MENTAL HEALTHCARE USERS' PERCEPTIONS OF MENTAL HEALTH SERVICES AT A PRIMARY HEALTHCARE LEVEL

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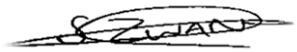
Abstract

This study interrogates the complexities of mental healthcare in primary healthcare settings, focusing on the experiences and perceptions of participants within the Makana municipality in the Eastern Cape Province, which is characterised by a low socio-economic status. The matter of mental healthcare is of great significance within the context of South Africa, a country grappling with multifaceted challenges. Over the years, mental health has progressed from being marginalised to being more widely acknowledged. While the integration into tertiary and urban healthcare settings has become smoother, primary healthcare has encountered numerous obstacles. This presents a concern, due to the socioeconomic difficulties faced by individuals accessing primary care, which predispose them to mental health issues. Consequently, it is imperative to conduct research focusing on the experiences and perspectives of mental healthcare users within primary healthcare, a relatively underexplored area. The primary objective of the current research study was to contribute to the existing knowledge base, providing valuable insights for relevant stakeholders and policymakers, such as the National Mental Health Policy Framework 2023-2030, to reference when formulating strategies to enhance the integration of mental healthcare into primary healthcare. The study used purposive sampling to interview mental healthcare users within the Makana municipality. Employing a qualitative design facilitated in-depth dialogue between the participants and the researcher, generating valuable data. Thematic Analysis was employed to analyse and present meaningful data, providing an overview of the participants' shared experiences. The study identified four significant themes: the utility of primary health clinic; the urgent need for mental health education; socioeconomics, and mental health, and the complex dynamics of help-seeking behaviours. The findings underscore the pressing need to integrate quality mental health into PHC,

emphasising the importance of mental health education, increased resources, task-sharing, and the prioritisation of both physical and mental illnesses.

DECLARATION

I confirm that this thesis is completely my own work, and I acknowledge any sources that are not my own. This thesis is being presented as part of the requirements, for obtaining a Master of Arts degree in Clinical Psychology at Rhodes University. It has not been submitted at any university before for any degree or assessment purposes.



14 October 2024

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Signed Date

Acknowledgments

I would first like to thank the almighty Jesus Christ for giving me the ability to endure the emotional and mental challenges that came with completing this research. It is stated in Your word that “Commit to the Lord whatever you do, and he will establish your plans” (Proverbs 16:3).

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I would like to thank my parents for their patience and belief in me. This thesis is dedicated to you two! It is my wish to make you both proud during all stages of my life. I love you both.

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List of Abbreviations

CAMH	Child and Adolescent Mental Health
CFIR	Consolidated Framework for Implementation Research
DOH	Department of Health
DSD	Department of Social Development
LMICs	Low-Middle Income Countries
MHCN	Mental Healthcare Nurses
MHCUs	Mental Healthcare Users
MHPF	Mental Health Policy Framework
NHI	National Health Insurance
PHC	Primary Healthcare
PRPHC	Public Rural Primary Healthcare
PSW	Peer Support Workers
PWMI	Person with a Mental Illness
SASH	South African Stress and Health Study
SSI	Semi-Structured Key-Informative Interviews
WHO	World Health Organisation

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CHAPTER ONE

INTRODUCTION

1.1 Chapter Overview

The main goal of this study was to investigate the viewpoints of individuals using health services within a semi-rural area in the Makana municipality. The research specifically looked at an underprivileged community in the Eastern Cape in the Makana municipality. This entailed exploring the perceptions of community members at PHCs on mental healthcare services. This chapter provides a concise overview of the study, addresses the research rationale, and provides the research question and the study's main objective.

1.2 Background of the research problem

There is limited research on how individuals access mental healthcare services in the Eastern Cape (Makana municipality). Given that the Eastern Cape is one of the most impoverished provinces in South Africa, there is significant pressure on the mental healthcare system to offer suitable services to its residents (Statistics et al., 2018). According to Kohrt et al. (2018), considering the difficulties faced by healthcare systems in low to middle-income countries (LMICs), it is crucial to identify ways to collaborate with communities and community-based service providers, for delivering appropriate mental healthcare in settings with limited resources. Hence, it is essential to interrogate the perspectives of individuals utilising these services to better understand the current status of primary healthcare and suggest a way forward, especially through community-based mental health initiatives.

According to Donnelly (2021), delivering services, care and support within communities and primary healthcare settings enhances access to mental healthcare. This

strategy can help identify undiagnosed individuals and narrow the treatment gap. While tertiary facilities are components of a mental healthcare system relying solely on them for most mental health services, such as prevention and promotion, is not practical nor sustainable. This highlights the significance of initiatives involving stakeholders, such as mental health professionals, policymakers, and community leaders, collaborating to implement such programmes effectively.

The World Health Organisation (WHO) defines health as a complete physical, mental and social well-being, rather than simply the absence of illness or infirmity. Nevertheless, many primary healthcare systems worldwide, primarily focus on care without addressing mental healthcare for their populations (WHO, 2008). There is increasing evidence indicating that factors, such as poverty, inequality, urbanisation, unemployment, trauma, violence and substance abuse, play a significant role in the development of illness. These issues contribute to a prevalence of health problems and disabilities in society (Lund et al., 2010). In a developing country such as South Africa, which is faced with numerous social issues impacting one’s mental well-being, prioritising mental healthcare alongside physical health is deemed crucial (de Villiers, 2021).

The right to quality healthcare is fundamental to all individuals' physical and mental well-being and a necessary condition for exercising other human rights, including the pursuit of an adequate standard of living (Mulaudzi, 2007). According to the 2017 General Household Survey, 71.2% of the population use public providers as their first choice of consultation when in ill health (Wolf et al., 2021), with primary healthcare (PHC) serving as the first point of entry into the health system. The quality of care in PHC facilities is a recurring topic that attracts public attention and scrutiny, following convincing evidence that the health system should be more responsive (Kelly et al., 2019). The Department of Health's

(DOH) mission is to create a caring and humane society where all South Africans can access affordable, good-quality mental healthcare (Health/ South African Government, 2014).

The PHC approach has been adopted as the most feasible means to achieve this mission (Health/ South African Government, 2014). Since 1994, the year of liberation from Apartheid rule, emphasis has been placed on building and developing primary care and reorienting hospitals as referral facilities for complex or severe cases that require secondary and tertiary-level care (Glover, 2014). According to the Mental Health Policy Framework (MHPF), the Mental Health Care Act of 2002 integrates scientific evidence and best practices, emphasising human rights and vulnerable populations (Stein, 2014).

Following the establishment of the mental health policy and legislation, provincial and local health planners have been challenged to manage the transformation from hospital-based to community-based care and to expand mental health prevention and promotion initiatives (Stein, 2014). Despite South Africa's progressive mental health legislation (i.e., MHCA), multiple barriers to the financing and development of mental health services exist. These barriers result in (i) psychiatric hospitals remaining outdated, falling into disrepair, and often unfit for human use; (ii) severe shortages of mental health professionals; (iii) an inability to develop crucial tertiary-level psychiatric services (such as child and adolescent services, psychogeriatric services, neuropsychiatric services, etc.); and (iv) community mental health and psychosocial rehabilitation services remaining undeveloped. As a result, patients end up institutionalised, without hope of rehabilitation back into their communities (Lund, 2016).

The National Mental Health Policy Framework has undergone significant transformation from its previous version (2003-2018) to the new iteration (2023-2030). The updated policy places a strong emphasis on comprehensive, high-quality, integrated mental

health promotion, prevention, care, treatment, and rehabilitation. This strategic shift not only refines the focus but also the approach, ensuring evidence-based strategies, continuity with updated action areas, and a commitment to prioritising cost-effective implementation through National Health Insurance (NHI). The framework also emphasises human rights, collaboration across sectors, and continuous monitoring to ensure accountability and measure progress. Overall, the new objectives aim to promote mental well-being, prevent mental health issues, provide accessible and equitable mental health services, and uphold a recovery-oriented approach for all mental health facilities.

1.3 Rationale for this Research

With the growing burden and need for mental health provision in community-based healthcare it was crucial to investigate the perspectives and experiences of individuals accessing health services at a community level. Based on the few studies on this topic, Faitema et al. (2021) highlighted the limited availability of mental healthcare in South Africa's PHC. Booysen and colleagues (2021) also emphasised this and further reported that factors, such as stigma commonly exacerbate the difficulties in accessing mental healthcare in underprivileged communities. Therefore, in response to this issue, this study probed the thoughts and experiences of individuals regarding their perceived utility and need for mental health provision in the Makana municipality.

1.4 Research Aim and Question

The existing literature shows a lack of research on this topic. Thus, the primary objective of this study was to explore perceptions regarding mental healthcare at the PHC level. This unique study aimed to enhance health services in underserved communities by gathering insights from individuals' utilising primary care facilities. The research sought to address the following question.

"How do individuals receiving healthcare at the primary care level perceive mental healthcare?".

1.5 Significance of the study

This research plays a role in meeting the needs of MHCUs accessing healthcare services at community level. The research will contribute to the understanding thereof, while also identifying avenues for development. Therefore, understanding patients' opinions on the quality of care in government institutions could empower policymakers to enhance service quality and boost service utilisation standards (Baltussen, 2002). By bridging the gap between health policy creators and enhanced service delivery as acknowledged by healthcare users, this study has the potential to pave the way for an improved landscape in mental health provision. In addition, it may stimulate research in other underserved communities, echoing the necessity for ongoing research to ensure consistent, high-quality care across all primary healthcare clinics.

1.6 Outline of the Research Dissertation

Chapter 1 begins by introducing the research topic and its significance while, chapter 2 explores the literature on the importance and necessity of health care at community level in the Makana municipality. Chapter 3 outlines the study design and methodology, including the use of Thematic Analysis to identify key study themes. Chapter 4 presents the study's findings and chapter 5 discusses these findings, along with the existing literature. Lastly, chapter 6 concludes the study by summarising the findings and their relevance to NMHPF 2023-2030, addressing any limitations of the study, proposing research recommendations, and giving the researchers reflective statements.

1.7 Chapter Summary

In summary, Chapter One acts as an introduction to the research project. It demonstrates why it is essential to investigate MHCUs perceptions of mental healthcare at a community-based level, such as the Makana municipality. Furthermore, it highlights the need for investigations within this specific context, due to limited prior research conducted in this area. The subsequent chapter will review the existing literature that supports the significance of this study.

CHAPTER TWO

Literature review

2.1 Chapter overview

This chapter seeks to consult the relevant literature about the research topic. The chapter defines mental health and mental illness. The chapter then discusses the topic globally, within low-middle income countries, and finally, within primary healthcare. The chapter then discusses and seeks to understand the policies regarding mental health in primary care. The perceptions and experiences of mental healthcare users are discussed briefly, as well as the barriers mental healthcare users encounter in community-based facilities. Lastly, the chapter gives an overview of the trajectory of mental health within the Eastern Cape and gives a rationale for the importance of the current study and its contribution to primary healthcare.

2.2 Literature Search Strategy

This literature review discussed both the historical and recent literature concerning mental healthcare in primary care. The literature was extracted from Google Scholar, PubMed Central, Springer Link, ACADEMIA, Science Direct, Research Gate, WILEY Online Library, South African Journal of Psychiatry, and News24.

The primary keywords used to find this literature were “mental healthcare,” “primary healthcare,” “barriers to help-seeking,” “mental healthcare users,” “community-based care,” and “users, experiences, and perceptions of primary healthcare.”

2.3 Defining Mental health

The World Health Organisation (WHO) defines mental health as “a state of well-being in which the individual realises their abilities, can cope with the everyday stressors of

life, can work productively and fruitfully, and can contribute to his or her community" (WHO, 2004).

According to WHO (2004), a highly functioning individual is someone who can access their mental capacities and respond appropriately, even when faced with a challenge. This ability to persevere without a lack of functionality is crucial for maintaining good mental health. Mental health is an integral part of the body system and is essential for a person's physical and social functioning. Without good mental health, a person may experience deficits that affect their quality of life in their relationships, work, and community (WHO, 2004).

2.4 Defining Mental illness

The designation 'mental illness' has evoked diverse reactions, often described as "madness," "insanity," or "lunacy" (Eghigian, 2017). Moncrieff (2014) asserts that social forces influence psychiatric concepts. Thus, it is imperative to contextualise the term "mental illness" within the framework of modern professionalism (Rensburg, 2021).

Mental illness significantly impacts an individual's cognitive processes, emotional state, behavioural patterns, and overall functioning. Conditions, such as schizophrenia, bipolar disorder, and other psychotic disorders are categorised as severe mental illnesses. These disorders can be further exacerbated by inadequate access to treatment and socio-economic factors, as highlighted by the National Alliance on Mental Illness (NAMI, 2015).

2.5 Mental Health Globally

"The prevailing situation stemming from the policy of apartheid presents an obstacle to achieving the highest level of health for all individuals" (WHO, 1975, p. 5). Mental health issues are a significant concern worldwide, but they have been largely ignored and marginalised. The lack of resources and the need for a paradigm shift in psychiatry have

made it challenging to address this issue (Saraceno, 2004). Global mental health involves improving mental health worldwide, while addressing disparities in access to mental health services (Wainberg et al., 2017). It is essential to shift power towards local actors to hold national authorities accountable and reap the benefits of Global Mental Health (Eaton, 2019). The field of global mental health has traditionally prioritised addressing treatment gaps in LMICs as a moral and ethical responsibility (PMC). The prevalence of mental health conditions underscores the importance of global efforts to raise awareness, reduce stigma, and increase support for mental health initiatives worldwide (Shisana, et al., 2024). The need for stepped-care approaches, as demonstrated in the Perinatal Mental Health Project in South Africa, emphasises the importance of tailored interventions for specific populations (Honikman et al., 2012). However, there are gaps in the global epidemiological data for mental disorders, as highlighted by Baxter et al. (2013). The insufficient availability of comprehensive data highlights the urgency to adopt measures to enhance data collection efforts. These efforts can help in comprehending the extent of mental health disorders across the world and their impact (Samartzis & Talias, 2020). Global mental health discussions have questioned the effectiveness of current approaches; therefore a new framework is needed to address these issues and improve outcomes (Kirmayer & Pedersen, 2014). This new approach advocates community-based practices and ongoing research to promote global equity and social justice in access to mental healthcare. The COVID-19 pandemic has highlighted the need to address global mental health, as evidenced by studies by Torales et al. (2020) and Jakovljevic et al. (2020). The pandemic has had a significant impact on mental health worldwide, particularly in LMICs, where resources for mental health have historically been limited (Kola et al., 2021).

The field of global mental health is constantly evolving, and with a growing recognition of the need to address mental health challenges on a global scale. To improve

mental health outcomes worldwide, it is crucial to strengthen data collection efforts, implement tailored interventions, and promote equity in access to mental healthcare. By taking these steps, progress is possible in the fight against mental health issues.

2.6 Mental Health in Low- and Middle-Income Countries

A study conducted by Mendenhall and colleagues (2014) identified persisting inconsistencies in the effective implementation of mental health policies. The study revealed that 75% of the global mental health burden is concentrated in LMICs, where a significant deficit in mental health services exists. The shortage of resources in these settings is a cause for concern; therefore, to tackle this issue, the exploration of task-sharing approaches is underway. This study's primary objective was to assess the viability of task-sharing for mental health care in LMICs.

The study sample was extracted from consultations with primary care service providers, community members, and service users in Ethiopia, India, Nepal, South Africa, and Uganda; all countries involved in the Programme for Improving Mental Health Care (PRIME). Moreover, 36 focus group discussions and 164 in-depth interviews were conducted at the pre-implementation stage (Mendenhall et al., 2014).

Task-sharing mental health services in LMICs can be successfully implemented under specific conditions, including enhanced human resources, improved medication access, ongoing supportive supervision, and adequate training and compensation for healthcare professionals. The study by Mendenhall et al. (2014), supports these findings.

With regard to Mendenhall et al. (2014), provision of mental health services through task-sharing is feasible. However, Petersen and colleagues (2017) emphasise that inadequate governance in LMICs has posed a significant barrier to integrating mental healthcare systems. Governance plays a pivotal role in developing and enforcing policies and legislation

aimed at promoting, directing, and safeguarding the mental health of the populace (Petersen et al., 2017). His study's main objective was to help governance pinpoint facilitators who could aid in the appropriate integration of mental health into PHC settings in LMICs (Petersen et al., 2017).

Data were gathered by conducting qualitative interviews with 141 important participants in emerging systems research programmes in Ethiopia, India, Nepal, Nigeria, Uganda, and South Africa. The data were then transcribed and translated into English, where needed, and analysed using thematic framework analysis. This analysis was conducted nationally and across the countries involved (Petersen et al., 2017).

The study found that all five countries had good national mental health policies but executing them was challenging. Strengthening managers' capacity, improving critical aspects of the health system, and developing mechanisms for collaboration, engagement, and innovative approaches to reducing stigma, were identified as crucial. The biggest challenge was inadequate financing. Strategies were recommended for improving governance in integrated mental healthcare in LMICs (Petersen et al., 2017).

It is important to note that the studies of Mendenhall et al. (2014) and Petersen et al. (2017) were undertaken to examine the problems associated with integrating mental health services into PHC in LMICs. The studies produced similar results, highlighting the difficulties with implementation. It is worth noting that the studies were conducted a year apart, indicating that little or no progress had been made in implementing mental healthcare services during that time.

Similarly, the study by Esponda and colleagues (2020) further reinforced the findings of the studies conducted by Mendenhall et al. (2014) and Petersen et al. (2017). Esponda et al. (2020) conducted a systematic review to explore the barriers and facilitators to

implementing mental health programs in PHC settings, within LMICs. These authors concurred that integrating mental health services into PHC is crucial for improving access to care in LMICs, thus solidifying the consensus among these studies (Esponda et al., 2020). Their study aimed to improve our understanding of how to effectively integrate mental health services into PHC, especially for individuals with common mental disorders (Esponda et al., 2020).

The study found two groups of challenges – (1) implementation challenges and (2) determinants. Integration challenges included a lack of mental health services, the availability of services at the primary level, human resource shortages, and historical factors, such as stigma related to mental illness. Implementation determinants were related to coordination among stakeholders, level of preparedness of the organisation, knowledge, beliefs, and attitudes of healthcare providers, addressing complex needs of individuals seeking mental health care, perceived advantages and adaptability of interventions, and effective planning and evaluation during implementation (Esponda et al., 2020).

Unlike Mendenhall et al. (2014) and Petersen et al. (2015), the Esponda et al. (2020) study was helpful, in that it sought to look not only at challenges but also at factors that require attention to improve implementation of service delivery. Understanding and addressing implementation challenges can improve mental health programmes in primary care (Esponda et al., 2020). However, the similarity within the studies is found in their recommendations, which suggest an ongoing emphasis on integrating mental healthcare into PHC.

The literature reviewed indicates that mental healthcare services must be strengthened at the primary care level. Barriers to access must be addressed, service users must be involved in policy-making decisions, and innovative strategies must be used to improve care

coordination and service delivery. The studies also highlight a continuing concern of a lack of prioritisation of mental health integration into PHC settings in LMICs, which is a cause of concern. Therefore, according to Mendenhall et al. (2014), Petersen et al. (2017), and Esponda et al. (2020), improving access to care for individuals with mental health conditions requires ongoing efforts.

2.7 Policy Implementation towards Mental Healthcare Systems

Owing to the previously established issues around the implementation of PHC in LMICs, the development of mental health policies has become an area of interest. Omar et al. (2010) conducted a comparative study of mental health policy processes in Ghana, South Africa, Uganda, and Zambia as part of the Mental Health and Poverty Project. They argued that even though mental illnesses are recognised worldwide as a leading cause of disability, many countries lack a functional mental health policy or implementation. Therefore, their study focused on policy development and practical implementation in these four countries (Omar et al., 2010).

Researchers used purposive sampling to select participants from different mental health policy levels. Data were collected through interviews and document analysis to understand factors affecting mental health policy development. A conceptual framework was developed to guide data analysis. Researchers used a framework approach to analyse data, including themes that emerged from the data and framework (Omar et al., 2010).

The study results revealed that mental health policies were poorly developed or non-existent in the four countries. In addition, there was a lack of awareness and negative perception surrounding mental health, which was further amplified by a lack of prioritisation by donors and policymakers (Omar et al., 2010).

On the other hand, Marais and Petersen (2015) took a more focused look at South Africa's new policy framework and its vision towards supporting the integration of mental health care into PHC. They argued that it was insufficient to ensure the transformation of the healthcare system towards integrated primary mental healthcare. Consequently, Marais and Petersen's (2015) main goal was to identify systemic factors within institutional and policy contexts likely to aid or hinder the implementation of integrated mental healthcare in South Africa.

The research was carried out by conducting semi-structured qualitative interviews with 17 essential individuals who work in the DOH and Department of Social Development (DSD) at the national, provincial, and district levels in the Dr Kenneth Kaunda district. The participants were selected purposefully, based on their positions and job responsibilities (Marais & Petersen, 2015).

The study results found that mental healthcare has improved due to several factors, such as implementing the MHPF, which has a national action plan promoting integrated care through a task-sharing model. The policy emphasises establishing district mental health teams and implementing the integrated chronic disease service delivery platform. Lastly, NGOs' involvement in service delivery has been beneficial (Marais & Petersen, 2015).

Challenges in providing mental healthcare include the low prioritisation and stigmatisation of mental illness; weak managerial and planning capacities; poor pre-service training; weak orientation to integrated care; high staff turnover; weak intersectoral coordination; infrastructural constraints, and no dedicated mental health budget (Marais & Petersen, 2015).

Marais and Petersen's (2015) argument is evidenced by a study by Mokitimi et al. (2018), who echoed that mental health problems represent the greatest global burden of the disease among children and adolescents in South Africa. LMICs lack policy development for

child and adolescent mental health (CAMH). South Africa, an upper-middle-income country, may not be advanced in CAMH policymaking (Mokitimi et al., 2018).

In 2003, a national CAMH policy framework was created to guide provinces in establishing their policies; it is unclear if they did. The study aimed to investigate the development of CAMH policy (Mokitimi et al., 2018).

The study methodology involved a comprehensive search to identify all provincial mental health and comprehensive general health policies across South African provinces. The Walt and Gilson policy triangle framework (1994) was used for analysis (Mokitimi et al., 2018).

With regard to the study's findings, no South African province had a CAMH policy or implementation plan to support the policy. Provincial health policies only partially addressed CAMH issues and were focused on tackling HIV/AIDS problems. Moreover, CAMH professionals or users were not involved in the policy development (Mokitimi et al., 2018).

The results reinforce the neglect of CAMH even at the policy level, despite the burden of CAMH disorders in South Africa. There is an urgent need to develop and implement CAMH policies in South Africa and other LMICs. Further research will be required to identify and explore the barriers to policy development and implementation, as well as to service development and scale-up in CAMH (Mokitimi et al., 2018).

It should be noted that all three studies at different times emphasise the importance of implementing mental health policies. In the conclusion section (Omar et al., 2010 and Marais & Petersen, 2015) recommend strengthening mental health policy processes in South Africa and other African countries and good governance to implement relevant policy imperatives. However, five years later (Marais & Petersen, 2015), in their results section, admitted that although some changes had begun through the development of a national mental health

policy; it was clear, that not much shift had taken place in the integration of the policies which were emphasised in the last five years.

Moreover (Mokitimi et al., 2018) further provide evidence of a lack of policy optimisation through CAMH in South Africa. The difference in this study is seen in the conclusion, where further research is suggested to identify and explore the barriers to policy development, implementation, service development and scale-up in CAMH (Mokitimi et al., 2018). On the other hand, unlike Omar et al. (2010) and Marais and Petersen (2015), a limitation of this study is the choice of data collection through a comprehensive search. In contrast, the previous studies were qualitative and collected data through semi-structured interviews. Therefore, the study could be subjective in nature.

2.8 Mental Health in Primary Healthcare Settings

Integrating mental health into PHC in South Africa offers significant benefits. It provides early access to mental healthcare without disruption, leading to better health outcomes, full recovery, and maintained social integration (Funk et al., 2008).

Petersen (2000) suggests expanding mental health care to include non-psychiatric issues and promotion. Nurses lack comprehensive training and follow doctors' instructions, ignoring other factors contributing to an illness. As Parker et al. (1995) emphasised, reorienting nurses and integrating them into primary care is crucial for transforming the healthcare system.

The study was conducted in rural Kwa-Zulu Natal and focused on PHC nurses who form the backbone of the PHC system in South Africa. Ethnographic research methods were used to understand the nature of the care provided by PHC nurses and how it was sustained by the context within which it was provided (Petersen, 2000). The study revealed that nurses'

approach to patients was biomedical, and when psychological or emotional matters arose, nurses tended to dismiss such issues (Petersen, 2000).

Similarly, Kigozi-Male et al. (2023) conducted a study to uncover nurses' knowledge and attitudes toward patients and mental health care. They argued that successful integration and quality mental healthcare services at primary levels depend highly on mental healthcare providers (Kigozi-Male et al., 2023).

The study involved selecting a sample of 205 PHC nurses from 47 clinics. The selection was based on self-administered questionnaires. With reference to the knowledge of the nurses, they scored 23 out of 30. However, they seemed to have less knowledge about the recovery, employment, and help-seeking behaviours of individuals with mental illnesses. The study also revealed that the nurses had stigmatising attitudes towards mental illness. Their scores indicated a tendency to hold negative attitudes towards mentally ill persons and mental health. (Kigozi-Male et al., 2023).

Two studies (Petersen 2000 and Kigozi-Male et al., 2023) revealed negative connotations towards mental illness by nurses who have direct implications for MHCUs. Noteworthy is the study by Kigozi-Male et al. (2023) which was conducted on a large scale across 47 clinics, suggesting good generalisability of its results.

The limitations of this method arise from the fact that the data are collected through self-administered questionnaires. This can be problematic as participants may lack guidance and misunderstand some information, leading to poor responses. Similarly, the ethnographic data collection method by Petersen et al. (2000) is also problematic. According to Malinowski (cited in Hammersley & Atkinson, 1983), an investigator using the ethnographic approach is more interested in discovery than verification. The investigator usually begins the investigation with some ideas or "foreshadowed problems."

De Kock and Pillay (2017) discuss the persistent issue of delivering essential mental health services in South Africa in their study. Most of its prescribing mental health specialists practice in private and urban areas (De Kock & Pillay, 2017).

The paper presents a situation analysis audit of the number of psychiatrists in the public rural primary healthcare (PRPHC) sector. This audit was based on both primary and secondary data. The data collection method was undertaken through key informant interviews with the clinical heads of 160 PRPHC provisions, while the secondary data were obtained through a literature review (De Kock & Pillay, 2017).

The results indicate that psychiatrists are severely underrepresented, employed at a rate of 0.03 per 100,000 population in SA's PRPHC settings (De Kock & Pillay, 2017). Because of a lack of mental health nurses and medical officers dedicated to mental health in PRPHC facilities, recommendations are made that the current task-shifting strategy be revisited to include more mental health professionals with specialised psychopharmacological training such as non-medical prescribers at the PRPHC level. It is advised that visiting psychiatrists and family physicians be involved in constructing training and supervision programmes for nonmedical prescribers at the PHC level (De Kock & Pillay, 2017).

As previously reported, each study presented evidence of low-resourced mental health care in primary care. Therefore, to ease the burden, Selohilwe et al. (2023) argued that lay counselling in PHC could close this gap. Thus, the study's main goal was to understand all factors contributing to the success or failure of such a service for people with depression in PHC (Selohilwe et al., 2023).

Semi-structured key informant interviews (SSI) were conducted with a purposive sample of PHC providers, lay-counsellor supervisors, district and provincial managers, and patients receiving services. A total of 86 interviews were conducted. The Consolidated

Framework for Implementation Research (CFIR) was used to guide the data collection and Framework Analysis, to determine barriers and facilitators for implementing and disseminating the lay-counselling service (Selohilwe et al., 2023).

According to Selohilwe et al. (2023), the factors that could be helpful were supervisors and support for counsellors. Subsequently, the challenges identified were a lack of support for the counsellors who lacked counselling space and treatment modalities, insufficient counsellors, and a lack of inclusion of counselling as part of the patient's treatment plan (Selohilwe et al., 2023).

According to Seholiwe et al. (2023), some recommendations were made to improve the integration of lay counselling services. These included ensuring facility organisations were ready for such improvements, formally recognising the counselling services provided by lay counsellors. This included lay counselling as a treatment modality within mental health treatment data element definitions. It was also emphasised that psychologists should play a more diversified role, which included training and the supervision of lay counsellors (Selohilwe et al., 2023).

Overall, these studies emphasised the need for integrated mental health services in primary care settings in South Africa to address the treatment lacuna for mental disorders, as well as improving access to care for the population. They highlighted the need for mental healthcare education amongst nurses to improve nurse intervention with mentally ill persons and eliminate stigmatisation by staff members (Petersen, 2000; Kigozi-Male et al., 2023). Moreover, evidence of low resources in health professionals is highlighted (De Kock & Pillay, 2017). Finally, they present evidence of the usefulness of task-sharing, as argued by Selohilwe et al. (2013).

2.9 Experiences and perceptions of mental healthcare users

Kohrt et al. (2018) reported that given the challenges in mental health care in LMICs, it is vital to determine how to effectively work in communities and with community-based service providers for mental healthcare delivery in low-resource settings. Thus, the views of MHCUs should be explored to gain insight into the state of mental healthcare in the Makana municipality and contextualise the way forward. It should be noted, however, that there is a considerable gap in the literature on service users' experiences and perceptions of the use of mental health services in PHC, especially in South Africa.

Booysen et al. (2021) were some of the few who conducted a study that interrogated the perceptions and experiences of MHCUs in PHC. The study took place in a low-resourced region in the Eastern Cape. The researchers aimed to explore the participants' experiences and perceptions of having a mental disorder and seeking treatment from their local clinics. The data collection method was semi-structured interviews with 8 participants (Booysen et al., 2021).

The study's results indicated that participants were blamed for not functioning optimally within their communities, due to a lack of education, stigma, and efficiency in service delivery by healthcare providers. The study also revealed experiences of feeling socially withdrawn, which is maintained by a lack of knowledge, discrimination, and labelling by their community members (Booysen et al., 2021).

Comparably, a study by Baker and Naidu (2021) took an interest in providing services, as an interference in providing good services. The study interviewed 15 participants who identified problems, such as the lack of infrastructure and resources, shortage of staff members, long waiting periods, and a shortage of medication.

Both studies reveal major challenges to the PHC system, which can have major implications for patients' treatment and improved well-being. Moreover, a positive factor in

both studies is their relatively small sample sizes, which could make the data less complicated to work with and thus yield reliable results. Furthermore, both studies are qualitative, which helped gain in-depth feedback on participants' experiences.

While both Booysen (2021) and Baker and Naidu (2021) report that one of their limitations is the languages used during interviews and contextual considerations, which tend to limit generalisability, it is evident that issues in PHC may be a shared experience across MHCUs from different communities.

Another significant limitation of the Baker and Naidu (2021) study was the choice of sample, which is from an urban community as opposed to the Booysen et al. (2021) study, where the users were predominantly from rural Eastern Cape, which meets the interest of this current study. However, this gives a fascinating insight into the shared experiences of people with a mental disorder endure, regardless of the environmental context. Thus, in conclusion, both studies in their recommendations highlight the importance of education and training through, for instance, mass media campaigns and other interventions.

Similarly, Trevillion et al. (2022) examined service users' perceptions of community mental health services for people with complex emotional needs. The study sample consisted of 30 participants who had received a 'personality disorder' diagnosis at some point in their lives. The researchers were interested in their experiences and perceptions of community-based mental health services, for their emotional-related needs.

The participants were encouraged to discuss their perceptions of the services at community-based levels and how these could be improved to meet their needs better. Participants reported some experiences of good practice but also severely stigmatising interventions, a lack of adequate support, and service fragmentation (Trevillion et al., 2022).

Trevillion et al. (2022) argued that the overarching central theme, called “Relational Practice,” could help describe how community services can better help service users with complex emotional needs. This approach involves care, delivered in a non-stigmatising, individualised, and compassionate way, with trauma-informed care. It involves care planned collaboratively with service users to ensure their multiple needs are addressed flexibly, holistically, and consistently, accounting for their fluctuating and long-term needs (Trevillion et al., 2022).

One can argue that the study by Trevillion et al. (2022) is not beneficial to this current study because it was conducted in England, which holds significant economic and social differences, as opposed to South Africa. However, the study is conducted in community-based care, highlighting an approach that ceases to address the issue of community-based services and adequate care provided to its users; an approach that can also be adopted into LMICs, such as South Africa.

The study's limitation was its use of a sample of people diagnosed with a personality disorder. It is vital to use sensitivity and caution when working with people with personality disorders, as they can tend to exaggerate, minimise, or distort their experiences.

One similarity between Booysen et al. (2021), Baker and Naidu, (2015) and Trevillion et al. (2022) is the theme of stigma amongst MHCUs. It highlights the reality that stigma is present globally in both high- and low-income countries, further emphasising the need for education and knowledge on mental health, as suggested by Booysen et al. (2021) and Baker and Naidu, (2015) in their concluding statements.

2.10 Barriers to mental healthcare for users at a Primary Healthcare level

Various obstacles to accessing mental health services have been recognised, contributing to human rights violations (Seedat et al., 2009, p. 346; Andersson et al., 2013; Drew et al., 2011, p. 1664).

Patel et al. (2008) note the limited research on barriers affecting access to and use of mental health services. These barriers may result in individuals with mental illness in LMICs, such as in South Africa, not receiving essential treatment (Andersson et al., 2013; WHO, 2011). A deeper insight into the barriers preventing care for individuals with mental illness could aid in enhancing access to such services. In addition, Ahad et al. (2023) emphasises the impact of internal and external obstacles to seeking mental healthcare. The association of negative perceptions, such as shame and stigma of having a mental illness might deter individuals from seeking care. Personal, negative beliefs about mental illness could also influence one's attitude toward seeking care. Furthermore, concerns about judgement and ridicule from family and friends may contribute to the fear of seeking help (Ahad et., 2023).

A study by Strumpher et al. (2016) aimed to understand the perceptions of professional nurses in the Eastern Cape on the barriers to mental healthcare. Nurses were interviewed to understand the societal and healthcare system barriers that mentally ill people face. The primary societal barriers were a lack of knowledge, socioeconomic status, and stigma. The primary barriers to adequate services from the healthcare system were a lack of support from stakeholders and leaders in the mental health sector and financial, human, and infrastructure resources (Strumpher et al., 2016).

The health professionals' recommendations included better community knowledge production about mental health and more robust support from stakeholders to improve the quality and accessibility of mental healthcare (Strumpher et al., 2016).

While the current study is interested in the users' perceptions, rather than the providers of mental healthcare services, it is worthwhile to get an idea of the healthcare professionals' views. Nurses have regular contact with patients thus, their perspective could reveal what is happening in mental healthcare system.

The study's limitations (Strumpher et al., 2016) were quite significant, considering the level of interest on which this study is focused. First, the study did not include a sample of nurses working in PHC. Second, the study did not consider any patients or their caregivers' perspectives. Their experiences could yield valuable insights into the barriers to accessing and utilising mental health services in the Eastern Cape Province. On the other hand, the study was valuable because it was conducted within the Eastern Cape.

A study by Bruwer et al. (2011) focused on the barriers to mental health care and predictors of treatment dropouts among South African adults. Face-to-face interviews were conducted with more than 4000 individuals who met the criteria for a diagnosis in the previous 12 months. The study's main aim was to assess the severity of a disorder, barriers to treatment, and service use (Bruwer et al., 2011).

Results showed that low perceived need was the main reason for not seeking treatment. Moreover, attitudinal barriers influenced those who recognised the need. The lack of treatment-seeking was mainly attitudinal. Furthermore, substance abuse and no health insurance influenced dropouts. (Bruwer et al., 2011).

The study suggested educating the public, creating affordable healthcare, providing accessible substance abuse rehabilitation services, and increasing awareness among healthcare professionals to improve mental health advocacy and care in South Africa (Bruwer et al., 2011).

The study highlighted the link between low socioeconomic status, lack of education, and the resultant health consequences. A caution regarding this study, however, is the large sample size. While it can be beneficial in allowing the generalisability of its findings, it can also yield extensive data that could be difficult to manage accurately, thus amplifying the detection of differences while emphasising the statistical differences that are not clinically relevant (Altman, 1991).

Similarly, Alemu (2023) and colleagues took an interest in a systematic study on internalised stigma among people with mental illness in Africa. He explained that 'internalised stigma' is a form of accepting a negative but socially accepted connotation to one's mental illness.

The study revealed a high prevalence of internalised stigmas among people with a mental illness. Moreover, people with co-morbid factors, such as unemployment or previous suicidal behaviours, tend to have a higher chance of internalised stigma (Alemu et al., 2023).

Future research should use a sample, focusing on a specific diagnosis, and quantitative and qualitative studies to address stigmas and mental illness (Alemu et al., 2023).

This study provides valuable advice and recommends that future studies concentrate on one specific diagnosis. More in-depth ideas could be provided about how populations experience different diagnoses and whether there are any differences in attitudes towards people with those mental illnesses, based on severity. This could, in turn, shape a way of educating people on the differences in mental disorders, based on these findings.

Oegba et al. (2014), on the other hand, described a phenomenon called 'Psychiatric stigma,' which encompasses both the internalised and externalised stigma. The stigma surrounding mental health can exacerbate social anxiety and impact self-esteem, leading to adverse effects on employment, relationships, and access to care (Oegba et al., 2014).

The study aimed to explore the experiences of users with a psychiatric stigma to create interventions targeted at reducing stigmas in South Africa. The study sample included 77 adults over 18, including professional nurses, auxiliary workers, counsellors, social workers, and service users. The study method included individual qualitative interviews and focus group discussions. The study site was in the North-West province in the Dr Kenneth Kaunda District, an urban location with about only 10% rural population. The results of the study reported on four key themes.

The study found that service users experienced internalised stigmas and discrimination. They were afraid of others knowing about their condition and reported being excluded and abused by family, friends, community members, and health professionals (Oegba et al. 2014). The second theme was that a psychiatric stigma is caused by misconceptions about mentally ill individuals, such as the belief that some may be faking their illnesses, or when someone experiencing hallucinations may be dismissed as faking it (Egbe et al., 2014).

The study's third theme was the impact of stigmas on MHCUs. Adverse treatment by healthcare workers led to a decline in help-seeking, affected users' ability to live normal lives, and worsened their health. Furthermore, those who did not adhere to treatment were reluctant to return to clinics (Egbe et al., 2014).

For the fourth theme, users suggested raising awareness about mental illnesses through advocacy and education (Egbe et al., 2014).

The study revealed that internalised and externalised stigmas are at the core of health users' attitudes toward help-seeking. It negatively affects their health and the chances of recovery. Health workers also perpetuate this behaviour; thus, anti-psychiatric stigma interventions are mandatory in community health clinics, as a shift towards quality health

care at low-resourced clinics. On the positive side however, the results demonstrate that MHCUs can contribute with ways to improve mental health provision through promotion.

A study by De Wet and Pretorius (2020) acknowledged the existence of barriers to mental healthcare. Therefore, their study focused on uncovering the prominent barriers amongst users as a facilitator toward recovery. Despite recovery being mandated in the MHFP 2013-2020, significant shortfalls remain, due to limited financial resources (South African Department of Health, 2013). The study collected data through individual interviews and focus groups with MHCUs, caregivers, and providers.

Despite the presence of potentially debilitating barriers, participants also discussed many facilitators. The most common facilitators were the support of family or friends, helpful Service Providers, and empowerment (De Wet & Pretorius, 2022).

Unlike previous studies, De Wet and Pretorius (2022) were valuable, in that they reported some of the positives that the users, health workers, and caregivers noted as helpful in the recovery process. Moreover, since support was the underlying theme within barriers and recovery, the study highlighted a solution and recommendation regarding peer support workers (PSWs).

PSWs can support service users, Service Providers, and mental health services. They can relieve the burden of care and address the stigma of mental health in communities, while generating an income for themselves (De Wet & Pretorius, 2022).

Stigmas can hinder access to health, education, employment, housing, and other basic needs (MHPF, 2023). Fortunately, the MHPF 2023-2030 policy sees the gap and aims to address issues of stigma of MHCUs through addressing stigma related to mental illness. This policy, along with additional interventions, such as educating and training professional staff

members on anti-stigma, holds the potential for significant, positive change in mental health provision.

2.11 The current state of the mental health system in the Eastern Cape

The poor economy of the Eastern Cape is rooted in the legacies of the Apartheid era, where the province inherited the largely impoverished and corrupt former Ciskei and Transkei homelands (Westaway, 2012). The Eastern Cape economy is further affected by the current poor governance. With the Eastern Cape being one of the leading impoverished provinces, there is a considerable burden on the mental healthcare system to provide appropriate services for its population (Statistics et al., 2018). Alan et al. (2023) suggest that in South Africa, substance use, the rate of crime, and HIV/AIDS exposure have created a vulnerability to ill mental health. This is the case in the Eastern Cape, a low-resourced province that carries a mental healthcare service burden, due to its poor socio-economic status, lack of early detection of mental disorders, and limited access to mental healthcare in low-resource communities (Lund, 2012).

In 2017, the Eastern Cape exhibited the highest prevalence of mental illnesses in South Africa, despite demonstrating lower rates of general illnesses. The region faced significant challenges due to a lack of community-based mental health facilities and integration into Primary Health Care (PHC) services, combined with prevalent stigmas and discrimination. Moreover, rural areas lacked licensed mental health facilities, leading to inadequate service provision for the rural population. Consequently, a recommendation was put forth to allocate staffing for the provincial mental health directorate and finalise a strategic plan to enhance access to mental healthcare in rural areas (Mehlwana & October, 2021).

In 2018, the Health Ombudsman investigated an incident at Tower Hospital in Fort Beaufort, which exposed substantial deficiencies in mental healthcare provision. While the investigation did not uncover deliberate human rights violations, it revealed negligent practices within the department, resulting in substandard care. The recommendation at the time entailed appointing a mental health administrator and addressing the shortages in human resources (Mehlwana & October, 2021).

By 2021, mental health institutions in the Eastern Cape were severely understaffed, exacerbating the impact of the COVID-19 pandemic on mental health services. Despite commendable plans, evidence of their implementation remained scarce (Mehlwana & October, 2021).

In light of the significant mental healthcare challenges prevalent in the Eastern Cape, particularly in rural areas, such as the Makana municipality, there is a pressing need to explore the perceptions of MHCUs regarding the value and necessity of mental healthcare at PHC level. This need is underscored by the dearth of research in this domain in previous years and the historically inadequate state of the region's health system. This paucity of information was evident during the current study, where sourcing literature on the perceptions and experiences of MHCUs proved problematic, with an estimated five or six studies conducted in South Africa and only one study by Booysen and colleagues (2021), explicitly focusing on the Eastern Cape. The existing literature predominantly centres on the perceptions of healthcare professionals and caregivers. Consequently, there exists a clear gap in understanding patients' perspectives on mental healthcare in underserved communities.

2.12 Chapter Summary

This literature review chapter examined the global and local state of mental health, particularly in PHC, and identified various policy implementation obstacles in mental

healthcare in LMICs. The chapter also explored the barriers MHCUs face from the perspectives of both the users and providers of care. It notably emphasised the limited literature in South Africa, regarding MHCUs' perceptions and experiences of services in primary care, stressing the need for more information from MHCUs to improve mental health in PHC. The chapter concluded that PHC must be improved to prioritise and adequately care for the population in these contexts, aligning with human rights. Chapter three will elaborate on the study design and methodology.

CHAPTER THREE

Research Design and Methodology

3.1 Chapter overview

This chapter will discuss the details and overview of the study's research design and methodology employed by the researcher. This includes the thematic analysis used to guide and use the data collected in this study to yield pertinent information. The rationale for using a qualitative study design to answer the research question, will be explained. Information on how the researcher collected data, analysed the data, chose the sample and sampling techniques, and the trustworthiness and ethical considerations of the study, will be explained.

3.2 Qualitative Research Design

As mentioned in chapter 1, the study aimed to explore the experiences and perceptions of patients from the Makana municipality seeking and accessing services at primary health clinics. The aim was to improve mental health provision in low-resourced communities by gaining relevant information from its users. The study sought to answer the following question: "How do individuals receiving healthcare at the primary care level perceive mental healthcare?".

To best answer this research question, a qualitative research method was deemed most appropriate for collecting data from MHCUs in the Makana municipality. According to Denzin and Lincoln (2011), qualitative research draws from interpretivism and constructivist paradigms, seeking to understand a research subject, rather than predict outcomes deeply. Interpretivism aims to develop knowledge by understanding unique perspectives and their meanings. On the other hand, constructivism views knowledge as constructed by individuals seeking to make sense of their experiences (Creswell & Poth, 2018). Qualitative research is subjective, and values lived experiences, but it is also sensitive to the biases of both participants and researchers (Tomaszewski et al., 2020). The advantage of using a qualitative

approach is that it provides descriptive information, rather than statistical or numerical data (Nieuwenhuis, 2020). According to Lincoln and Guba (1985), when conducted thoughtfully, qualitative research provides valuable insights into people's lives and answers crucial questions. Therefore, the qualitative data method allowed the researcher to gain in-depth information on participants' lived experiences as mental healthcare users. Walsh (2023) concurs that it is a subjective way of looking at life as it is lived, attempting to explain the studied behaviour. For instance, this method was helpful because the researcher could tailor semi-structured questions to obtain pertinent data; this would not be possible with a quantitative data method.

The qualitative approach focuses on documents and aims to interpret the "meaning-making" process. (Patton, 2015, p. 48). This process of constructing meaning occurs within a socially constructed reality (Denzin & Lincoln, 2005). In essence, qualitative research seeks to comprehend how individuals interpret their experiences, what significance they attribute to them, and how their social contexts shape their worldviews (Merriam, 2009; Creswell, 2014). Hence, this approach allowed for no predetermined objective. Nevertheless, it allowed participants to communicate their experiences and perceptions; thus, the study's findings were based solely on the collected data (Creswell, 2014).

The most used qualitative data collection methods in health research include document studies, observations, semi-structured interviews, and focus groups (Shenton, 2004). Consequently, the current study collected data through one-on-one, in-person, semi-structured interviews with 12 MHCUs across four clinics in the Makana municipality. The purpose was to gain in-depth and elaborative thoughts, opinions, and feelings on participants' lived experiences of getting mental healthcare services in their local primary clinics. Not only was this form of analysis not possible in quantitative data, but it would also not add to the

limited research available in the in-depth nature of a qualitative study (Merriam, 2009; Austin & Sutton, 2014).

3.3 Participant Sampling and Sampling Technique

In this study, purposive sampling was employed as the sampling strategy. Purposive sampling is important in qualitative research because it allows researchers to select participants based on specific criteria to achieve the research goals. Palinkas (2015) suggested that qualitative research aims to describe, explore, and explain phenomena and often uses purposive sampling strategies. According to Alkassim and colleagues (2016), purposive sampling involves recruiting participants who can offer information or experience based on a set objective. In this study, participants who received services from a specific clinic in the Makana district and could discuss their perceptions and experiences of the clinics, were recruited based on specific criteria.

Qualitative research usually involves smaller sample sizes compared to quantitative research, and the sampling is flexible until data saturation is reached (Moser & Korstjens, 2018). Therefore, the study used a sample size of 12 participants, which was manageable and minimal. Purposive sampling is crucial in qualitative research because it allows researchers to strategically select participants to address research questions and achieve data saturation effectively. This approach reflects the growing importance of context in sampling decisions (Poulis et al., 2013).

When establishing the criteria for inclusion in this study, the researcher targeted individuals who were service users of any of the four clinics in the Makana municipality, namely Joza Clinic, Raglan Road Clinic, NG Dlukula Clinic and Middle Terrace Clinic. These participants had to have attended the clinic for at least six weeks and be 18 years or older. This criterion aimed to ensure that the study would encompass participants who could provide detailed information about the facility and their experiences and perceptions.

Unlike the studies discussed in Chapter 2, which included a mix of participants, such as staff members, service users, and caregivers, this study focused solely on MHCUs, due to the limited research in this area. Contributing to the limited body of knowledge on studies focusing on individuals' perceptions of mental healthcare at a community-based level was deemed crucial.

The choice of the Eastern Cape context was intentional, due to the high levels of poverty in the province, leading to numerous psychosocial issues. It was also observed that mental health rights and advocacy were not a priority in this province, significantly affecting those seeking services from primary healthcare facilities. Therefore, it was advantageous to conduct the study in this environment to help inform and guide areas of improvement.

To recruit participants, the researcher met with the head nurses at the identified clinics to inform them of the research study and discuss the intention to include participants from their clinics. An information booklet was left with the head nurses for further information prior to the day of data collection. On the scheduled day, the researcher approached potential participants who had come to the clinic to collect their treatment. The researcher informed them about the study and invited them to participate. Interviews were conducted with three to five participants from each facility, resulting in a total study sample of 12 participants.

3.4 Data Collection

Data in qualitative research can be generated in various ways, such as through interviews, observations, documents, and written stories. Qualitative researchers are interested in giving voice to the participants about a particular situation (Newhart & Patten, 2023). Therefore, the data was collected through semi-structured, open-ended questions to gain insight into the participant's perceptions of community-based mental healthcare services. A semi-structured interview is a commonly used data generation method in qualitative research (Braun et al., 2016). Open-ended questions are utilised independently or with other

interviewing methods to comprehensively investigate topics, comprehend procedures, and recognise potential causes of observed correlations (Weller et al., 2018).

Moreover, face-to-face interviews align with qualitative research and offer many advantages. The researcher noted that this method helped build rapport quickly with the participants, potentially easing anxiety and fostering greater participant transparency. The interviews were tape-recorded with the participants' consent. Using a tape-recording during interviews promotes better non-disturbed communication between researcher and participant and improves data accuracy (Weller et al., 2018). The interviews occurred either in a room provided by the clinic (before or after their clinic consultation) or outside, where clinics lacked available rooms. Where interviews were held outside the clinic, confidentiality was maintained by sitting away from other patients in a reserved area without any distraction. This setup was convenient as it eliminated the need for participants to allocate time for interviews or incur travel expenses (Dineva & Nedeva, 2020). Each interview lasted between 30-45 minutes.

Before the commencement of the interview, the researcher first gained informed consent from participants (see Appendix D). The consent provided participants with the nature and purpose of the research study. For participants who were not fluent in English, the researcher explained this information in their preferred language to ensure they were well acquainted with what was required. The consent form disclosed information, such as, the participation was voluntary, no compensation would be given for participation, COVID-19 precautions would be adhered to if needed, and the researcher would maintain confidentiality and anonymity of all data collected.

Once consent was secured, the interview proceeded according to a structured interview guide (see Appendix E). As recommended by Pietkiewicz and Smith (2014), it was

essential to maintain a conversational style and rapport while following the guide during the interviews.

The interview began with the patients briefly introducing themselves and informing the researcher about their geographical background. These introductions were prompted by questions about the participants' residential context, access to services, employment, and education. These questions were essential for determining if the participant met the study criteria, as well as for building rapport. The interview then focused on the clinic's services that the patients accessed. Inquiries included, “What is your experience with the services at the clinic?" The interview further delved into the patient’s mental health, exploring questions, such as: "What is mental health?"; "What causes mental health difficulties?”; "How do you perceive individuals with mental health issues?”; "Where can individuals find support for mental healthcare?”; "Do individuals with mental health issues face specific challenges?”, and “Is there a need for mental healthcare in your community?” The audio recordings were transcribed verbatim, allowing the researcher to fully engage with the data from the start, as Smith et al. (2009) recommended.

3.5 Thematic Analysis

Thematic analysis is an easily accessible and theoretically flexible interpretative approach to qualitative data analysis that facilitates identifying and analysing patterns or themes in each data set (Braun & Clarke, 2019). It also allows readers to gain a greater sense of the essential themes that dominate in an area that is under-researched and less known, for example, mental healthcare users' perceptions and the utility of primary healthcare services (Braun & Clarke, 2006). Braun and Clarke (2006) also reported that thematic analysis is considered ideal, as it is not tied to any particular epistemological perspective.

Thematic analysis helped arrange the data stored in the voice recording from the semi-structured interviews into a document transcript for careful analysis. The researcher

then followed a six-phase data analysis method, as Braun and Clark (2019) recommended. The researcher maintained a neutral stance during the analysis and interpretation phase, ensuring that my opinions, values, and beliefs did not influence the data results, following Braun and Clarke's (2022) proposal.

3.5.1 Phase one- Getting to know the data

The researcher familiarised themselves with the data by rereading and listening to audio recordings of the dataset several times to understand the contents. This was particularly important, as the researcher had not transcribed the data themselves. Often, data may not have been gathered or transcribed by the researcher, so it is beneficial for the researcher to watch or listen to video or audio recordings, to achieve a greater contextual understanding of the data (Braun & Clark, 2019). Moreover, in carefully reading the data, the researcher noted critical issues and interesting facts in the data (Braun & Clarke, 2022). The researcher then made notes of all the similar ideas that emerged, while engaging with the data. This process required patience and rigour from the researcher.

3.5.2 Phase two- Coding data

To mitigate the time and volume of thematic analysis, the researcher used hand coding and Atlas. ti to ensure comprehensive data handling, organising, and storing (Miles et al., 2014). The researcher identified segments from the data that answered the research question (Braun & Clarke, 2022). The researcher coded these segments, then collated code labels and compiled relevant data segments for each code (Braun & Clarke, 2022). Here, the researcher began to note their initial impressions and thoughts. Organisation, structuring, and repeated patterns of the initial codes were recorded.

3.5.3 Phase three- Searching for themes and coding.

In this phase, the researcher developed initial themes based on the data and research questions. Their knowledge and insight were then used for the research focus, which was

important in generating appropriate codes (Braun & Clarke, 2022). After coding the data, the researcher arranged it according to the themes developed, to address the research questions (Kiger & Varpio, 2020; Braun & Clarke, 2022).

3.5.4 Phase four- Reviewing themes.

Braun and Clark (2022) suggested that at this phase of analysis, the researcher consistently assesses the relevance of the themes to the data and revises them as needed, either by combining, splitting, or removing them. At this point, the researcher changed themes multiple times to retain relevant data. This involved mainly removing and replacing themes which was helpful, as the researcher had to continuously think of what was significant and keep sight of the aim of the current study.

3.5.5 Phase five- Refining themes

In this phase, the researcher continuously refined and checked the theme's relevance to the data presented and which gave meaning to the theme (Braun & Clarke, 2022). The researcher had to change and refine themes multiple times, to ensure they captured meaning according to the codes used under such a theme. Thus, the researcher ensured that themes were unique; however, they collectively had a shared purpose: to answer the research question comprehensively. Furthermore, the researcher used third-party opinions to help arrive at a decision with which the researcher was satisfied.

3.5.6 Phase six- Producing the report.

At this point, a helpful task would be establishing the order in which themes are reported. Themes should connect logically and meaningfully, building a coherent narrative of the data (Braun & Clark, 2012). Where relevant, themes should build upon previously reported themes while remaining internally consistent and capable of communicating their narrative, if isolated from other themes (Braun & Clarke, 2012). In this phase of the study,

specific data sets were reported to express each theme, and these were compared with the literature and the research question.

3.6 Trustworthiness

Reliability in qualitative research is crucial for influencing future research paths and advancing cumulative knowledge. Trustworthy qualitative research findings are also vital for informing policy decisions and improving the provision of services in various fields. Although qualitative research can be subjective and resource-intensive, thorough application of measures to ensure trustworthiness significantly improve the accuracy and reliability of the research (Ahmed, 2024). Cypress (2017) argues that rigor and trust are crucial for establishing the credibility and reliability of findings, due to their subjective nature, when conducting qualitative research. Trustworthiness in qualitative research comprises various essential elements, such as credibility, transferability, dependability, and confirmability (Dodgson, 2019).

3.6.1 Credibility

Lincoln and Guba (1985) argue that credibility is crucial to establishing trustworthiness. According to Merriam (1998), credibility is the qualitative investigator's equivalent of validity, which concerns the extent to which the findings are consistent with reality.

Of the strategies suggested by Shenton (2004) to ensure credibility, the researcher engaged in the following. Each person approached was allowed to refuse participation in the project, to ensure that the data collection sessions involved only those genuinely willing to participate and prepared to offer data freely (Shenton, 2004). I disclosed my independent identity, which informed the participants that I was not affiliated to the clinic; therefore, they were more open and expressive without objection. Consultation and scrutiny of the interview guide with my supervisor, ensured a non-biased and clear focus on the research purpose and

question. My education level and previous research experience were instrumental in guaranteeing credibility with data collection and analysis (Patton, 1990).

3.6.2 Transferability

Merriam writes that external validity "concerns the extent to which the findings of one study can be applied to other situations" (Merriam, 2009, p. 69). In positivist research, the primary objective is to prove that the study's outcomes can be generalised to a larger population. However, with regard to qualitative research, the results are limited to a specific group of individuals and environments. Therefore, it is impossible to demonstrate that a qualitative study's findings and conclusions can be applied to other populations and situations. This is particularly difficult to achieve, especially when working with a few participants. However, in attempts at transferability, the researcher indicated the participants' demographics (MHCUs in primary healthcare). They detailed the study design, data generation methods, and research findings to enhance transferability (Shenton, 2004; Fabio & Maree, 2012). Thus, other researchers interested in a similar study could use this information for their benefit.

3.6.3 Dependability

Dependability involves acknowledging environmental context variability and monitoring decision-making when collecting data (Thomas & Magilvy, 2011). To demonstrate reliability, positivists use techniques to illustrate that similar results would be achieved if the work were repeated in the same context, using the same methods and participants (Shenton, 2004). The study's processes should be reported in detail, to address the dependability issue more directly. This would enable a future researcher to replicate the study, even if the same results are not obtained (Shenton, 2004).

3.6.4 Confirmability

Fabio and Maree (2012) argue that confirmability refers to the objectivity of data collection and analysis and that it ensures no errors. According to Haq and colleagues (2023), confirmability refers to the objectivity and impartiality of research findings, ensuring they remain untainted by researcher bias or preferences. Moreover, other researchers can confirm the results to establish validity and prevent researcher bias (Korstjens & Moser, 2018). The study of MHCUs is not biased for the researcher, as it is a study that seeks to benefit the marginalised population, in hopes of influencing future policies concerning community-based care in mental health. Therefore, the researcher has no personal motive to conduct this study.

3.7 Ethical Considerations

According to O'Brien (2010), ethical considerations are crucial in research to protect participants and address sensitive issues, while emphasising the role of the researcher.

Before conducting the study, the researcher had to ensure that it aligned with the Rhodes University Ethical Standards Committee (RUSCE) guidelines. Thereafter, an approval for the proposed study was received from the Research Proposals and Ethics Review Committee (RPERC) to commence with the study, referencing (2022-5578-7109) (see Appendix A). Finally, before approaching the health facilities, a request to conduct research was requested from the Eastern Cape Department of Health (ECDoH) to conduct interviews at the four identified clinics (see Appendix B). Thereafter, the Gatekeeper clearance and ethical approval was obtained (see Appendix C).

3.8 Limit harm

Qualitative researchers have an ethical obligation to identify, minimise, and address the risks of research-related distress (Whitney & Evered, 2022). Thus, the researcher ensured that no harm was done and that all participants' rights, safety, and well-being were safeguarded (Leavy, 2017). Fortunately, no harmful events required cautionary measures during or after the researcher's contact with participants.

3.9 Informed consent

Participants involved in scientific research should do so willingly and voluntarily (Hesse-Biber & Leavy, 2011). Before giving consent, individuals should be clear on the aims, methodology, and potential risks they may encounter, when they are involved in the research. As reported previously, all the participants were given consent forms, which were read or explained in their language, and allowed to agree or disagree to be part of the study. They were informed that they could withdraw at any stage from participation without consequences. They were informed that interviews would be tape-recorded, and the study would contribute to creating academic articles, a Master's thesis, and conference presentations.

3.10 Confidentiality

Cacciattolo (2015) argued that confidentiality in most research refers to how data are managed and stored; it also refers to who is granted access to the data and the degree to which it is shared with others outside the research project. Sieber (1992) posited that confidentiality also refers to protecting participants' identities to minimise exposure to harm and scrutiny. The names and identifying information of participants were not required in the study to maintain confidentiality. Participants should be informed who would access their data during and after the research (Brinkman & Kavale, 2008). Thus, participants were told about the study being used for academic purposes and possible publications, to which they could request access should they desire.

3.11 Chapter Summary

This chapter focused on the research design and methodology of the study. The rationale for utilising a qualitative study and how it assisted in answering the research question and achieving the study's goals were explained. Details on the sampling methods, data collection, thematic analysis, and the six phases were discussed. Finally, the study’s

trustworthiness and ethical consideration steps were outlined in detail. The next chapter will discuss the findings of the data collected.

CHAPTER FOUR

Findings

4.1 Chapter Overview

This chapter effectively communicates the current study's findings by capturing the participants' common perceptions and experiences. The widespread agreement among most participants underscores the importance of including these findings in the chapter. The selected themes were directly relevant to addressing the research topic and associated questions. The superordinate and sub-themes can be found below in Table 1.

Table 1

List of Super-ordinate and Sub-themes

Super-ordinate themes	Sub-themes
4.3 The utility of the primary health clinic	4.3.1 The overall perception of the clinic
	4.3.2 Poor professionalism of staff
	4.3.3 Patients' attitudes towards nurses
	4.3.4 The problem of resources
4.4 The urgent need for mental health education	4.4.1 What is mental health?
	4.4.2 Discriminatory behaviours
4.5 Socioeconomics and mental health	4.5.1 Stress triggers
4.6 The complex dynamics of help-seeking behaviours	4.6.1 Beliefs and perceptions of mental illness
	4.6.2 Bio-medical reasons for consultation

The chapter will begin by briefly describing the research participants, including their demographic information and relevance as participants. Then, it will discuss the themes in conjunction with the existing literature.

4.2 Brief summary description of Participants

The current study consisted of twelve participants who volunteered to be a part of the study. All the participants resided in the Eastern Cape in the Makana municipality. The persistent challenges faced in this district, like many regions in South Africa, are unemployment, inadequate infrastructure, and limited access to essential services. This is evidenced through the demographical descriptions of the participants. The age of the participants ranged between 18 and 67 years of age. The majority were black African isiXhosa, first-language speakers, with only two coloured females who were Afrikaans first-language speakers.

Many of the participants had only a primary or high school level of education, were unemployed or struggling grantees, and only a few had temporary jobs. The participants had chronic illnesses which affected their quality of life both physically and mentally. Some female participants reported being in single-parent households with no emotional or financial support from their partners or families. The male participants reported that it was difficult to support a family while unemployed.

4.3 Super-ordinate Theme 1: The utility of primary health clinics

All participants willingly shared their overall perceptions and opinions about the clinic they attend for regular treatment. Their opinions, often filled with gratitude, are formed based on the time they have been coming to the facilities. The times range from one month to ten years, since being clinic patients. Therefore, this super-ordinate theme strives to capture the participants' opinions on the “utility of the primary healthcare clinic” and how the

services and facility are run, considering these are primary health care facilities within low-resourced communities, as the Makana municipality in the Eastern Cape Province.

4.3.1 Sub-theme 1: Overall perceptions of the clinic

The participants' experiences are divided between pleasant and unpleasant experiences, thus revealing that the experience is not linear or the same for all participants. The patients' positive feedback is primarily based on which clinic the participants attend within the Makana municipality (as some are more resourced than others), the relationship the patients have with the staff members, and the patients' appreciation for the extra role staff members play, regardless of the facility's limited resources. These positive comments, a testament to the dedication and commitment of the staff, are captured in the following participants' comments:

"*I am treated very well in this clinic. Everything is all right, even though they are slow. Yes, they are slow, but they eventually attend to us."* (P6)

"*The culture of this clinic, the way we are served, they are trying but there is a shortage of staff, the space is limited because there are no private rooms…you see? And even if someone is sick, especially if they need to be put on these oxygen things, the whole service stops because the same room that is used for pressure is the same room that must be used to help patients with oxygen*." (P10)

P6 and P10 provide valuable feedback and a sense of acknowledgement that even though the staff members treat them well, they recognise that the staff may also be disadvantaged through infrastructure and being short-staffed; thus, services are "slow" and "limited".

On the other hand, some participants such as P2 expressed dissatisfaction with the overall services; this is demonstrated by their statement below:

"*The service here is very poor….*" (P2)

The data by P2, compared to P6 above, indicates variations in the quality of care provided across clinics in the Makana municipality. It suggests an unequal distribution of resources, leading to an imbalance in the level of service offered to patients. As a result, certain clinics experience higher patient volumes, due to the available resources, straining their capacity to deliver timely care. This highlights the potential impact of resource availability on patients' experiences within primary healthcare facilities.

4.3.2 Sub-theme 2: Poor professionalism of staff members

In a tone of concern, some participants reported that nurses displayed poor conduct, creating doubt and mistrust in the patients. Nurses do not act professionally and, in the patient's best interest; therefore, patients' perceptions of healthcare professionals can be harmful, based on such poor encounters. The following participants reported instances where nurses displayed incompetence and poor conduct:

"*Sometimes nurses fail to concentrate while helping people because they are distracted by cell phones…Or sometimes they spend too much time socialising with friends at work.*" (P3)

"*Because now even if you want to speak with the nurse, you know that you will see about your business on Facebook, they will talk about you on WhatsApp. You, see? So, you cannot be comfortable because they write about you on WhatsApp or Facebook.*" (P4)

The statement by P3 indicates that the patient's health needs are unimportant and thus not prioritised. The statement above by P4 highlights issues of ethical conduct that all healthcare practitioners should abide by, namely confidentiality. Patients' confidentiality is crucial for building trust when disclosing specific psychological and emotional issues concerning them. On the other hand, when nurses gain patients' trust, they can yield better

assessment and treatment outcomes. This also emphasises the need to implement task-sharing through training nurses to handle mental healthcare-related issues and understand how their behaviours can influence patient care. In addition, issues of trust are further illustrated by the following participant below.

"*And, I should make a point of it, you should always know your medication. If you don't know your medication, you'll poison yourself.*" (P7)

The above statements from P7 further refer to the issues of trust/mistrust. They cautioned on a common experience at the clinic where one is given either no or incorrect medication due to nurse error. P7 statement "…*I should make a point of it*…" gives the idea that they have experienced or know this error occurs at least more than once. This error is unfavourable to patients, as it puts the onus solely on them to ensure they collect the correct medication, likely perpetuating mistrust toward healthcare staff, while increasing the potential of harming the patient.

4.3.3 Sub-theme 3: Patients' attitudes towards nurses

Some participants responded to their experiences of the clinic environment with statements about their feelings and attitudes toward the nurses. Getting an idea of how patients experience the nurses helps identify whether nurses are part of the problem in PHC, or whether they help to navigate quality care even under such circumstances. The patients' attitudes toward nurses can also determine the likelihood of patients returning to the clinic, significantly impacting their treatment adherence.

"*Shame, nurses are very friendly in this clinic.*" (P1)

"*Healthcare workers here are very compassionate, and they are caring as well.*" (P3)

"*Just because healthcare workers are very caring here."* (P9)

P3's comment suggests a positive and trustworthy connection between MHCUs and the staff, stemming from the MHCUs' positive attitudes toward the nurses. Furthermore, P9's comment, *"Just because healthcare workers are very caring here,"* emphasises the significance of the relationship between MHCUs and staff, regardless of the clinic's circumstances, indicating its potential impact on overall health outcomes. This highlights the importance of fostering positive staff-patient relationships, which play a crucial role in enhancing the effectiveness of nursing practice.

4.3.4 Sub-theme 4: The problem of resources

There was a recurring theme in the feedback from patients regarding the challenges they faced in accessing care. These included the impact of the shortages of nurses and the scarcity of employed mental health professionals in PHC. Many patients felt that a shortage of nurses was causing delays in service provision. They believed that hiring younger, more energetic nurses would improve care and alleviate the burden on current staff, making timely, efficient service provision possible. This is evident from the following participants.

"*I wish more nurses could be added because they are few*." (P2)

"*If they could get fresh staff like young people, not these old nurses. Young people will be fresh, and they will know their job*." (P4)

The above statements by P2 and P4 highlight the patients' frustration with scarce human resources in PHC. P2's use of the phrase *"I wish"* emphasises a strong desire for improvement, while the statement by P4 can be understood as patients' acknowledging that nurses are limited and overworked and, therefore, unable to meet patients' needs promptly. Consequently, the statement below points to some of the negative impacts patients face as a result of the shortages of nurses in PHC:

"*It becomes difficult when my diabetic sugar levels are very high, and I have to wait in the queue*." (P3)

"There are people who wait in queues… For example, people on wheelchairs. Like, old grannies should not wait in queues. You see what is happening here? I wish they could see how severe someone's sickness is." (P5)

Statements from P3 and P5 show that the scarcity of human resources could adversely affect patients' overall health. Both participants felt that service provision was slow, posing a threat to patients with hypertension, the elderly, or those in wheelchairs who should not have to wait in queues, due to the severity of their health conditions.

Furthermore, participants, such as P7 below, illuminate the lack of mental healthcare professionals in PHC.

"*Because there's one psychologist that I hear… The sister asked on Thursday, don't I want to see a psychologist? She said she just think that I need someone… You know? Like 45 minutes, like once a week or so. But now she's fully booked up to February. So you can see that we need more people. You see? Not once that comes for a year to do the practical for a year and then go back to wherever*." (P7)

P7 reported that despite occasional visits by a psychologist to their clinic, they expressed difficulty in accessing mental healthcare, due to extended waiting lists and concerns about the quality of the care. In light of this concern, it is clear that mental health conditions exist within PHC; however, there is an imbalance between the demand and availability of mental healthcare provision, due to the limited number of psychologists employed in PHC. Consequently, this suggests that many patients are deprived of their right to mental healthcare in PHC.

Moreover, participant P7 shared a deeply personal experience, highlighting the issue of infrastructure and private consulting space with a mental health provider in the clinic.

"Yes. There's a psychologist here, but I don't feel comfortable coming here. I don't have a problem with her but I have a problem with where I have to see her." (P7)

The psychologist's placement without regard for patient confidentiality and dignity underscores the obstacles that can arise, due to insufficient resources for mental health service provision in PHC. Consequently, P7's experience highlights the significance of the NMHPF 2020-2030 policy, which prioritises improving accessibility through expanded infrastructure and healthcare professional support.

4.4 Super-ordinate Theme 2: The urgent need for mental health education

As highlighted in Chapter 2, mental healthcare is considered a fundamental human right of all individuals in South Africa. Thus, patients should be informed about this right to utilise it accordingly. People's knowledge of mental health can empower them to identify when, where, and how to seek the necessary help. This theme demonstrates whether a need for mental healthcare education exists within the Makana municipality.

4.4.1 Sub-theme 1- What is mental health?

All participants were asked to share their understanding of mental health. It was evident that most participants were unfamiliar with the concept, which was apparent in their responses. In the statements below, P1 did not fully understand mental health. While P12 mainly referred to psychotic or externalised behaviours, as related to mental health without acknowledging mental illness as equally related to internalised disorders.

"*I think it has something to do with being disturbed mentally.*" (P1)

"*Mental health is crazy. It's mental illness, and you don't have a mind.*" (P12)

Consequently, P1s use of the word *"disturbed"* or P12s use of the word *"crazy"* carries negative and dehumanising connotations. The use of these words also perpetuates the idea that people with mental illness are dangerous and unpredictable, which promotes social fear and exclusion from those with a mental illness. Moreover, participants shared blurred ideas of what mental illness entails, which is demonstrated by the comments below.

"*These are the things you need help with that bother you as a person.*" (P2)

"*Mental health maybe is based on the brain. Then they check how you are coping. That's what I'm thinking.*" (P5)

The above participants, P2 and P5, expressed uncertainty and confusion in their attempt to respond to the question. Similarly, the statements below suggested an even greater lack of knowledge in the following participants:

"*I don't know, I don't know. I hear it, but I don't know what it means.*" (P11)

The statement *"I don't know"* made by P11 suggests no mental health literacy (MHL). These responses are interpreted as highly problematic and indicate that little or no information is given to patients. This hypothesis is evidenced by the following participants, P5 and P6, who report no recollection of mental health awareness programmes within clinics in the Makana municipality.

"*No. I can't remember. Maybe they do. When I occasionally get here maybe I arrive after they have spoken about it.*" (P5)

"*I haven't heard anything.*" (P6)

The existing theme points to the need for clinics in the Makana municipality to actively engage in educating, raising awareness, and advocating mental health education. By

doing so, they can help reduce the stigma and discriminatory behaviours in these under-resourced communities.

4.4.2 Sub-theme 2: Discriminatory behaviour

It was observed that due to a lack of MHL and advocacy in the clinics, participants experienced a sense of exclusion and isolation, resulting from the community's misguided beliefs about mental illness. The community tends to perceive individuals with mental illness as primarily dangerous, but some participants expressed empathy towards people with mental illness, driven by their observations of ill-treatment. Furthermore, it is apparent that there is still a significant stigma surrounding people with mental illness, especially in low-resourced communities. This stigma leads to the marginalisation of individuals through discriminatory and disrespectful behaviour. Notably, some participants' personal experiences align with the assumptions about the community's attitudes, highlighting the need for constructive change.

"*Sometimes people discriminate against you because they say you are 'mad'. Because sometimes when I'm stressed, I even talk to myself and not talk to anyone.*" (P3)

"*Other people, wow, they treat them very bad; they don't care about them. They think they are crazy…Like people laugh at them*." (P5)

The above P3 and P5 reported that the community frequently uses words like *"crazy"* or *"mad"* when describing how mentally ill persons are perceived. The terminology appears to be derogatory and affects the person's self-perception, as described by the following participant:

"*So now I will be viewed as valueless.*" (P1)

Similarly, the participant below recalls how they were marginalised during their school days.

"*So, during my school days I had mental problem; I was younger than my classmates. They would tease me because of that.*" (P9)

The act of stigmatisation on a person seems to make them feel rejected and not worthy in the eyes of the rest of the population, as in the case of P1. This can instil shame in the rejected individual and cause long-term damage to a person's self-esteem, such as in the case of P9. One can begin to resent the illness or even blame themselves for it. Thus, the findings of this theme suggest that stigma could negatively affect one's self-worth and positive treatment outcomes.

It's worth noting that some participants expressed empathy and compassion towards individuals dealing with mental illness. Their responses were positive, with some individuals showing support for those with mental illness. The following participants expressed this:

"*I feel bad for them.*" (P2)

"*I feel sorry for him.*" (P4)

The reported feelings of *"bad"* by P2 and expressions of feeling *"sorry"* by P4 toward PWMI may indicate their disapproval of the prevalent discriminatory behaviours directed at PWMI. However, none of the participants proposed solutions for assisting these individuals, exemplifying how limited MHL can result in a sense of helplessness. Moreover, the sentiments expressed by P10 appear to reflect frustration arising from this lack of knowledge.

"*I feel sorry for them because I can't push that person away; I have to try to understand what they need. If I don't have, I must tell them that I don't have. I am a sensitive person.*" (P10)

The above statement by P10 supports the idea that the community's healthcare workers are not doing enough to educate the population on mental health. If people do not

have enough knowledge, expressing further views on the subject is complex. As a result, stigmatisation and rejection continue, as illustrated below by P1, who offered their recommendation on how the community should not view them differently.

"*What I am saying is, they shouldn't treat them as people of less value.*" (P1)

The findings of this theme indicate that some individuals have compassion toward those experiencing mental illness. Many people express a desire to help; however, their lack of understanding regarding the challenges faced by individuals with mental illness leave them feeling incapable. As a result, those living with mental illness continue to experience isolation and rejection from their communities. Meanwhile, the prevailing lack of knowledge ill-equips and discourages potential helpers from offering support.

4.5 Super-ordinate Theme 3- Socioeconomics and mental health

The participants described concerns regarding their living conditions, which act as precipitants to their mental health. They noted issues about socio-economic backgrounds and how these factors constantly work against their mental health.

4.5.1 Sub-theme 1: Stress triggers

The participants mentioned that their distress was caused by living in low-resourced communities. It was interesting that even though many did not have knowledge about mental health issues, they were able to attribute the causes of their distress to stressful life circumstances. Furthermore, when describing how they were impacted, they talked about internalised disorders rather than externalised ones, unlike when assigning mental illnesses to others. This suggests that the participants may have experienced depression or anxiety; however, they lacked the awareness or the vocabulary to articulate it. Participants reported issues including unemployment, substance abuse, and the lack of family support.

"…*Because some people do not have enough money for basic needs. So, they end up doing... They get depressed… And the stress of my daughter, is not getting a job."* (P2)

Most participants reported that one of the prevalent triggers to their mental health was being unemployed. For example, P2 expressed feelings of helplessness and worry over his daughter's unemployment, an issue that appeared prevalent amongst most participants. Similarly, some participants reported that substance abuse contributed negatively to one's mental well-being.

"*…maybe his parents abuse alcohol*." (P4)

"Many causes. Stress is one of them. Drugs is." (P8)

In low-resourced communities and clinics, people often face stressful conditions with very few avenues of support. This is evidenced by some participants in the study. For instance, P4 suggests that many people abuse substances to cope with their distress, while P8 suggests that drug abuse can contribute to mental health issues. This aligns with reports from South Africa, which estimates that one in six people are addicted to substances. Contributing factors include socio-economic issues such as poverty, urbanisation, and inequality.

Furthermore, the participants indicated that loss and the lack of family support are contributing factors to mental health issues.

"…*maybe your mom has passed away. Your mom was your helper, providing you with everything. So, once she passes you don't know where you will run to. So, that's how depression happens. Maybe you think you should hang yourself and follow your mom. Then you commit suicide and follow your mom.*" (P5)

"*I am not studying; I have 4 children and the 5th one could not survive. That happened this year and I don't have parents. I am HIV positive.*" (P6)

The participants are predisposed to mental health problems, due to a lack of familial support and unresolved grief. A prevailing theme of parental loss is reflected across the participants, who reported difficulties in managing both their personal losses and their associated responsibilities. P5 articulated the severity of their loss and admitted to contemplating suicide. P6, burdened with caring for four children and being HIV positive, experienced feelings of helplessness. Moreover, a lack of parental support heightens the challenges of caring for their children. All participants cited the prevalence of typical socio-economic hardships endured by individuals in low-resourced communities.

This theme thus highlights the burden of poverty experienced by individuals in the Makana municipality. It proves that many participants are faced with chronic stressful situations that impact their mental health severely. However, as discussed earlier, it is evident that these conditions are not as prioritised and equally treated as physical illnesses in these clinics.

4.6 Super-ordinate Theme 4: The complex dynamics of help-seeking behaviours

Participants' beliefs and knowledge of mental illness strongly influence their help-seeking behaviours. The participants in this current study shared what influences their help-seeking behaviours.

4.6.1 Sub-theme 1: Beliefs and Practices about Mental Illness

With reference to mental health, the culture of the society that surrounds us influences our attitudes about seeking help, the type of support we need, and whether we decide to seek help at all. Cultural norms can account for minor differences to significant omissions in how people communicate their symptoms and which symptoms they report. The participant below

expressed a belief about how mental illness manifests, which influences their help-seeking behaviours.

"Because we are the world where these things are happening, someone might be ruining people, you understand. They are now bewitched by other residents. They cast a spell on him to make him sick and stop talking." (P11)

P11 suggests that they believe mental illness is caused by witchcraft and spell casting. According to this belief, the illness is not organic but rather manufactured to disrupt another person's life. This raises concerns about the potential for misdiagnosis and inadequate treatment, further exacerbating the condition.

"*Maybe there is a church for example, maybe a lake, St Johns. Others ask, this kid, why was he born like this? I think it's because of witchcraft. So, they realise, no, let's take him to the lake and see him. Maybe at the lake they will say, no you must slaughter maybe something, so that this child becomes ok.*" (P5)

P5 suggests a connection between Christianity, witchcraft, and the manifestation of mental illness. They believe that performing animal sacrifices to honour their ancestors can cure mental illness. These findings indicate that many people in resource-constrained communities believe that mental illness is closely associated with culture and religion. Consequently, individuals in these communities often turn to churches or traditional healers for treatment, instead of seeking help from healthcare facilities.

4.6.2 Sub-Theme 2: Bio-medical reasons for treatment

A significant proportion of the patients at the clinic on the day were seeking medical attention for physical illnesses, while only a minority presented with mental health-related concerns. Consequently, there is a notable allocation of nursing staff, resources, and healthcare funding towards the treatment of conditions, such as HIV and diabetes. This trend

is consistent with patients in the Makana municipality, as evidenced by the accounts of participants who sought consultation on the day.

> "*I get all my medication, including ARVs, mental health medications, and high blood pressure."* (P9)

Numerous patients presented with chronic health conditions such as hypertension, diabetes, or HIV-related illness. Noteworthy is that hypertension, as in the case of P9, is commonly linked to stress, which is prominently featured among the patients. This correlation is unsurprising, given that the Makana community is characterised by a low socio-economic status and burdened by various stressors that impact mental well-being. Addressing the interrelationship between specific physical illnesses resulting from or exacerbated by untreated, underlying emotional or psychological conditions is imperative.

Participant 6 provided an illustrative example of how stress and worry manifest into physical symptoms. Moreover, this participant's experience highlighted the need to shift towards a more holistic approach in primary healthcare centres, integrating mental health interventions with traditional biomedical treatments.

> "*I had pain here. I said, "No, I think my neck is sore." They said, "No you think a lot." I said, "No, there is nothing I am thinking about." They said, "You will not know what you are thinking about." I say, "No man, there is nothing I am thinking about, but this thing is painful." They said, "No you cannot rub it." I came to the clinic, and they gave me pills and I was better*." (P6)

The onset of certain conditions, such as hypertension, can often be linked to persistent chronic stress which is likely, as in the case of P6. In addition to medical intervention, these conditions can be addressed through psychological or psychopharmacological treatments. This concept sheds light on the prevalence of illness within underprivileged communities.

Furthermore, it emphasises the correlation between physical and mental health conditions, highlighting their comorbid nature and the reciprocal impact on each other. Thus, it is essential to prioritise both aspects. Notably, this theme's findings suggest that in PHC, there has not been an adjustment to accommodate the escalating burden of mental health conditions, with the treatment remaining predominantly biomedical in nature.

4.7 Chapter Summary

This chapter presents the findings obtained from the data analysis of participant interviews. These findings are crucial to understanding the impact of cultural, religious, and socio-economic factors on mental health treatment in resource-constrained communities. The relevant themes related to the research topic were generated from the data and thoroughly discussed. The next chapter, along with the existing literature, will facilitate a comprehensive discussion based on these findings.

CHAPTER FIVE

Discussion

5.1 Chapter Overview

This chapter discusses the findings presented in the previous chapter. It will be structured like the findings chapter, seeking to broadly examine the main themes by linking with the existing literature to support the discussion.

The themes will be discussed in the following order: the utility of the primary health clinic; the urgent need for mental health education; socioeconomics and mental health, and the complex dynamics of help-seeking behaviours. The chapter aims to discuss these critical issues comprehensively, engaging the reader in thoroughly exploring the current research question.

5.1.1 The Utility of the Primary Health Clinic

Despite the post-democracy era in South Africa being a time of hope for improved public healthcare service delivery and policy implementation, progress in health departments has been sluggish overall (Maphumulo, 2019). This is directly evidenced by the challenges reported by participants in their experiences with PHC. While not directly addressed in the current study, previous literature by Marais and Petersen (2015) has highlighted the inadequacy of policy implementation in affecting transformation in the healthcare system in South Africa. This study further supports this finding, as participants expressed their dissatisfaction with the healthcare system in PHC. It is worth noting, however, that policy implementation in PHC in the Makana municipality was not a primary focus of this study, making it a potential area for future research.

This study aligns with previous research by Mendenhall et al. (2022) and Esponda et al. (2019) in Chapter 2, which identified a lack of resources as a significant concern in PHC. Govender et al. (2018) also emphasised the challenge of insufficient medical resources and staff shortages in PHC. This issue emerged as a common theme among participants in the current study. Despite overall satisfaction with the facility, participants recognised that inadequate resources hindered care. Mendenhall and colleagues (2022) investigated the potential of task sharing in LMICs to address these resource challenges. Their study recommendations aligned with the current participants' interests, who suggested that employing younger nurses and mental health practitioners could be beneficial. Therefore, the present study participants unequivocally support the concept of task-sharing in PHC, providing reassurance about potential solutions to resource shortages. Thus, these findings are not unique to previous research concerning issues in PHC, reinforcing the validity of the current study.

In addition, what was unique about this study was that it found that resource shortages had an emotional impact on participants, who raised their fears and concerns about the potential impact of resource shortages on patients' health. Participants feared that they were at risk of further illness, due to the strain of waiting in long queues, especially for those patients in wheelchairs, the elderly, or with hypertensive disorders. This finding from a patient perspective gives both evidence and emphasis to Tana (2013), who cautioned that the shortage of healthcare workers is likely to result in patients' physical and mental illness and, in some cases, further deterioration of their medical and/or mental healthcare conditions.

Nonetheless, when patients acknowledge and give positive feedback, nurses feel appreciated for their efforts, regardless of being poorly resourced, which can promote good practice, as suggested by Gillespie (2021). Moreover, Luker and colleagues (2000) explained

that the quality of relationships between patients and nurses directly impacts the care provided, making it crucial for the effectiveness of nursing practice.

On the other hand, some participants reported dissatisfaction with their overall experience of the clinic's utility. The study found that the difference between participants' feedback denotes a resource divide in healthcare, within the Makana municipality (Gillespie, 2021). This finding is echoed by Lund and colleagues (2015), that resource limitations, such as staff shortages and inadequate infrastructure, are expected in PHC and often result in a significant gap between the needs of the population and the services provided (Barron & Padarath, 2017). This finding is a well-documented and prevalent issue in PHC settings; however, identifying its root causes is crucial for meeting the research goals of this study. The research has shown that variations in patients' experiences within the same communities are influenced by intricate human behaviour. Patients' preference for one clinic over another perpetuates issues, such as extended waiting times and perceived inadequacies in nurse responsiveness. Addressing these issues is imperative to breaking the cycle of negative perceptions and experiences in PHC. The issue is echoed by Barron and Padarath (2017), who noted that healthcare problems in South Africa are worsened by the unequal distribution of healthcare professionals between the private and public sectors and among the provinces.

Moreover, although the primary focus of the study is on patients, it is crucial to recognise the significant impact of nurses on patient experiences of PHC. This is evident from patients' continuous reflection on nursing practice and nurses' influence on patient care. Previous studies by Petersen (2000) highlighted nurses' lack of training, while Kigozi and colleagues (2015) examined nurses' knowledge and attitudes toward patients with mental illnesses. Furthermore, this study contributes to the existing knowledge base by finding patients' concerns over nurses' poor professional conduct. It was revealed that some patients do not trust nurses, due to concerns about their problems and conditions being disclosed on

social media without their consent. One patient wrote, "*…So, you cannot be comfortable because they write about you on WhatsApp or Facebook....*"

The comment sheds light on the issue of confidentiality breaches among some nurses, presenting an opportunity for improvement. Confidentiality is crucial in building trust and enabling patients to openly discuss their emotional and psychological challenges with nurses, a vital aspect of patient care (Parsa, 2009). The Code of Ethics for Nursing Practitioners emphasises respecting the confidentiality and privacy of personal information and belongings of healthcare users (Lachman, 2009). This insight suggests a need to address potential ethical oversight among PHC nurses to safeguard patients' well-being. The findings provide important insights for incorporating patient perspectives into mental healthcare task-sharing strategies. This is essential as task-sharing strategies, which seek to improve mental healthcare provision in low-resource communities and guarantee the delivery of high-quality services for individuals with mental health conditions. They are highlighted in the NMHPF 2023-2030.

In addition, a study cited in the literature review chapter by Baker and Naidu (2021) on the challenges MHCUs face in a primary care setting, found that most participants felt disrespected and uncared for, especially when treated by unskilled or overworked staff. In the current study, some participants shared similar views and further found that nurses might lack skills in specific work areas, due to feeling overworked and overwhelmed by the burden of care in PHC. Therefore, this study's findings concur that mental healthcare nurses (MHNs) should be redistributed to PHC areas to increase human resources, to address the mental healthcare workforce crisis, as the issue remains fluid (De Kock & Pillay, 2017). As per the literature discussed by De Kock and Pillay (2017), it is evident that most mental health practitioners work in urban areas, rather than in rural or semi-urban facilities.

In their study, De Kock and Pillay (2017) focused on the importance of having psychiatrists working in low-resourced communities. Similarly, the current study identified a growing need for psychologists in PHC, to address mental health conditions, particularly in a mentally burdened society, such as the Makana municipality. This recalls a recurring pattern in healthcare, where PHC tends to prioritise patients with severe mental illnesses over those with milder disorders. In evidence, the 'SASH study', a research project that investigated the prevalence and impact of mental health disorders in South Africa, found that only adults with severe or moderately severe disorders received treatment, neglecting those with milder cases (Docrat et al., 2019). Consequently, the participants in this study expressed concerns about the shortage of psychologists in their clinics. One participant shared, *"There's only one psychologist here... But she's fully booked up to February. So, you can see that we need more people..."*. This situation presents challenges for individuals in need of care. Therefore, the current study findings are an important reminder of the growing need for non-prescribing mental health practitioners in PHC.

5.1.2 The urgent need for mental health education

Nurses are the first point of contact and are in a prime position to educate their patients about mental health. However, past studies have revealed that PHC nurses encounter significant challenges, including a lack of skills and training in providing mental healthcare services. To tackle these challenges, PHC nurses must embrace lifelong learning and consistently enhance their knowledge, skills, and competence throughout their careers (Hlongwa & Sibiya, 2019; Petersen, 2002; Kigozi et al., 2015).

Emphasising the pivotal role of nursing staff in patient care, underscores the necessity for nurses to possess the required skills to educate patients about mental health and effectively manage mental health crises, as underscored by Petersen (2002). The findings of

the present study further support this notion, as participants demonstrated a lack of understanding of mental health and mental illness, possibly due to a reported lack of mental health education and awareness in their clinics. This finding is concerning, as the study's participants reported a high likelihood of having mental health issues related to stressors linked to their socioeconomic status. Therefore, the study underscores the growing need for MHL within this specific demographic.

As with the previous literature, the current study found an interrelationship between low MHL, and high rates of stigma which is still prevalent in PHC due to ignorance (Strumpter et al., 2020; Booysen et al., 2021, Oegba et al., 2014). For example, due to their established lack of education on mental health, some participants used the words *"crazy"* or *"mad"* when referring to PWMI. These terms carry negative and dehumanising connotations, which can make PWMI feel shameful and cause them to refrain from disclosing their mental health statuses. This was the case of one participant who feared being judged for having a mental illness, and another who experienced stigma and social rejection, due to having a mental illness, which ultimately caused them to feel of less value. Both experiences support the findings of a study by Corrigan and Watson (2002), who came up with the concept called *self-stigma*. Their study outlined the process of self-stigma in three stages: first, individuals develop negative beliefs about themselves, followed by internalising these beliefs, and eventually, engaging in behaviours influenced by these beliefs. In this study, these behaviours are demonstrated by individuals with mental illness not seeking treatment, based on self-stigma, thus adversely affecting their lives and indicating a poor prognosis.

Furthermore, an interesting finding of this study was the participants' compassionate attitudes towards individuals with mental illness. Many expressed feelings of empathy and understanding, with one participant stating, *"I feel for them"*. This raised questions about whether people were willing to share their genuine views on PWMI or whether they felt

discomfort in openly advocating them in the face of community stigma. Furthermore, it seemed that this pattern was linked to a deficiency in MHL, as people expressed a willingness to help but lacked the necessary preparation to advocate individuals with mental illness, against discriminatory attitudes and behaviours. Thus, highlighting the different ways MHL can be a valuable tool for community members who wish to extend their support to PWMI.

5.1.3 Socioeconomics and mental health

Several studies, including Bruwer et al. (2011), have investigated the impact of substance use and untreated mental illness. Their study examined barriers to mental health care and predictors of treatment dropouts among South African adults. It revealed that low perceived need and attitudinal barriers affected those who acknowledged the need, while substance abuse influenced dropouts. However, this study has uncovered a complex interplay between substance abuse, mental illness, and the perpetuation of stigma in the Makana municipality.

According to Statistics et al. (2011), the Eastern Cape Province boasts the second-highest unemployment rate among the nine provinces, resulting in widespread poverty. This was exemplified by participants in the study who expressed feeling stressed or worried, due to unemployment, often resorting to substance abuse as a coping mechanism. This is problematic for various reasons; for instance, Bolton et al. (2009) noted that when individuals self-medicate through substance use to alleviate specific symptoms, it becomes even more challenging for them to receive treatment. Moreover, individuals with both substance abuse and psychiatric disorders are more likely to face unemployment, homelessness, violence, and instability in family and interpersonal relationships, therefore creating a vicious cycle (Lander et al., 2013). This is the situation faced by community members in the Makana municipality, as reported by the study participants.

More so, participants believe that most people with mental illness were due to substance abuse, which aligns with a study by Corrigan et al. (2006), demonstrating that people often attribute severe mental illness to drug addiction. Unfortunately, this notion leads to the idea that individuals with mental illness are at fault for their conditions and are therefore blamed and shown less compassion. This is particularly the case with participants in this study who believed that their mental illness was caused by substance use. This can be problematic as PWMI may believe they are to blame for their conditions and thus accept marginalisation. This is demonstrated in a study by Alemu and colleagues (2023) who took an interest in systematic research on internalised stigma among people with mental illness in Africa. Their study found that individuals may accept a negative but socially accepted connotation of one's mental illness, a term they coined *self-stigma*. These individuals then believe they do not deserve empathy or respect from others. In such cases, MHL could play a crucial role by providing advocacy and protection for individuals with mental illness to correct misinformation and reduce stigma. The study's findings suggested that people in these communities face significant challenges with limited options of mitigating their predicaments.

Moreover, De Wet and Pretorious (2023) conducted a study on the strategies for managing mental health challenges, highlighting the vital role of family and friends in providing support. The findings of the present study emphasise the importance of such support. A prominent theme among the participants was the impact of parental loss and grief, resulting in a lack of support and causing individuals to perceive life as overwhelming and stressful. Some participants mentioned parental loss due to HIV-related illnesses, while others highlighted the difficulties of raising multiple children without parental support. These challenges mirror those experienced in underprivileged communities, shedding light on the likely chronic mental health issues faced by the participants, including unresolved grief,

anxiety, and depression. These issues are often overlooked and untreated in PHC, as supported by Meyer and colleagues (2019). Their study warned that in LMICs, conditions such as anxiety, depression, substance use disorders, and mood disorders are frequently reported and diagnosed. At the same time, South Africa grapples with a significant burden of these mental health conditions. This finding concurs with the existing literature on the mental health challenges encountered by PHC patients.

5.1.4 The complex dynamics of help-seeking behaviours

People's first line of treatment was found to be strongly influenced by their knowledge and belief systems regarding mental illnesses. Lezcano (2021) corroborates that with reference to mental health, society's culture influences people's attitudes about seeking help, the type of support they need, and whether they decide to seek help. Cultural norms can account for minor differences in how people communicate their symptoms, to significant omissions of which symptoms they report. Each cultural group brings its own beliefs, traditions, and practices concerning the concept of mental health. Therefore, it makes it crucial to understand the role of these cultural factors in the person's overall approach to getting treatment (Lezcano, 2021).

The participants' comprehension of mental illness as stemming from witchcraft and being amenable to traditional healing, presents an opportunity for constructive engagement. Some participants cited that witchcraft was associated with others' envy or jealousy, portraying mental illness as a man-made condition that is curable. This understanding aligns with the findings of Oegba and colleagues' study (2014), which highlighted a tendency among individuals to seek solace from traditional African healers, before exploring Western treatment options. Furthermore, the study by Tilolo et al. (2015), on the beliefs of indigenous peoples concerning mental illness, suggested that the association of mental illness with

witchcraft, driven by jealousy, leads to difficulties in acceptance of one's mental illness as manifested in any other form. Although this perception may lead to resentment, it highlights an inclination among participants to resist Western models of mental illness, due to historical oppression and concerns about coercion. Thus, understanding and addressing these perspectives can be pivotal in promoting constructive dialogue and developing culturally sensitive approaches to mental healthcare.

Furthermore, in a study conducted by Petersen (2000) in chapter 2, it was observed that nurses would benefit from more comprehensive training. The study revealed that nurses often relied solely on doctors' instructions and overlooked other factors contributing to illnesses. It was further found that nurses tended to approach patient care primarily from a biomedical perspective, sometimes dismissing psychological or emotional aspects. Evidence of this trend was seen in the current study, where a participant reported: *I had pain here. I said, "No, I think my neck is sore." They said, "No you think a lot… they gave me pills and I was better"*. The patient consulted their clinic for symptoms of muscle tension and headaches, and while the nurse acknowledged the potential role of stress in the symptoms, they were ultimately prescribed only medication. This example highlights the opportunity for nurses to consider a more holistic approach, integrating biomedical and psychological perspectives into patient treatment. However, there is still a persistent trend that negates the latter.

Furthermore, participants reported visiting clinics mainly for biomedical consultations. They sought treatment for communicable diseases (HIV-related illnesses) and lifestyle diseases (hypertension and diabetes), with only one participant seeking treatment for a mental illness. This observation supports the Minister of Health, Phahlaa's (2023) announcement that physically-related illnesses significantly burden the health system, compared to mental health demands. However, it can be argued that some of the patients'

physical illnesses might be as a result of untreated or underlying mental illnesses, such as depression or anxiety. This highlights the dilemma of patients not being treated holistically in PHC. With the established burden of mental health as a result of individuals' socioeconomic statuses in the Makana municipality, this is unfavourable. The WHO (2014) emphasises the importance of a comprehensive healthcare strategy that focuses on overall healthcare, as an integrated way of managing and preventing mental disorders and other physical illnesses. In this regard, the current findings on help-seeking behaviours align with what is known in previous research.

5.2 Chapter Summary

This chapter discusses the main findings and relevant literature to support these findings. The findings reported challenges, experiences, and opinions of the state of mental health in PHC within the Makana municipality. The next chapter will deal with the concluding chapter, containing the final conclusions, limitations of the study, and recommendations for further research.

CHAPTER SIX

Conclusion

6.1 Chapter Overview

This chapter aims to consolidate the study by providing a broad overview of the current study. The chapter will recall the rationale and then report its main findings. The chapter includes a discussion of the findings in relation to the national mental health policy framework objectives. The chapter then includes a final conclusion, the study's limitations, and recommendations for future research and the researcher's reflective comments.

6.2 Rationale of the study

The study's purpose was to explore community members' perceptions on mental healthcare in primary healthcare settings. Given the limited research in this field, the study aims to explore the experiences and perspectives of mental healthcare users in disadvantaged communities in South Africa. Furthermore, it seeks to identify gaps in policy implementation that impede healthcare system transformation and consider solutions, such as task-sharing in healthcare as recommended by past studies and the NMHPF 2023-2030. Understanding the findings of the study and their implications for healthcare users in primary healthcare settings, is essential for enhancing the current primary healthcare system for its beneficiaries and informing the NMHPF 2023-2030 on appropriate areas of intervention.

6.3 Summary of Findings

The participants perceived primary healthcare in Makana municipality as having insufficient resources in the form of nurses, mental healthcare workers and appropriate consultation rooms which create obstacles to providing and receiving effective patient care. The participants feared that staff shortages could directly worsen the patients' existing

medical and mental health conditions. Therefore, to address these problems the participants suggested more nurses and mental healthcare practitioners be employed in PHC to mitigate the burden of patient influx. More consultation rooms should be built to accommodate those seeking mental health provision in private rooms. Moreover, patients reported concerns about the trustworthiness of PHC nursing staff, due to their previously known lack of confidentiality concerning patients' personal issues.

Furthermore, patients had varying perceptions of mental health which was due to limited mental health literacy across the majority of the participants. Consequently, patients did not seek mental health services, and some were reluctant to disclose their conditions, due to the fear of being stigmatised. Some participants who wanted to support people with mental illness felt helpless, due to not feeling equipped to support. An emphasis on incorporating health education into mental health, to draw awareness to the importance of both physical and psychological care for outpatient treatment, was highlighted. This carries the potential to demystify the idea that healthcare is related to only physical health. Moreover, mental health education has the potential to combat stigma and equip individuals with skills to support those with mental illnesses.

Importantly, participants perceived mental health provision as a vital need in such a community burdened with socio-economic factors, including a lack of employment, familial support, and substance abuse. Moreover, participants perceived the manifestation of mental illness as a result of cultural and religious factors. They thus believed that it could be treated through traditional doctors or religious healers. As a result, participants made use of PHC mainly for their biomedical needs, as compared to mental health needs.

Overall, the findings suggest the need for specific actions to enhance the effectiveness of primary healthcare. This involves policy reforms; resource allocation; mental health

education, and efforts to improve the quality of patient-provider relationships in primary mental healthcare settings. Therefore, the study aligns with what is already known about the state of primary healthcare based on previous research, thus highlighting opportunities for development and refinement in the healthcare system.

6.4 The relevance of this research to the National Mental Health Policy Framework

Based on the current study themes, it is evident that the findings have significant implications for the National Mental Health Policy Framework 2023-2030. Moreover, the results of the current research align with important goals set out by the framework. To begin with, the emphasis on healthcare settings aligns well with the policies' aim to enhance the efficiency and accessibility of health services at these facilities. This involves tackling resource shortages, improving patient experiences, and ensuring access to mental healthcare for all.

Moreover, the pressing need for health education highlighted in the study is consistent with the framework's objectives to increase mental health literacy, awareness and education across various sectors of society. Both the research outcomes and policy guidelines stress the importance of strategies to reduce the stigma and discrimination of people with mental health issues, through the integration of health education into different communities and healthcare platforms.

Furthermore, the findings regarding socioeconomic influences are in line with the framework's aim to ensure availability across all levels of care and early interventions. Moreover, the study's discovery of how socio-economic factors influence well-being, is in line with the policy framework's acknowledgment of the social determinants of mental health. By recognising the relationship between the socio-economic aspects and mental health, the study contributes to the framework's aim of tackling mental health disparities and

ensuring fair access to mental healthcare services. The help-seeking behaviours mirror the framework's goals to uphold the rights of people with a mental illness, by upholding autonomy and involving them in decision making.

In summary, this research aligns with the targets outlined in the mental health policy framework for 2023-2030, underscoring its significance in advancing overarching goals related to mental health policy and service delivery. The study's results carry implications for the health policy framework for 2023-2030 by presenting concrete evidence and valuable insights that can guide the creation and execution of mental health programmes in South Africa's healthcare system. By addressing challenges, in delivering healthcare advocating health education, and acknowledging how socio-economic factors impact mental well-being, the study results can inform and direct the strategies outlined in the national mental health policy framework.

6.5 Final Conclusions

There are many intricacies of mental healthcare in PHC, as established by the participants in this study. The most persistent issue is integrating quality mental health into primary care, as reiterated in the previous literature in the study. It was emphasised even more through the shared lived experiences of participants utilising PHC. Policies on improving PHC are still lacking, at least within the Eastern Cape Province. The current population needs a focus on primary healthcare through education, increased resources, and task-sharing. A prioritisation of both physical and mental illnesses at the core of overall care is urgently required. Thus, the current study is valuable, as it demonstrates evidence of how critical the objective of the NMHPF 2023-2030 is.

6.6 Limitations

The study has several limitations that should be noted. Since the research was carried out on one group, the results may not reflect the experiences of all individuals utilising primary healthcare. This limitation also restricts how broadly we can apply the study findings to all healthcare facilities in South Africa, considering their socioeconomic backgrounds and available resources. Hence, it is crucial to understand that the insights and challenges highlighted in this study, might not capture the spectrum of healthcare across various primary healthcare settings or regions.

Interview questions were asked in English; however, the participants answered in their preferred languages (isiXhosa and Afrikaans), which required translating the data back into English. This translation process might have led to inaccuracies in expressions and meanings, which could have been lost.

In addition, the analysis of the findings was influenced by the viewpoints of the participants. They do not claim to represent entire truths or be applicable to all individuals with mental health conditions in PHC settings. Therefore, the study could be influenced by the biased perspectives of the participants, based on their personal experiences.

Moreover, because of the approach taken in Thematic Analysis, the research was qualitative in nature. This means it could be less structured and may not disprove hypotheses or measure the frequency and severity of reported issues as would a quantitative study. Qualitative data allow for an exploration of experiences but may lack capturing a comprehensive overview of the various difficulties faced in primary mental healthcare, as highlighted by Tenny et al. (2022).

The study overlooked the problems and hurdles that healthcare workers in the Makana municipality face. This omission led to a limited understanding of the pressing problems presented in healthcare. Hence, it is important to interpret the study results, while keeping

these limitations in mind. Furthermore, considering the barriers identified it is vital to conduct further research to fully comprehend and tackle the issues associated with delivering high quality mental health services in primary care settings.

6.7 Recommendations for future research

This study is one of a few that examines the opinions of MHCUs within primary care; thus, it goes without question, that more research is needed. A recommendation for a larger sample size across rural areas in different provinces around South Africa would help make study findings more generalisable. Furthermore, recent research highlights the growing burden of mental illness in South Africa, therefore, future research is crucial to mitigate this problem.

There is a need for MHL advocacy, and awareness campaigns are needed to educate community members on mental illness, as the findings of this study suggest. This will increase a shift towards more curiosity and less judgement and stigma for those who have a mental illness. People may become more compassionate and empathetic to those with a mental illness. Moreover, this strategy could help cultivate the growing burden of mental illness; when individuals are more aware of their mental health, they are likely to seek prompt help, which increases the advantage of early detection. In addition, it is recommended that more mental health providers be employed in PHC. This would provide community members who were battling mental health a greater probability of being treated by a mental health practitioner.

In addition, an investigation on whether strategies on task-shifting for nurses in primary care are feasible for nurses to adopt and practice. Strategies should be employed to cultivate ways of educating nurses on mental health issues and the importance of managing such cases with as much depth as physical illnesses. Moreover, strategies to ensure that

nurses are kept accountable for advocating and promoting mental health care awareness to patients and communities by stakeholders. Studies should be undertaken on the influence of cultural beliefs on help-seeking behaviours for mental illness and the integration of traditional healing practices with modern mental health interventions in primary healthcare.

Finally, research is needed to develop and implement policies to integrate quality mental health services into primary care, particularly in rural and low-socioeconomic areas, such as the Makana municipality in the Eastern Cape Province.

6.8 Reflective comments by the researcher

Throughout my research I have begun to understand how much an individual's financial status can shape their life path. One's economic status impacts heavily the kind of lifestyle one lives or can afford. This includes the quality of education, opportunities and even the quality of healthcare one receives. This awareness grew during my engagement with community members of the Makana municipality.

Growing up in a rural area in Kwa Zulu-Natal helped me to connect deeply with the participants in my study. The struggles they face in accessing healthcare and mental health services are familiar to me. At times, it was difficult to set aside my own views, as I could identify with many of their experiences and concerns. However, I knew it was important to remain neutral, to allow their authentic voices.

As a female, my identity played a role in how I approached and interacted with the participants, which possibly helped build faster rapport with my participants. Moreover, sharing a similar background, gender, and ethnicity likely persuaded my participants to feel comfortable during our interactions. However, not being fluent in isiXhosa presented a challenge, as the participants expected that level of proficiency from me. On the other hand,

this experience highlighted how crucial it is to establish safe ground and trust within these communities, when engaging with such a community.

Furthermore, the participants, in the study highlighted the psychological effects of unemployment and a lack of family support, thus their resorting to substance abuse as a coping mechanism. These behaviours, while harmful, are commonly observed in low-resourced communities. It was interesting to learn how substance abuse, and a lack of mental health knowledge played a pivotal role in perpetuating a stigma. Therefore, I had empathy for both those experiencing stigmas and those perpetuating it, as well as deepening my empathy for individuals dealing with mental illness amidst limited community support. It became clear that a lack of health education in impoverished areas plays a role in sustaining stigmas rooted in ignorance.

Moreover. the participants' beliefs that mental illness manifests through witchcraft and jealousy shed light on how cultural beliefs influence help-seeking behaviours emphasising the importance of understanding these aspects as a mental health professional, in order to best engage at patients' level of understanding. I acknowledge the privilege that has allowed me to view mental illness through the perspectives of others, living in such communities. I am dedicated to advocating enhanced access to health services, mental health education and combating stigmas, as a professional in this field.

This experience has prompted me to reassess my assumptions and perspectives as I advance in my training, as a healthcare practitioner. As a mental health professional, my goal is that this study will enhance an awareness of health issues in underserved communities and push for policy changes to assist those utilising primary healthcare.

References

Ahad, A. A., Sanchez-Gonzalez, M., & Junquera, P. (2023). Understanding and Addressing Mental Health Stigma Across Cultures for Improving Psychiatric Care: A Narrative Review. *Cureus*, *15*(5). https://doi.org/10.7759/cureus.39549

Ahmed, M. (2024). Reliability in qualitative research. *Journal of Research in Nursing*, *29*(4), 285-293.

Alemu, W. G., Due, C., Muir-Cochrane, E., Mwanri, L., & Ziersch, A. (2023). Internalised stigma among people with mental illness in Africa, pooled effect estimates and subgroup analysis on each domain: systematic review and meta-analysis. *BMC Psychiatry*, *23*(1), 480. https://doi.org/10.1186/s12888-023-04950-2

Alkassim, R. S., Etikan, I., & Musa, S. A. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics*, *5*(1), 1-4. https://doi.org/10.11648/j.ajtas. 20160501.11

Altman, D. G. (1991). *Practical Statistics for Medical Research*. Chapman and Hall.

Andersson, L. M. C., Schierenbeck, I., Strumpher, J., Krantz, G., Topper, K., Backman, G., Ricks, E., & Van Rooyen, D. (2013). Help-seeking behaviour, barriers to care and experiences of care among persons with depression in Eastern Cape, South Africa. *Journal of affective disorders*, *151*(2), 439–448. https://doi.org/10.1016/j.jad.2013.06.022

Austin, Z., & Sutton, J. (2014). Qualitative research: Getting started. *The Canadian Journal of Hospital Pharmacy*, *67*(6), 436–440. https://doi.org/10.4212/cjhp.v67i6.1406

Baker, N., & Naidu, K. (2021). The Challenges Faced by Mental Health Care Users in a Primary Care Setting: A Qualitative Study. *Community mental health journal*, *57*(2), 285–293. https://doi.org/10.1007/s10597-020-00647-y

Baltussen, R. M., Yé, Y., Haddad, S., & Sauerborn, R. S. (2002). Perceived quality of care of primary health care services in Burkina Faso. *Health policy and planning*, *17*(1), 42-48. https://doi.org/10.1093/heapol/17.1.42

Barron, P., & Padarath, A. (2017). Twenty years of the South African health review. *South African Health Review*, *2017*(1), 1-10.

Baxter, A. J., Scott, K. M., Vos, T., & Whiteford, H. A. (2013). Global prevalence of anxiety disorders: a systematic review and meta-regression. *Psychological medicine*, *43*(5), 897–910. https://doi.org/10.1017/S003329171200147X

Bernard, H. R. (2002). Research methods in anthropology: *Qualitative and quantitative approaches* (3rd ed.). Walnut Creek, CA: Altamira Press.

Bolton, J. M., Robinson, J., & Sareen, J. (2009). Self-medication of mood disorders with alcohol and drugs in the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of affective disorders*, *115*(3), 367-375. https://doi.org/10.1016/j.jad.2008.10.003

Booysen, D., Mahe-Poyo, P., & Grant, R. (2021). The experiences and perceptions of mental health service provision at a primary health centre in the Eastern Cape. *The South African Journal of Psychiatry: SAJP: the Journal of the Society of Psychiatrists of South Africa*, *27*. https://doi.org/10.4102/sajpsychiatry.v27i0.1641

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597.

Braun, V., & Clarke, V. (2022). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.

Braun, V., Clarke, V., & Weate, P. (2016). Using thematic analysis in sport and exercise research. In B. Smith & A. C. Sparkes (Eds.), *Routledge handbook of qualitative research in sport and exercise* (pp. 191-205). New York, NY: Routledge.

Bresick, G. F., Sayed, A. R., Le Grange, C., Bhagwan, S., Manga, N., & Hellenberg, D. (2016). Western Cape Primary Care Assessment Tool (PCAT) study: Measuring primary care organisation and performance in the Western Cape Province, South Africa (2013). *African journal of primary health care & family medicine*, *8*(1), 1–12. https://doi.org/10.4102/phcfm.v8i1.1057

Brinkman, B., & Kavale, K. A. (2008). Limitations and misconceptions of qualitative research methods and data. *Exceptional Children, 74*(3), 301-321.

Bruwer, B., Sorsdahl, K., Harrison, J., Stein, D. J., Williams, D., & Seedat, S. (2011). Barriers to mental health care and predictors of treatment dropout in the South African Stress and Health Study. *Psychiatric services (Washington, D.C.)*, *62*(7), 774–781. https://doi.org/10.1176/ps.62.7.pss6207_0774

Burr, V. (2015). *Social constructionism* (3rd ed.). Routledge. https://doi.org/10.432/9781315715421

Byrne, D. (2022). A Worked Example of Braun and Clarke's Approach to Reflexive Thematic Analysis. *Quality & Quantity*, *56*, 1391–1412. https://doi.org/10.1007/s11135-021-01182-y

Cacciattolo, M. (2015). Ethical considerations in research. In *The Praxis of English Language Teaching and Learning (PELT)* (pp. 55-73). Brill.

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry*, *1*(1), 16.

Corrigan, P. W., Watson, A. C., & Miller, F. E. (2006). Blame, shame, and contamination: the impact of mental illness and drug dependence stigma on family members. *Journal of family psychology: JFP: journal of the Division of Family Psychology of the American Psychological Association (Division 43)*, *20*(2), 239–246. https://doi.org/10.1037/0893-3200.20.2.239

Creswell, J. W. (2014). *Research design qualitative, quantitative, and mixed methods approaches* (4th ed.). Sage Publications.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Cypress B. S. (2017). Rigor or Reliability and Validity in Qualitative Research: Perspectives, Strategies, Reconceptualization, and Recommendations. *Dimensions of critical care nursing: DCCN*, *36*(4), 253–263. https://doi.org/10.1097/DCC.0000000000000253

De Kock, J. H., & Pillay, B. J. (2017). A situation analysis of psychiatrists in South Africa's rural primary healthcare settings. *African Journal of Primary Health Care & Family Medicine*, *9*(1). https://doi.org/10.4102/phcfm.v9i1.1335

De Villiers K. (2021). Bridging the health inequality gap: an examination of South Africa's social innovation in health landscape. *Infectious diseases of poverty*, *10*(1), 19. https://doi.org/10.1186/s40249-021-00804-9

De Wet, A., & Pretorius, C. (2022). From darkness to light: Barriers and facilitators to mental health recovery in the South African context. *The International journal of social psychiatry*, *68*(1), 82–89. https://doi.org/10.1177/0020764020981126

Denzin, N. K., & Lincoln, Y. S. (2011). *The SAGE Handbook of Qualitative Research*. Sage.

Di Fabio, A., & Maree, J. G. (2012). Group-based Life Design Counselling in an Italian context. *Journal of Vocational Behaviour, 80*(1), 100 - 107. https://doi.org/10.1016/j.jvb.2011.06.001

Dineva, S., & Nedeva, V. (2020). *The 15th international conference on virtual learning: Virtual learning-virtual reality* [Conference session]. ICVL 2010-2030: International Conference on Virtual Learning, University of Bucharest.

Docrat, S., Besada, D., Cleary, S., Daviaud, E., Lund, C., & Petersen, I. (2019). The "SASH" Study: A population-based survey of mental health and substance use in the Eastern Cape, South Africa. *Journal of Affective Disorders,* 252, 96-103.

Dodgson, J.E. (2019). Reflexivity in Qualitative Research. *Journal of Human Lactation*. *35*(2), 220-222. doi:10.1177/0890334419830990

Donnelly, R., & Patrinos, H. A. (2022). Learning loss during Covid-19: An early systematic review. *Prospects, 51*(4), 601- 609. https://doi.org/10.1007/s11125-021-09582-6

Drew, N., Funk, M., Tang, S., Lamichhane, J., Chavez, E., Katontoka, S., Pathare, S., Lewis, O., Gostin, L. & Saraceno, B. (2011). Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. *The Lancet, 378*(9803), 1664 -1675.

Eaton, J., 2019. Global Mental Health: *A Resource Map for Connecting and Contributing*. [online] Available at: https://www.psychiatry.org/global-mental-health

Eghigian, G. (Ed.). (2017). *The Routledge History of Madness and Mental Health* (1st ed.). Routledge. https://doi.org/10.4324/9781315202211

Esponda, G. M., Hartman, S., Qureshi, O., Sadler, E., Cohen, A., & Kakuma, R. (2020). Barriers and facilitators of mental health programmes in primary care in low-income and middle-income

countries. *The lancet. Psychiatry*, *7*(1), 78–92. https://doi.org/10.1016/S2215-0366(19)30125-7

Esterberg, K. G. (2002). *Qualitative methods in social research*. McGraw-Hill.

Fabio, A., & Maree, K. (2012). Resolving the tension between trustworthiness and authenticity: A concrete example. *The Qualitative Report, 17*(39), 1-18.

Funk, M., Saraceno, B., Drew, N., & Faydi, E. (2008). Integrating mental health into primary healthcare. *Mental health in family medicine*, *5*(1), 5–8.

Gentles, S. J., Jack, S. M., Nicholas, D. B., & McKibbon, K. A. (2014). Critical Approach to Reflexivity in Grounded Theory. *The Qualitative Report*, *19*(44), 1-14. https://doi.org/10.46743/2160-3715/2014.1109

Gillespie, A., & Reader, T. W. (2021). Identifying and encouraging high-quality healthcare: an analysis of the content and aims of patient letters of compliment. *BMJ quality & safety*, *30*(6), 484-492. https://doi.org/10.1136/bmjqs-2019-010077

Glover, C. N. (2014). Experiences of primary health care nurses providing mental health care services at primary health care clinics in eThekwini South Sub-District, KwaZulu-Natal. https://core.ac.uk/download/196549353.pdf

Govender, S., Gerwel Proches, C. N., & Kader, A. (2018). Examining leadership as a strategy to enhance health care service delivery in regional hospitals in South Africa. *Journal of Multidisciplinary Healthcare*, *11*, 157-166. https://doi.org/10.2147/JMDH.S151534

Hammersley, M., & Atkinson, P. (2019). Ethnography: *Principles in Practice* (4th ed.). Routledge. https://doi.org/10.4324/9781315146027

Haq, I. U., Hyder, A. A., Akhtar, T., & Shah, S. (2023). Rethinking the approach to qualitative research in pedagogy: Value and challenges. *Quality in Primary Care, 20*(1), 1-6.

Haynes, K. (2012). Reflexivity in qualitative research. *Qualitative Social Work, 11*(3), 390-405.

Hesse-Biber, S., & Leavy, P. (2011). *The practice of qualitative research*. Sage Publications.

Hlongwa, E. N., & Sibiya, M. N. (2019). Challenges affecting the implementation of the Policy on Integration of Mental Health Care into primary healthcare in KwaZulu-Natal province. *Curationis*, *42*(1), 1-9.

Honikman, S., van Heyningen, T., Field, S., Baron, E., & Tomlinson, M. (2012). Stepped care for maternal mental health: a case study of the perinatal mental health project in South Africa. *PLoS medicine*, *9*(5), e1001222. https://doi.org/10.1371/journal.pmed.1001222

Jack, H., Wagner, R. G., Petersen, I., Thom, R., Newton, C. R., Stein, A., Kahn, K., Tollman, S., & Hofman, K. J. (2014). Closing the mental health treatment gap in South Africa: a review of costs and cost-effectiveness. *Global Health Action*, *7*(1), 23431. https://doi.org/10.3402/gha.v7.23431

Jakovljevic, M., Bjedov, S., Jaksic, N., & Jakovljevic, I. (2020). COVID-19 Pandemia and Public and Global Mental Health from the Perspective of Global Health Securit. *Psychia tria Danubina*, *32*(1), 6–14. https://doi.org/10.24869/psyd.2020.6

Jensen, L. A. (2008). The ethics of Internet research: *A rhetorical, case-based process*. Peter Lang.

Kelly, G., Mrengqwa, L., & Geffen, L. (2019). "They don't care about us": older people's experiences of primary healthcare in Cape Town, South Africa. *BMC geriatrics*, *19*(1), 98. https://doi.org/10.1186/s12877-019-1116-0

Kiger, M. E., & Varpio, L. (2020). Thematic analysis of qualitative data: AMEE Guide No. 131. *Medical teacher*, *42*(8), 846–854. https://doi.org/10.1080/0142159X.2020.1755030

Kigozi-Male, N. G., Heunis, J. C., & Engelbrecht, M. C. (2023). Primary health care nurses' mental health knowledge and attitudes towards patients and mental health care in a South African

metropolitan municipality. *BMC nursing*, *22*(1), 25. https://doi.org/10.1186/s12912-023-01188-x

Kirmayer, L. J., & Pedersen, D. (2014). Toward a new architecture for global mental health. *Transcultural psychiatry*, *51*(6), 759–776. https://doi.org/10.1177/1363461514557202

Koch, T. (1994). Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing*, *19*(5), 976–986.

Kohrt, B. A., Asher, L., Bhardwaj, A., Fazel, M., Jordans, M. J. D., Mutamba, B. B., Nadkarni, A., Pedersen, G. A., Singla, D. R., & Patel, V. (2018). The Role of Communities in Mental Health Care in Low- and Middle-Income Countries: A Meta-Review of Components and Competencies. *International journal of environmental research and public health*, *15*(6), 1279. https://doi.org/10.3390/ijerph15061279

Kola, L., Kohrt, B. A., Hanlon, C., Naslund, J. A., Sikander, S., Balaji, M., Benjet, C., Cheung, E. Y. L., Eaton, J., Gonsalves, P., Hailemariam, M., Luitel, N. P., Machado, D. B., Misganaw, E., Omigbodun, O., Roberts, T., Salisbury, T. T., Shidhaye, R., Sunkel, C., Ugo, V., … Patel, V. (2021). COVID-19 mental health impact and responses in low-income and middle-income countries: reimagining global mental health. *The lancet. Psychiatry*, *8*(6), 535–550. https://doi.org/10.1016/S2215-0366(21)00025-0

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120-124.

Lachman V. D. (2009). Practical use of the nursing code of ethics: part I. *Medsurg nursing: official journal of the Academy of Medical-Surgical Nurses*, *18*(1), 55–57.

Lander, L., Howsare, J., & Byrne, M. (2013). The Impact of Substance Use Disorders on Families and Children: From Theory to Practice. *Social Work in Public Health, 28*, 194. https://doi.org/10.1080/19371918.2013.759005

Leavy, P. (2017). Research design: *Quantitative, qualitative, mixed methods, arts-based, and community-based participatory research approaches*. The Guildford Press.

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. *International Journal of Intercultural Relations, 9*(4), 438–439.

Locke, L. F., Spirduso, W. W., & Silverman, S. J. (2013). Proposals that work: *A guide for planning dissertations and grant proposals*. Sage Publications.

Luker, K. A., Austin, L., Caress, A., & Hallett, C. E. (2000). The importance of 'knowing the patient': community nurses' constructions of quality in providing palliative care. *Journal of advanced nursing*, *31*(4), 775–782. https://doi.org/10.1046/j.1365-2648.2000.01364.x

Lund, C. (2016). Mental health and human rights in South Africa: the hidden humanitarian crisis. *South African Journal on Human Rights, 32*(3), 403– 405.

Lund, C., Breen, A., Flisher, A. J., Kakuma, R., Corrigall, J., Joska, J. A., Swartz, L., & Patel, V. (2010). Poverty and common mental disorders in low- and middle-income countries: A systematic review. *Social Science & Medicine, 71*(3), 517–528.

Lund, C., Petersen, I., Kleintjes, S., & Bhana, A. (2012). Mental health services in South Africa: Taking stock. *African Journal of Psychiatry (South Africa), 15*(6), 402–405. https://doi.org/10.4314/ajpsy.v15i6.48

Malinowski B (1922). *Argonauts of the Western Pacific*. London: George Routledge & Sons.

Maphumulo, W. T., & Bhengu, B. R. (2019). Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. *Curationis*, *42*(1). https://doi.org/10.4102/curationis.v42i1.1901

Marais, D. L., & Petersen, I. (2015). Health system governance to support integrated mental health care in South Africa: challenges and opportunities. *International journal of mental health systems*, *9*, 14. https://doi.org/10.1186/s13033-015-0004-z

Mehlwana, L., & October, A. (2021). Analysis: Eastern Cape needs mental health services, gets mostly empty promises. *Spotlight*. Retrieved from https://www.spotlightnsp.co.za/2021/11/15/analysis-eastern-cape-needs-mental-health-services-gets-mostly-empty-promises/

Mendenhall, E., De Silva, M. J., Hanlon, C., Petersen, I., Shidhaye, R., Jordans, M., Luitel, N., Ssebunnya, J., Fekadu, A., Patel, V., Tomlinson, M., & Lund, C. (2014). Acceptability and feasibility of using non-specialist health workers to deliver mental health care: Stakeholder perceptions from the PRIME district sites in Ethiopia, India, Nepal, South Africa, and Uganda. *Social Science & Medicine*, *118*, 33-42. https://doi.org/10.1016/j.socscimed.2014.07.057

Merriam, B., & Associates. (1998). *Qualitative research and case study applications in education*. Jossey-Bass Publishers.

Merriam, S. B. (2009). *Qualitative Research A Guide to Design and Implementation* (2nd ed.). Jossey-Bass.

Meyer, J. C., Matlala, M., & Chigome, A. (2019). Mental health care - a public health priority in South Africa. *South African Family Practice*, *61*(5), 25-30. https://doi.org/10.4102/safp.v61i5.4946

Miles M, Huberman M, & Saldana J (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). Thousand Oaks, CA: Sage.

Mokitimi, S., Schneider, M., de Vries, P. J., & Kafaar, Z. (2018). Policy implementation for child and adolescent mental health in South Africa: a qualitative study. *BMC Health Services Research, 18*(1), 851-859. https://core.ac.uk/download/560376422.pdf

Moncrieff, J. (2010). Psychiatric diagnosis as a political device. *Social Theory & Health, 8*(4), 370–382. https://doi.org/10.1057/sth.2009.11

Monteiro, N. M. (2015). Addressing mental illness in Africa: Global health challenges and local opportunities. *Community Psychology in Global Perspective*, *1*(2), 78-95.

Moser, A., & Korstjens, I. (2018). Series: Practical guidance to qualitative research. Part 3: Sampling, data collection and analysis. *The European journal of general practice*, *24*(1), 9–18. https://doi.org/10.1080/13814788.2017.1375091

Mukiapini, S., Bresick, G., Sayed, A.-R., & Le grange, C. (2018). Baseline measures of primary health care team functioning and overall primary health care performance at Du Noon Community Health Centre. *African Journal of Primary Health Care & Family Medicine, 10*(1).

Mulaudzi. (2007). Access to health care services for children: The Child Healthcare Problem Identification Programme (Child PIP). Submission to the Public Inquiry into Access to Health Care Services.

National Alliance on Mental Illness (NAMI), 2015. Mental Health By the Numbers. [online] Available at: <https://www.nami.org/mhstats> [Accessed 29 October 2021].

NATIONAL HEALTH INSURANCE BILL. (n.d.). https://www.gov.za/sites/default/files/gcis_document/201908/nationalhealth-insurance-bill-b-11-2019.pdf.

Neuman, W. L. (2002). Social Research Methods: Qualitative and Quantitative Approaches. *Teaching Sociology*, *30*(3), 380.

Newhart, M., & Patten, M.L. (2023). *Understanding Research Methods: An Overview of the Essentials* (11th ed.). Routledge. https://doi.org/10.4324/9781003092049

Nieuwenhuis, J. (2020). *Qualitative Research Designs and Methods*. Cape Town: Juta and Company Ltd.

O'Brien, B. C. (2010). Harris, P.A., Taylor, R., Thielke, R., et al. (2009). Research electronic data capture (REDCap) - a metadata-driven methodology and workflow process for providing translational research informatics support. *Journal of Biomedical Informatics, 42*(2), 377-81.

Oegba, C. O., Brooke-Sumner, C., Kathree, T., Selohilwe, O., Thornicroft, G., & Petersen, I. (2014). Psychiatric stigma and discrimination in South Africa: Perspectives from key stakeholders. *BMC Psychiatry, 14*(1), 191. https://doi.org/10.1186/1471-244X-14-191

Omar, M. A., Green, A. T., Bird, P. K., Mirzoev, T., Flisher, A. J., Kigozi, F., Lund, C., Mwanza, J., & Ofori-Atta, A. L. (2010). Mental health policy process: a comparative study of Ghana, South Africa, Uganda and Zambia. *International journal of mental health systems*, *4*, 24. https://doi.org/10.1186/1752-4458-4-24

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health*, *42*(5), 533. https://doi.org/10.1007/s10488-013-0528-y

Parsa, M. (2009). Privacy and confidentiality in medical field and its various aspects. *J Med Ethics Hist*, *4*, 1-14.

Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A.S., Silva, M.J., Hosman, C.M., McGuire, H., Rojas, G., & Ommeren, M.V. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *The Lancet, 370*, 991-1005.

Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods* (2nd ed.). Newbury Park, CA: Sage Publications, Inc.

Patton, M. Q. (2015). *Qualitative Research & Evaluation Methods: Integrating Theory and Practice*. Sage Publications.

Petersen, I. (2000). Comprehensive integrated primary mental health care for South Africa. Pipedream or possibility? *Social Science & Medicine*, *51*(3), 321-334. https://doi.org/10.1016/S0277-9536(99)00456-6

Petersen, I., Marais, D., Abdulmalik, J., Ahuja, S., Alem, A., Chisholm, D., Egbe, C., Gureje, O., Hanlon, C., Lund, C., Shidhaye, R., Jordans, M., Kigozi, F., Mugisha, J., Upadhaya, N., & Thornicroft, G. (2017). Strengthening mental health system governance in six low- and middle-income countries in Africa and South Asia: challenges, needs and potential strategies. *Health policy and planning*, *32*(5), 699–709. https://doi.org/10.1093/heapol/czx014

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Czasopismo Psychologiczne Psychological Journal*, *20*(1), 7-14.

Pillay, Y. (2019). State of mental health and illness in South Africa. *South African Journal of Psychology*, *49*(4). https://doi.org/10.1177/0081246319857527

Poulis, K., Poulis, E., & Plakoyiannaki, M. E. (2013). The role of context in case study selection: An international business perspective. *International Business Review, 22* (1). 304 - 314.

Samartzis, L., & Talias, M. (2020). *Epidemiology and Impact of Mental Health Disorders*. Sydney: Elsevier.

Saraceno, B. (2004). Mental health: Scarce resources need new paradigms. *World Psychiatry*, *3*(1), 3-5. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414651/

Schmid, R., Hopkins, D. J., & Webster. M. (1998). Merriam-Webster's Geographical Dictionary. *Taxon, 47*(2), 535.

Seedat, S., Williams, D.R., Herman, A.A., Moomal, H., Williams, S.L., Jackson, P.B., Myer, L. & Stein, D.J. (2009). Mental health service use among South Africans for mood, anxiety and substance use disorders. *South African Medical Journal*, *99*(5):346–352.

Seema, P., Barbui, C., & Saxena, S. (2016). Services for mental disorders in South Africa: Costs and policy implications. *Health Policy and Planning*, *31*(3), 350-356

Selohilwe, O., Fairall, L., Bhana, A., Kathree, T., Zani, B., Folb, N., Lund, C., Thornicroft, G., & Petersen, I. (2023). Challenges and opportunities for implementation and dissemination of a task- sharing counselling intervention for depression at primary health care level in South Africa. *International journal of mental health systems*, *17*(1), 7. https://doi.org/10.1186/s13033-023-00575-w

Shenton, A.K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*, 63-75. https://doi.org/10.3233/EFI-2004-2220

Shisana, O., Stein, D. J., Zungu, N. P., & Wolvaardt, G. (2024). The rationale for South Africa to prioritise mental health care as a critical aspect of overall health care. *Comprehensive psychiatry*, *130*, 152458. https://doi.org/10.1016/j.comppsych.2024.152458

Sieber, J. E. (1992). *The ethics of social research: Surveys and experiments*. Springer Science & Business Media.

Smith, J. A., Flowers, P., & Larkin, M. (2009). Planning an IPA research study. In P. Flowers & M. Larkin (Eds.), *Interpretative phenomenological analysis: Theory, method and research* (pp. 40-55). London, England: SAGE Publications.

South African Department of Health. (2013). *National Mental Health Policy Framework and Strategic Plan 2023-2030*.

Statistics South Africa. (2011). *Quarterly labour force survey*. Pretoria: Statistics South Africa.

Stein D. J. (2014). A new mental health policy for South Africa. *South African medical journal = Suid-Afrikaanse tydskrif vir geneeskunde*, *104*(2), 115–116. https://doi.org/10.7196/samj.7938

Strümpher, J., Van Rooyen, R. M., Topper, K., Andersson, L. M. C., & Schierenback, I. (2016). BARRIERS TO ACCESSING MENTAL HEALTH CARE IN THE MENTAL HEALTH IN EASTERN CAPE PROVINCE OF SOUTH AFRICA. *Africa Journal of Nursing and Midwifery, 16*(1), 45–59. https://doi.org/10.25159/2520-5293/1487

Tana, V.V. (2013). *'Experiences of chronic patients about long waiting time at a community health care centre in the Western* Cape'. Master of Nursing Sciences in the Faculty of Health, University of Stellenbosch.

Teachman, G., & Gibson, A. (2013). Reflections on enhancing interviewer sensitivity in qualitative research. *International Journal of Qualitative Methods*, *12*(1), 402-416.

Tenny, S., Brannan, J. M., & Brannan, G. D. (2022). Qualitative Study. In *StatPearls*. StatPearls Publishing.

The Role of Culture in Mental Health | Psychology Today. https://www.psychologytoday.com/us/blog/becoming-resilient/202103/the-role-culture-in-mental-health

Thomas, E., & Magilvy, J. K. (2011). Qualitative rigor or research validity in qualitative research. *Journal for specialists in paediatric nursing: JSPN*, *16*(2), 151–155. https://doi.org/10.1111/j.1744-6155.2011.00283.x

Thornicroft, G., Ahuja, S., Barber, S., Chisholm, D., Collins, P. Y., Docrat, S., Fairall, L., Lempp, H., Niaz, U., Ngo, V., Patel, V., Petersen, I., Prince, M., Semrau, M., Unützer, J., Yueqin, H., & Zhang, S. (2019). Integrated care for people with long-term mental and physical health conditions in low-income and middle-income countries. *The lancet. Psychiatry*, *6*(2), 174–186. https://doi.org/10.1016/S2215-0366(18)30298-0

Thornicroft, G., Brohan, E., Kassam, A., & Lewis-Holmes, E. (2008). Reducing stigma and discrimination: Candidate interventions. *International Journal of Mental Health Systems*, *2*(1), 1-9.

Tilolo, L., Magadla, N. I. N., & Tshotsho, N. (2015). Perceptions of indigenous people regarding mental illness at Cacadu district in the Eastern Cape province, South Africa. *African Journal of Physical Health Education, Recreation and Dance, 21*(2.2), 397–406.

Tilolo, L., Magadla,N.I.N., & Tshotsho, N. (2015). Perceptions of indigenous people regarding mental illness at Cacadu district in the Eastern Cape province, South Africa. *Afr J Phys Health Educ Recreat Dance, 21*(2.2), 397–406.

Tindimwebwa, L., & Adeniyi, O. (2021). Prevalence and Demographic Correlates of Substance Use among Adults with Mental Illness in Eastern Cape, South Africa: A Cross-Sectional Study. *International Journal of Environmental Research and Public Health, 18*(10), 5428.

Tomaszewski, L. E., Zarestky, J., & Gonzalez, E. (2020). Planning Qualitative Research: Design and Decision Making for New Researchers. *International Journal of Qualitative Methods*, *19*. https://doi.org/10.1177/1609406920967174

Torales, J., O'Higgins, M., Castaldelli-Maia, J. M., & Ventriglio, A. (2020). The outbreak of COVID-19 coronavirus and its impact on global mental health. *The International journal of social psychiatry*, *66*(4), 317–320. https://doi.org/10.1177/0020764020915212

Trevillion, K., Stuart, R., Ocloo, J., Broeckelmann, E., Jeffreys, S., Jeynes, T., Allen, D., Russell, J., Billings, J., Crawford, M. J., Dale, O., Haigh, R., Moran, P., McNicholas, S., Nicholls, V., Foye, U., Simpson, A., Lloyd-Evans, B., Johnson, S., & Oram, S. (2022). Service user perspectives of community mental health services for people with complex emotional needs: a co-produced qualitative interview study. *BMC psychiatry*, *22*(1), 55. https://doi.org/10.1186/s12888-021-03605-4

Van Rensburg, A.J. (2021). *The Political Economy of Mental Illness in South Africa* (1st ed.). Routledge. https://doi.org/10.4324/9780429201455

Wainberg, M. L., Scorza, P., Shultz, J. M., Helpman, L., Mootz, J. J., Johnson, K. A., Neria, Y., Bradford, M. E., Oquendo, M. A., & Arbuckle, M. R. (2017). Challenges and Opportunities in Global Mental Health: A Research-to-Practice Perspective. *Current Psychiatry Reports*, *19*(5), 28. https://doi.org/10.1007/s11920-017-0780-z

Walsh, S. (2023). "Subjective Perspectives on Studied Behavior". *Journal of Behavioral Studies*, *45*(2), 76-89.

Weller, S. C., Vickers, B., Bernard, H. R., Blackburn, A. M., Borgatti, S., Gravlee, C. C., & Johnson, J. C. (2018). Open-ended interview questions and saturation. *PloS one*, *13*(6), e0198606. https://doi.org/10.1371/journal.pone.0198606

Westaway, A. (2012). Rural poverty in the Eastern Cape Province: Legacy of apartheid or consequence of contemporary segregationism? *Development Southern Africa, 29*(1), 115–125. https://doi.org/10.1080/0376835X.2012.645646

Whitney, C., & Evered, J. A. (2022). The Qualitative Research Distress Protocol: A Participant-Centered Tool for Navigating Distress During Data Collection. *International Journal of Qualitative Methods, 21*. https://doi.org/10.1177/16094069221110317

Wolf, J. A., Niederhauser, V., Marshburn, D., & LaVela, S. L. (2021). Re-examining "Defining Patient Experience": The human experience in healthcare. *Patient Experience Journal, 8*(1), 16–29.

World Health Organization. (1948). *International Organization, 2*(2), 374–377.

World Health Organization. (2005). *Mental Health Evidence and Research Team*. Mental health atlas. World Health Organization.

World Health Organization. (2011). *Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level*. Executive Board, 130th session. http://apps.who.int/gb/ebwha/pdf

World Health Organization. (2014). *Promoting mental health: concepts, emerging evidence, practice (Summary Report)* Geneva: World Health Organization.

World Health Organization. (2004). Promoting mental health: concepts, emerging evidence, practice: summary report / a report from the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. World Health Organization. https://iris.who.int/handle/10665/42940

World Health Organization. (2008). The world health report 2008: primary health care now more than ever: *Introduction and overview*. World Health Organization. https://iris.who.int/handle/10665/69863

APPENDIX A: ETHICS APPROVAL

RHODES UNIVERSITY
Where leaders learn

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20 September 2022

Dr Duane Booysen

Psychology

Email: d.booysen@ru.ac.za

Review Reference: 2022-5578-7109

Dear Dr Duane Booysen

Re: Public mental health needs, challenges, services, barriers, and opportunities in the Makana Municipality in the Eastern Cape Researcher: Dr Duane Booysen

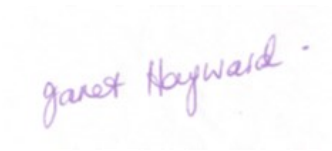
Supervisor(s): , Ms Phillipa Haine, Ms Siphelele Zwane, Ms Zandisiwe Piliso,

This letter confirms that the above research proposal has been reviewed by the Rhodes University Human Research Ethics Committee (RU-HREC) and

PROVISIONALLY APPROVED PENDING PERMISSION/GATEKEEPER LETTER(S).

Gatekeeper permission is required from: Mr Mohamed Docrat (Department of health, Makana).

Once the Gatekeeper permission letter/s has been received please forward it to the Ethics Coordinator, in order to finalize your ethics approval. Sincerely,



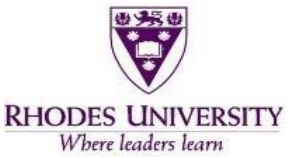
Dr Janet Hayward

Chair: Rhodes University Human Research Ethics Committee, RU-HREC

cc: Ethics Coordinator

Page 1 of 1

APPENDIX B: REQUEST FOR PERMISSION TO CONDUCT RESEARCH



ACCESS LETTER REQUESTING PERMISSION TO CONDUCT RESEARCH

September 2022

Mr Mohamed Docrat

Eastern Cape Department of Health

Manager: Makana Sub-district

Fort Beaufort Street,

Grahamstown,

6139

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am a Senior Lecturer and Clinical Psychologist in the Department of Psychology at the Rhodes University.

The title of the project is: Public mental health needs, challenges, services, barriers, and opportunities in the Makana Municipality in the Eastern Cape (ref: 2022-5578-6957).

The last decade has highlighted the need to prioritise and improve mental healthcare on a global level (World Health Organisation [WHO], 2021). The lack of mental healthcare has not only been described as a public health crisis but also as a human rights violation (WHO, 2011). Moreover, low- and middle-income countries (LMIC) such as South Africa (SA), have longstanding mental healthcare challenges (Burns, 2011; Saxena & Skeen, 2016).

Considering the increasing focus on improving and prioritizing global mental health, the proposed study will explore and describe the systemic nature of mental health service provision and its prioritization in the Makana Municipality in the Eastern Cape.

The broad aim of the proposed study is to explore and describe the state of mental healthcare in the Makana municipality, and to ascertain the nature of the existing challenges, services, barriers, and opportunities. The proposed research will be guided by the following research questions:

- How do persons (healthcare users) accessing healthcare at a primary care level understand and perceive the need for and utility of mental healthcare at a community-based level?
- How do facility managers of primary health clinics perceive the need for and utility of mental healthcare at a community-based level?
- How do mental healthcare stakeholders perceive the status of mental healthcare in the Makana Municipality?

Rhodes University, Research Office, Ethics

Ethics Coordinator: ethics-commitee@ru.ac.za t: +27 (0) 46 603 7727 f: +27 (0) 86 616 7707

Room 220, Main Admin Building, Drostdy Road, Grahamstown, 6139

RHODES UNIVERSITY
Where leaders learn

I am hereby seeking your consent to conduct the research across all the designated primary health clinics in the Makana municipality, to recruit staff and patients at the various clinics to conduct interviews in relation to the aim of the project. To assist you in reaching a decision, I have attached to this letter:

(a) A copy of an ethical clearance certificate issued by the University

(b) A copy the research proposal which I intend using in my research

Should you require any further information, please do not hesitate to contact me or my supervisor. Our contact details are as follows:

Tel: 0466038507

Cell: 0781676607

Email: d.booysen@ru.ac.za

Upon completion of the study, I undertake to provide you with feedback.

Your permission to conduct this study will be greatly appreciated.

Yours sincerely,

Duane D. Booysen, PhD

Rhodes University, Research Office, Ethics

Ethics Coordinator: ethics-commitee@ru.ac.za t: +27 (0) 46 603 7727 f: +27 (0) 86 616 7707

Room 220, Main Admin Building, Drostdy Road, Grahamstown, 6139

APPENDIX C: GATEKEEPER PERMISSION

Province of the
EASTERN CAPE
HEALTH

Makana Sub District Office•49 Beaufort Street • Grahamstown • Eastern Cape
Private Bag X1023 • Grahamstown • 6140 • REPUBLIC OF SOUTH AFRICA
Tel.: +27 (0)46 622 4901 • Fax: +27 (0)46 622 6225 • Website· www.ecdoh.gov.za

Enquiries	**M. Docrat**	**Our Reference**	:	
Telephone	**:046-6224901**	**Your Reference**	:	
Fax :	**046: 6226225**	**Date**	:	2022/10/11
E-mail	**:Mohamed.docrat@echealth.gov.za**			

Department of Psychology
Faculty of Humanities
Makhanda (Grahamstown)
6139
Dear Dr Duane, Booysen

Research Proposal: Public mental health needs, challenges, services, barriers, and opportunities in the Makana Municipality in the Eastern Cape.

.

This serves to confirm that you have been granted permission to conduct your proposed research at the following primary health care facilities:

1. Joza Clinic
2. NG Dlukulu Clinic
3. Middle Terrace Clinic
4. Raglan Road Clinic

Your sincerely,

M. Docrat (Acting Sub- District Manager)

APPENDIX D: PARTICIPANT INFORMED CONSENT

PARTICIPANT INFORMED CONSENT DECLARATION

(To be signed by research participants)

Research Project Title: Public mental health needs, challenges, services, barriers, and opportunities in the Makana Municipality in the Eastern Cape

Dr Duane Booysen from the Department of Psychology, Rhodes University, has requested my permission to participate in the above-mentioned research project.

The nature and the purpose of the research project and of this informed consent declaration have been explained to me in a language that I understand.

I am aware that:

1. The purpose of the research project will explore and describe the systemic nature of mental health service provision and its relevance in the Makana Municipality in the Eastern Cape.

2. Rhodes University has given ethical clearance to this research project ***(2022-55787109)*** and I have seen/may request to see the clearance certificate by contacting the Ethics Coordinator (ethics-committee@ru.ac.za).

3. By participating in this research project, I will be contributing towards research about the systemic nature of mental health service provision and its relevance in the Makana Municipality in the Eastern Cape.

4. I will participate in the project by being interviewed about my experiences and perceptions regarding mental health services provision at a community level.

5. I understand that my participation in this research will also contribute to the creation of a series of academic articles, a master's thesis, and conference presentations.

6. My participation is entirely voluntary and should I at any stage wish to withdraw from participating further, I may do so without any negative consequences.

7. I will not be compensated for participating in the research.

8. The following risks are associated with my participation: The contraction of Covid-19 through in-person interviews which will be prevented through the full disclosure of my vaccination and masks will be worn throughout the interview. If at risk or not vaccinated, the interview will take via Zoom or telephonically.

9. The Researcher will maintain confidentiality and anonymity of all data collected, and my name and identity will not be revealed to anyone who has not been involved in conducting the research, *unless I indicate to the contrary/recognise that as a public figure, my identity will inevitably be/become known in which case I agree to and accept the loss of confidentiality.*

10. In terms of the Protection of Personal Information Act (No. 4, 2013), it remains my right to request the Researcher to provide me with a detailed explanation of exactly how confidentiality and anonymity will be achieved. I may request to know how my personal information will be stored securely, and for how long it will be stored.

11. If any data collected from me for this research project is to be used by the researcher for any further project, I am to be informed in writing, and my written consent requested again. I need not give consent if such further research is incompatible with the initial data presented for this study (POPIA, s15(3)). Equally, I can simply reject the request. In such cases a formal request needs to be made by the researcher via the Ethics Coordinator (ethics-committee@ru.ac.za).

12. In terms of the Protection of Personal Information Act, I possess the right to receive feedback about this research. This will take the form of receipt of a copy of the academic articles and MA thesis work made from the research I participate in, *unless I elect not to receive feedback.*

13. Any further questions that I might have regarding the research, or my participation will be answered by Dr Duane D. Booysen who can be contacted at d.booysen@ru.ac.za or 0466038507.

14. By signing this informed consent declaration, I am not waiving any legal claims, rights or remedies.

15. I **agree/disagree** with the Researcher's request to voice record my comments and opinions during interviews, the purpose of which is to ensure the accurate recording of my views. The environment of my choosing where the interview will take place will also be taken into consideration in the research results for further analysis in this research project. Furthermore, I have the right to request a copy of interview transcriptions to confirm that my opinions are accurately recorded.

16. A copy of this informed consent declaration will be given to me, and the original will be kept on record by the researcher.

I, ……., have read the above information / confirm that the above information has been explained to me in a language that I understand and I am aware of this document's contents. I have asked all the questions that I wished to ask and these have been answered to my satisfaction. I fully understand what is expected of me during the research.

I have not been pressurised in any way and I voluntarily agree to participate in the abovementioned project.

……. …….

Participant's signature **Date**

APPENDIX E: INTERVIEW GUIDE

Draft Interview Guide – Patients

Interview Orientation

My name is _Siphelele Zwane_____ and I am a researcher/student researcher at Rhodes University working on the Public Mental Health project.

Before we begin, I would like to take a minute to explain why I am inviting you to participate in this interview today and what I will be doing with the information you provide to me. Please stop me at any time if you have any questions. After I've told you a bit more about this interview, you can decide whether or not you would like to participate.

We are conducting interviews with managers in the Makana Municipality. The purpose of this interview is to help us understand your experience and perceptions of accessing mental health services at a primary care level. I am interested in hearing about the things that you consider important regarding mental healthcare, service provision, and primary care level services and also any particular ways you think mental healthcare could have been improved. There are no right or wrong answers.

Participation is purely voluntary. If you agree to participate in this interview, you will be asked questions related to your experiences in the public mental health services in Makana. We will NOT ask you any questions about your personal life or health related conditions, rather, we are only interested in your experiences and perceptions of mental health service provision in Makana. The interview should take approximately 30-45 minutes and will be audio taped so that we do not miss anything that you have to say.

If at any time and for any reason, you would prefer not to answer any questions, please feel free not to answer. If at any time you would like to stop participating, please tell me. We can take a break, stop and continue at a later date, or stop altogether. You will not be penalized in any way for deciding to stop participation at any time.

Any information you provide will be handled in a confidential manner. Only people working on this study will use the interview recordings. We will take steps to ensure your answers stay confidential. Your name will not appear on any of the transcripts. The interview transcript will be labelled only with a project ID number and any personal references that would identify any individuals will be removed.

We may be required to break confidentiality if we believe that there is a risk of harm to yourself or someone else (for example, you may harm yourself, someone else, or someone is harming you, or in cases of child or elder abuse). This means that we may be required to inform the authorities to protect you or others. As with any research study, there may be other risks that are unforeseeable at this time. As mentioned before, if at any time you would like to stop participating, please tell me. We can take a break, stop, and continue at a later date, or stop altogether.

Draft Questions

1. Can you briefly introduce yourself; tell me about your background?

(Prompt: Residential context? Accessing service? Employment? Education?)

I would like to start with questions about the services at the clinic

2. What's your experience of the services you access at the clinic?

(Prompt: What services do you receive? How frequent? How long does it take? Any difficulties? Any positives? What would they like to have differently)?

I would like to start with questions about mental health

3. What is mental health?

(Prompt: For example: sadness, stress, worry, bizarre behaviour, etc. Also explore cultural idioms and understandings.)

4. What are the causes of mental health difficulties?

(Prompt: biological? Social? Cultural?)

5. How do you view persons who have mental health difficulties?

(Prompt: Do they know of persons living with mental health difficulties? What are their attitudes and beliefs? Stigma?)

6. Where could a person access support for mental healthcare?

(Prompt: Medical? Traditional? Social? Religious?)

7. Do persons with mental health difficulties experience any specific challenges? *(Prompt: For example: access to treatment, stigma, etc.)*

8. Is there a nee d for mental healthcare in your community?

(Prompt: If not, explore why? If yes, explore why?)

End