	Prevention of Mother to Child Transmission.
LBW	-	Low Birth Weight
IUGR	-	Intrauterine Growth Retardation
KNH	-	Kenyatta National Hospital
LAM	-	Lactation Amenorrhea
EC	-	Emergency Contraception
IUD	-	Intrauterine Device
CBD	-	Community Based Distributors
CPR	-	Contraceptive prevalence Rate
SPSS	-	Statistical Package for Social Sciences
STI	-	Sexually Transmitted Infections
WHO	-	World Health Organization
FP	-	Family Planning
KES	-	Kenya Shillings
CNS	-	Central Nervous system
MINI PLUS	-	Mini International Neuropsychiatric Interview Plus
ANOVA	-	Analysis of variance
G.A.D	-	Generalized Anxiety Disorder.
M.D.D	-	Major Depressive Disorder.
O.R	-	Odds Ratio.
P-Value	-	Level Of Significance**.**

ABSTRACT

Background

Reproductive health is a basic human right enshrined in the Kenya constitution 2010.All women should be able to make informed reproductive health choices in order to attain safe motherhood. This requires family planning, for which contraception is essential.

Women with psychiatric illness have reproductive health needs and psychiatrists should be able to offer them as necessary, inclusive of contraception .This is because reproduction has greater risks in patients with mental health problems than in the general population.

Aims

This study aimed to establish knowledge and utilization of contraceptives among women with psychiatric diagnosis attending MNTRH outpatient services. Other associated factors assessed were contraceptive counseling, place of sourcing, awareness of their side effects and what to do in case they occured.

Methods

The study was descriptive cross sectional and involved 306 women attending Mathari psychiatric outpatient services, systematically sampled. A face to face interview took place with each patient after they signed an informed consent. Data collection instruments were a researcher designed social demographic and the woman questionnaires from Kenya demographic health survey (KDHS).Mini International Neuropsychiatric Interview Plus {MINI PLUS} questionnaire was used to establish patient diagnosis.

Data Analysis

Data was analysed using SPSS version 21. The standard MINI PLUS guide was used to establish psychiatric diagnosis. Chi square or analysis of variance (ANOVA) were used to determine association where the predictor variable was categorical or continous respectively. Results are presented in tables and text narratives

Results

Knowledge of contraceptives was high with 99% of respondents knowing atleast one method. Modern methods were more known than tradition ones. Factors that influenced knowledge of contraception were high education (OR 1.39, CI 1.02 – 1.90, $p < 0.04$), counseling by a

clinician (OR 2.69, CI 1.52 – 7.22, p< 0.029) and if lack of employment was not due to illness (OR 3.331, CI 1.11 – 6.57, p< 0.003).

Current contraceptive utilization was 42.2% while previous was 53.6%. There was greater utilization of modern methods than tradition one's. Factors associated with current utilization were counseling by a clinician (OR 4.69, CI 1.11 – 6.51, p< 0.0001) and employement (OR 1.60, CI 1.14 – 2.24, p<0.007).

Conclusion

Contraceptive counseling by clinicians increases both knowledge and utilization of methods. Counseling should be enhanced among those with poor education and the unemployed, especially due to illness.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

The constitution of Kenya 2010 articles 23 and 43 guarantees "reproductive health rights" which include the right of all individuals to attain the highest level of sexual and reproductive health. Women should be able to make informed decisions about their reproductive lives free from discrimination, coercion or violence. The ultimate goal of "right to safe motherhood" is to have both a healthy mother and baby. For these outcomes to be realized pregnancy needs to be planned for in advance. The constitution also states that both National and County Governments will provide contraception information and avail the methods.

In the year 2012 the African Commission union report assessing progress of Millennium Development Goals (MDG's) in Africa placed Kenya among ten African countries with regressing indicators on maternal health. Indeed, the Kenya Demographic Health Survey 2008/9 had concluded that it was not possible to confidently show improvement in maternal mortality since 2003. MDGS aim to reduce maternal mortality by three quarters and achieve universal access to reproductive health by 2015. The current Kenya maternal mortality ratio is 488/100000 live births against a target of 147/100000. The major causes of these deaths are preventable and include bleeding, infection, hypertension, unsafe abortion and obstructed labor (Khalid, *et al.* 2006) Contraception is one of the major strategies of averting maternal mortality and morbidity.

1.1 Background

Patients with psychiatric illnesses also have reproductive health needs and are at risk for several complications of reproduction including abortion. These needs include sex education, provision of family planning, managing gender based violence and prevention of sexually transmitted infections such as HIV (Prince, *et al. 2007*). Use of contraceptives can mitigate for many of these reqiurements, which are often ignored in psychiatric health care settings. Reproductive health is a right for all as enshrined in the Kenya constitution 2010. Practitioners caring for psychiatric patients should ensure that reproductive health services are available as and when appropriate.

The reproductive behaviors of women with psychiatric illness have not been systematically investigated despite their impact in determining bio psychosocial and emotional wellbeing.

Studies can help to identify the needs for contraceptive counseling, provision and uptake among the mental health patients.

Pregnancies in women with mental illness pose a higher risk than those of normal women. Hence reproductive health needs are aspects of physical and psychological health that should be addressed in women seeking mental health services. Pregnancy planning and management are crucial in reducing risk of relapse or occurrence of psychiatric illness. Unplanned pregnancies also have adverse psychosocial and behavioral outcomes for the offspring. It is not uncommon to see women with overt psychiatric illness who are pregnant walking around in urban centers in Kenya. It is likely that such pregnancies were not intended.

Medications used in psychiatry have impacts on reproductive lives of patients and clinicians should do a risk benefit analysis for continued use of psychotropic in pregnancy. Contraception can help in pregnancy planning hence reducing the risks.

CHAPTER TWO

LITERATURE REVIEW

2.1 Importance of Contraception in mental health.

Adverse exposures for mental health patients dictate that pregnancy must be well planned for in absolute number, timing and spacing. This is in order to produce near optimum psychiatric outcomes for mother, child and community .Adverse experiences are in relation to etiology of mental illness, HIV/AIDS and effect of pregnancy on mental illness as discussed below.

2.1.1Etiology of mental illnesses

Family, twin and adoption studies have revealed that behavioral and psychological conditions can be inherited (Sadock & Sadock, 2007). The conditions have precipitating and perpetuating factors that are mostly environmental (Ndetei, et al. 2006). Thus mental illness can be familial and may also be triggered by environmental factors. Depending on the factors a woman with a mental illness is currently facing or is at risk of, it becomes essential that she plans her family. The table below illustrates risk factors for schizophrenia, which contraception may mitigate to some extent.

Table1: A Table of Risk factors and antecedents of schizophrenia (adopted from the African text book of clinical psychiatry and mental health).Source:(Sartorius, *et al.* 1966)

Risk factor	**Estimated effect size (odds ratio or relative risk**
A. Family member with schizophrenia	
• One biological parent	7.0 – 10.0
• Both Biological parents	37.0
• Monozygotic twin	45-50
• Dizygotic twin	14.0
• Non twin sibling	9.0-12.0
• Second degree relative	1.1
B. Pregnancy and birth related factors	
• Perinatal brain damage	6.9
• Birth weight less than 2kg	6.2
• Birth weight less than 2.5 kg	3.4
• Obstetric complications	2.0 -4.4
C. Social and demographic factors	
• Low social economic status	3.0
• Single marital status	4.0
• Stressful life events	1.5
• Urban birth	1.4
• Migration and minority status	1.7-10.7
D. Neurodevelopment	
Early central nervous system infection	4.8
Epilepsy	2.3
Low IQ (<74)	8.6
Social adjustment difficulty in childhood and adolescence	30.7

Other mental illnesses also follow the bio-psychosocial model of etiology just like schizophrenia above. However the relative risks for each factor may not be documented for all illnesses.

2.1.2 Mental health and parenting

Mental illness and poverty estimates show that in UK, 50-66% of patients with severe mental illnesses live with one or more children less than 18 years (Bee, 2013). Parenting is both rewarding and difficult for any person. However, it is a challenge for mentally ill patients who may not have enough support or resources. Frequent hospitalizations may mean that the parent is physically and psychologically absent from the child. Mental illness may make one unable to cope with daily activities including parenting. As a parent, there is stigmatization and poor help seeking behavior since she/he will not want to appear as less capable. The child whose parent has mental illness is at risk of developing social, emotional and behavioral problems (Quintona, 2009)which may be due mainly to an inconsistent and unpredictable family environment as a result of parental mental illness.(American Academy of Child and Adolescent, 2008).Other factors may include poverty, occupational and marital difficulties, poor parent-child communication, co morbid substance use and parental hostility(Mental Health America, 1998).These factors are more prevalent where families are large, have short birth intervals or pregnancies are unplanned and therefore unwanted (Billings & Moos, 1983; Reupert & Maybery, 2007). Contraception can be used to limit and plan the family hence improving the health outcome for both child and parent. A study done in Kenya demonstrated that negative maternal parenting behavior and maternal depressive disorder are associated with major depressive disorder in the children (Khasakhala, et al.2013).

2.1.3 Mental Health and HIV AIDS

The prevalence of HIV among people with mental health problems is four times higher than in the general population (Blank, et al. 2014). HIV can lead to psychiatric symptoms such as acute emotional distress, anxiety, depression and substance use disorders. HIV can also directly invade the brain to cause psychosis, dementia and delirium. Some medications used to treat HIV may cause cognitive disorders. Thus HIV infection increases the burden of psychiatric disorders (Semple, 2013). In a similar domain having a psychiatric illness can increase the risk for HIV. This is because the patient may engage in Intravenous (IV) drug use, abuse substances and engage in risky sexual behavior (Susser, 1993).

Psychiatric disorder can reduce Anti retroviral therapy (ART) adherence and thus increase risk of psychosis (Treisman, 2006). Poverty, acute psychiatric illness, poor negotiating skills for safe sex, rape and gender based violence are all risk factors for HIV in mentally ill patients (Seeman, 2002).Contraception is a strategy for reduction of HIV transmission since it can be used to delay conception until the viral load is very low to help Prevention of Mother

to Child Transmission (PMTCT) (Nouga, 2010). Pregnancy may also be avoided completely. Condom use is known to prevent pregnancy as well as horizontal transmission of HIV and other STIs. Thus to mitigate for the high prevalence of HIV in mentally ill patients, contraceptive use is essential. Reduction in HIV rates of infection will also reduce the burden of mental illness.

2.1.4 Pregnancy and Mental Health

Mental Health problems are more likely to occur during pregnancy or in the first year after delivery (Kendell, *et al.* 1987).The illness may progress faster and become more severe after delivery than at any other time. Particularly at risk are women who have history of mental illness and discontinue psychiatric medication when gravid. The risk for relapse in defaulters is five times higher than for those who take medication during pregnancy (Cohen, et al. 2006). According to the Demographic Health Surveys of 1985- 2009, many pregnancies are unplanned and may occur when one is on treatment for a psychiatric disorder. On the other hand the first episode of a mental illness may present during pregnancy (Carter & Kostaras, 2005). Thus decisions regarding continuation or initiation of psychiatric medication have to be made. The decisions depend on risks associated with in utero exposure to a particular medication and those in untreated maternal psychiatric illness. Maternal mental illness may cause long-term morbidity for both mother and child, hence stopping medication may not be a safe option. On the other hand, no psychotropic medication can be said to be completely safe in pregnancy (Taylor, et al. 2003).

Women who suffer psychiatric illness are less likely to attend prenatal care (Zisook & Burt, 2003) and are likely candidates for substance abuse that is known to produce adverse pregnancy outcomes (Nguyen, et al. 2010). Low birth weight and intra uterine growth retardation have been described in babies born to mothers with depression. Anxiety and depression in late pregnancy have been associated with increased risk of preeclampsia, operative delivery, neonatal hypoglycemia, respiratory distress and prematurity (Bonari, et al. 2004). Although some psychotropic medications may be used in pregnancy if clinically warranted, long term effects of prenatal exposure to these substances are not completely known. Teratogenesis and long term neuro behavioral disorders are documented (Kohen, 2003). As an example, in utero exposure to antidepressants causes future cognitive defects or behavioral problems (Yonkers, et al. 2014). Lithium use in pregnancy is associated with higher rates of cardiovascular malformations (e.g. Ebstains anomaly) and use of

carbamazepine in the first trimester carries a 1% risk of neural tube defects (Taylor, et al. 2003). Sodium valproate is associated with 1-6% risk of neurotube defects, craniofacial abnormalities, limb defects, cardiovascular malformations, genital defects and poor neurocognitive development (Zisook & Burt, 2003). This demonstrates that pregnancy and mental illness is both a risk to the mother and child. Careful planning or avoidance of the same needs should be considered, hence the need for contraception.

2.2 Contraceptive Counseling in Mental Health

Contraceptive counseling is essential for all women of reproductive age. It is particularly important in psychiatry for pregnancy planning since conception has more risk to the patient and her child (Hendrick, 2015). The women also need special consideration when using hormone based contraceptive due to possible interactions with psychotropic medication. However they can safely use many of the available methods (Cullins, 2015).

Unplanned pregnancies occur in women with psychiatric illness not using contraception because of barriers to ready access, concern about adverse effects and inconvenience in use. It is therefore important that patients are counseled with regard to their values, preferences, expectations, benefits, side effects and possible choices. Counseling is a dialogue between two experts; the counselor has technical expertise while the patient is an expert of her needs, life circumstances, previous contraceptive experiences and current expectations. There is evidence that FP counseling is unlikely to be offered in mental illness by psychiatrist. Indeed only about a third of patients with psychiatric illness have birth controls discussed with care giver (Henshaw & Protti, 2010).

In New Zealand (Coverdale & Aruffo, 1992) low levels of contraceptive counseling were found to be due to psychiatrists feeling that Family Planning counseling is not their primary responsibility, perceiving patients as having adequate knowledge and not at risk of unwanted pregnancy or discomfort discussing sexual history with mental patients. Providers were also found to have barriers towards preventive interventions of Family Planning and STI for psychiatric patients. Indeed professionals had discussed STI with 21% and counseled 17% on FP of their female psychiatric outpatients. At least 33% of care givers expressed discomfort in discussing condom use and sexual preferences with their patients (Coverdale, et al. 1997).

In Glasgow UK contraception was discussed with only 17% and 13% of patients taking carbamezepine and valproate respectively with the prescribing pyschiatrist (Langan, et al. 2013).

In Istanbul Turkey, a study established that only 11% and 13% of schizophrenia and bipolar disorder patients respectively had discussed contraception with their psychiatrist. Most of the patients got information from neighbors and friends although they would have preferred to get it from a psychiatrist, especially a female one (Pehlivanoglu, et al. 2007).

In Nigeria, among women attending psychiatric outpatient only 5% had received FP information from the said clinic although 81% would have wished for it. Barriers to contraception would have been addressed by counseling (Ayinmode, 2013).

In Kenya low levels of contraceptive counseling would be expected due to a generic health system weakness that impacts negatively on efforts to integrate mental health into routine primary health practice. The integration should be at community, primary care and district level rather than just at national and provincial levels (Jenkins, et al. 2013).

2.3 Contraceptive Knowledge and Utilization in Mental Health

Limited health literacy is prevalent and is highly associated with education, ethnicity and age. It is thus important to simplify health services and improve health education. Better knowledge will result in more and appropriate utilization of health services including contraception (Orlow, et al. 2005).

Women with mental health issues are sexually active, have less knowledge on contraception and have more barriers to contraceptive utilization. They perceive methods as difficult to obtain (Ciuhodar, et al. 2011, Miller & Finnerty, 1998). The most common reason that mentally ill patients give for non-use is lack of expectation to have sex as opposed to side effects in those without psychiatric diagnosis. Many women with psychiatric illness can benefit from long acting reversible contraception but lack of awareness of option and perception that they are difficult to obtain hinder use. Integrating family planning with mental health care can address the unique needs of this population.

Mental health patients report a higher incidence of contraceptive unprotected coitus, unwanted pregnancy and births (Abernethy, 1974). This reduces the patient's quality of life and can be addressed by sex education. The psychiatrist should openly discuss sex, birth control and child bearing with patients whose ideas could be affected by psychopathology (Hatcher, et al. 1983). The discussion should be aimed at increasing knowledge and competence for decision making without coercion. It should be done when psychopathology is not severe and implication of the patient refusal to contraception must be examined, noting that the decision must be voluntary.

Clinicians identify unmet need for family planning in psychiatric patients but are not able or willing to provide direct service regarding FP. Thus the role of adult mental health clinician in comprehensive and integrated approach is an open question. Clinicians express interest but quote heavy caseloads in not offering FP services and this can be addressed by strengthening collaborations with other stake holders. Adolescent girls are particularly at risk of pregnancy and should receive closer attention (Kessler, et al. 1997).

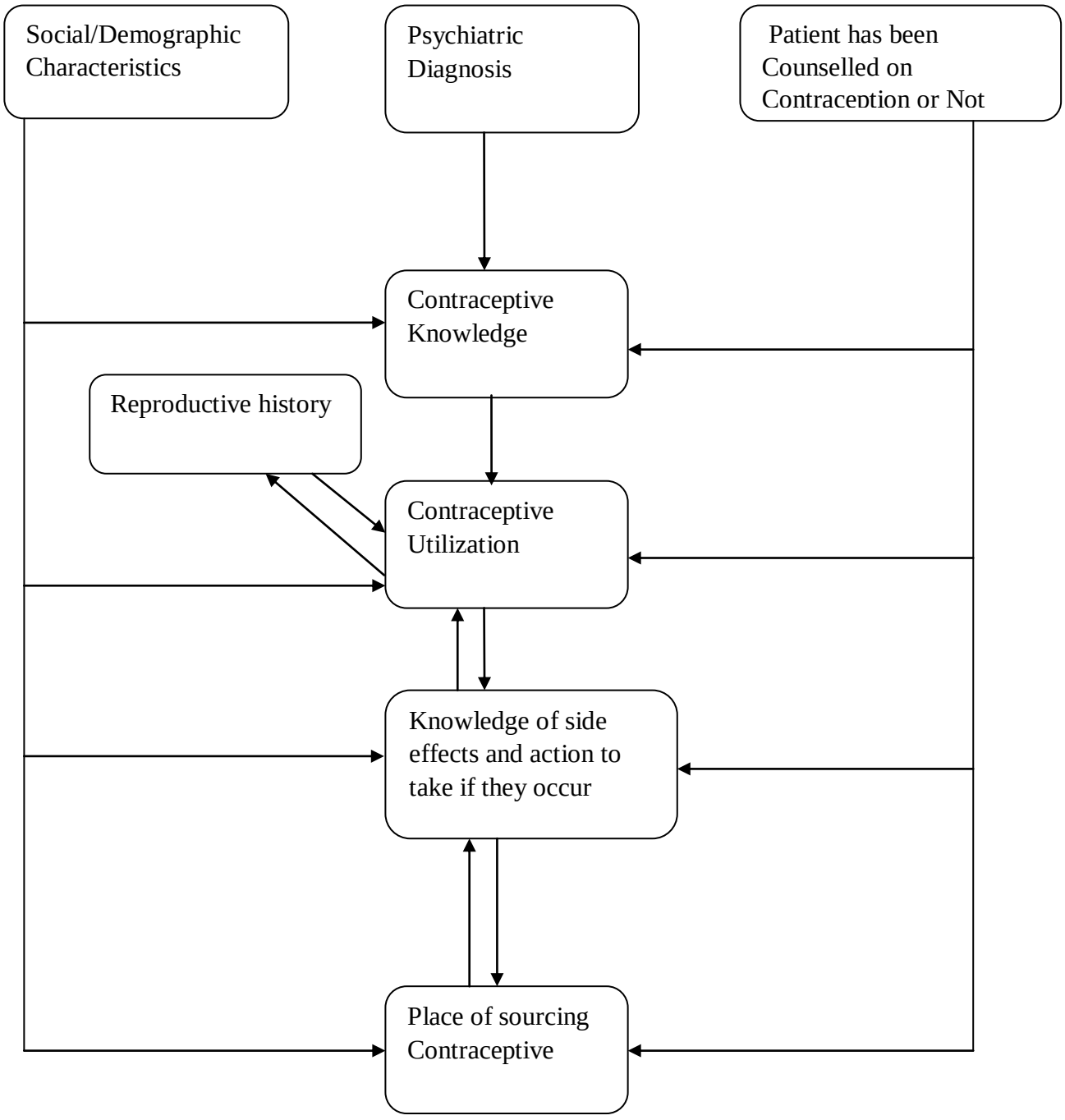
In a study on necessities of contraception in women suffering from schizophrenia in Romania, Ciuhodar,et al.(2011), found that only 13% of the patients had consulted a gynecologist for the service while the rest (87%) had never. From the 46% that were married, 62% were using coitus interruptions, 33% IUD and 5% hormonal contraceptive. Out of the 22% that were in a relationship but not married, 7% were using condoms and 72% natural methods. Singles comprised 20% out of whom 6% used condoms, 12% coitus interruptions and the rest nothing .This indicates low condom and prevalent use of unreliable methods.

In a Nigerian study, Tunde-Ayinmode, et al. (2013),found contraceptive knowledge in women attending psychiatric outpatient to be 88%, 27% were currently using a method and 51% had never used at all. The gap in family planning need was 61%. The methods most known in decreasing order was male condom (68%), injectable (64%), pills (56%), IUD (37%) and sterilization (16%). The methods that were currently being used in decreasing order were condom (10%), injectable (6%), and pills (2%).

Among contraceptive users, 48% discussed family planning issues with spouses. The most common reasons for nonuse were fear of side effects (39.7%), desire for more children (33.3%), cultural and religious inhibition (14.3%), indecision (3%) and spousal opposition (1.6%). The most common reasons for use were termination of child bearing (18.5%), spacing (29.6%) and limiting the number of children (14.8%). The reasons for not having any interest in family planning in order of frequency were wish to have unlimited number of children (41%), religious and cultural inhibitions (15.4%), fear of side effects (12.8%) and other unlisted factors (30.8%). The reasons for discontinuation following previous use were fear of methods (72.7%), pregnancy (9.1%) and termination of sexual activity (9.1%). Methods previously used included pills (29.6%), injectables (7.4%), male condoms (14.8%) and IUD (11.1%).The study demonstrates high knowledge level but low utilization.

2.4 Conceptual framework

KEY; relationship direction



Narrative to conceptual framework.

The conceptual framework is adopted from Magesa, 2014 and modified by the researcher. Independent factors that influence knowledge and utilization of contraceptives in mental health include social-demographic characteristics, psychiatric diagnosis and whether or not the patient has been counseled on contraception.

Young women may be single, have less knowledge and utilization since they may not be sexually active and are unlikely to have come into contact with family planning services. They are unlikely to use long term methods if at all. Among the young but married, utilization may be low regardless of knowledge since they want to have children. Older women are likely to have finished child bearing and have come into contact with family planning services. Their knowledge and utilization, especially of long term methods is expected to be high.

Education increases information base and can lead to increased knowledge and utilization. Better educated women are likely to know the most appropriate source of contraception, side effects and what to do in case they occur. Education and some forms of occupation may dictate delay of conception and hence encourage contraceptive use. The purchasing power of a woman is determined by her education or occupation which in turn determines where she can get contraception and the type she can afford.

Some religions discourage use of contraceptives. Women affiliated to them may not seek knowledge on contraception and are unlikely to utilize. If they choose to use, they will most likely get them from unconventional sources, their knowledge of side effects and what to do in case they occur is likely to be limited. Continued use would thus be jeopardized.

Some psychiatric diagnoses are associated with intellectual and cognitive impairment. Patients with such diagnosis will have less knowledge and utilization of contraceptives. They most likely would use long term methods that require less attention.

Contraceptive counseling can take place at both the community and health facilty levels. Some of the patients may have been counseled previously regardless of whether they are users or not. They are expected to have more knowledge and utilization. They will also know the most appropriate place to get contraceptives, their side effects and what action to take in case they occur.

Patients with many children and adverse reproductive health outcomes are likely to use contraceptives more.Those who desire children will not use regardless of knowledge. Reproductive outcomes can also be influenced by contraceptive use.

Place of sourcing contraceptives, knowledge of their side effects and what to do when they occur can be determined by both social demographic characteristics and counseling. These will then influence utilization of contraception.

2.5 Problem Statement

According to KDHS 2008/09 the contraceptive prevalence rate (CPR) in Kenya was 46% (modern methods 39% and traditional methods 6%) and the target was to raise the Kenya CPR to 75% 2015. The unmet need for family planning was 26% (KDHS 2008/09). This is defined as the percentage of women in reproductive age group not using any method of contraception and do not want any children in future or in the next two years. Among married women, 43% reported their current pregnancies as mistimed or completely unwanted. Contraceptive utilization has been documented for some special groups such as women living in slums and attending HIV clinics. No study on contraception had been done among mental health patients in Kenya.

Women with psychiatric illness are sexually active and are at risk of unwanted pregnancy. Pregnancy planning is of importance in mental health since it can lead to relapse of psychiatric illness, psychotropic use in pregnancy can have adverse outcome for the child and the general reproductive health outcomes are poorer for the affected women. In clinical practice it is not unusual to see women on multiple psychotropic medications who have also conceived. Others with acute psychiatric illness are obviously pregnant. It is likely that those pregnancies were not planned.

Reproductive health choices are meant to be voluntary and based on informed consent. Contraceptive use decisions are at times made on behalf of mentally ill patients by relatives and the choices are not necessarily what the patient would have wanted or desired. Conversely, due to misinformation some patients make contraceptive choices when it is too late or choose methods that are not in line with their reproductive aspirations. The study determined if patients had been counseled on contraception, thus equipping them with knowledge to make proper choices and resist those that were not appropriate.

Contraceptives are free in government facilities but available elsewhere at a fee. Government hospitals have personnel who are knowledgeable in contraception and are not biased. Most women with mental illness have low social economic means which can impact negatively on utilization of contraception and faith based organizations may discourage use. This study determined where women with psychiatric illness sourced their contraceptives from.

2.6 Rationale

Although contraceptive utilization is well documented for the general population and some other special needs groups, the situation among our psychiatric patients is little known. A study in a psychiatric referral hospital would capture a near true picture. This study helped to determine the need for contraceptive counseling so as to increase knowledge and uptake in tandem with reproductive aspirations of women with mental health illness. It also pointed out where these women get their contraceptive methods from.

Patients who required contraceptive counseling and uptake were referred to the FP clinic. Those using inappropriate methods were helped to change to better ones and women with barriers to contraceptive use were helped to overcome them. Their reproductive health will improve, leading to a reduction in mental health burden.

Attainment of the highest level of reproductive health is a basic human right that is provided for in the Kenya constitution. It is also a basic component of vision 2030. Every available support should be used to provide for highest reproductive health status for the mentally ill patients. This should include raising contraceptive prevalence rate to 75% which was the national target for the year 2015. This study gave contraceptive prevalence rate and demonstrated unmet need for FP in women with mental health issues. Policy makers can use this information to address the gap. This can be through increased counseling to enhance knowledge and uptake. Methods can also be availed more easily in government hospitals. The need for psychiatrists to participate in primary care services such as contraceptive counseling was demonstrated. Although time consuming considering the psychiatric case loads, this will reduce mental health burden in the long term.

Mentally ill patients are at increased risk of poor reproductive health outcomes than the normal population. They may engage in unsafe sexual practices exposing them to unwanted pregnancies, have lower than normal parenting capacities, belong to lower socio - economic class and pregnancy may make their mental illness worse or relapse. Heritability of mental illness makes them transmissible vertically. These adversities dictate that pregnancy must be well thought out and prepared for long before it happens. Use of contraceptive can ensure limited occurrence of mistimed or unwanted pregnancies and can be a public health measure of preventing and limiting mental illnesses. Relevant policies and planning should be put in place to ensure availability and use of contraceptives to mentally ill patients.

Attendance of outpatient clinic presents an opportunity for contraceptive counseling and uptake. Mathari hospital offers integrated services including family planning. However, for those with psychiatric illness attending outpatient services, emphasis is on control of the mental condition. Offering contraception and family planning services when patients come for their psychiatric clinic can improve knowledge and uptake. There should be enough supply and education to enable adequate use. This study identified gaps in knowledge, use and place of sourcing contraceptive for mentally ill patients.

2.7 Study questions

Among women attending MNTRH out patient services:

1. Whatwas their level of contraceptive knowledge?
2. Did their knowledge translate to use of contraceptive?
3. Were they counseled for contraception?
4. Where did they obtain contraceptives from?

2.8 Objectives

2.8.1 Broad objective

To determine knowledge and utilization of contraception among women with mental illness attending outpatient services at MNTRH

2.8.2 Specific objectives

Among women of reproductive age attending psychiatric outpatient at MNTRH:

i. Determine their psychiatric diagnosis.
ii. Determine their knowledge on contraception.
iii. Determine their contraceptive practice.
iv. Determine if they had received contraceptive counseling.
v. Describe the type and source of contraceptive.

2.9 Hypothesis

Contraceptive utilization is low in women with mental illness.

CHAPTER THREE

METHODOLOGY

3.1 Study design

The study design was descriptive cross-sectional.

3.2 Study area

The study was conducted at MNTRH which is located about 8 Km from Nairobi City Centre along Thika Super High way in Nairobi county. It is the major referral hospital for psychiatric patients in Kenya who come from all over the country, although the major catchment areas are counties in the former Central, Eastern and Nairobi provinces. The hospital offers medical outpatient, comprehensive care, family planning, dental services, diagnostic investigations, inpatient and outpatient psychiatric services. Patient management is multidisciplinary. The staffs include Doctors, Nurses, Clinical officers, psychologists, social workers, public health officers, occupational therapists, probation officers, laboratory technicians, administrative and support staff.

3.3 Study population

The target population was women of reproductive age (18-49 years) with psychiatric diagnosis attending MNTRH outpatient Clinics.

3.3.1 Inclusion criteria

1. Women of reproductive age (18-49yrs) with a psychiatric diagnosis
2. Willingness to participate

3.3.2 Exclusion criteria

1. Decline to consent for the study.
2. Presence of acute physical or psychiatric illness.

3.4 Sample size calculation

The sample size was determined by using the formula below (Mugenda & Mugenda, 2003).

$$n = \frac{Z^2P(I-P)}{d^2}$$

Where

1. n = Minimum sample size

2. p = contraceptive prevalence rate for Psychiatric outpatients.
3. Z = table value for standard normal distribution at 5% level of significance which is 1.96
4. d = degree of precision at 5%

A study done in Nigeriafound contraceptive prevalence rate among psychiatric patients attending outpatient clinic to be 27% (Ayinmode, 2013). Hence the value of P above is taken as 0.27. The calculation is shown below:-

$$\frac{(1.96)^2 x(0.27)(1-0.27)}{0.05^2} = 303$$

A total of 306 patients were recruited for the study.

3.5 Sampling method

Systematic random sampling was used where every fourth woman attended by the duty doctor was invited to participate so long as she did not have acute physical or psychiatric illness.The researcher completed about 10 questionnaires from about 40 patients who were attended, daily.

3.6 Study implementation

Data collection mainly took place in the female wards every Tuesday of the week when patients attended their scheduled outpatient clinic. These were the female patients who had previously been discharged from the ward after getting mental stability and gaining insight. They were on routine outpatient follow up. Additional data was collected from the emergency psychiatric outpatient where those who missed the scheduled clinics were attended. The time for data collection was between 8.am and 6.pm on Tuesdays at the female wards where routine clinics were held and any other day at the emergency psychiatric outpatient clinic.

All the staff in the out patient clinic were sensitized about the study. The researcher liased with the duty doctor and nurse so that they refered every fourth woman they attended for possible participation in the study. They were requested to refer patients without acute physical or mental illness, which they had ascertained in their routine examination.

When the women were reffered, the researcher introduced himself, explained the study and consent document. He then invited them for participation. Those interested were screened for inclusion criteria. If they met the inclusion criteria, the study and consent procedure were explained to them in more detail. They were then asked to sign two copies of informed

consent, one of which was for their retention.Patients could opt to use a left thumb imprint for signature on the informed conset form. For patients with a language barrier, interpreters from among the clinical staff were provided.The interpreter provided was able to speak and comprehend that particular patient's language. One interpreater was provided for each patient in need.

After signed consent, questionnaire administration took place in a face to face interview with each patient. Those who got psychological distress from the questions were reffered for counseling.

Patients not interested, not meeting criteria or those who declined to sign consent were thanked and released to go home.

Specific Roles for team members.

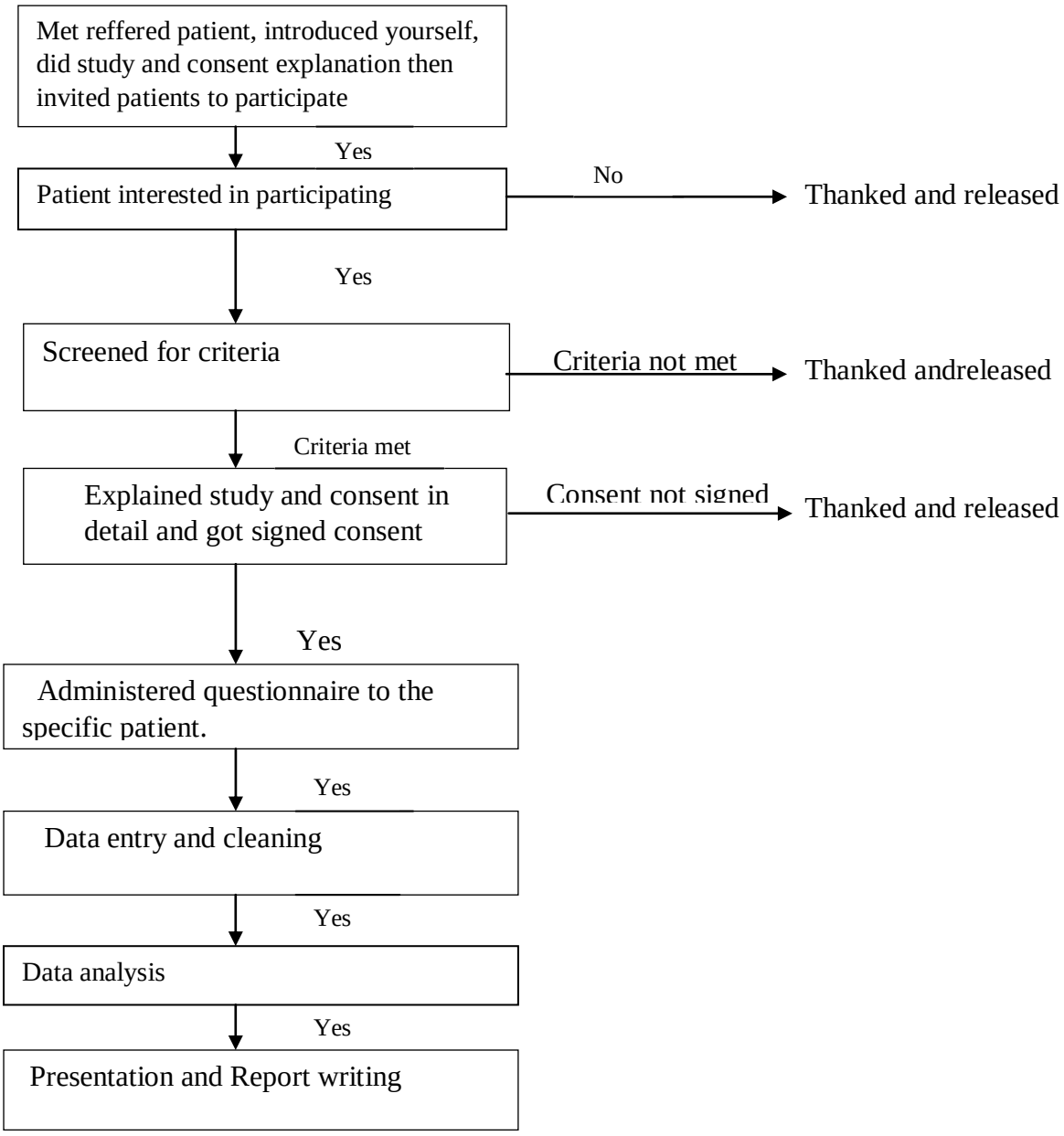
The principle researcher oversaw the logistics of study implementation, including meeting the budget. He led the implementation. He explained to the participants about the study, consent document, got signed consent and administered the questionnaires. He refered patients with various needs appropriately.

The supervisors were consultants for their expert opinion inputs to maintain quality of research.

The duty doctor did a physical and mental state examination and recommened every fourth woman attended for the study so long as she was not acutely ill. The duty nurse sensitized patients recommended by the doctor about the study and refered them to the principle researcher. She/He provided an interpreter for patients with language barrier.

The statistician recruited and trained data entry clerks. In conjuction with the principle researcher, he did data cleaning and analysis.

3.7 Flow Chart of Study Implementation



3.8 Data collection instruments

Three sets of questionnaires as indicated below were used.

1. A researcher designed socio- demographic questionnaire with variables as age, duration of illness, marital status, residence, religion, level of education, occupation and estimated income per month.

2. The woman questionnaire from the KDHS. The sections administered were on reproduction and contraception. Demographic health survey questionnaires are standard tools with acceptable reliability and validity.

3. The MINI PLUS questionnaire. Its standard guide was used to establish the psychiatric diagnosis of the patients. The MINI PLUS is an extension of the MINI which was developed by psychiatrists and clinicians in the United States of America and Europe as a short structured diagnostic interview for DSM IV and ICD-10 psychiatric disorders. The MINI had 17 psychiatric disorders while the MINI PLUS has 23. The MINI PLUS has questions to rule out disorder sub typing and chronology. It is a short (takes about 30 minutes) but accurate structured interview that is useful in clinical trials and researches. Validity, reliability, specificity and sensitivity studies have been done with results indicating that the MINI PLUS has acceptably high scores for diagnosis of psychiatric disorders(Sheehan , et al ., 1998)

3.8.1 Pretesting

Pretesting was done at Thika District Hospital Psychiatry unit. Thirty patients (about 10% of sample size) were invited to take part in a face to face administration of the questionnaire. The purpose was to determine how long the interview was expected to last and how questions would be rephrased to make them more user friendly. The researcher identified areas of difficulties and discussed them with expert supervisors for solutions. This improved reliability and validity of the questionnaire, confirmation of which was done by analysis of the pretest data.

3.8.2 Reliability and Validity

Reliability is the consistency of a measure of the concept under study (mugeda & mugeda, 2003). This was enhanced by pretesting and ascertained by calculating a reliability coefficient of the pretest data.

Validity denotes how accurately data obtained represents the variables of the study. If the data is a true reflection of the variables, the inferences made are accurate and meaningful. To

improve on the validity, the researcher engaged his professional supervisors in their expert fields for input.The expertise was in psychiatry, psychiatric social work, obstetrics and gynecology. Validity analysis was done on pretest data. The MINI PLUS and Demographic Health Survey questionnaires are standard tools with acceptable levels of reliability and validity.

3.8.3 Variables

Independent variables

1. Psychiatric diagnosis of the respondents
2. Demographic characteristic of respondents
3. Contraceptive counseling for respondents

Dependent variables

1. Knowledge of contraceptive types.
2. Method and types of contraception used by the patients.
3. User knowledge of side effects and what to do in case they occured.
4. Place where users got contraception from.

Other variables

1. Reproductive history of respondent.

3.8.4 Quality assurance procedures

Prior to the study commencement, the purpose of the study was explained to the participants. The lack of material benefits for participating was communicated. Participants were informed of the option to opt out of the study anytime they wanted and that there would be no resulting loss of services.

The informed consent form contained the title, area of study, names and contacts of the researcher, supervisors, the KNH ethics and research committee.

During data collection emphasis was placed on ascertaining participants fully understood the questions, interpretation of which was avoided.A question was read out up to a maximum of three times to the participant and if they still did not understand, it was skipped.

Confidentiality was ensured by using serial numbers on the questionnaires instead of names. Data collected was recorded in soft and hard copies. Hard copies were kept in a lockable safe.

After data collection, all questionnaires were checked to ensure completeness. On completion of data entry, a random sample of 10% of questionnaires was selected for comparison with entered data to check accuracy. Repeat entry of data was done if the accuracy was unsatisfactory.

3.9 Ethical considerations

Approval was sought from UON/KNH Ethics and research committee. Written permission was obtained from the administration of MNTRH. A signed consent was obtained from all respondents after the study had been explained to them in a language that they could comprehend. Confidentiality was observed and no identifiers were on the study instruments except serial numbers.

Participation was voluntary, non discriminatory and no material benefit was given. Refusal to participate did not lead to loss of any service. Patients requiring emergency treatment, contraception or counseling were referred to relevant sections.

The results will be shared with UON, MNTRH and published in Peer reviewed journal.

3.9.1 Data management, Analysis and presentation

All questionnaires were reviewed for completeness before entry commenced. The questionnaires were kept in a lockable cabinet. Data was entered into a password protected Microsoft Access Database accessible only to its Manager, Clerk and the Principal Investigator. Once entry was complete, a random sample of 10% of the questionnaires was selected for comparison with the entered data to assess accuracy. If unsatisfactory, repeat entry was done.

Exploratory data analysis was carried out to identify inconsistencies and extreme values. While describing the study population, knowledge and utilization of contraceptives, categorical variables were summarized as counts and percentages by use of frequency tables while continuous variables were summarized using measures of central tendency and dispersion (mean, standard deviation, median, minimum, maximum, range).

In order to determine factors associated with knowledge and utilization of contraceptives, chi-squared tests was carried out where the predictor was a categorical variable and analysis of variance (ANOVA) if it was continuous. This was followed by logistic regression to determine independent factors associated with knowledge and utilization of contraceptives.

Results are presented using tables and text narratives.

3.9.2 Limitations

1. Provider and health facility characteristics were not be studied.
2. The study population was hospital based, hence its not possible to generalize results.
3. The study design was cross sectional, hence causation and patterns of contraceptive utilization could not be accurately determined.

Time Lines

February -June2015	-	Proposal development
July –August2015	-	Ethical clearance
September-December 2015	-	Data collection
January – February 2016	-	Data cleaning and analysis
March – April	-	Report writing
May	-	Report presentation

CHAPTER FOUR

RESULTS

4.1 Sample Description

4.1.1 Demographic Characteristics.

The tables 2a and 2b below summarise the demographic characteristics of the sample.

Table 2a Social-demographic Characteristics

	Mean	**Median**	**Minimum**	**Maximum**	**Standard Deviation**
Age(years)	33	32	18	49	8
Duration of illness (years)	8	6	1	34	7

Table 2b Social-demographic characteristics (continued)

Variable	Category	n	%
Marital status	Single	152	49.7
	Married	106	34.6
	Separated	14	4.6
	Divorced	23	7.5
	Widowed	11	3.6
Residence	Rural	53	17.5
	Town	84	27.7
	City	166	54.8
Religion	Protestant	217	71.4
	Roman Catholic	77	25.3
	Muslim	4	1.3
	Others	8	2
Education level	Pre-primary	1	0.3
	Primary	108	35.4
	Post-primary	4	1.3
	Secondary	129	42.3
	College	50	16.4
	University	13	4.3
Employment	None	170	55.6
	Self-employed	97	31.7
	Salaried job	39	12.7
Why unemployed	Illness	219	71.6
	Others	87	28.4
Income per Month	Below 1000	190	62.1
	1001-10000	61	19.9
	10001-20000	37	12.1
	Above 20000	18	5.9

4.1.2 Psychiatric diagnosis

Table3 below summarises the psychiatric diagnosis of women in the sample

Table 3: Psychiatric Diagnosis

PSYCHIATRIC ILLNESS	n	%
Psychotic Disorders	137	44.8
Mood Disorders with psychosis	87	28.4
Major Depressive Disorder	62	20.3
Alcohol Dependence	6	2.0
Hypomanic	4	1.3
Suicidality	2	0.7
Generalized Anxiety Disorder	3	1.0
Panic Disorder	2	0.7
Bulimia Nervosa	1	0.3
Dysthymia	1	0.3
PTSD	1	0.3

4.1.3 Contraceptive Counselling.

Table 4 below shows the number of women contraceptively counseled by a clinician in a health facility they visited and by a field worker in the last one year. Others had received no counseling at all in the same period.

Table 4: Contraceptive counseling in the last One Year

Category	n	%
None	201	65.7
By Clinician	72	23.5
Field worker	33	10.8

4.1.4 Knowledge of contraceptives.Knowledge of contraceptive methods and that of safe days are summarized in tables 4 and 5 respectively. Tables 6 and 7 are a summary of factors associated with knowledge of contraceptive methods by Bivariate and multivariate analysis respectively.

Table 5: Knowledge of contraceptive Methods

Method	**Knowledge**	
	n	**%**
Pills	298	97.4
Injectable	295	96.4
Male Condom	288	94.1
IUD	286	93.5
Implants	283	92.5
Female Condom	265	86.6
Female Sterilization	262	85.6
Rhythm Method	237	77.5
Male Sterilization	229	74.8
Emergency Contraception	222	72.5
Withdrawal	197	64.4
LAM	162	52.9
Other Methods	10	3.3

Table 6: knowledge of safe daysVariable

	Response	n	%
Knows unsafe days	Yes	238	79.0
	Don't know	45	15.0
	No unsafe days	18	6.0
Specific unsafe period	Halfway between two periods	153	51.7
	Don’t know	71	24.0
	Right after her period has ended	62	20.9
	Just before her period begins	8	2.7
	During her period	2	7

Table 7: Factors associated with Knowledge of Contraceptive methods in Bivariate analysis at 95% confidence.

		Number of family planning methods known			
		Median	**Minimum**	**Maximum**	**P VALUE**
Residence	Rural	9	0	12	≤0.0001
	Town	12	6	12	
	City	10	0	12	
Education level	Pre-primary	0	0	0	≤0.0001
	Primary	10	0	12	
	Post-primary	9	8	10	
	Secondary	11	0	12	
	College	11	5	12	
	University	11	4	12	
Why unemployed	Illness	10	0	12	≤0.0001
	Others	12	1	12	
Spoken to by clinician at health facility about family planning methods	No	11	0	12	≤0.007
	Yes	12	4	12	

Table 8: Independent factors associated with knowledge of Contraceptive Methods in Multivariate Analysis at 95% confidence.

Factor	**OR**	**LL OR**	**ULOR**	**p value**
Higher education level	1.39	1.02	1.90	≤0.040
Unemployed due to other reasons not illness	3.31	1.52	7.22	≤0.003
Spoken to by staff at health facility about family planning methods	2.69	1.11	6.51	≤0.029

4.1.5 Utilization of Contraceptives.

Table 8 below is a summary of current and previous utilization of contraceptives by respondents. Tables 9 and 10 summarize factors associated with current contraceptive use by Bivariate and multivariate analysis respectively.

Table 9: Current and previous utilization of contraceptives

	Current use		**Previous use**	
Method	**n**	**%**	**n**	**%**
Injectable	28	9.2	59	19.3
Implants	26	8.5	16	5.2
Pills	24	7.8	49	16.0
IUD	20	6.5	16	5.2
Female Sterilization	14	4.6	0	-
Male Condom	8	2.6	13	4.2
LAM	3	1.0	1	0.3
Rhythm Method	3	1.0	5	1.6
Other Methods	3	1.0	3	1.0
Male Sterilization	-	-	1	0.3
Female Condom	-	-	-	-
Withdrawal	-	-	1	0.3
Emergency Contraception	-	-	-	-
TOTAL	129	42.2	164	53.6

Table 10: Factors associated with current Contraceptive Utilization in Bivariate analysis at 95% confidence.

		Currently using contraception				
Factor	**Category**	**No**		**Yes**		
		n	**%**	**n**	**%**	**P value**
Marital status	Married	45	42.5	61	57.5	<0.001
	Widowed	6	54.5	5	45.5	
	Divorced	13	56.5	10	43.5	
	Single	105	69.1	47	30.9	
	Separated	10	71.4	4	28.6	
Employment	Self-employed	49	50.5	48	49.5	<0.048
	Salaried job	20	51.3	19	48.7	
	None	110	64.7	60	35.3	
Visited by a field worker in the last 12 months	Yes	10	30.3	23	69.7	<0.001
	No	169	61.9	104	38.1	
Spoken to by staff at health facility about family planning methods	Yes	23	31.9	49	68.1	<0.0001
	No	156	66.7	78	33.3	

Table 10: Factors associated with current Contraceptive Utilization in Bivariate analysis at 95% confidence (continuation).

		n	%	n	%	P value
Diagnosis	Bulimia nervosa	0	0	1	100.0	<0.021
	Dysthymia	0	0	1	100.0	
	PTSD	0	0	1	100.0	
	Suicidality	0	0	2	100.0	
	Alcohol dependence	2	33.3	4	66.7	
	Mood disorder with					
	Psychotic features	40	46.0	47	54.0	
	(Hypo) manic episode	2	50.0	2	50.0	
	Panic disorder	1	50.0	1	50.0	
	M.D.D	40	64.5	22	35.5	
	Psychotic disorders	91	66.4	46	33.6	
	G.A.D	3	100.0	0	.0	

Table 11: Independent factors associated with current utilization of contraceptives by multivariate analysis at 95% confidence.

Factor	OR	LL OR	UL OR	p value
Employment	1.60	1.14	2.24	0.007
Spoken to by staff at health facility about family planning methods	4.69	2.63	8.35	<0.0001

4.1.6 Knowledge of side effects and their remedy by contraceptive users.

Among the users 71% (n=91) were told about other methods of family planning that they could use and the side effects to expect from their chosen method. However only 62.7% (n=81) were told what to do in case the side effects occured. Table 11 below summarises findings for contraceptive counseling on methods, side effects and their remedies at the start of a method for users.

Table 12: Contraceptive counseling on alternative methods, side effects and their remedies

Information about family planning	n	%
Told about family planning side effects	91	71.0
Told what to do after experiencing side effects	81	62.7
Told about other family planning methods	91	71.0

4.1.7 Place of sourcing contraceptives by users.

Majority of women (89.1%) knew that they could obtain contraception from government hospital and (5.3%) from health centre. Only (3.5%) knew they could get contraceptives from pharmacies/ chemists and (2.1%) of women knew private hospital/clinics as sources of contraception.

Sixty seven point two percent (67.2%) of the women obtained the method from government hospital, 20.3% from private hospitals or clinics, 8.5% from pharmacy or chemist and 2.3% from government health centre at initiation. Corresponding figures for the last time clients obtained methods are 65.0%, 18.8%, 8.5% and 6.0% for the respective facilities. Table 10 summarises these findings.

Table 13: knowledge and place of sourcing contraceptives

Source of family planning	Place known for family planning		Last time source of family planning		First time source of family planning		Place performed sterilization	
	n	%	n	%	n	%	n	%
Govt. Hospital	254	89.1	76	65.0	86	67.2	9	64.3
Govt. Health center	15	5.3	7	6.0	3	2.3	2	14.3
Pharmacy or chemist	10	3.5	10	8.5	10	8.5	-	-
Private hospital or clinic	6	2.1	22	18.8	26	20.3	3	21.4

4.1.8 Reproductive history of respondents.

Table 13 below summarizes the reproductive history of the respondents.

Table 14: Reproductive history

Variable	Category	n	%
Ever given birth	No	102	33.3
	Yes	204	66.7
Living with sons or daughters	No	115	37.6
	Yes	191	62.4
Has sons or daughters not living with	No	287	93.8
	Yes	19	6.2
Has had children deaths	No	285	93.1
	Yes	21	6.9
Pregnant	No	278	94.2
	Unsure	5	1.7
	Yes	13	4.1
Pregnancy intentional	No	7	53.8
	Yes	6	46.2
Wanted more children	Later	4	30.8
	No	3	23.1
Has had a miscarriage, abortion or still birth	No	284	92.8
	Yes	22	7.2

CHAPTER FIVE

5.0 DISCUSSION

5.1 Social Demographic Characteristics

The average age in years of the women in the sample was 33 with a range of 18 – 49 and a median of 32.The standard deviation was 8. The average duration of illness in years was 8, range of 1-34 and median of 6. The standard deviation was 7.

Single women comprised 49.7% of the sample,34.6% were married, 7.5% divorced and 3.6% widowed. Most lived in the city (54.8%) and towns (27.7%), while a minority were from rural setups (17.5%).The high number of singles could be due to stigma of mental illness which makes it difficult for patients to get suitors.

Religious compostion was 71.4% Protestant, 25.3% Roman Catholic, 1.3% Muslim and 2% belonged to various minor denominitions.This is as expected in Kenya where 80% population is Christian(Ndetei, et al.2009)

Educational level was 35.4% primary, 42.3% secondary, 4.3% university, 1.3% post primary and 0.3% pre primary.

Most of the women were unemployed (55.6%), few were in salaried employement (12.8%) and the rest were in self-employement (31.7%). Their income levels in Kshs. Per month were 62.1% below 1000/=, 19.9% between 1001/= and 10000/=, 12.1% at 10001-20000/= and 5.9% above 20000/=. For those that were not employed 71.6% said it was due to illness while 28.4% had other varied reasons. These findings indicate that women with mental illness have low social economic status as compared to those in the general Kenyan population (KDHS, 2014) and is consistent with the drift hypothesis (Sadock, B. & Sadock, V. 2007). The drift hypothesis holds that impaired people slide down the social scale due to their illness.

5.2 Psychiatric Diagnosis.

The psychiatric diagnosis of the women as per the MINI-PLUS International neuropsychiatric interview were psychosis (44.8%), mood disorder with psychosis (28.4%), major depressive disorder (20.3%), alcohol dependence(2.0%), hypomania(1.3%), suicidality(0.7%), generalized anxiety disorder (1.0%), panic disorder(0.7%). PTSD, Bulimia navosa and Dysthymia were each found in 0.3% of the women. Some women had multiple diagnosis.The

prevalence of diagnosis is consistent with findings of Atwoli, et al(2012).Low levels of substance use disorders are as expected in women.

5.3 Contraceptive counseling

Contraceptive counseling can be provided by different cadres of family planning staff in various setups. The purpose is to provide non users with information to enable them make a decision to use and to ensure continued utilization for current users. In the last one year, 10.8% (n=33) of the sampled women had been visited by a field worker who talked to them about contraception. A further 23.5% (n=72) were told about contraceptives when they attended clinics in the same period. These figures are higher than those of KDHS (2014) which were 6% and 14% respectively.Mental health patients could be perceived as more in need of contraception, hence receive more counseling.

The 23.5% for those counseled by clinicians is higher than the 5% found in a Nigerian study (Ayinmode, 2013). It is also higher than that of a Turkish study where only 11% and 13% of schizophrenia and bipolar patients respectively had discussed contraception with their attending psychiatrist (pehlivanoglu, et al. 2007).

In the United Kingdom, langan, et al., (2013) found that only 17% and 13% of patients taking carbamazepine and valproate respectively had discussed contraception with the prescribing physician.

These figures demonstrate lost opportunities where pontential and current users could be educated on the benefits of contraception. Clinicians should thus take responsilbilty to offer contraceptive counseling to all their patients with psychiatric illness at every opportunity.

5.4 Contraceptive Knowledge.

Ninety nine percent (99%) of the women knew at least one method and most knew several. Most known contraceptives were pills (97.4%), injectables (96.4%), male condoms (94.1%), IUD (93.5%), implants (92.5%), female condoms (86.6%), female sterilization (85.6%), rhythm method (77.5%), male sterilization (74.8%), EC (72.5%), withdrawal (64.4%), LAM (52.9%) and other methods (3.3%).These figures are comparable to those of KDHS(2014) where knowledge for at least one method was 95%. Most known (KDHS 2014) were male condom(96%), Injectable(95%) and pill(94%) while least knowledge was for LAM(12%), male sterilization(47%) and EC(59%).

Existence of safe days was known by 79% of the women. However, among those only 51% of them could estimate the safe days to be roughly in the middle of two menstrual periods as

opposed to26% in KDHS(2014).They are the only ones who can be expected to correctly use the rhythm method.

Using bivariate analysis (ANOVA), factors found statistically significant in influencing knowledge of contraceptives included, residence, education level, reason for lack of employement among the non-employed and contraceptive counseling by a health facility staff in the last one year on.

Most knowledgable lived in town followed by city and then rural residents ($p<0.0001$). Being highly educated increased knowledge of methods ($p<0.0001$). For the unemployed, if the reason was not due illness, knowledge of contraceptives was found to be higher ($p<0.0001$). For the patients who had been counseled about family planning by a health worker when they visited a health facility in the last one year, knowledge of methods was significantly higher ($p<0.007$).

Confounding was addressed by doing a multivariate analysis where independent factors that influenced knowledge of contraceptives were higher level of education (OR=1.39, CI 1.02-1.90, P<0.04), being spoken to about family planning by staff at a health facility in the last one year (OR= 2.69, CI 1.52-7.22, P<0.029) and among the non employed, the reason not being due to illness (OR=3.31, CI 1.11-6.57, P<0.003). All the above P values were calculated at 95% confidence.

In a Nigerian study, 88% of the respondents knew at least one method (Tunde-Ayinmode, et al. 2013). In this study, knowledge for condom was 68%, injectable 64%, pills 56%, IUD 37% and sterilization 16%. Findings for the same methods in the Kenyan sample were 84.6%, 96.4%, 97.4%, 93.5% and 80.4% respectively. This shows higher knowledge in the Kenyan women with mental illness than for those in Nigeria. Kenyan women are thus more likely to make a decision to use.

5.5 Contraceptive Utilization.

The contraceptive utilization for the sampled women was 42.2% (n=129). Modern methods were used by 41.2% while 1% of the women used traditional methods. The most popular methods by descending order were injectables 9.2%, implants 8.5%, pills 7.8%, IUD 6.5%, female sterilization 4.6% and male condoms 2.6%. LAM, rhythm and other methods were each used by 1% of the women. Among the respondents 53.6% (n=164) have ever used contraception, meaning that 11.2% have since stopped. The methods that were previously used in order of prevalence were injectables 19.3%, pills 16%, IUD 5.2%, implants 5.2%, male condoms 4.2% and rhythm 1.6%. LAM and male sterilization were ever used by only

0.3% of the women for each method. 1% of the women had ever used methods classified as others.

Bivariate analysis (chi-square) at 95% confidence yeilded factors that influenced contraceptive uitilization in a statistically significant way as marital status ($p<0.001$), employement ($p<0.048$), having been counseled about family planning by field worker in the last one year ($p<0.001$) and having been talked to about contraception by a staff member when the women visited a health facility in the last one year ($p<0.0001$). Confounding was addressed by doing a multivariate analysis where independent factors associated with contraceptive utilization were employement (OR= 1.60, CI 1.14-2.24, $P<0.007$) and counseling by staff at a health facility in the last one year (OR= 4.69, CI 1.11-6.51, $P<0.0001$).

In decreasing order, utilization was most among married (57.5%), widowed (45.5%), divorced (43.5), single (30.9%) and lastly separated (28.6% women). More of the employed (self employed 49.5%, salaried 48.7%) used contraception than the non employed (35.3%). Having been counseled for FP in the last one year increased utilization (clinician 68.1% and field worker 69.7%).

Contraceptive prevalence (CPR) rate is defined as the percentage of currently married women using a method.This was found to be 57.5% in the study.The figure is comparable to 58% of KDHS 2014. Lower rate of current utilization for all women in the sample(42.2%) was due to low use by those in other marital categories. Although the CPR of mental health patients is comparable to that of the general Kenyan population, their needs are more.

Tunde-Ayinmode, et al. (2013) found a contraceptive utilization of 27% in a Nigerian sample of women with psychiatric diagnosis attending outpatient services. He also found that 51% of the women had never used contraception as opposed to 46.4% deduced from this study. The higher utilization of contraception by Kenyan women could be as a result of their higher knowledge.

In current utilization, the Nigerian women mostly used condom 10%, injectable 6% and pills 20%. Similar figures in the Kenyan sample were 2.6%, 9.2% and 7.8% for respective methods.More Kenyans were using long term and more reliable methods than the Nigerians.

Methods previously utilized by Nigerian women were pills 29.6%, male condoms 14.8%, IUD 11.1% and injectable 7.4%. Similar figures of previous use by Kenyan women were 16%, 4.2%, 5.2% and 19.3%. This demonstrates higher level of discontinuation of contraception in the Nigerian than Kenyan women. This can be due to in adequate counseling regarding

altenative methods, side effects of chosen method and what to do in case the adverse effects occured among the Nigerians.

5.6 Reproductive History of respondents

Among the women sampled, 66.7% (n=204) had ever given birth. Parenting responsibilities are present in 62.4% of those living with their children. In the U.K, Bee (2013) found 50-66% of patients with severe mental illness lived with their children. Children whose parents of mental illness are at risk of developing social, emotional and behavioral problems (Quintona, 2009). Severe difficulties in parenting could be present in those not living with some of their children 6.2% (n=19). Adverse reproduction outcomes for the women included own child deaths 6.9% (n=21), miscarriages/abortion 7.2% (n=22). These difficulties in parenting and reproduction call for enhanced family planning and contraceptive use.

Among the respondents 4.1 (n=13) were pregnant. Only 46.2% (n=6) of the pregnancies were intentional. The rest included four women who would have preffered to get pregnant at a later date and three who had no intention of ever getting pregnant in future. This demonstrates unmet need for contraception although calculation of the actual figure was beyond the scope of the study.

5.7 Conclusion.

Women with psychiatric diagnosis have low economic capacity and need to source contraceptives from government facilities they are free. This is more so because they have parenting challenges which exposes their children to future behavioral and psychological disturbances. Reproductive health challenges could also worsen the women's mental illness.

Contraceptive counseling by both field workers and clinicians needs to be scaled up to enhance knowledge and utilization.

Contraceptive knowledge among the patients was high but did not translate to utilization. This is despite the higher need for family planning in patients with mental illness.It is notable however that sample CPR was nearly equal to that of KDHS2014.

Among the current users 29% were not told about alternative methods at initiation of contraception. This means that their method may not have been by informed choice. Others (37.2%) were not told about side effects from their chosen method or even what to do incase the adversities occurred. This are potential candidates for discontinuation of contraception.

There exist unmet need for family planning as demonstrated by the finding that few women (n=13) were pregnant and some of the pregnancies (n=7) were not intended.

5.8 Recommendations.

The researcher recommends enhanced contraceptive counseling by clinicians attending to women with psychiatric illness in order to increase uptake and continued use of methods. Counselling should be more on those with less education and those unemployed due to illness.Due to the high prevalence of HIV/AIDS among mental health patients condoms use should be encouraged even among those already on another method. Reduction of HIV infection can reduce mental health burden.

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APPENDICES

APPENDIX I: BUDGET (AMOUNT IN KENYA SHILLINGS)

ITEM	UNITS	COST (Kshs)	TOTAL
Typesetting	-	-	5,000
Printing and Binding ……	9	1,000	9,000
Snacks ……..	50	500	25,000
Stationery ……..……..	-	-	1,000
Photocopy ……..……	24,500	2	49,000
Transport ……...	-	-	2,000
Ethics committee Fees ……..……	1	2000	2,000
Data entry, Cleaning and Analysis……	-	-	70,000
Miscellaneous ……..	-	-	32,000
GRAND TOTAL (KSH)			**195,000**

The total budget will be met by the principle researcher.

BUDGET JUSTIFICATION

1. Typesetting of the research documents is estimated to cost Kshs. 5,000.
2. The researcher has to print and bind about nine copies of the research document at about Kshs. 1,000 each, six to go to Ethics review and three for final research findings.
3. The researcher proposes to buy snacks to be taken with tea each day he is in the field for all who work at the out patient clinic. This is to motivate them help in the study implementation. The cost is Kshs. 500 a day for about 50 days.
4. Pencils, rubbers and other stationery for filling questionnaires are estimated to cost Kshs. 1,000.
5. The researcher will need to photocopy about 24500 pages of the questionnaire and consent documents at Kshs. 2 per page, making it a total of 49,000. The number of questionnaires and consent documents is about 350, each set with 70 pages.
6. During pretest, the researcher will require transport to Thika District Hospital at about Kshs. 400 daily for five days.

7. Ethics committed requires a review fee of Kshs. 2000.
8. The researcher will engage a statistician for Kshs. 70,000. The statistician is expected to engage data entry clerks, who he will pay from the said fee.

APPENDIX II: CONSENT EXPLANATION FORM.

Title

Knowledge and utilization of contraceptives by psychiatric outpatients at mathari national teaching and referral hospital (MNTRH)

Introduction

I, Dr Anthony Kariuki Gitari a student in the Department of Psychiatry-University of Nairobi wishes to conduct a study on Knowledge and utilization of contraceptives by psychiatric outpatients at Mathari National Teaching and Referral Hospital. Kindly receive my invitation to participate in the study.

Objectives

Broad objective

To determine knowledge and utilization of contraception among women with mental illness attending outpatient services at MNTRH

Specific objectives

Among women of reproductive age attending psychiatric outpatient at MNTRH:

Determine their knowledge on contraception.

Determine their contraceptive practice.

Determine if they have received contraceptive counseling.

Describe the type and source of contraceptive.

Benefits

Appropriate referral for contraceptive counseling and uptake for participants.
Policy makers can institute measures to increase contraceptive prevalence rate and improve reproductive health among mental health patients using the information.

Risks

The length of the interview may inconvenience the participant.
Distress may arise from some questions but psychological support will be offered through referral to counselors.

Compensation

There is no payment for participating in this study.

Voluntarism

Your participation in the study;

Is voluntary.

May be withdrawn at any time you wish.

Failure to participate will not lead to loss of services.

Type of specimen.

No specimen is required from you.

Expected time in study.

A face to face interview will take 30-60 minutes of your time after you sign an informed consent. All your questions and concerns should be fully addressed by the researcher before you sign the consent.

Confidentiality.

Your name will not appear on any of the questionnaires, and after data collection the informa tion you shared will be kept under lock and key.

Information on researchers.

For further information or any concerns you may have about this study feel free to contact;

Investigator: Dr Anthony Kariuki Gitari 0722310821

Supervisors: Prof. Wangari Kuria 0722755681

Dr Onesmus Gachuno 0722851914

Prof. Anne Obondo 0721849686

OR

Information on KNH/OUN/ERC.

KNH/UON Ethics Committee chairperson on +254 2726300 ext. 44102

Thank you for your time.

Dr Anthony Kariuki Gitari
0722310821

APPENDIX III

INFORMED CONSENT FORM

I ……..……. (Name of participant), agree to participate in the study titled "Knowledge and utilization of contraceptives by psychiatric outpatients at mathari national teaching and referral hospital".
I further affirm that consent explanation has been done to me by the researcher, i understand the objectives, benefits and risks of the study. I voluntarily participate without expectation for any compensation and am aware i can withdraw my participation any time without lose of services.I understand that my identity and the information i give will be kept confidential at all times and i know who to contact incase of any clarifications.

Signature of participant/left thumb imprint ……. Date ……

Signature of witnes/left thumb imprint ---------- Date……

Decline/Withdrawal form

I, being a patient at Mathari Psychiatric outpatient and having been explained to about the above mentioned study and its purpose on…….2015, Hereby Decline/Withdraw Participation.

Signature of participant/left humb imprint---------- Date……

Signature of witness/left thumb imprint---------- Date……

Reseacher DR. Antony Kariuki Gitari; Contacts 0722310821

Main Supervisor Prof. Wangari Kuria; Contacts 0722755681

APPENDIX IV CURRICULUM VITAE

DR. ANTHONY KARIUKI GITARI,

P.O.BOX 29955-00100,

NAIROBI.

MOBILE PHONE 0722310821,

E-MAIL: agitari@uonbi.ac.ke

BIODATA:

Date of birth: 22nd June, 1968.

I.D Number: 10432120.

Nationality: Kenyan.

Marital status: Married.

Languages: English, Kiswahili & Kikuyu.

WORK EXPERIENCE:

- 2002 To Date : Medical officer, University of Nairobi Healths Services.
- 1999 – 2001 : Medical Officer, Mwea Mission Hospital.
- 1997 – 1998 : Medical Officer, Meru District Hospital.
- 1993 : Data entry Clerk, Reproductive health research unit – Kenya Medical Research Institute.

EDUCATION:

- 1989 – 1996 : University of Nairobi – MBCHB.
- 1983 – 1988 : Starehe Boys Centre and School – KACE – 16 Points.
- 1975 – 1982 : Kagarii Primary School – CPE – 35 Points.

REFFREES:

1. Dr. Billy Muigai,
   c/o UHS, P.O. BOX 30197,
   Nairobi.
   Mobile 0722765057
2. Mr. B.M. Kiige,
   P.O. BOX 30197,
   Nairobi.
   Mobile 0722751153.

APPENDIX V QUESTIONNAIRES

Questionnaire Number _____ Date of interview

_____

SECTION 1: Social demographic details

NO	QUESTIONS AND FILTERS	CODING CATEGORIES
1	What is your age in yrs?	Age in years…… ☐☐
2	Since which year have you had mental illness?	Month…….. ☐☐ Year…….. ☐☐☐☐
3	What is your marital status?	A Married …… ☐ B Widowed…… ☐ C Divorced…… ☐ D Separated……... ☐
4	Where do you live (residence last one year)	A City (Nairobi, Kisumu, Mombasa) ……. ☐ B Town (Any other urban setting) …… ☐ C Rural area ……. ☐
5	What is your religion?	A Roman Catholic ☐ B Protestant/other Christian ☐ C Muslim ☐ D Others (specify)……
6	What is the highest level of school you attended?	A Pre-Primary ☐ B Primary ☐ C Post primary/Vocational ☐ D Secondary/A level ☐ E College (Middle level) ☐ F University ☐ G Others – specify……
7	Employment	A None ☐ B Self-employment ☐ C Salaried employment ☐
8	Reasons for unemployment	A Illness ☐ B Retirement ☐ C Others (specify) …… ☐

☐
☐
☐
☐
☐

9	Estimated income per month	A Less than Kshs. 1000 B 1000 – 10000 C 10000 – 20000 D 20000 - 50000 E Above - 50,000

SECTION 2: REPRODUCTION

1	Now I would like to ask about all the births you have had during your life. Have you ever given birth?	YES…….. . . . . 1 NO……. 2
2	Do you have any sons or daughters to whom you have given birth who are now living with you?	YES…….. . . . . 1 NO……. 2
3	How many sons live with you? And how many daughters live with you?	Sons at home . . . . . …….. Daughters at home . . ……...
4	Do you have any sons or daughters to whom you have given birth who are alive but do not live with you?	YES…….. . . . . 1 NO……. 2
5	How many sons are alive but do not live with you? And how many daughters are alive but do not live with you? If none, record '00'.	Sons elsewhere . . . . . …… Daughters elsewhere……
6	Have you ever given birth to a boy or girl who was born alive but later died?	YES…….. . . . . 1 NO……. 2
7	How many boys have died? How many girls have died? If none, record '00'.	Boys dead . . . . . …….. Girls dead . . . . . ……...
8	Sum answers to 3, 5, and 7, and enter total. If none, record '00'.	Total births . . . . . ……
9	Just to make sure that I have this right: you have had in total _____ births during your life. Is that correct?	YES…….. . . . . 1 NO……. 2
10	Are you pregnant now?	YES…….. . . . . 1 NO……. . . . . 2 Unsure……...8

11	How many months pregnant are you?	Months . . . . .
12	When you got pregnant, did you want to get pregnant at that time?	YES…….. . . . . 1 NO…….. 2
13	Did you want to have a baby later on or did you not want any (more) children?	LATER…….. . . . . 1 NO MORE…….. 2
14	Have you ever had a pregnancy that miscarried, was aborted, or ended in a stillbirth?	YES…….. . . . . 1 NO…….. 2
15	When did the last such pregnancy end?	Month…… Year……
16	How many months pregnant were you when the last such pregnancy ended?	Months . . . . .
17	Since January 2009, have you had any other pregnancies that did not result in a live birth?	YES…….. . . . . 1 NO…….. 2
18	Did you have any miscarriages, abortions or stillbirths that ended before 2009?	YES…….. . . . . 1 NO…….. 2
19	When did the last such pregnancy that terminated before 2009 end?	Month . . . . . . Year . . . . .
20	When did your last menstrual period start?	Days ago…… Weeks ago……. Months ago……. Years ago…… Inmenopause/has had hysterectomy……994 Before last birth……...…995 Never menstruated……..……996
21	From one menstrual period to the next, are there certain days when a woman is more likely to become pregnant?	YES…….. . . . . 1 NO…….. . . . . 2 Don't know 8
22	Is this time just before her period begins, during her period, right after her period has ended, or halfway between two periods?	Just before her period begins……...……1 During her period . . . . . 2 Right after her period has ended.……..……3 Halfway between two periods……..……...….4 Other (specify)_____ 6 Don't know…….…....8

SECTION 3: CONTRACEPTION

1	Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy. Have you ever heard of (method)?	
A	Female sterilization. Probe: women can have an operation to avoid having any more children.	YES……. . . . . 1 NO……. 2
B	Male sterilization. Probe: men can have an operation to avoid having any more children.	YES……. . . . . 1 NO……. 2
C	IUD. Probe: women can have a loop or coil placed inside them by a doctor or a nurse.	YES……. . . . . 1 NO……. 2
D	Injectables. Probe: women can have an injection by a health provider that stops them from becoming pregnant for one or more months.	YES……. . . . . 1 NO……. 2
E	Implants. Probe: women can have one or more small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years.	YES……. . . . . 1 NO……. 2
F	Pill. Probe: women can take a pill every day to avoid becoming pregnant.	YES……. . . . . 1 NO……. 2
G	Male condom. Probe: men can put a rubber sheath on their penis before sexual intercourse.	YES……. . . . . 1 NO……. 2
H	Female condom Probe: women can place a sheath in their vagina before sexual intercourse.	YES……. . . . . 1 NO……. 2
I	Lactational amenorrhea method (lam).	YES……. . . . . 1 NO……. 2
J	Rhythm method	YES……. 1

	probe: to avoid pregnancy, women do not have sexual intercourse on the days of the month they think they can get pregnant	NO…….. 2
K	withdrawal probe: men can be careful and pull out before climax	YES…….. . . . . 1 NO…….. 2
L	Emergency contraception. Probe: as an emergency measure, within three days after they have unprotected sexual intercourse, women can take special pills to prevent pregnancy.	YES…….. . . . . 1 NO…….. 2
M	Have you heard of any other ways or methods that women or men can use to avoid pregnancy?	YES…….. . . . . 1 Specify _____ NO…….. . . . . 2 Specify _____
2	Are you currently doing something or using any method to delay or avoid getting pregnant?	YES…….. . . . . 1 NO…….. 2
3	Which method are you using?	Female sterilization . . . . ……... . .. . A Male sterilization . . . . . ……. . . . B IUD . . . . . ……. .. . . . . ……. . . . . C Injectables . . . . ……. . . ….... . . D Implants . . . . . ……... . . . . ….. . E Pill . . . . . …….....F Male condom . . . . . ……. . . . . …. . . G Female condom . . . . . ……. . . . … . .. . . H Lactational amen. Method . . . ……... . I Rhythm method . . . . . ……. . . . . J Withdrawal . . . . . ……...…. . . K Other modern method . . . ……... . ,…. L Other traditional method. . ……..…….,,….
4	In what facility did the sterilization take place?	**PUBLIC SECTOR** Govt. Hospital . . . . . ……... . .11 Govt. Health center. . ……..... . . . . 12 Govt. Dispensary . . . . . ……. . . . .13 Other public sector……. 16

		PRIVATE MEDICAL SECTOR Faith-based, church, Mission hospital / clinic. . …….. . 21 Family options/fhok clinic ……..... 22 Private hospital/clinic. . …….. . . 23 Nursing/ maternity home. ……. . 24 Mobile clinic……..25 Other private medical sector…….26 specify don't know……..…….98
5	The last time you obtained (highest method on list), how much did you pay in total, including the cost of the method and any consultation you may have had.	cost . . . . . □□□□□ Free…….……99995 Don't know……..99998
6	In what month and year was sterilization performed?	Month …… …….. Year…… □□□□
7	Since what month and year have you been using (current method) without stopping	Month …… ……. Year…… □□□□
8	Have you ever used anything or tried in any way to delay or avoid getting pregnant?	YES……. . . . . 1 NO……. 2
9	What have you ever used	Female sterilization . . . . . ……. . 01 Male sterilization . . . . ……... . . . . . 02 IUD . . . . ……. . . ..03 Injectables . . . . ……... . ... ..04 Implants . . . . . ……..... . . . 05 Pill . . . . . ……. . . . 06 Male condom . . . ……... . . . . 07 Female condom. ……. . . . . .08 Lactational amen. Method. . ……. . . ..11 Rhythm method . . . . . ……..... . . . . .12 Withdrawal . . . . . ……... . . . . . 13 Other modern method . . . . . ……. 95 Other traditional method . . ……96

10	When you first started using current method, where did you get it at that time?	**PUBLIC SECTOR** Govt. Hospital . . . . . ……... . . 11 Govt. Health center. . ……..... . . . . 12 Govt. Dispensary . . . . . ……. . . . . 13 Other……...16 **PRIVATE MEDICAL SECTOR** Private hospital/clinic . . . ……..... … 21 Pharmacy/chemist . . . . . ……. . . . . …22 Nursing/maternity home. . ……... . . …23 Faith-based,church,Mission hospital/clinic…24 Family options/fhok clinic. . ……..…….. … 25 **OTHER PRIVATE MEDICAL SECTOR** Shop . . . . . ……. . . . . … . 31 Mobile clinic . . . . ……. . . . . …. . 32 Community-based distributor…….. 33 Community health worker/chw……....34 Friend/relative . . . . . ……..……...35 Other_____96 Specify
11	At that time, were you told about side effects or problems you might have with the method?	YES……. . . . . .1 NO……. 2
12	When you got sterilized, were you told about side effects or problems you might have with the method?	YES……. . . . .1 NO……. 2
13	Were you ever told by a health or family planning worker about side effects or problems you might have with the method?	YES……. . . . . 1 NO……. 2
14	Were you told what to do if you experienced side effects or problems?	YES……. . . . . 1 NO……. 2
15	When you obtained current method, were you told about other methods of family planning that you could use?	YES……. . . . . 1 NO……. 2
16	Were you ever told by a health or family planning	YES……. 1

	worker about other methods of family planning that you could use?	NO……. 2
17	Where did you obtain current method the last time?	**PUBLIC SECTOR** Govt. Hospital . . . . . ……... . … 11 Govt. Health center. . ……..... . . . . 12 Govt. Dispensary . . . . . ……. . . . . … 13 Other public sector…….16 **PRIVATE MEDICAL SECTOR** Private hospital/clinic . . . ……..... …21 Pharmacy/chemist . . . . . ……. . . . . .. 22 Nursing/maternity home. . ……... . . … 23 Faith-based,church,Mission hospital/clinic…24 Family options/fhok clinic. . ……..…….. …25 **OTHER PRIVATE MEDICAL** Shop . . . . . ……. . . . . 31 Mobile clinic . . . . ……. . . . . …. 32 Community-based distributor…….. 33 Community health worker/chw…….....34 Friend/relative . . . . . ……..……...35 Other_____96 specify
18	Do you know of a place where you can obtain a method of family planning?	YES……. . . . . 1 NO……. 2
19	Where is that?	**PUBLIC SECTOR** Govt. Hospital . . . . . ……... . … A Govt. Health center. . ……..... . . . . B Govt. Dispensary . . . . . ……. . . . . …C Other public sector……..D **PRIVATE MEDICAL SECTOR** Private hospital/clinic . . . ……..... ….E Pharmacy/chemist . . . . . ……. . . . . ….F Nursing/maternity home. . ……... . . ….G Faith-based, church,

		Mission hospital / clinic . . . . . …. . . . . …H Family options/fhok clinic. . …….…….. ….I Other private medical center……..J **OTHER SOURCE** Shop . . . . . .…….. . . . . ….K Mobile clinic . . . . ……. . . . . L Community-based distributor…….. ...M Community health worker/chw…….....N Friend/relative . . . . . …….……..O Other_____X Specify
20	In the last 12 months, were you visited by a fieldworker who talked to you about family planning?	YES……. . . . . 1 NO……. 2
21	In the last 12 months, have you visited a health facility for care for yourself (or your children)?	YES……. . . . . 1 NO……. 2
22	Did any staff member at the health facility speak to you about family planning methods?	YES……. . . . . 1 NO……. 2

KIAMBATISHO II FOMU YA MAELEZO YA IDHINI.

Kichwa

Maarifa na matumizi ya dawa za kuzuia mimba na wagonjwa wa akili katika hospitali ya kitaifa ya mafudisho na rufaa ya Mathari (MNTRH).

Kuanzishwa

Mimi, Dk Anthony Kariuki Gitari ni mwanafunzi katika Idara ya Psychiatry-Chuo Kikuu cha Nairobi nataka kufanya utafiti juu ya Maarifa na matumizi ya dawa za kuzuia mimba na wagonjwa wa akili katika hospitali ya kitaifa ya mafudisho na rufaa ya Mathari (MNTRH). Pata mwaliko wangu wa kushiriki katika utafiti.

Malengo ya Utafiti

Lengo pana

Kuamua maarifa na matumizi ya mipango ya uzazi miongoni mwa wanawake wenye ugonjwa wa akili wanaohudhuria ibada ya outpatient katika MNTRH.

Malengo mahususi

Miongoni mwa wanawake wenye umri wa kuzaa wanaohudhuria matibabu ya akili katika MNTRH

i. Kuamua ujuzi wao juu ya mipango ya uzazi.
ii. Kuamua mazoezi yao ya mipango ya uzazi.
iii. Kuamua kama wamepokea ushauri nasaha ya kuzuia mimba.
iv. Kuelezea aina na chanzo cha njia ya kuzuia mimba.

Faida

Rufaa kwa ushauri nasaha wa mipango ya uzazi na matumizi kwa washiriki.

Watunga sera wanaweza kuanzisha hatua za kuongeza kiwango cha miango ya uzazi kwa maambukizi na kuboresha afya ya uzazi kati ya wagonjwa wa akili kwa kutumia habari hizi.

Hatari

Urefu wa mahojiano unaweza kusumbua mshiriki.

Dhiki inaweza kutokea kutokana na baadhi ya maswali lakini msaada wa kisaikolojia utapatikana kupitia rufaa kwa washauri.

Fidia

Hakuna malipo kwa kushiriki katika utafiti huu.

Hiari

Ushiriki wako katika utafiti;

Ni kwa hiari yako.

Unaweza kujiondoa wakati wowote unataka.

Kushindwa kushiriki hakutasababisha kukosa huduma.

Aina ya kielelezo.

Hakuna kielelezo inahitajika kutoka kwako.

Wakati katika utafiti.

Mahojiano ya uso kwa uso itachukua muda wa dakika 30-60 ya wakati wako baada yako kutia saini ridhaa.

Maswali yako yote na wasiwasi ni lazima ishugulikiwe kikamilifu na mtafiti kabla yako kutia saini ridhaa.

Usiri.

Jina lako halitaonekana mahali yoyote, na baada ya ukusanyaji wa habari takwimu zitafungiwa.

Taarifa juu ya watafiti.

Kwa taarifa zaidi au wasiwasi wowote unaweza kuwa nayo kuhusu somo hili jisikie huru kuwasiliana na;

Mpelelezi Dr Anthony Kariuki Gitari 0722310821

Wasimamizi Prof. Wangari Kuria 0722755681

Dr Onesmus Gachuno 0722851914

Dr Anne Obondo 0721849686

AU

Mwenyekiti KNH / UON Maadili Kamili ya 254 2726300 ext. 44102.

Asante kwa muda wako.

Dr Anthony Kariuki Gitari

0722310821

Fomu ya ridhaa

Mimi .... (Jina la mshiriki), nimekubali

kushiriki katika utafiti wenye jina la 'Maarifa na matumizi ya dawa za kuzuia mimba na wagonjwa wa akili katika hospitali ya kitaifa ya mafudisho na rufaa ya Mathari (MNTRH).

Nathibitisha kwamba maelezo ya ridhaa nimepewa na mtafiti, naelewa malengo, faida na hatari za utafiti. Nashiriki kwa hiari bila matarajio ya fidia yoyote, nafahamu kwamba naweza kuondoa ushiriki wangu wakati wowote bila kupoteza huduma. Naelewa kwamba utambulisho wangu na taarifa nawapa itakuwa siri wakati wote tena najua wa kuwasiliana naye juu ya ufafanuzi wowote.

Saini ya mshiriki/alama ya kidole gumba cha kuchoto .....Tarehe .....

Saini ya shahidi/alama ya kidole gumba cha kuchoto.....Tarehe .....

Fomu ya kujiondoa

Mimi, nikiwa mgonjwa wa akili wa Mathari, na baada ya kuelezwa kuhusu utafiti uliotajwa hapa juu na madhumuni yake tarehe ..... 2015, Kwa sasa najiondoa kushiriki.

Saini ya mshiriki/alama ya kidole gumba cha kuchoto.....Tarehe .....

Saini ya shahidi/alama ya kidole gumba cha kuchoto.....Tarehe .....

Mtafiti	DR. Antony Kariuki Gitari;	Mawasiliano 0722310821
Msimamizi mkuu	Prof. Wangari Kuria;	Mawasiliano 0722755681

MASWALI YA KIJAMII

	MASWALI	
1	Umri wako ni miaka ngapi	Miaka……
2	Tangu mwaka gani umekuwa na ugonjwa ya akili	Mwezi…….. Mwaka……..
3	Hali yako ya ndoa ni namna gani?	A Nimeolewa …….... B Mjane …… C Talaka …… D Tumetengana……..
4	Unaishi wapi?	A Jiji…….. B Mji…….. C Kijiji……..……
5	Ndini yako ni gani?	A Katoliki…….. B Kiprotestanti…….. C Mwislamu……. D Ingine yoyote(elezea)_____
6	Umesoma mpaka kiwango gani?	A Kabla ya msingi……. B Msingi…… C Ufundi …… D Upili…… E Chuo…… F Chuo kikuu……. G Ingine yoyote(elezea)_____
7	Ajira yako ni gani?	A Hakuna ……. B Ajira binafsi……..…… C Ajira mishahara ……
8	kwanini hauna ajira?	A Ugonjwa …….. B Kustaafu…….. C Sababu ingine…….
9	Mapato yako ya kila mwezi ni kama pesa ngapi	A chini ya 1000…….. B 1000-10000……

		C 1000-20000……. D 20000-50000……... E zaidi ya 50000 …….

SEHEMU YA 2. UZAZI

1	Sasa ningependa kukuuliza kuhusu mimba zote ulizozaa katika maisha yako. Je umewahi kuzaa?	NDIO……. . . . . 1 LA..……. 2
2	Na, una watoto wakiume au wakike wowote uliowazaa ambao kwa hivi sasa unaishi nao?	NDIO……. . . . . 1 LA..……. 2
3	Ni watoto wangapi wakiume unaishi nao? Ni watoto wangapi wa kike unaishi nao?	Wakiume nyumbani . . . . . …. Wakike nyumbani . . . . …….....
4	Je, una watoto wakiume au wakike wowote uliowazaa ambao kwa hivi sasa hawaishi na wewe?	NDIO…. . . . . ……1 LA..…… 2
5	Ni watoto wangapi wakiume walio hai lakini hauishi nao? ni watoto wangapi wa kike walio hai lakini hauishi nao?	wakiume wasioishi nawe . . . . . …….. wakike wasioishi nawe……..
6	Je, umewahi kuzaa mtoto wakiume au wakike, akiwa hai lakini akafariki baadaye?	NDIO……. . . . . 1 LA..…….. 2
7	Watoto wangapi wakiume walifariki? na watoto wangapi wakike walifariki?	wakiume waliofariki . . . . . . wakike waliofariki . . . . . …
8	Jumuisha 03, 05, na 07,na uandike jumla yao.	kizazi chote . . . . . …….
9	Ili kuhakikisha kuwa nimepata idadi sahihi, kwa jumla, uliwahi kupata uzazi _____katika maisha yako. Je hiyo ni sawa?	NDIO……. . . . . 1 LA.(chunguza tena na usahihishe) 2
10	Je, hivi sasa unamimba/ umja mzito?	Ndio……. . . . . .1 La..……. . . . . 2 Sina hakika……..……...…..8
11	Mimba yako ina miezi mingapi?	Miezi……
12	Uliposhika mimba, je ulikuwa unataka upate mimba wakati huo?	NDIO……. . . . . 1 LA..……. 2
13	Je, ulitaka upate mtoto siku za baadaye ama hukutaka kupata watoto wowote (Zaidi)?	Baadaye……. . . . . 1 Sikutaka zaidi. 2
14	Je, umewahi kupata mimba ikaharibika/ikatoka, ikatolewa ama ukazaa mtoto aliyefariki tumboni?	NDIO……. . . . . 1 LA..……. 2
15	Mimba kama hiyo mara ya mwisho ilitamatika lini?	Mwezi……

		Mwaka……
16	Mimba hiyo ya mwisho iliyotamatika , ilikuwa ya miezi mingapi?	Mwezi . . . . .
17	Je, kuanzia januari 2009, umewahi kuwa na mimba ambayo hukujifungua mtoto akiwa hai?	NDIO……. . . . . 1 LA..……. 2
18	Je, uliwahi kupata mimba ikaharibika, ama ikatolewa ama ukazaa mtoto aliyefariki tumboni kabla ya mwaka wa 2009?	NDIO……. . . . . 1 LA..……. 2
19	Je, mimba ya aina hiyo iliyotamatika kabla ya mwaka 2009, ilitamatika lini?	Mwezi Mwaka
20	Siku zako za mwezi ama hedhi mara ya mwisho zilianza lini?	Siku zilizopita…….. Wiki zilizopita…… Miezi iliyopita…… Miaka iliyopita…… Nimepitisha miaka ……994 Kabla ya kujifungu mwisho……..….995 Sijawahi pata hedhi……996
21	Kutoka siku za mwezi/hedhi hadi siku ya mwezi/hedhi inayofuata, je kuna siku ambazo mwanamke ana uwezekano mkubwa wa kushika mimba anapofanya ngono/mapenzi?	NDIO…….. . . . . 1 LA..……. . . . . 2 SIJUI……...…8
22	Wakati huo ni mara tu kabla ya siku za mwezi/hedhi kuanza, ni wakati wa siku za mwezi/hedhi, ni mara tu baada ya siku za mwezi/hedhi kumalizika ama ni siku za katikati kutoka mwezi/hedhi moja hadi nyingine?	Kabla ya hedhi ……...……...…1 Katika hedhi . . . . ……..…….….. 2 Baadaya hedhi ……..……3 Katikati ya hedhi zinazofuatana……...….4 Wakati mwingine yeyote_____6 Sijui …….…….…..…....8

SEHEMU3. KUPANGA UZAZI

1	Sasa ningependa kuzungumza kuhusu kupanga uzazi - njia tofauti ambazo mume na/au mke wanaweza kutumia kucheleweshe ama kuzuia kushika mimba. je, umewahi kusikia kuhusu (njia ya kupanga uzazi)?	
A	Njia ya kufunga uzazi cha mwanamke. wanawake wanaweza kufanyiwa upasuaji ili kuzuia kupata watoto (zaidi).	NDIO……. . . . . 1 LA..…… 2
B	Njia ya kufunga uzazi cha mwanamume. wanaume wanaweza kufanyiwa upasuaji ili kuzuia kupata watoto (zaidi).	NDIO……. . . . . 1 LA..…… 2
C	**Kitanzi/koili.** wanawake wanaweza kuingizwa kitanzi ama koili ndani ya sehemu zao za siri na daktari ama muuguzi.	NDIO……. . . . . 1 LA..…… 2
D	**Sindano.** wanawake wanaweza kudungwa sindano na muhudumu wa afya ambayo inazuiya kushika mimba kwa muda wa mwezi mmoja au zaidi.	NDIO……. . . . . 1 LA..…… 2
E	**Vichupa** wanawake wanaweza kuingizwa vichupa chini ya mkono na daktari au muuguzi vinavyoweza kuzuia kushika mimba kwa mwaka mmoja ama zaidi.	NDIO……. . . . . 1 LA..…… 2
F	**Tembe.** wanawake wanaweza kumeza tembe kila siku kujikinga kushika mimba.	NDIO……. . . . . 1 LA..…… 2
G	**Kodomu ya mwanamume.** Wanaume wanaweza kuvaa mpira mwembamba juu ya uume wao kabla ya kufanya ngono.	NDIO……. . . . . 1 LA..…… 2
H	**Kodomu ya wanawake.** wanawake wanaweza kuingiza mfuko wa mpira mwembamba ndani ya uke wao kabla ya kufanya ngono.	NDIO……. . . . . 1 LA..…… 2

I	**Kunyonyesha pekee**	NDIO……. . . . . 1 LA..……. 2
J	**Njia ya kuhesabu siku/kalenda.** ili kuzuia mimba, wanawake hawafanyi ngono katika siku za mwezi ambazo wanafikiria wanaweza kushika mimba.	NDIO……. . . . . 1 LA..……. 2
K	**Kuchomoa uume.** wanaume wanaweza kuwa waangalifu, wanaweza kuchomoa uume wao na kumwaga manii inje kabla ya kumaliza	NDIO……. . . . . 1 LA..……. 2
L	**Tembe za dharura** kama njia ya dharura, ndani ya muda wa siku tano baada ya kufanya ngola bila kinga, wanawake wanaweza kumeza tembe maalum kuzuiya kushika mimba.	NDIO……. . . . . 1 LA..……. 2
M	Je, umewahi kusikia njia nyingine zozoteambazo wanawake au wanaume wanaweza kutumia kuepuka kushika mimba?	NDIO……. . . . . 1 Fafanua _____ LA..……. . . . . 2 Fafanua_____
2	Je, kwa sasa unafanya chochote ama unatumia njia yoyote ili kucheleweshа au kuzuia kushika mimba?	NDIO……. . . . . 1 LA..……. 2
3	Unatumia njia gani?	Kufunga uzazi wa mwanamke……...A Kufunga uzazi wa manaume……..…B Koili……..……..……C Sindano ……..……D Vichupa ……..……E Tembe ……..……F Kondomu ya mwanaume ……..……...G Kondomu ya mwanamke……..……H Kunyonyesha pekee……..……I Kalenda……..……...J Kuchomoa uume……..……K Njia zingine za kisasa……..……L Njia zingine za kale……....

4	Ni katika kituo gani cha afya ulipofungwa uzazi?	**SEKTA YA UUMA** Hospitali ya serikali. . …….. . . . .. 11 Kituo cha afya cha serikali. . . ……..... .. . 12 Zahanati ya serikali. . . . .……. . .. . . 13 Sekta ingine yoyote ya serikali……..……..16 **SEKTA BINAFSI YA MATIBABU** Hospitali/zahanati za kanisa….....21 Family options/fhok clinic..... 22 Hospitali/zahanati za kibinafsi……..23 Hospitali ya uuguzi/uzazi. . ……..….. 24 Zahanati ya kuhamahama……. 25 Mahali ingine yoyote ya matibabu ya kibinafsi…….…….....26 Sijui . . . . . ……...…….98
5	Mara ya mwisho ulipopata (njia unayo tumia kwa sasa) ulilipa jumla ya pesa ngapi, ukijumlisha gharama ya nji kumuona muhudumu wa afya?	Malipo . . . . . ……..☐☐☐☐☐ Bure…….……...99995 Sijui……99998
6	Ni mwezi na mwaka gani ulipofungwa uzazi?	Mwezi . . . . . ☐☐ Mwaka . . . . . ……. ☐☐☐☐
7	Kutoka mwezi na mwaka gani umekuwa ukitumia mfululizo bila ya kuacha?(njia unayo tumia kwa sasa)	Mwezi . . . . . ☐☐ Mwaka . . . . . ……. ☐☐☐☐
8	Umewahi kutumia chochote, ama kujaribu njia yoyote, kucheleweshe ama kuzuia kushika mimba?	NDIO……. . . . . 1 LA...……. 2
9	Njia gani umewahi tumia:	Kufunga uzazi wa mwanamke…….…..01 Kufunga uzazi wa mwanaume…..……..02 Koili……...……..03 Sindano……...……..04 Vichupa……...…05 Tembe ……..…06 Kodomu ya mwanaume……...…07 Kodomu ya mwanamke……...…08 Kunyonyesha pekee…….…...11 Kalenda……...…12

		Kuchomoa uume…….……...…...13 Njia ingine yoyote ya kisasa……...…..95 Njia ingine yoyote ya kale……..96
10	Mara ya kwanza kutumia njia unayotumia kwa sasa,ulipata wapi njia hii ya kupanga uzazi wakati huo?	**SEKTA YA UUMA** Hospitali ya serikali…….…..11 Kituo cha afya cha serikali…….....12 Zahanati ya serikali……...13 Sekta ingine yoyote ya uuma……16 **SEKTA BINAFSI YA MATIBABU** Hospitali/zahanati za kibinafsi…….….21 Duka la dawa……...…….22 Hospitali ya uuguzi/uzazi…….….23 Hospitali/zahanati za kikanisa……..….24 Family options/fhok clinic……...…...25 **MAHALI INGINE YOYOTE YA MATIBABU YA KIBINAFSI** Duka…….……..31 Zahanati ya kuhamahama…….……..32 Muuzaji wa kijijini…….33 Mfanyikazi wa afya kijijini…….…...34 Rafiki/ndugu…….…….35 Mahali ingine yoyote…….……....96
11	Wakati huo, ulielezwa kuhusu madhara ama matatizo ambayo ungeweza kupata kwa njia hiyo?	NDIO……. . . . . 1 LA...……. 2
12	Ulipofungwa uzazi, je ulielezwa kuhusu madhara ama matatizo ambayo ungeweza kupata kwa kutumia njia hiyo?	NDIO……. . . . . 1 LA...……. 2
13	Kuna wakati wowote ulielezwa na mhudumu wa afya ama wa kupanga uzazi kuhusu madhara ama matatizo ambayo ungeweza kupata kwa kutumia njia hiyo?	NDIO……. . . . . 1 LA...……. 2
14	Je, ulielezwa la kufanya endapo utapata madhara ama tatizo lolote?	NDIO……. . . . . 1 LA...……. 2

15	Je,wakati ulipata njia ya kupanga uzazi ulielezewa juu ya njia zingine ambazo ungeweza tumia?	NDIO……. . . . . 1 LA...……. 2
16	Je, umewahi wakati wowote kuelezwa na muhudumu wa afya ama wa kupanga uzazi kuhusu njia nyingine za kupanga uzazi ambazo ungeweza kutumia?	NDIO……. . . . . 1 LA...……. 2
17	Ulipata wapi (njia unayotumia kwa sasa) mara ya mwisho?	**SEKTA YA UUMA** Hospitali ya serikali……...…..11 Kituo cha afya cha serikali……....…...12 Zahanati ya serikali……....13 Sekta ingine yoyote ya uuma……..…16 **SEKTA BINAFSI YA MATIBABU** Hospitali/zahanati za kibinafsi……..….21 Duka la dawa……...…….22 Hospitali ya uuguzi/uzazi…….…….23 Hospitali/zahanati za kikanisa…….…….24 Family options/fhok clinic……..…....25 **MAHALI INGINE YOYOTE YA MATIBABU YA KIBINAFSI** Duka…….……..…31 Zahanati ya kuhamahama…….……32 Muuzaji wa kijijini……...33 Mfanyikazi wa afya kijijini……..….34 Rafiki/ndugu…….……35 Mahali ingine yoyote…….……..96
18	Je, unajua pahali ambapo unaeza kupata njia ya kupanga uzazi?	NDIO……. . . . . 1 LA...……. 2
19	Ni wapi hapo?	**SEKTA YA UUMA** Hospitali ya serikali……..A Kituo cha afya cha serikali…….....B Zahanati ya serikali……...C Sekta ingine yoyote ya uuma……D **SEKTA BINAFSI YA MATIBABU** Hospitali/zahanati za kibinafsi……..E Duka la dawa…….F

		Hospitali ya uuguzi/uzazi……G Hospitali/zahanati za kikanisa……H Family options/fhok clinic……..…..I Mahali ingine yoyote ya matibabu ya kibinafsi..J **MAHALI INGINE YOYOTE** Duka……K Zahanati ya kuhamahama……L Muuzaji wa kijijini……...……..M Mfanyikazi wa afya kijijini……...…….N Rafiki/ndugu……0 Mahali ingine yoyote……..X
20	Ndani ya miezi 12 iliyopita, je umewahi kutembelewa na mfanyikazi wa nyanjani aliyekuzungumzia kuhusu kupanga uzazi?	NDIO……. . . . . 1 LA..……. 2
21	Ndani ya miezi 12 iliyopita,je umewahi kutembelea Kituo cha afya kwa matibabu yako(ama ya watoto wako)?	NDIO……. . . . . 1 LA..……. 2
22	Je kuna mfanyi kazi yeyote katika kituo hicho cha afya aliyekuzungumzia kuhusu njia za kupanga uzazi?	NDIO……. . . . . 1 LA..……. 2

Mini International Neuropsychiatric Interview

English Version 5.0.0

DSM-IV

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Powers for her advice on the modules on Anorexia nervosa and Bulimia. Printed, 6 October, 2016

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

N. UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KULA MNO		
O. GENERALIZED ANXIETY DISORDER O. UGONJWA WA WASIWASI MKUBWA	Current (past 3 months)	
P. ANTISOCIAL PERSONALITY DISORDER P. UGONJWA WA MAKUZI YA HULKA NA TABIA ZINAZOPINGANA NA JAMII	Lifetime	Optional

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 <u>each dimension</u> of the question is taken into account by the patient (i.e.: time frame, frequency, severity, « and/or » alternatives).

<u>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.</u> 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? Je, ulishawahi kukosa raha muda mwingi wa siku, karibu kila siku, kwa muda wa wiki mbili zilizopita?	NO HAPANA	YES NDI YO	1 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 ? Katika wiki mbili zilizopita, je, umekosa hamu/ari katika vitu vingi au kukosa raha	NO	YES	2

	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)

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)

IF **YES** TO EITHER, CODE **YES**

IWAPO **J**IBU NI **N**DIYO KWA **L**OLOTE, **J**AZA **N**DIYO

NO	YES		3
HAPANA	NDIYO		3

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	YES		4
HAPANA	NDIYO		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	YES		5
HAPANA	NDIYO		5

d Did you feel tired or without energy, almost every day?

Je, ulijisikia mchovu au kutokuwa na nguvu karibu kila siku?

NO	YES		6
HAPANA	NDIYO		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	YES		7
HAPANA	NDIYO		7

f Did you have difficulty concentrating or making decisions, almost every day? NO YES 8

Je, ulikuwa na matatizo ya kuwa makini au kufanya maamuzi karibu kila siku? HAPANA NDIYO 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 YES 9

HAPANA NDIYO 9

A4 ARE **3** OR MORE **A3** ANSWERS CODED **YES** ?

(OR **4A3** 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**)

NO
YES

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? → NDIYO HAPANA 10

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?

b 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? NO YES 11

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	1 2
	JE KIPENGELE **A2** KIMEJIBIWA NDIYO?	HAPANA	NDIYO	1 2
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? **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	NO HAPANA	YES NDIYO	1 3 1 3
		➔		
	IS EITHER **A6a** OR **A6b** CODED **YES**?	NO	YES	
		➔		
	JE, KIPENGELE **A6a** AU **A6b** KIMEJIBIWA NDIYO?	HAPANA	NDIYO	

Over the past two weeks period, when you felt depressed and uninterested :

Katika kipindi cha wiki mbili zilizopita, ulipojisikia kukosa raha au kukosa ari:

A7	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 siku?	HAPANA	NDIYO	16
	e	IS **A3c** CODED **YES**?	NO	YES	17
		JE, KIPENGELE **A3c** KIMEJIBIWA NDIYO?	HAPANA	NDIYO	17
	d	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?			
		JE, **A3e** IMEJIBIWA NDIYO (KUJILAUMU KUPITA KIASI, AU KUJILAUMU KUSIVYOSTAHILI)?	NO	YES	19
			HAPANA	NDIYO	19

ARE **3** OR MORE **A7** ANSWERS CODED **YES**?

JE, VIPENGELE **VITATU** AU ZAIDI VYA **A7** VIMEJIBIWA **NDIYO**?

NO	**YES**
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

NO	**YES**

IS **B4** CODED **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 JUU, KIMEJIBIWA **NDIYO**?	**HAPANA**	**NDIYO**

SUICIDE RISK

CURRENT

HATARI YA KUJIUA

KWA SASA

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

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	HAPANA	NDIYO	1
	IF YES :			
	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?	HAPANA	NDIYO	4

		➔		
	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?	NO	YES	5
	Ulijisikiakuweza kufanya vitu ambavyo wengine hawawezi au kujiona kuwa mtu pekee muhimu	HAPANA	NDIYO	5
b	Need less sleep (e.g., feel rested after only a few hours sleep)?	NO	YES	6
	Ulihitaji usingizi mchache (kwa mfano, kujisikisa mapumziko baada ya muda mdogo tu wa kulala)?	HAPANA	NDIYO	6
c	Talk too much without stopping, or so fast that people had difficulty understanding?	NO	YES	7
	Uliongea sana bila kunyamaza, au kwa haraka zaidi kiasi kwamba watu wakapata tabu ya kukuelewa?	HAPANA	NDIYO	7
d	Have thoughts racing?	NO	YES	8
	Umekuwa na mawazo ya harakaharaka	HAPANA	NDIYO	8
e	Become easily distracted so that any little interruption could distract you?	NO	YES	9
	Ulikuwa mwepesi wa kuvurugwa kiasi kwamba hata kukatizwa			

	kidogo kunakuvuruga?	HAPANA	NDIYO	9
f	Become so active or physically restless that others were worried about you?	NO	YES	10
	Ulikuwa mashuhuri au kutotulia kiasi kwamba watu wengine wakapata wasiwasi juu yako?	HAPANA	NDIYO	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)?	NO	YES	11
	Ulitaka sana kujiingiza katika shughuli za starehe na kutojali hatari zake au matokeo yake (mfano, kufanya shamrashamra, udereva wa kizembe, au ngono bila kujihadhari)?	HAPANA	NDIYO	11
	ARE **3** OR MORE **D3** ANSWERS CODED **YES**	➔		
	OR **4** IF **D1a = NO** (PAST EPISODE) OR **D1b = NO** (CURRENT EPISODE)?	NO	YES	
	JE, VIPENGELE **3** AU ZAIDI VYA **D3** VIMEJIBIWA **NDIYO**			
	AU VIPENGELE **4**, IKIWA **D1a** = **HAPANA** (TUKIO LILILOPITA) AU **D1b** = **HAPANA** (TUKIO LA SASA)	➔ HAPANA	NDIYO	
D4	Did these symptoms last at least a week **and** cause significant problems at home, at work, or at school,	NO	YES	12
	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?	HAPANA	NDIYO	12
	IF YES TO EITHER, CODE YES			
	KAMA JIBU NI NDIYO KWA LOLOTE, JAZA NDIYO			

IS **D4** CODED **NO?**

JE, KIPENGELE **D4** KIMEJIBIWA **HAPANA**?

NO	**YES**
HAPANA	**NDIYO**

HYPOMANIC EPISODE

TUKIO LA MANIA NDOGO

CURRENT	•

IF YES, SPECIFY IF THE EPISODE EXPLORED IS

CURRENT OR PAST

KAMA NDIYO, ELEZA NI TUKIO LA SASA AU LILILOPITA

KWA SASA •

PAST •

LILILOPITA •

IS **D4** CODED **YES**?

JE, KIPENGELE **D4** KIMEJIBIWA **NDIYO**?

NO **YES**

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?	NO	YES	1
	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?	HAPANA	NDIYO	1
	CODE YES ONLY IF THE SPELLS PEAK WITHIN 10 MINUTES JAZA NDIYO IKIWA TU MSHITUKO HUO ULIISHA NDANI YA DAKIKA KUMI			

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?	NO	YES	2
	Katika wakati wowote uliopita, je, vipindi hivi au mishituko hiyo ilikuja bila kutegemea au kutokea katika namna isiyobashirika au kuchochewa?	HAPANA	NDIYO	2

IF **E2 = NO**, CIRCLE NO IN E5 AND SKIP TO F1

KAMA **E2 = HAPANA**, JAZA HAPANA KATIKA **E5** NA NENDA KIPENGELE **F1**

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?	NO	YES	3
	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?	HAPANA	NDIYO	3

IF **E3 = NO**, CIRCLE NO IN E5 AND SKIP TO F1

KAMA **E3 = HAPANA**, ZUNGUSHIA HAPANA NA NENDA KIPENGELE **F1**

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
m	Did you have hot flashes or chills?	NO	YES	16
	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 KAMA **E5= HAPANA**, NENDA KIPENGELE E7	***Panic Disorder*** ***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 KAMA **E6 = NDIYO**, NENDA **F1**	***Panic Disorder*** ***Current*** ***Hofu kubwa*** ***kwa sasa***		
E7	ARE **1**, **2** OR **3E4** ANSWERS CODED **YES**?	NO	YES	18

Limited Symptom Attacks

Lifetime

F.

G. 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**

and

IS **E5** (PANIC DISORDER LIFETIME) CODED **NO**?

NO **YES**

AGORAPHOBIA
without history of
Panic Disorder
CURRENT

G. SOCIAL PHOBIA

G. 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.			
G1		→		
		NO	YES	1
G2	Is this fear excessive or unreasonable?	→		
G2	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?	→		
		NO	YES	3
G3	Je unahofia sana mazingira haya kiasi cha kujitenga nayo au kuteseka kwa ajili ya mazingira hayo.			
G4	Does this fear disrupt your normal work or social functioning or cause you significant distress?	NO	YES	
				4
G4	Je hofu hizi zinavuruga shughuli zako za kawaida au shughuli za kijamii au zinakusababishia shida kubwa.			

IS **G4** CODED**YES**?

Je kipengele G4 kimejibiwa ndiyo?

NO	**YES**
SOCIAL PHOBIA CURRENT	

H. OBSESSIVE-COMPULSIVE DISORDER

H. SHAUKU LAZIMISHO

In the past month, have you been bothered by recurrent thoughts,

H1	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? IF **H2 = NO**, SKIP TO H4		NO YES	2
H2	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?		NO YES	3

H3	Je, unadhani kwamba shauku hizi zinatokana na mawazo yako mwenyewe na kwamba hazijalazimishwa kutoka nje?			
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 ?	NO	YES	4
H4	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.			
	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?	➔		
H5	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?			
H6	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**	**YES**	
		OBSESSIVE-COMPULSIVE DISORDER		
		CURRENT		

I. POSTTRAUMATIC STRESS DISORDER (optional)

I. 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?	➔ NO	YES	1
I1	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...			
I2	During the past month, have you re-experienced the event in a distressing way (i.e., dreams, intense recollections, flashbacks or physical reactions)?	➔ NO	YES	2
I2	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)?			
I3	**In the past month :**			
I3	**Katika mwezi uliopita:**			
a	Have you avoided thinking about the event, or have you avoided things that remind you of the event?			
a	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?	NO	YES	4
b	Je, umepata tabu ya kukumbuka baadhi ya sehemu muhimu juu ya kilichotokea?			
c	Have you become less interested in hobbies or social activities?	NO	YES	5
c	Je umekuwa na mvuto hafifu kwa mambo uyapendayo au kazi za kijamii?			
d	Have you felt detached or estranged from others?	NO	YES	6
d	Je, ulijisikia umejitenga au kutenganisha na wengine?			
e	Have you noticed that your feelings are numbed?	NO	YES	7
e	Je, ulitambua kwamba mawazo yako ni mazito?			

f	Have you felt that your life would be shortened because of this trauma?	NO	YES	8
f	Je, ulijisikia kwamba maisha yako yangekuwa mafupi kutokana na tukio hili?			
		➔		
	ARE **3** OR MORE **I3** ANSWERS CODED **YES**?	NO	YES	
	JE, VIPENGELE **VITATU** AU ZAIDI VYA **I3** VIMEJIBIWA NDIYO?			
I4	**In the past month :**			
14	**Katika mwezi uliopita:**			
a	Have you had difficulty sleeping?	NO	YES	9
a	Je ulipata tabu ya usingizi?			
b	Were you especially irritable or did you have outbursts of anger?	NO	YES	10
b	Je ulikuwa mwenye kuudhika upesi, au ulipatwa na milipuko ya hasira?			
c	Have you had difficulty concentrating?	NO	YES	11
c	Je, umepata tabu ya kuwa makini?			
d	Were you nervous or constantly on your guard?	NO	YES	12
d	Je, ulikuwa na wahaka/wasiwasi au muda wote kujilinda?			
e	Were you easily startled?	NO	YES	13
e	Je, ulikuwa mwepesi wa kushtushwa?			
		➔		
	ARE **2** OR MORE **I4** ANSWERS CODED **YES**?	NO	YES	
	JE VIPENGELE **2** AU ZAIDI YA **I4** VIMEJIBIWA **NDIYO**?			
I5	During the past month, have these problems significantly interfered with your work or social activities, or caused significant distress?	NO	YES	14
I5	Katika mwezi uliopita, je matatizo haya kwa kiasi kikubwa yalivuruga utendaji wa kazi yako au shughuli za kijamii au kusababisha mashaka makubwa?			
	IS **I5** CODED **YES**?	**NO**	**YES**	

POSTTRAUMATIC STRESS

JE I5 IMEJIBIWA NDIYO?

DISORDER
CURRENT

J. ALCOHOL ABUSE AND DEPENDENCE

J. 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?			
J2	**Katika miezi 12 iliyopita:** Je, ulihitaji kunywa zaidi ili upate matokeo sawa nay ale uliyokunywa mara ya kwanza?	NO	YES	2
a				
b	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?	NO	YES	3
b	Je, wakati ulipoacha kunywa mikono yako ilitetemeka ulitokwa na majasho, au kujisikia wasiwasi? 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			
c	During the times when you drank alcohol, did you end up drinking more than you planned when you started?	NO	YES	4
c	Wakati ambapo umelewa pombe, je uliishia kunywa zaidi kuliko ulivyopanga mwanzoni?			

d	Have you tried to reduce or stop drinking alcohol but failed?			
d	Je ulijaribu kupunguza au kuacha ulevi ikashindikana?	NO	YES	5
e	On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol?	NO	YES	6
e	Katika siku ambazo umelewa, je ulipoteza muda mwingi kupata pombe, kunywa au kupata nafuu kutoka katika athari za pombe?			
f	Did you spend less time working, enjoying hobbies, or being with others because of your drinking?	NO	YES	7
f	Je ulitumia muda mchache kufanya kazi kufurahia uvipendavyo au kuwa na wenzako kwa sababu ya ulevi wako?			
g	Have you continued to drink even though you knew that the drinking caused you health or mental problems?	NO	YES	8
g	Je uliendelea kulewa japo kuwa ulifahamu kuwa ulevi ulikusababishia matatizo ya kiafya na kiakili?			

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 :**

J3 **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?	NO	YES	9
a	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)

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

b 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

c 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

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

ARE **1** OR MORE **J3** ANSWERS CODED **YES**? **NO**

JE KIPENGELE **KIMOJA** AU ZAIDI CHA **J3** KIMEJIBIWA NDIYO? ***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	NO	YES	6

madawa?

g Have you continued to use [NAME OF SELECTED DRUG / DRUG CLASS] even though it caused you health or mental problems?

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

NO YES 7

ARE **3** OR MORE **K2** ANSWERS CODED **YES**?

SPECIFY DRUG(S) : _____

JE VIPENGELE **3** AU ZAIDI VYA **K2** VIMEJIBIWA **NDIYO?**

TAJA DAWA / MADAWA:_____

NO	**YES**
DRUG(S) DEPENDENCE CURRENT	

➔

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., NO YES 9

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).

c Did you have any legal problems because of your [NAME OF SELECTED DRUG / DRUG CLASS] use, e.g., an arrest or disorderly conduct? NO YES 10

Je, ulipata matatizo yeyote ya kisheria kwa sababu ya matumizi ya madawa mf. Kutiwa mbaroni au kufanya vurugu.

d Did you continue to use [NAME OF SELECTED DRUG / DRUG CLASS] even though it caused problems with your family or other people? NO YES 11

Je uliendelea kutumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), japokuwa ilisababisha matatizo kwa familia yako au watu wengine

	NO	YES
ARE **1** OR MORE **K3** ANSWERS CODED **YES**?	***DRUG(S) ABUSE***	
	CURRENT	
SPECIFY DRUG(S) : _____	**NDIYO**	**HAPANA**
JE, KIPENGELE **KIMOJA** AU ZAIDI CHA **K3** KIMEJIBIWA **NDIYO?**	**MATUMIZI YA MADAWA KWA SASA**	
TAJA DAWA/MADAWA :_____		

L. PSYCHOTIC DISORDERS
L. 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.

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	BIZARRE 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	NO		YES	5

	ISIYOHUSIANA NA KURUKWA AKILI				
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 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?	NO	YES	YES	11
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?	NO	YES		13

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?

B **IF YES**: Have you seen these things in the past month? : NO YES 14

INTERVIEWER'S JUDGMENT :

KAMA NDIYO: Je umeviona vitu hivi katika mwezi mmoja uliopita?

UAMUZI WA TABIBU

L8 b IS THE PATIENT CURRENTLY EXHIBITING INCOHERENCE, DISORGANIZED SPEECH, OR MARKED LOOSENING OF ASSOCIATIONS? NO YES `115

L8 b JE MGONJWA KWA SASA ANAONYESHA MAMBO YASIYOELEWEKA, MANENO YASIYO NA MPANGILIO, AU MAMBO YASIYOUNGANIKA.

L9 b IS THE PATIENT CURRENTLY EXHIBITING DISORGANIZED OR CATATONIC BEHAVIOR? NO YES 16

L9 b JE KWA SASA MGONJWA ANAONYESHA TABIA ISIYOELEWEKA AU KUZUBAA?

L10b

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

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** :

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

OR

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

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).

NO	**YES**
PSYCHOTIC CURRENT	***SYNDROME***

L12 FROM **L1 TO L7** :

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

OR

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

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

OR

- IS **L11** CODED **YES**?

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

L12 **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**?

NO	**YES**
PSYCHOTIC LIFETIME	***SYNDROME***

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?

NO YES 18

b 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?

IS **L13b** CODED **YES**?

JE, **L13b** IMEJIBIWA **NDIYO**?

NO	**YES**
MOOD DISORDER WITH PSYCHOTIC FEATURES	
CURRENT	

M. ANOREXIA NERVOSA

M. UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KUTOKULA

				Ft	℘
M1 a	How tall are you?	|__|__|__|		Ins	℘
a	Una urefu kiasi gani?			Cm	℘
				Lbs.	℘
b	What was your lowest weight in the past 3 months?	|__|__|__|		Kg	℘
b	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	➔			
		NO	YES	1	
c	JE, UZITO WA MGONJWA NI MDOGO KULIKO KIWANGO KINACHOLINGANA NA UREFU WAKE? (ANGALIA JEDWALI CHINI)				
	In the past 3 months :				
	Katika miezi 3 iliyopita:	➔			
M2	In spite of this low weight, have you tried not to gain weight?	NO	YES	2	
M2	Pamoja na uzito huu mdogo, je ulijaribu kutoongeza uzito?				

Have you feared gaining weight or becoming fat, even though you

M3	were underweight?	➔		
M3	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?	NO	YES	5
b	Je, uzito wa mwili wako au umbile umeathiri kwa kiasi kikubwa jinsi unavyojiona?			
c	Have you thought that your current low body weight was normal or excessive?	NO	YES	6
c	Je, ulifikiria kwamba uzito wako mdogo wa sasa ni kawaida au umezidi?			
		➔		
M5	ARE **1** OR MORE **M4** ANSWERS CODED **YES**?	NO	YES	
M5	JE, KIPENGELE **KIMOJA** AU ZAIDI VYA **M4** VIMEJIBIWA **NDIYO?**			
		➔		
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)?	NO	YES	7
M6	Kwa wanawake tu: Katika miezi mitatu iliyopita, Je ulikosa siku zako zote za hedhi pale ambapo ulizitarajia kutokea (wakati hukuwa mjamzito)?			

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

N. 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?	➔ NO	YES	8
N1	Katika miezi mitatu iliyopita, je uliwahi kula kupita kiasi au wakati ambapo umekula chakula kingi sana ndani ya masaa mawili?			
N2	In the last three months, did you have eating binges as often as twice a week?	➔ NO	YES	9
N2	Katika miezi 3 iliyopita, je umewahi kula kupita kiasi kila mara, mara 2 kwa wiki?			
		➔		
N3	During these binges, did you feel that your eating was out of control?	NO	YES	10
N3	Katika milo hii, ulijisikia kwamba kula kwako ni kwa kushindwa kujitawala?			

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 ? ➔

NO YES 11

N4 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?

N5 Does your body weight or shape greatly influence how you feel about yourself? ➔

NO YES 12

N5 Je uzito wako au umbile lako linaathiri kwa kiasi kikubwa jinsi unavyojiona?

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 **YES**

BULIMIA NERVOSA

CURRENT

NO

IS **N7** CODED **YES**?

JE, **N7** IMEJIBIWA **NDIYO**?

YES

ANOREXIA NERVOSA

Binge-Eating/Purging Type

CURRENT

O. GENERALIZED ANXIETY DISORDER

O. 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?	➔ NO	YES	1
	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)...			
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?	➔ NO	YES	3
O2	Je unapata tabu kujizuia na woga, au je inavuruga uwezo wako wa kuwa makini kwa unachokifanya?			
O3	FROM O3a TO O3f, CODE NOTHE SYMPTOMS CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT			
O3	**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?	NO	YES	4
a	Ulijisikia kutotulia, kuamshwa, au mwenye kiherehere?			
b	Feel tense?	NO	YES	5
b	Ulijisikia kukakamaa?			

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

ARE **3** OR MORE **O3** ANSWERS CODED **YES**?

JE VIPENGELE **3** AU ZAIDI VYA **O3** VIMEJIBIWA **NDIYO**?

NO	**YES**
GENERALIZED DISORDER	***ANXIETY***
CURRENT	

Q. ANTISOCIAL PERSONALITY DISORDER (optional)
Q. 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?	NO	YES	1
	Ulikuwa ukitoroka shule mara kwa mara au kuondoka nyumbani usiku?			
b	Repeatedly lie, cheat, « con » others, or steal?	NO	YES	2
	Ulikuwa ukidanganya mara kwa mara, ukilaghai, kutapeli wengine, au kuiba?			
c	Start fights or bully, threaten, or intimidate others?	NO	YES	3
	Ulianzisha ugomvi au kudhulumu, kutishia au kutisha wengine?			
d	Deliberately destroy things or start fires?	NO	YES	4
	Kwa makusudi uliharibu vitu au kuwasha moto?			
e	Deliberately hurt animals or people?	NO	YES	5
	Kwa makusudi kuwadhuru wanyama au watu?			
f	Force someone to have sex with you?	NO	YES	6

Kumlazimisha mtu kufanya mapenzi na wewe?

➔

ARE **2** OR MORE **P1** ANSWERSCODED **YES**? NO YES

JE, VIPENGELE **2** AU ZAIDI VYA **P1** VIMEJIBIWA **NDIYO**?

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	