

Analysing Effectiveness of the Mental Health Integration Policy on Primary Health Care: A Case of Hhohho Region in Eswatini

Benele Kunene¹ & Chrispin Matuka²

¹*School of Humanities and Business, Information and Communications University, Lusaka, Zambia*

²*School of Humanities and Business, Information and Communications University, Lusaka, Zambia*

* Corresponding Author: Benele Kunene, Email: ben35kunene@gmail.com

APA Citation and Referencing: Kunene, B., & Matuka, C. (2026). Analyzing Effectiveness of the Mental Health Integration Policy on Primary Health Care: A Case of Hhohho Region in Eswatini. *JENER Journal of Empirical and Non-Empirical Research*, 2(1), 238-242

ARTICLE INFORMATION	ABSTRACT
<p>Article history: Published on 21st Jan 2026</p> <p>Keywords: Mental health integration Primary health care Community health Policy effectiveness Hhohho Region</p>	<p>Mental health disorders are a growing global concern due to their significant contribution to the overall disease burden. The World Health Organization estimates that 1 in 4 people will experience a mental health condition in their lifetime. Despite the high prevalence, mental health services remain under-prioritized in many low- and middle-income countries, where treatment gaps can exceed 75% due to limited resources and stigma. This study analyzed the effectiveness of the mental health integration policy within primary health care in the Hhohho Region, Eswatini. A mixed-methods cross-sectional design was utilized, incorporating quantitative data from 384 respondents (random sampling through questionnaires) and qualitative data from 20 purposively selected participants (in-depth interviews). Quantitative analysis was conducted using STATA version 14, while qualitative data were thematically analyzed. Policy awareness was moderate (54.2%), and respondents reported moderate agreement with integration strategies such as training of health workers, referral pathways, and community engagement. Improved awareness was the only strategy significantly associated with better community support. Qualitative findings highlighted the role of culturally accepted practices (e.g., storytelling, rituals, prayer) in improving trust and treatment adherence. Barriers included resource limitations, clinic resistance to traditional practices, and lack of formal policy inclusion for community health workers and traditional healers. Mental health integration in primary care demonstrated moderate effectiveness in the Hhohho region. Strengthening resources, inclusive engagement of community health workers, and integrating cultural practices into policy frameworks are recommended to enhance outcomes.</p>

1. Introduction

Globally, mental health disorders are becoming a major cause of concern due to the well-established association between health, mental health, and disease burden at the population level. According to the World Health Organization (WHO), 1 in 4 people across the globe will be affected by a mental health condition in their lifetime.

1.1 Mental Health in Low- and Middle-Income Countries

While the prevalence is high, mental health services remain a low priority in many low- and middle-income countries (LMICs), where treatment gaps can exceed 75% due to limited human resources, health infrastructure, and stigma.

1.2 The Case of Eswatini

Eswatini faces similar challenges, with centralized mental health services historically limiting access, especially in rural areas like Hhohho. The government introduced a Mental Health Integration Policy to decentralize services into primary health care (PHC), but implementation challenges persist.

2. Literature Review

The integration of mental health into PHC is advocated by the WHO as a sustainable and equitable approach. However, evidence from Eswatini and similar contexts highlights barriers such as workforce shortages, stigma, and poor community awareness.

2.1 *The Role of Community and Traditional Actors*

Community health workers (CHWs) and traditional healers play a vital bridging role but are often excluded from formal policy frameworks, limiting the potential of culturally appropriate care.

2.2 *Gaps in Policy Implementation*

Studies indicate a significant gap between policy aspirations and on-the-ground reality, particularly in under-resourced regions, affecting service equity and outcomes.

3. Methodology

A mixed-methods cross-sectional design was employed. The study population comprised PHC workers and adult community members in Hhohho Region.

3.1 *Quantitative Component*

A sample of 384 participants was determined using Cochran's formula. Data were collected via structured questionnaires and analyzed using STATA version 14.

3.2 *Qualitative Component*

Twenty key informants were purposively selected for in-depth interviews. Thematic analysis was conducted following Braun and Clarke's framework

3.3 *Ethical Considerations*

Ethical approval was obtained from the Eswatini Health and Human Research Review Board. Informed consent, confidentiality, and voluntary participation were ensured.

4. Findings

This section presents the results of the mixed-methods analysis on the effectiveness of mental health integration in primary health care within the Hhohho Region. Quantitative findings from 384 survey respondents are presented alongside qualitative insights from 20 key informants. The results are organized to address the study objectives, beginning with demographic characteristics, followed by perceptions of integration strategies, their effectiveness, relationships with community health outcomes, and limitations of the policy.

4.1 *Demographic Characteristics*

The sample was fairly balanced in gender (52.9% female). A wide range of ages, occupations, and education levels was represented. Policy awareness was 54.2%.

Table 1: Demographic characteristics

Variable	Category	Frequency	Percentage (%)
Gender	Female	203	52.86
	Male	181	47.14
Age Group	Below 25	79	20.57
	25–34	88	22.92
	35–44	65	16.93
	45–54	64	16.67
	55 and above	88	22.92
Occupation	Community health volunteer	77	20.05
	Community member	75	19.53
	Health worker	87	22.66
	Other	68	17.71
	Traditional healer	77	20.05
Education	No formal education	85	22.14
	Primary	88	22.92
	Secondary	61	15.89
	Tertiary	63	16.41
	Other	87	22.66
Aware Policy	Yes	208	54.17
	No	176	45.83

Source: Research Data, 2025

4.2 *Mental Health Integration Strategies*

Perceptions of integration strategies (trained health workers, referral pathways, improved awareness, community engagement, reduced stigma) were mixed, with responses spread across agreement and disagreement scales.

RESEARCH ARTICLE

Table 2: descriptive statistics

Variable	Category	Frequency	Percentage (%)
Trained Health Workers	Strongly Disagree	70	18.23
	Disagree	72	18.75
	Neutral	71	18.49
Referral Pathways	Agree	85	22.14
	Strongly Agree	86	22.40
	Strongly Disagree	73	19.01
	Disagree	78	20.31
	Neutral	77	20.05
Improved Awareness	Agree	83	21.61
	Strongly Agree	73	19.01
	Strongly Disagree	79	20.57
	Disagree	87	22.66
	Neutral	71	18.49
Community Engagement	Agree	82	21.35
	Strongly Agree	65	16.93
	Strongly Disagree	80	20.83
	Disagree	73	19.01
	Neutral	69	17.97
Reduced Stigma	Agree	84	21.88
	Strongly Agree	78	20.31
	Strongly Disagree	91	23.70
	Disagree	66	17.19
	Neutral	82	21.35
Services Frequency	Agree	73	19.01
	Strongly Agree	72	18.75
	Daily	72	18.75
	Weekly	76	19.79
	Monthly	76	19.79
	Rarely	85	22.14
	Never	75	19.53

Source: Research Data, 2025

4.3 Effectiveness of Strategies and Community Health

Mean scores for effectiveness were moderate, ranging from 2.91 to 3.12 across variables. Logistic regression revealed that only improved awareness had a statistically significant positive effect on community support (Coef = 0.185, p = 0.042).

Table 3: Descriptive

Variable	Obs	Mean	Std. Dev.	Min	Max
Accessible~s	384	2.971354	1.420371	1	5
Improved_A~s	384	2.914063	1.392036	1	5
Trained_He~s	384	3.117188	1.423164	1	5
Early_Iden~n	384	2.963542	1.385763	1	5
Reduced_St~a	384	2.919271	1.434831	1	5

Source: Research Data, 2025

4.4 Relationship Between Integration and Community Health Outcomes

The logistic regression model was not statistically significant overall (LR chi-square = 11.61, p = 0.2364). Improved awareness was the only significant predictor.

Table 4: Logistic regression

Iteration 0: log likelihood = -204.23901					
Iteration 1: log likelihood = -198.51294					
Iteration 2: log likelihood = -198.43576					
Iteration 3: log likelihood = -198.43574					
Iteration 4: log likelihood = -198.43574					
Logistic regression			Number of obs	=	384
Log likelihood = -198.43574			LR chi2(9)	=	11.61
			Prob > chi2	=	0.2364
			Pseudo R2	=	0.0284
CommSup_bin	Coef.	Std. Err.	z	P> z	[95% Conf. Interval]
Trained_Health_Workers	.1325663	.0898216	1.48	0.140	-.0434807 .3086134
Referral_Pathways	.0773994	.0905016	0.86	0.392	-.0999806 .2547794
Improved_Awareness	.1853913	.0910748	2.04	0.042	.0068879 .3638947
Community_Engagement	-.0235417	.0871114	-0.27	0.787	-.1942769 .1471936
Reduced_Stigma	.0186283	.0868348	0.21	0.830	-.1515648 .1888213
Gender_num	.2906221	.2502601	1.16	0.246	-.1998787 .781123
AgeGroup_num	-.0795713	.0856918	-0.93	0.353	-.2475241 .0883816
Education_num	-.0637586	.092017	-0.69	0.488	-.2441085 .1165913
Occupation_num	-.1075389	.0908547	-1.18	0.237	-.2856108 .070533
_cons	-2.14973	.8445556	-2.55	0.011	-3.805029 -.4944319

Source: Research Data, 2025

4.5 Limitations of the Policy

The majority of respondents reported no limitations across various factors, though significant minorities reported challenges related to culture, funding, medical resources, trained personnel, and monitoring.

Table 6: Descriptive

Variable	Category	Frequency	Percentage
lim_cultural	No	263	68.49
	Yes	121	31.51
lim_funding	No	232	60.42
	Yes	152	39.58
lim_med	No	250	65.10
	Yes	134	34.90
lim_trained	No	263	68.49
	Yes	121	31.51
lim_me	No	253	65.89
	Yes	131	34.11
lim_none	No	238	61.98
	Yes	146	38.02

Source: Research Data, 2025

5. Summary, Conclusion and Recommendations

This section synthesizes the key findings from the study, draws conclusions regarding the effectiveness of mental health integration in primary health care in Hhohho Region, and offers evidence-based recommendations for policy improvement and future practice. The discussion is structured to provide a concise summary of results, interpret their implications, and propose actionable steps for strengthening mental health service delivery and integration frameworks.

5.1 Summary

The study found moderate effectiveness of mental health integration in Hhohho. Awareness was the most significant factor linked to community support. CHWs and traditional healers played crucial bridging roles but faced exclusion and lack of recognition.

5.2 Conclusion

The mental health integration policy has led to some improvements, but substantial barriers remain. Enhanced resource allocation, inclusive policy frameworks, and stronger collaboration are needed to maximize impact.

5.2 Recommendations

- i. Include traditional healers and CHWs in policy development and training.
- ii. Develop integrated referral systems with feedback mechanisms.
- iii. Allocate dedicated funding and resources for mental health in PHC.
- iv. Implement robust monitoring and evaluation systems.
- v. Conduct ongoing community awareness campaigns tailored to cultural contexts.

References

- [1] Agyapong, V. I. O., et al. (2021). Collaborative mental health care in Nigeria: Strengthening the continuum of care through primary health care integration. *African Journal of Primary Health Care & Family Medicine*, 11(1), 1–8.
- [2] Bolton, P., Bass, J., & Verdelli, H. (2023). Community-based mental health care in low-resource settings: A collaborative approach. *Global Mental Health*, 10(1), 45–56.
- [3] Chibanda, D., et al. (2025). The friendship bench: Developing and scaling up a community-based psychological intervention in Zimbabwe. *World Psychiatry*, 24(2), 200–209.
- [4] Dlamini, N., & Mkhabela, T. (2018). Task-shifting mental health care in rural Eswatini: Experiences of nurses and lay workers. *African Journal of Psychiatry*, 21(3), 145–152.
- [5] Dlamini, T. (2017). *Mental health care services in Eswatini: Challenges and opportunities*. Mbabane: Ministry of Health.
- [6] Keynejad, R. C., et al. (2021). Mental health stigma in low- and middle-income countries: A systematic review. *The Lancet Psychiatry*, 8(12), 1057–1068.
- [7] Lund, C., et al. (2020). Social determinants of mental disorders and the Sustainable Development Goals: A systematic review of reviews. *The Lancet Psychiatry*, 7(4), 357–369.
- [8] Ministry of Health Eswatini. (2018). *National mental health integration policy*. Mbabane: Government of Eswatini.
- [9] Motsa, N., & Simelane, M. (2019). Strengthening mental health services in Eswatini: Current status and future priorities. *African Journal of Primary Health Care & Family Medicine*, 11(1), 1–6.
- [10] Patel, V., et al. (2018). The Lancet Commission on global mental health and sustainable development. *The Lancet*, 392(10157), 1553–1598.
- [11] Petersen, I., Fairall, L., & Bhana, A. (2020). Integrating mental health into primary health care in South Africa: Lessons from task-sharing models. *BMC Health Services Research*, 20(1), 1–12.
- [12] Rathod, S., et al. (2023). Task-sharing for depression treatment in Eswatini: Lessons from the Healthy Activity Program. *BMC Health Services Research*, 23(1), 4352.
- [13] UNICEF. (2022). *Primary health care investment case: Eswatini*. Mbabane: UNICEF.
- [14] World Health Organization. (2021). *Universal health coverage: Mental health*. Geneva: WHO.
- [15] World Health Organization. (2020). *Depression and other common mental disorders: Global health estimates*. Geneva: WHO.